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	08/08/2024

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949 Based on observation, interview, and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for one (Resident #2) of four residents reviewed for quality of care. The facility failed ensure Resident #2 was assessed by a nurse after he was found on the ground in the dining room on [DATE]. He laid on the ground for over an hour and a half until family members arrived and assisted him to bed. There was no nursing documentation or incident report created by RN H. This failure resulted in an identification of an Immediate Jeopardy (IJ) on [DATE] at 5:22 PM. While the IJ was removed on [DATE] at 3:55 PM, the facility remained at a level of no actual harm at a scope of isolated that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk of not receiving necessary medical care, harm, and death. Findings included: Review of Resident #2's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including age-related physical debility, repeated falls, muscle wasting and atrophy (wasting away), and history of stroke and heart attack. Review of Resident #2's quarterly MDS assessment, dated [DATE], reflected a BIMS score of 00, which indicated his cognition was severely impaired. Section E (Behavior) reflected he had not had any physical or verbal behavioral symptoms directed toward others. Section GG (Functional Abilities and Goals) reflected he required substantial/maximal assistance with being able to sit to stand. J (Health Conditions) reflected he had not had any recent falls. Review of Resident #2's quarterly care plan, dated [DATE], reflected he was at risk for falls related to gait/balance problems and being unaware of safety needs and had actual falls on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE] with an intervention of monitoring/documenting/reporting for s/sx: pain, bruises, change in mental status, new onset: confusion, sleepiness, agitation. (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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #2's progress notes in his EMR, from [DATE], reflected no documentation about him being found on the floor in the dining room. Review off the facility's 24-hour report, dated [DATE], reflected no documentation regarding the incident in the evening of [DATE]. Review of Resident #2's vitals in his EMR, on [DATE] reflected the last time his blood pressure, o2 sats, respirations, and pulse were taken was in the morning of [DATE]. Review of Resident #2's progress note, dated [DATE] at 3:27 AM and documented by LVN I, reflected the following: CNA requested this nurse to check on [Resident #2]. Upon assessment, [Resident #2] noted with no signs of life. No apical pulse, no breath sounds, no BP. DNR on file and confirmed by 2 nurses. DON notified. Call placed to EMS to pronounce. Review of Resident #2's progress note, dated [DATE] at 3:55 AM and documented by LVN I, reflected the following: EMS arrived. EKG confirmed [Resident #2] deceased . Pronounced at 3:54 AM. Observation of a photograph of Resident #2, dated [DATE] at 7:34 PM and taken by CR J, revealed Resident #2 laying on his right side in the dining room next to his wheelchair. He was covered with a blanket. Observation of a photograph of Resident #2, dated [DATE] at 8:05 PM and taken by FM K, revealed Resident #2 laying on his back in the dining room next to his wheelchair. His eyes were slightly open and there was a small, darkened area above his left eye. Observation of video footage from the dining room on [DATE] revealed Resident #2 roll into the dining room in his wheelchair around 6:35 PM. Two aides were seen walking up to him and talking to him and then they walked away. Resident #2 rolled over to the left (and further from the viewpoint of the video camera) a few tables. Due to tables and chairs partially obstructing the view, it was hard to fully determine what happened next. It did appear that Resident #2 laid a sheet/blanket on the ground. No one is seen pushing him out of his wheelchair, but he either fell or laid on top of the sheet/blanket around 6:38 PM. It was unknown if he hit any part of his body on the way down. There were no staff members seen in the footage at that time. CNA M noticed him on the floor and went over to him. He then left the dining room to get RN H. RN H went to Resident #2 and bended slightly at the knees to speak to him. Due to the tables and chairs obstructing the view, no movement by Resident #2 was observed. RN H spent about two minutes with him and then left the dining room. He did not reappear in the footage until Resident #2's FM K and L arrived and transferred Resident #2 to his wheelchair. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on [DATE] at 10:31 AM, FM K stated she received a call from RN H around 7:35 PM notifying her that Resident #2 was on the ground and they were unable to get him up. She stated she and FM L arrived at the facility at 8:05 PM they found him on the ground in the dining room with no staff around. She stated RN H told them he was unable to get him up or assess him because he had been so combative. She stated FM L was able to get him into his wheelchair without anyone offering to assist. She stated he was not aggressive or combative at all. She stated RN H still did not assess him, he just messed with his catheter because there had been a kink in the tubing. She stated they pushed him to his room and got him into bed without any offer of assistance by staff. She stated she then noticed a small laceration above his left eye. She stated she had seen him earlier that day and it had not been there. She stated he had been more alert during the day and it worried her. She stated before she and FM L left the facility, RN H did not perform any kind of assessment. She stated just a few hours later around 4:00 AM she got a fall notifying her that Resident #2 had passed away. She stated it broke her heart to think he spent his last night laying on the cold, hard floor. During an interview on [DATE] at 10:52 AM, CR J stated he was having a hard time because his friend had passed away earlier that morning. He stated the night prior, [DATE], he was notified by another resident that Resident #2 was on the floor in the dining room. He stated he went to the dining room and brought a blanket for him. He stated he took a picture and waited for FM K and L to get there. He stated from 7:30 PM - 8:05 PM, no staff members checked on him. He stated when FM L assisted him to his wheelchair, he was not aggressive or combative. During an interview on [DATE] at 11:34 AM, RN H stated he was working the night before, [DATE]. He stated he did not see Resident #2 get out of the wheelchair but a CNA came and notified him that he was on the floor, but he could not remember what time it had been. He stated he did remember the residents had been done eating by that point and were not in the dining room. He stated he walked into the dining room and asked him what happened and Resident #2 told him to leave him alone. He stated he couldn't conduct an assessment and do neuro checks because he was being combative. He stated after about five minutes, he decided he could not force him to get up, but believed he was safe, and he would try a little later. He stated his plan was to hopefully let him calm down, give it time, and maybe he would want to get up. He stated he ended up not trying to assess him again. He stated he was not sure how much time went by until FM K and L arrived. He stated he explained to them right away that Resident #2 had put himself on the floor and would not let them (staff) do anything. He stated FM L was able to get him into the wheelchair, they talked to him for a bit, and put him to bed. He stated he was not combative towards them. He stated he did not do any neuro checks after they left because he would not let him. He stated as far as documentation and an incident report, he was guilty and he messed up. He stated he felt like he remembered notifying LVN I upon shift change. During a telephone interview on [DATE] at 2:41 PM, the NP stated she as notified yesterday evening ([DATE]) that Resident #2 either fell or laid himself on the ground. She stated she was told he would not let the staff get him up but the family was eventually able to do so. She stated she her expectations would be that once he was finally up, some kind of assessment be conducted, such as vitals, neuro checks, ensured he did not his head, range of motion, and a full-body skin check. She stated it would not be okay for a resident to be left on the ground for over an hour and a half. She stated if staff had been unable to get him up or assess him, she would assume they would have notified her and also have a staff member sit with him to monitor him. She stated she would also expect to see ample documentation regarding the incident along with an incident report. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on [DATE] at 2:47 PM, LVN I stated RN H did notify her that Resident #2 had put himself on the floor on the evening of [DATE]. She stated she was not told how long he was on the floor. She stated RN H told her he was unable to assess him because he was combative. She stated she was able to assess him because he was resting. During an interview on [DATE] at 3:58 PM, the DON stated her expectations, from the incident the night prior with Resident #2, would be that RN I assessed his behavior. She stated she knew the family came to visit almost every night and she was not sure if RN I was just waiting for them to get there to help intervene. She stated the NP had been working with the resident every day on his combativeness and agitation. She stated he had recently been started on Seroquel. She stated her expectation would be that the nurse conducted an assessment after the resident was gotten up. She stated RN I should have documented the incident in Resident #2's progress notes and should have created an incident report. She stated it was important to document thoroughly so everyone was on the same page with what was going on with the residents. Review of the facility's Fall Management System Policy, revised ,d+[DATE], reflected the following: It is the policy of this facility to provide each resident with appropriate assessments and interventions to prevent falls and to minimize complications if a fall occurs. . 3. When a resident sustains a fall, a physical assessment will be completed by a licensed nurse, with results documented in the medical record. Review of the facility's Incidents and Accidents Policy, reviewed ,d+[DATE], reflected the following: a. Render timely assistance. Do not move the victim until he/she has been examined for possible injuries; b. If possible, move the injured to the treatment room, or if it is a resident in his/her room, move the resident to his or her bed; and c. If assistance is needed, summon help. If you cannot leave the victim, ask someone to report to the nurses' station that help is needed; 2. Licensed nurse will assess the resident, including vital signs, neuro checks if needed, complaints of pain and location, and determine of treatment or additional care is needed, including accessing the EMS system. The ADM and DON were notified on [DATE] at 5:22 PM that an IJ had been identified and an IJ template was provided. The following POR was approved on [DATE] at 12:45 PM: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	F684: Quality of Care: The notification of Immediate Jeopardy states as follows: On [DATE], the facility failed to assess or assist Resident #1 after he transferred himself onto the floor and laid there for over an hour and a half without being checked on. The facility had no way of knowing if the resident had fallen or had hit his head and no monitoring took place. The facility failed to provide any documentation in Resident #1's chart or complete an incident report regarding this incident. Resident #1 passed away approximately eight hours later. 1. Medical Director was notified by DON of the IJ on [DATE] at 6:48 pm. 2. Incident reports from the last 7 days were audited to ensure assessment of resident was completed. An audit was completed on [DATE] by regional clinical resource team. 3. Licensed nursing staff were in-serviced regarding managing residents with combative behaviors on [DATE] by DON/designee. Full-time, PRN, contracted staff, or new licensed nurses will be in-serviced prior to their shift. 4. DON was in-serviced by clinical Resource and quiz completed on [DATE]. This training included: head to toe assessment of patients after a fall and initiation of neurological checks and completion of incident report. 5. Licensed Nurse involved was provided with 1:1 counseling regarding resident assessments and incident report documentation on [DATE] by ED. 6. In-servicing began on [DATE] for Licensed Nurses to include head to toe assessment of patients after a fall and initiation of neurological checks and completion of incident reports. Will be completed by [DATE] by DON or designee. Any Nurse who has not received the in-service will not be allowed to work until in-service has been completed. Any contracted staff, PRN or new licensed nurse will be in-serviced prior to their shift. In-service will be completed by DON/Designee. ED/DON or designee will review staffing schedule daily to ensure in-services are completed until reviewed by QAPI committee x 3 months and found to be in substantial compliance. 7. All licensed nursing staff will be in-serviced regarding the process of completing head-to-toe assessment after a fall and initiation of neurological checks upon hire, annually, and as needed by DON/designee starting on [DATE] and will be ongoing. 8. DON or Designee will monitor incidents and accidents daily during morning meeting to ensure completion of a head-to-toe assessment and initiation of neurological checks as needed. This practice will be ongoing. 9. Weekend Nursing supervisor will review incidents and accidents on Saturday and Sunday during the weekend to ensure completion of a head-to-toe assessment and the initiation of neurological checks. This will be reviewed through QAPI committee x 3 months to ensure substantial compliance. 10. Ad-hoc QAPI with IDT, medical director, and governing body representatives was completed on [DATE] to discuss findings of immediate jeopardy and POR; F684. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	11. Summary of IJ and corrective action results will be reviewed by QAPI Committee monthly x 3 months beginning [DATE] or until substantial compliance established to ensure ongoing compliance. The Surveyor monitored the POR on [DATE] as followed: During interviews conducted on [DATE] between 1:38 PM - 3:40 PM, two RNs and five LVNs from both shifts stated they were in-serviced on falls, assessments, and aggressive behaviors before they worked their most recent shifts. They all stated if a resident was found on the floor, they would treat it as an unwitnessed fall which included a head-to-toe assessment, ROM, and neuro checks would be initiated. All stated they would complete an incident report and would document thoroughly in the resident's chart. They stated they would report the fall to the DON, family, and NP immediately after assessing the resident. They all stated they would not get a resident off the ground until they were assessed because they needed to make sure they were not injured before moving them. They stated if they were combative/resisting, they would stay with the resident because anything could happen quickly especially if they possibly hit their head. They stated they would call another nurse for assistance and if they still could not get the resident to comply, they would contact the NP. They all stated documentation was imperative because if you did not document, it did not happen, and it was important for the following nurses to know the details of the incident. Review of the facility's Ad Hoc QAPI agenda, dated [DATE], reflected the MD, ADM, DON, CRN, two ADMs from sister facilities, two DONs from sister facilities, and two Regional Nurses were in attendance. Review of an Audit of Incident Reports, from [DATE] - [DATE] and conducted by the CRN, reflected all incident reports were reviewed to ensure residents had been assessed appropriately after their falls and the appropriate parties had been notified. Review of an in-service entitled Falls and Documentation, dated [DATE] and conducted by the CRN, reflected the ADM and DON were in-serviced on the following: If a fall occurs or patient observed on floor, Nurse should complete a full head to toe skin assessment, including ROM to ensure no injuries immediately, if fall is unwitnessed neuro checks should be started, if neuro checks are already being conducted from prior incident, then new neuro checks should be initiated. Neuro checks should also be initiated for witnessed falls if patient has injury to head. An incident report should be completed, a pain assessment and fall risk assessment, if skin injury occurs then a skin assessment should be completed as well. If patient refuses assessment, document and call MD/NP/RP immediately. Review of an in-service entitled Falls and Documentation, dated [DATE] - [DATE] and conducted by the CRN, reflected nurses from all shifts (Including RN H) were in-serviced on the following: If a fall occurs or patient observed on floor, Nurse should complete a full head to toe skin assessment, including ROM to ensure no injuries immediately, if fall is unwitnessed neuro checks should be started, if neuro checks are already being conducted from prior incident, then new neuro checks should be initiated. Neuro checks should also be initiated for witnessed falls if patient has injury to head. An incident report should be completed, a pain assessment and fall risk assessment, if skin injury occurs then a skin assessment should be completed as well. If patient refuses assessment, document and call MD/NP/RP immediately. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Post-Fall quizzes, dated [DATE] - [DATE], reflected all nurses took and passed a quiz on what to do after a resident had a fall. Review of an in-service entitled Managing Behaviors in Persons with Dementia, dated [DATE] - [DATE] and conducted by the CRN, reflected nurses from all shifts (including RN H) were in-serviced on different ways of managing/approaching/caring for residents with Dementia and/or behaviors. Review of Managing Behaviors in Persons with Dementia quizzes, dated [DATE] - [DATE], reflected all nurses took and passed a quiz on how to care for residents with aggressive behaviors. Review of a Counseling/Disciplinary Notice, dated [DATE], reflected RN H received a written warning for the following: [RN H] failed to conduct an assessment on a resident post-fall. [RN H] did not write a progress note nor an incident report. [RN H] will be counseled 1:1 on appropriate assessments and how to address residents with combative behaviors. The ADM and DON were notified on [DATE] at 3:55 that the IJ had been removed. While the IJ was removed on [DATE] at 3:55 PM, the facility remained at a level of no actual harm at a scope of isolated that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949 Based on interview and record review, the facility failed to ensure the residents environment remained as free of accident hazards as is possible and ensure each resident received adequate supervision for one (Resident #1) of three residents reviewed for accidents and hazards. The facility failed to ensure Resident #1 did not elope from the facility from an emergency exit door after CNA C utilized the exit code to the emergency door. LVN B observed the resident at a gas station after leaving work and did not stay with him until someone from the facility could assist. The temperature outside was a high of 95 degrees. He was later taken to the hospital where he tested positive for cocaine. This deficient practice placed residents at risk for unsafe elopements, falls, injuries, dehydration, and hospitalization . An Immediate Jeopardy (IJ) existed from 08/03/24 - 08/04/24. The IJ was determined to be at past noncompliance as the facility had implemented actions that corrected the deficient practice prior to the beginning of the investigation. This deficient practice placed residents at risk for unsafe elopements, falls, injuries, dehydration, and hospitalization . Findings included: Review of Resident #1's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including type II diabetes, pressure ulcers, schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves), acute kidney failure, and acquired absence of right leg below the knee. Review of Resident #1's admission MDS assessment, dated 05/19/24, reflected a BIMS of 9, indicating a moderate cognitive impairment. Section E (Behavior) reflected he had not exhibited any wandering behaviors. Section GG (Functional Abilities and Goals) reflected he utilized a wheelchair. Review of Resident #1's admission care plan, dated 06/21/24, reflected he was at risk for re-traumatization related to history of trauma and relocation stress syndrome or transfer trauma related to being homeless with an intervention of monitoring behavior episodes and attempting to determine the underlying cause. Review of Resident #1's Elopement/Wandering Evaluation, dated 06/16/24, reflected he was a low risk of elopement. Review of Resident #1's psychologist assessment, dated 06/21/24, reflected the following: [Resident #1] is new to this provider, introduced self as psychologist. Discussion focused on his desire to be outside of the facility. He reported I want to go out on pass . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's progress notes, dated 06/26/24 and documented by the DON, reflected the following: [Resident #1] began screaming that he wanted to be discharged . Review of Resident #1's psychologist assessment, dated 07/22/24, reflected the following: [Resident #1] approached provider in the common area. He as communicating a desire to understand how he can sign out of the facility. Review of Resident #1's progress notes, dated 08/03/24 at 4:11 PM and documented by the DON, reflected the following: Staff reported [Resident #1] left the facility and went to the store the staff verified that the resident was not in the facility . Review of Resident #1's progress notes, dated 08/03/24 at 6:09 PM and documented by the DON, reflected the following: Admin spoke with [Resident #1]'s [FM D] regarding the resident leaving. [FM D] reports that [Resident #1] frequents a store on (road), (store). Staff in route to location. Review of Resident #1's progress notes, dated 08/03/24 at 6:19 PM and documented by the DON, reflected the following: Notified NP of [Resident #1] leaving the facility. The NP reports the resident has a history of leaving previous facilities. Review of Resident #1's progress notes, dated 08/03/24 at 6:50 PM and documented by the DON, reflected the following: Clinical Resource found [Resident #1] at the store and the resident refusing to return to (facility). 911 was called per family request . Review of Resident #1's progress notes, dated 08/03/24 at 10:34 PM (late entry) and documented by LVN A, reflected the following: [LVN B] leaving work and noticed [Resident #1] at gas station next to facility. [LVN B] notified this writer [LVN B] stopped and spoke with [Resident #1] this notified ADON that [Resident #1] at gas station and that I was going to check on him when this writer arrived at gas station, [Resident #1] was not at location, returned to facility notified ADON and this writer and staff along with ADON started search throughout facility and surrounding facility after search this writer returned to gas station to research premises and bathroom at gas station drove around neighborhood to continue search then returned to facility to notify ADON, DON, and ADM. [sic] Review of Resident #1's ER records, dated 08/03/24, reflected the following: Acute Psychosis (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Found by EMS yelling at pedestrians, UDS positive for cocaine. - Likely 2/2 crack cocaine superimposed on schizophrenia. During an interview on 08/07/24 at 8:36 AM, the ADM and DON stated CNA C on the 300 hall left through the emergency door using the door code on 08/03/24. The ADM stated he was not sure how she got the code as only himself, the DON, and the MAINTD had the code. He stated this exit was to be used for emergencies only. He stated CNA C did not ensure the door was latched. He stated after staff realized Resident #1 was missing, he reviewed video footage and observed him leaving through the 300 hall door around 1:30 PM. The DON stated LVN B called LVN A around 2:30 PM and stated she saw Resident #1 at the gas station near the facility. The DON stated LVN A went to the gas station but he was no longer there. The ADM stated they had their clinical resources from other facilities assist with a search and he was found around 6 PM at a store his FM (D)'s suggestion. The ADM stated the Resident #1's FM (D) wanted him to be sent to the hospital for evaluation where cocaine was found in his system. The ADM stated although he had a history of leaving facilities AMA, he had a low elopement risk and had never voiced wanting to leave or exhibited exit-seeking behaviors. The DON stated the emergency exit door codes were changed monthly and she had conducted an in-service regarding the codes when she first started in May (2024) and had re-in-serviced staff starting on 08/03/24 and going forward. During an interview on 08/07/24 at 9:42 AM, CNA C stated Resident #1 had never voiced wanting to leave the facility or exhibited exit-seeking behaviors. She stated the day he left (08/03/24), she last saw him around lunchtime (12:00 PM) when she asked him if he wanted to eat in the dining room or in his room. She stated he ate in the dining room and she did not see him again before her shift ended. She stated around 1:40 PM, she needed to take trash and dirty laundry outside to get ready for the on-coming shift. She stated she could not remember how she got the code to the emergency exit doors. She stated she should have not utilized it but she was trying to get everything cleaned up quick and it was easier to dispose of her trash and laundry outside of the door. She stated she wished the door had closed quicker so he had not been able to leave. She stated she no longer had the code and she had been in-serviced on not utilizing emergency exit doors for any reason unless there was a true emergency. During an interview on 08/07/24 at 11:26 AM, the LSRD stated he was notified on 08/03/24 that the exit door codes had possibly been compromised and he notified the ADM immediately because he knew how to re-set the codes. He stated he knew the codes were re-set that day (08/03/24). He stated it was important for staff not to utilize emergency exit doors as they were for emergencies, such as fires, only. During a telephone interview on 08/07/24 at 2:49 PM, Resident #1's FM D stated she believed the facility was aware Resident #1 had a history of leaving facilities. She stated she made it very clear that while at the facility he was not to be outside of the facility alone. She stated the NP was very familiar with his history. She was very tearful and stated it was very upsetting to her that he was able to leave. She stated when she received the call that he was missing, her heart dropped. She stated he was still in the hospital and being treated for dehydration and high kidney levels. She stated he also had drugs in his system. She stated he would not be discharged until a facility with a locked unit had an available bed for him. (continued on next page)

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	08/08/2024

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.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 08/08/24 at 1:45 PM, the ADMC stated she had been in-serviced on exit door codes and elopement. She stated she did not know the codes for the emergency exit doors and only the ADM and MAINTD had the codes. She stated if they needed the code they could call them at any time, or just press on the bar for 15 seconds and the door would open. She stated the emergency exit doors were only for emergencies such as a fire. She stated if she saw a resident off-site, she would stay with the resident and call the ADM and/or DON immediately. She stated the only residents that could be outside alone were the ones not in the elopement binders which were located at the nurses' station and Receptionist's desk. During an interview on 08/08/24 at 1:52 PM, CNA E stated she was in-serviced on elopement procedures before her shift several days prior. She stated if there was an elopement or a resident missing, a code green should be called. She stated residents that were a high-elopement risk were in the elopement binders located at the nurses' station and Receptionist desk. She stated as a CNA it was important to lay her eyes on each of her residents at least every hour. She stated no door codes should be given out to any families, residents, or vendors. She stated she did not know the codes to the emergency exit doors and they should not be used except during an emergency. During an interview on 08/08/24 at 2:18 PM, the SW stated she had been in-serviced several days prior on the elopement process, how to determine which residents were at a higher risk, and their code status (code green was for elopement). She stated residents that were at a higher risk were in elopement binders located that the nurses' station and Receptionist desk. She stated there were also elopement assessments in their charts. She stated if a resident was missing, it was important to determine if they were out on pass. She stated if they still could not be located, she would notify the ADM and DON immediately. She stated if she saw a resident out in the community, she would stay with them and call the ADM/DON to ensure they got back to the facility safely. She stated she did not know the code to the emergency exit doors and only the ADM and MAINTD did, but if there were an emergency, the handle could always be pressed for 15 seconds until the door unlocked. During an interview on 08/08/24 at 2:31 PM, the ADON stated he was in-serviced on elopement. He was able to state where the elopement binders were located. He stated floor staff should be laying eyes on their residents at a minimum of every two hours. He stated if a resident could not be found, the ADM and DON should be notified immediately. He stated if he saw a resident out in the community, he would stay with them to make sure they were safe and would contact the ADM and DON. He stated he did not know the code to the emergency exit door and they should never be used except for emergencies. During an interview on 08/08/24 at 2:55 PM, LVN F stated she had been in-serviced on elopements several days ago. She stated there were elopement binders at the nurses' station and Receptionist desk which contained the residents that were at a high-risk of elopement. She stated elopement assessments were completed when they were admitted and she always asked if they had a history of it. She stated it was important to notice if a resident was continuing to go to the front door all the time to ensure they did not leave with a visitor going in/out. She stated she did not know the code to the emergency exit doors and those doors should only be utilized for an emergency. She stated if a resident was missing, code green would be called, which was their code for an elopement. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 08/08/24 at 3:04 PM, LVN G stated he was with agency but had been in-serviced on elopements prior to his shift that day. He stated residents that were a high-risk of elopement had behaviors such as wandering aimlessly. He stated there also was an elopement binder with residents at high risk at the nurses' station and the Receptionist desk. He stated if a resident could not be found he would call a code green. He stated he would then immediately notify the ADM and DON. He stated he did not know the code to the emergency exit doors and any other door cods were not to be given out to any residents, family members, or vendors. Review of an in-service, dated 05/02/24 and conducted by the DON, reflected all stat were in-serviced on the exit doors at the end of resident halls were for emergencies only and that the codes had been changed. Review of an in-service, dated 08/03/24 and conducted by the CRN, reflected the ADM and DON were in-serviced on their Elopement Policy. Review of the facility's IDT meeting notes, dated 08/03/24, reflected all residents' wandering/elopement assessments were reviewed and/or updated as necessary. Review of the facility's Ad Hoc QAPI meeting agenda, dated 08/04/24, reflected the ADM, DON, ADON, SW, MD, and CRN were in attendance. Review of an invoice from a door company, dated 08/04/24, reflected all doors were tested for working alarms/wander guard systems to ensure they were in working order. Review of a Counseling/Disciplinary Notice, dated 08/04/24, reflected CNA C received a written warning for the following: [CNA C] was counseled regarding improper use of emergency exit due to safety. [CNA C] used emergency exit door to take out trash after lunch. Review of a Counseling/Disciplinary Notice, dated 08/04/24, reflected LVN B received counseling/written warning for not staying with Resident #1 when she saw him at the gas station. Review of in-services, from 08/03/24 - 08/04/24, reflected all staff were in-serviced on emergency exits, reporting elopements, door codes, notifying the ADM/DON, and staying with a resident until help arrived if seen off the facility premises. Review of the facility census, from 08/03/24 - 08/07/24, reflected daily head counts were being conducted for all residents. Review of the facility's Elopement/Unsafe Wandering Policy, revised 01/2022, reflected the following: It is the policy of this facility to provide a safe environment for all residents through appropriate assessment and interventions to prevent accidents related to unsafe wandering or elopement. . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Elopement occurs when a resident leaves the facility premises or a safe area without authorization (i.e. an order for discharge, appointment, or leave of absence) and/or any necessary supervision to do so. An Immediate Jeopardy (IJ) existed from 08/03/24 - 08/04/24. The IJ was determined to be at past noncompliance as the facility had implemented actions that corrected the deficient practice prior to the beginning of the investigation.