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	11/18/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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 0580 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 interviews and record reviews, the facility failed to immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention for 1 (Resident #1) of 4 residents reviewed for notification of changes. The facility failed to ensure Resident #1's representative was notified after Resident #1 had an unwitnessed fall on 09/16/25. This failure could result in the family or representative not being aware of conditions that may require them to make medical decisions.Findings included: Review of Resident #1's face sheet printed 09/23/25 reflected an [AGE] year-old male admitted to the facility on [DATE] and discharged on 09/17/25. His diagnoses included unspecified dementia, hypertension (high blood pressure) congestive heart failure, and prostate (a gland below the bladder in males) cancer with metastasis (spread to other organs). Review of Resident #1's admission MDS assessment dated [DATE], Section C (Cognitive Patterns) reflected a BIMS score of 9, which indicated moderately impaired cognition. Section J (Health Conditions) reflected he had a fall in the month prior to admission. Review of Resident #1's care plan, initiated 09/12/25, reflected in part, Focus: Resident #1 is at risk for falls r/t hx of recurrent fall, unsteady gait, cognitive impairment. Goal: Will be free of falls through the review date. Interventions: Anticipate and meet needs, be sure the call light is within reach and encourage to use it to call for assistance as needed. Keep needed items in reach. Review of Resident #1's nursing progress note dated 09/16/25 at 5:46 PM by LVN A, reflected in part, Resident was observed on floor of resident's restroom. Resident stated that he was using the restroom and after standing up from the toilet, his legs became weak, and he fell to the floor. On-call NP notified. ADON made aware. Communication note placed in NP/MD binder. Facility fall protocol and neurochecks initiated. Review of Resident #1's nursing progress noted dated 09/17/25 at 12:21 PM by LVN B reflected in part, This nurse was notified by residents FM that resident was complaining of pain in left hip and left shoulder and was requesting pain medication or to go to the hospital. This nurse evaluated resident, found resident grimacing and guarding his left arm and left leg. During a telephone interview on 09/22/25 at 12:45 PM, Resident #1's FM stated they were notified of the 09/16/25 fall by Resident #1 when he called on the morning of 09/17/25 and described the fall, lying on the floor, and his pain. The FM stated she was the emergency contact and should have been notified on 09/16/25. The FM stated there were no missed calls and no messages on her phone from the facility. The FM stated when she contacted the facility on 09/17/25, and the nurse confirmed that the resident had fallen the day before. During an interview on 09/23/25 at 5:36 AM, LVN A stated she cared for Resident #1 on 09/16/25 when he had a fall. LVN A stated she was notified by a CNA that Resident #1 was on the floor. She stated she went to the room to assess the resident. LVN A stated Resident #1 had been using the toilet, stood up, was dizzy, and fell. LVN A stated Resident had a skin tear on his left hand, right arm by the elbow, and on his scalp. She stated she was not sure if the tear on the scalp was new because it was not bleeding. LVN A stated she assessed the resident, they got him up to a wheelchair, and then assisted him into bed. She stated she completed a full head-to-toe assessment. She stated the Resident #1 was able to extend his arms and move his legs. She stated, He had good range of motion in his legs. She stated the Resident #1 denied pain throughout the shift except when she cleaned the skin tear on the left elbow. She stated she notified the NP and the ADON. LVN A stated the resident was his own responsible party, so she did not contact a family member. During an interview on 09/23/25 at 10:07 AM, RN C described the assessments, documentation, and notifications that were made after a resident had a fall. She stated they had to notify a family member or other emergency contact, Even if the resident was responsible for their own finances. During an interview on 09/23/25 at 10:47 AM, the DON stated she assessed Resident #1 on 09/17/25. She stated she was spoke with the LVN A and provided education about family notification. She stated it did not meet her expectations that the family was not notified when Resident #1 fell. She stated the family had the right to know about any changes at all, including falls. The DON stated she was responsible to provide training, but the ADON and resource nurse also helped to train. She stated she had recently provided training on assessing after falls. During an interview on 09/23/25 at 11:18 AM, the ADON stated family was notified of any change such as a fall, a skin tear, a medication does increase. She stated if the family was not informed of a change or event, the family may think the facility was trying to hide something. During an interview on 09/24/25 at 1:20 PM, the ADM stated when there was a fall, he expected