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	03/31/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights for 1 of 25 (Resident #1) residents reviewed for care plans. The facility failed to ensure an assessment was conducted for risk of entrapment and that the use of bed rails was added to the care plan for Resident #1 prior to installation. She became entrapped in the bed rails on [DATE] and found deceased with her head and neck between the rails and her mattress. The noncompliance was identified as Past Noncompliance. The non-compliance began on [DATE] and ended on [DATE]. The facility had corrected the noncompliance before the survey began. This failure placed residents at risk of injury or death from entrapment in bed rails.Findings included: Review of the undated face sheet for Resident #1 reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included fracture of base of neck of left femur (broken hip bone), severe dementia, repeated falls, cognitive communication deficit (trouble communicating due to cognitive impairment, and need for assistance with personal care. Review of the admission MDS for Resident #1 dated [DATE] reflected a BIMS score of 03, indicating severe cognitive impairment. It reflected she required substantial staff assistance with bed mobility and was completely dependent on staff to transfer from bed to chair. Review of the care plan for Resident #1 dated [DATE] reflected the following: Focus: ADL Self Care Performance Deficit r/t UNSPECIFIED DEMENTIA.Goal: Will safely perform daily ADL's with staff assistance and/or supervision through the review date.Interventions: BED MOBILITY(ROLL LEFT AND RIGHT, SIT TO LYING, LYINGTO SITTING ON SIDE OF BED): Requires x1 staff participation to reposition and turn in bed. Encourage to participate to the fullest extent possible with each interaction. The care plan reflected no mention of bed rails or the risk of entrapment. Review of the miscellaneous documents for Resident #1 reflected a bed rail consent form signed and by Resident #1's FM and dated [DATE] with the following information: I (FM), representative for (Resident #1) have been fully informed of the potential dangers in the usage of the bedside rails. Possible dangers include:1. Suffocation:a period due to being caught between bed rail and side mattressb. Due to being caught in triangular space created by the white angle between bedside rail and headboard with mattress curve.2. Bedside rail land in bed in trapa. Insertion of head between widely spaced to vertical bars in the bedside rails.b. Insertion of body between mattress and bedside rail.3. Bedside rail and off bed entrapmenta. Sliding either on abdomen or back through space between upper and lower rails, becoming lodged in the space.4. Increased potential of injury due to fall from calling over the top of the bedside rails or out the end of bed over the footboard.Each of these situations stated above have been known to cause injury and/or even death.Having been informed, I consent to the use of bedside rails as follows:Check one:Upper bed side rails used only. Review of the assessments for Resident #1 from [DATE] to [DATE] reflected no assessment for bed rail safety. Review of the physician orders for Resident #1 from [DATE] to [DATE] reflected no order for bed rails. Review of a death in facility MDS for Resident #1 dated [DATE] reflected that she was discharged from the facility on [DATE] for the reason of deceased . Review of a facility self-reported incident dated (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE] reflected the following: (CNA H) observed patient (Resident #1) on the floor and reported her position to (LVN A). Upon assessment, (LVN A) observed the patient seated on the floor on the right side of the bed, off the mattress, with her head resting between the side rail and the bed mattress. The patient was unresponsive; CPR was initiated. EMS arrived onsite and assumed care. The patient was pronounced deceased . Review of a written statement from LVN A on [DATE] reflected: Approximately 5 AM CNA came out of room and reported that (Resident #1) was on floor. Upon entering room, this writer observed resident lying on floor on right side of bed. This nurse observed resident body position in a sitting position on right side of bed with head resting between side rail and bed mattress. This nurse immediately called for help and CPR was initiated after resident was placed on floor in position to perform CPR. EMS was notified immediately. Review of a written statement from CNA H on [DATE] reflected the following: ADM interviewed CNA to discuss incident on 3/29. He stated he made a round at approximately 2 AM and patient was observed resting calmly. He rounded again close to 5 AM and observed the patient partially out of bed with her head pinned between the assist bar and the mattress, he notified LVN charge nurse and CPR was initiated. During an interview on [DATE] at 10:18 AM, the county ME stated her understanding was that Resident #1 was found with her head and neck wedged between the mattress and the bed rails. She stated the ME office's investigator went to the scene, but Resident #1 had already been moved when the staff and EMS gave her CPR. The ME stated she found bruising and abrasions around Resident #1's neck and jawline during the autopsy and two spots of hemorrhaging in the neck muscle. She stated these injuries were consistent with being trapped between the mattress and the bed rails. She stated she would not be able to make a final determination of cause of death until all the pathology results came back, but it was likely that she would determine the cause of death to be strangulation on the bed rails or asphyxiation on the mattress. During an interview on [DATE] at 10:36 AM, a FM for Resident #1 stated he received a call from the ADM on Sunday morning [DATE] very early, probably before 06:00 AM. He stated the ADM said he was sorry about what had happened and notified him that Resident #1 had become entangled in the bed frame, and they were unable to revive her. He stated the police officer at the scene told him something about the scene did not look right but he did not specify. The FM stated he spoke to the ME investigator and got her card but was told he would not know the outcome of the autopsy for several weeks. He stated he had signed a consent for bed rails when Resident #1 first admitted to the facility, but she had not had any bed rails on her bed at that time. An attempt was made to interview LVN A by phone on [DATE] at 12:18 PM. A voicemail was left but not returned as of [DATE]. Observation on [DATE] at 12:43 PM revealed Resident #1's room was empty and her bed had a sign on it with the words DO NOT USE printed five times. The 1/3 bed rails were the same make and model as the bed frame, and a low air loss mattress was on the bed frame. The rails were not loose or ill-fitting, and there was very little space between the mattress and the rails. However, the mattress could be compressed so much due to being an air mattress, that significant space could be made between the mattress and the rails. During an interview on [DATE] at 12:48 PM, the MAINT stated he thought he had installed the bed rails on Resident #1's bed about two weeks ago, but he was not sure and did not have the date documented anywhere. He stated he was told to install the rails by a charge nurse, but he did not remember who. He stated he received a work order for a low air loss mattress for Resident #1 on [DATE], and he thought the bed rail installation might have been around that time, but he was not sure. The MAINT stated the normal procedure for adding bed rails was they got the consent from the resident or responsible party, the resident was assessed by therapy and the rest of the clinical team, and then a physician order for the bed rails, and then he got a work order. He stated in the case of Resident #1's bed rails, he had not thought it had occurred differently than normal. He stated he had thought all the clinical steps had been accomplished by the time the nurse asked him to install the bed rails. He stated he ensured bed rails were installed safely by checking the policy and the manufacturer's instructions. He stated there was a maximum allowable distance between the rails and the mattress, depending on the manufacturer, and he measured every (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	time he installed them. He stated there was also a maximum weight capacity, but not a minimum. He stated Resident #1 was not at all overweight and did not come close to the maximum capacity. He stated he checked all bed rails in the facility monthly during a walk through. He stated the potential negative outcome of the bed rail policy and procedure not being followed was injury and ultimately even death could happen. He stated after Resident #1's death, he was in-serviced on making sure the process went as it should. He now had to receive instructions to install bed rails directly from the IDT (DONs, ADON, DOR, SW) and there was a specific work order he would receive only if the IDT made the request. He stated he was made aware that he could no longer install bed rails based on word-of-mouth requests. He stated he also received the facility policy on bed rails and a facility policy on abuse/neglect/exploitation and took a quiz indicating knowledge of those topics. During an interview on [DATE] at 01:22 PM, the DON stated she had worked at the facility for eight months. She stated the procedure that should have happened before bed rails were installed was there should have been an assessment for safety from entrapment and to make sure that the bed rails would only be for bed mobility and not to prevent falls. She stated the facility did not use bed rails to prevent falls. She stated the facility had revamped their process for installing bed rails. She stated the first step in the change was to ensure the bed did not have rails installed when it was made ready for a new resident. She stated the process for approving bed rails would be exclusively for the IDT from here on out and would never be done at the level of the charge nurse. She stated the process did not happen as it should for Resident #1's bed rails. She stated the risk of entrapment assessment was not conducted, there was no physician order, and the bed rails focus was not added to Resident #1's care plan. She stated the IDT, which included nursing, therapy, and maintenance, should have met and done the assessment and obtained a physician order. She stated part of the procedure was to attempt alternatives to bed rails prior to installation, and they did not attempt other alternatives. She stated the rails were for bed mobility, though, so there would not be other appropriate alternatives. She stated after investigating, she thought the bed rails were installed entirely because they were requested by Resident #1's responsible party. The DON stated she did not know exactly what the facility policy said about bed rails, though she did read it. She stated she had been so shaken by what had occurred that she did not remember exactly what the policy stated. She stated her regional leadership had not asked why the failure to utilize the process occurred. The DON stated the first intervention was to start the process from admission by ensuring there were no bed rails on the bed at admission. She stated she in-serviced the nurses on never allowing a new resident to get in a bed with bed rails in it until they got the go ahead from the IDT. The CNAs were also in-serviced, and everyone knew that bed rails were never placed on a resident bed until there was informed consent, an assessment, a physician order, and a care plan item. She stated the issue had been added to the facility QAPI, and they would be monitoring it for several months before it the QAPI concluded their monitoring period. She stated she received in-servicing about the correct procedure from her corporate clinical supervisor. During an interview on [DATE] at 01:45 PM, the ADM stated he had been called at 05:25 AM on [DATE] to be notified that Resident #1 had become entangled in the bed rails and had expired. The ADM stated the facility was full of police officers when he arrived. He stated the police were not accusing anyone of anything, but the medical examiner investigator came out, and he understood they decided to perform an autopsy. He stated they did not know how she passed, but the way they described how she was found, he thought it was possible she was strangled on her bedrails or was trapped and asphyxiated. He stated to his knowledge, Resident #1 did not have an assessment for risk of entrapment, a physician order, or a care plan item for bed rails. He stated after Resident #1's death, they did a full sweep of all residents, auditing to ensure that if they had bed rails, they had all the required elements in place. He stated during the audit, he was not sure how many residents were identified who had bed rails and did not have an assessment for risk of entrapment. The ADM stated he could not say why the procedure did not happen the way it was supposed to, but it was the DON's and his responsibility to ensure it did. He stated he was (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	re-educated by his corporate leadership on the correct procedure for installing bed rails, and they added the failure to their QAPI to ensure it never happened again. He stated he and his DONs had in-serviced everyone at the facility and had procedures in place on their performance improvement plan to address new hires and newly admitted residents. An attempt was made on [DATE] at 02:27 PM to interview CNA H. A voicemail was left but contact was not returned as of [DATE]. Review of facility policy titled Bed Rails and revised [DATE], reflected the following: PolicyIt is the policy of this facility to attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails.DefinitionsEntrapment is an event in which a resident is caught, trapped, or entangled in the space in or about the bed rail.Bed rails are adjustable metal or rigid plastic bars that attached to the bed. They are available in a variety of types, shapes, and sizes ranging from full to 1/2, 1/4, or 1/8 length. Also, some bed rails are not designed as part of the bed by the manufacturer and may be installed on or used along the side of a bed. Examples of bed rails include, but are not limited to:-Side rails, bedside rails, and safety rails; and-Grab bars and assist bars.Procedure:After the facility has attempted alternatives to bed rails and determined that these alternatives failed to meet the residents assessed needs, the facility interdisciplinary team. IDT will assess the resident for risks of entrapment. The risks and benefits regarding the use of bed rails will be considered for each resident.If the use of bed rails is recommended by the IDT, the facility must obtain informed consent from the resident, or if applicable, the resident representative for the use of bed rails prior to installation or use.The facility should maintain evidence that it has provided sufficient information prior to installation so that the resident or resident representative could make an informed decision. Information that the facility must provide to the resident, or resident representative includes, but are not limited to:Before bed rails are installed or used, the facility should: a. Check with the manufacturers or review manufacturer use requirements to verify the bed rails mattress and bed frame are compatible, as in many instances, bed rails and mattresses are or maybe purchased separate separately from the bedframe. Bed rail should be selected and placed to discouraged climbing over the rails to get in and out of bed, which may result in falling over bed rails.when installing and using bed rails, the facility shall: a. Ensure that the bed dimensions are appropriate to accommodate the size (Height and weight) Of the resident. b. Verify the bed rails to be installed are appropriate for the size and weight of the resident using the bed. c. Install bed rails using the manufacturers instructions and specifications to ensure a proper fit and safe spacing.Update the resident care plan as needed related to the identified and/or ongoing need or resident choice for the use of bed rails. a. If the IDT determines bed rails are no longer needed or appropriate for resident use, discontinue the use of bed rails. Review of an undated QAPI binder related to Resident #1's death reflected the following documents. Review of a QAPI meeting sign-in sheet dated [DATE] reflected the following attendees: physician by phone, DON, ADM, ADON, MDS nurse, treatment nurse, marketing/admissions, dietary, maintenance, social services, human resources, rehab, rehabilitation, business office, and two clinical resource nurses Review of an undated root cause analysis reflected the following Problem IdentificationThe QIT identified deficiencies related to assessment completion, provider, orders, and care planning processes that placed the facility below benchmark expectations.Assessment route causesAssessments are not consistently updated following changes and condition. Risk assessments may lack sufficient detail or are not completed timely limiting early identification of resident risk and intervention.Orders root causeProvider orders are not always obtained or updated promptly upon following assessment findings. Communication delays between nursing staff and provide providers contribute to gaps between assessment findings and corresponding orders.Care planning root causesCare plans are not consistently revised to reflect updated assessments or new provider orders, resulting in interventions being implemented in practice, but not always clearly reflected or individualized in the care plan.Contributing FactorsWorkflow pressures, staffing turnover, competing clinical priorities, and limited interdisciplinary communication (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was an enhanced policy and procedure in which only the IDT could decide on bed rails. She stated when she returned to work on Monday [DATE], the facility had removed all the bed rails and was conducting new assessments, adding focus areas to care plans, and making sure there were orders for every set of bed rails used. She stated she was in-serviced on the new procedure before she started working on Monday morning [DATE] as well as on bed rail safety and LAL mattresses. She stated she had heard about Resident #1's death but did not know very much about it, as that occurred on a hall where she did not work.During an interview on [DATE] at 12:04 PM, LVN C stated he worked 6 AM to 6 PM and always worked on the hall where Resident #1 had lived. He stated he had been retrained on the process of resident bed rails. He stated the first issue was that the purpose for bed rails should only be for repositioning and not fall prevention. He stated Resident #1 had dementia, but she was able to use her bed rails to assist with her brief changes and changing her clothing. He stated the next step in the procedure was to notify the IDT and they would get consent from the family and notify the resident or responsible party about the risks and benefits of bed rails. He stated after that, a safety evaluation was done and then a physician order obtained. He stated finally the bed rails would go into the care plan. He stated there was a consent for bed rails included in the resident admission packet, so they got that signed for almost every resident. LVN C stated there was nothing about Resident #1 and her bed that made him concerned about risk of entrapment.During an interview on [DATE] at 12:19 PM, LVN D stated she usually worked the 6 PM to 6 AM shift. She stated she had been in serviced on the new policy and procedure for bed rails. She stated that the new policy and procedure was what usually happened but sometimes the charge nurses took it upon themselves to get bed rails for residents. She stated that they could do the assessment themselves before, and that they could ask for a physician order, but now everything had to go through the IDT. She stated she was also asked to check on residents with bed rails every two hours and make sure that the bed rails and air mattresses were safe.During an interview on [DATE] at 12:20 PM, LVN E stated she worked the 6 AM to 6 PM shift at the facility. She stated she had participated in a review of every single resident in the facility, but she had only reviewed residents on her hall. She had gone through and written down if they had bed rails, and then she checked to see if they had a consent, an assessment, an order, and that bed rails were in the resident care plans. She stated that she cannot remember if any of the residents she looked at did not have bed rail safety assessments in place. She stated from now on only the IDT could determine if a resident can use bed rails. She stated if a resident or responsible party wanted bed rails, she had to let the DON know and that would start the process. During an interview on [DATE] at 12:23 PM, LVN F stated she worked the 6 PM to 6 AM shift regularly. She stated she had been off work and has not been back to work since [DATE], but she got a phone call informing her of the new process. She stated that if a resident was going to have bed rails, they needed to notify somebody on the management team like the director of rehab or the DON. She stated what happened from there was that the IDT gets consent and a physician order, does an assessment, and then added bed rails to the care plan. They were told to make sure to review all the care plans from the list of residents who had bed rails in case there were any interventions they did not know about. They also had an abuse and neglect in-service, but they have those once a month and she was very familiar with the process. They had in-services on bed rail safety and LAL mattresses. She stated when she had to have an in-service, the DON or ADON came in on her shift- usually at the end of the shift, but sometimes at the beginning.During an interview on [DATE] at 12:27 PM LVN G stated she worked the 6 PM to 6 AM shift at the facility. She stated that there was a death related to bed rails, and so the facility had gone over the entire policy and procedure and retrained everybody on a new policy and procedure. She stated that if the resident or their family wanted bed rails, or if she as a nurse thought a resident could benefit from bed rails, they had to either put a note in the 24 hour logbook or report directly to somebody on the IDT, which included the DON, ADONs, Director of rehab and maybe some other people. She stated the IDT took it from there. She stated they were supposed to be rounding on residents every two hours anyway, but they were reminded to look at the bed rails (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	every time they rounded and make sure they were safe. She stated she had not seen or encountered anything that concerned her about bed rails in the facility. During an interview on [DATE] at 12:30 PM CNA J stated he worked the 10 PM to 6 AM shift at the facility. He stated he had never seen any problem bed rails. He stated he took care of Resident #1 sometimes and he did not notice anything unsafe. He stated the procedure for allowing bed rails happened above his level, but he was still trained on the process and now he knows that he could not just ask for bed rails for a resident. He stated they can only have bed rails if they were doing it to help move in bed. He stated they were supposed to check on the residents with bed rails and make sure to notice if there are any problems or anything unsafe happening. He stated they were supposed to report to their charge nurse if they see anything that looks unsafe. He has never seen anything like that.During an interview on [DATE] at 12:35 PM CNA K stated she worked the 6 AM to 2 PM shift at the facility. She stated she had to look out for bed rails and air mattresses because the resident can get stuck in there and be hurt. She stated the bed rails should be in the care plan and she looked at care plan sometimes, especially on the point of care system. She stated she always had to notice if the resident was being hurt by the rails, like skin, tears or other injuries or if the resident ever got stuck in the bed rails. She stated that she got some training about bed rails over the last two days and about abuse and neglect prevention and reporting. During an interview on [DATE] at 12:40 PM CNA L stated she worked the 2 PM to 10 PM shift at the facility. She stated bed rails were usually really helpful for residents and staff. She stated they got trained when she came to work yesterday about checking resident bed rails and checking air mattresses and making sure that nothing got stuck. She said they were also trained on rounding every two hours and on abuse and neglect.During an interview on [DATE] at 12:45 PM CNA M stated she worked the 10 PM to 6 AM shift at the facility and worked on the hall where Resident #1 had lived. She stated she had been at the facility the night Resident #1 was found but was not assigned Resident #1 that night. She stated after she came back to work, she had a lot of in-services about bed rails, mattresses, safety, and abuse and neglect. She stated residents were not supposed to have bed rails without an order. She stated they had to check for safety and if they saw anything with residents that was not safe, they had to report it immediately. She stated that was important to the overnight shift, because that was when residents were in bed the most and sleeping.Observation on [DATE] from 02:30 PM to 03:30 PM revealed Residents #2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, and 27 had properly fitted bed rails on 1/3 the length of their beds, and the bed rails were the same make and model as the beds. There were no hazards identified with the bedrails. During these observations, Residents # 2, 3, 4, 5, 8, 10, 13, 14, 15, 16, 20, 21, 22, 24, and 25 were observed in the beds with bed rails, and no obvious hazardous situation was observed for any resident.The noncompliance was identified as Past Noncompliance. The non-compliance began on [DATE] and ended on [DATE]. The facility had corrected the noncompliance before the survey began.

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	03/31/2026

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

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to attempt to use appropriate alternatives prior to installing a side or bed rail or to ensure correct installation, use, and maintenance of bed rails for 1 of 25 residents (Resident #1) reviewed for bed rails. The facility failed to ensure an assessment was conducted for risk of entrapment and that the use of bed rails was added to the care plan for Resident #1prior to installation. Resident #1 became entrapped in her bed rails on [DATE] and found deceased with her head and neck between the rails and her mattress. The noncompliance was identified as Past Noncompliance. The IJ began on [DATE] and ended on [DATE]. The facility had corrected the noncompliance before the survey began. This failure placed residents at risk of injury or death from entrapment in bed rails.Findings included: Review of the undated face sheet for Resident #1 reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included fracture of base of neck of left femur (broken hip bone), severe dementia, repeated falls, cognitive communication deficit (trouble communicating due to cognitive impairment, and need for assistance with personal care. Review of the admission MDS for Resident #1 dated [DATE] reflected a BIMS score of 03, indicating severe cognitive impairment. It reflected she required substantial staff assistance with bed mobility and was completely dependent on staff to transfer from bed to chair. Review of the care plan for Resident #1 dated [DATE] reflected the following: Focus: ADL Self Care Performance Deficit r/t UNSPECIFIED DEMENTIA.Goal: Will safely perform daily ADL's with staff assistance and/or supervision through the review date.Interventions: BED MOBILITY(ROLL LEFT AND RIGHT, SIT TO LYING, LYINGTO SITTING ON SIDE OF BED): Requires x1 staff participation to reposition and turn in bed. Encourage to participate to the fullest extent possible with each interaction. The care plan reflected no mention of bed rails or the risk of entrapment. Review of the miscellaneous documents for Resident #1 reflected a bed rail consent form signed and by Resident #1's FM and dated [DATE] with the following information: I (FM), representative for (Resident #1) have been fully informed of the potential dangers in the usage of the bedside rails. Possible dangers include:1. Suffocation:a period due to being caught between bed rail and side mattressb. Due to being caught in triangular space created by the white angle between bedside rail and headboard with mattress curve.2. Bedside rail land in bed in trapa. Insertion of head between widely spaced to vertical bars in the bedside rails.b. Insertion of body between mattress and bedside rail.3. Bedside rail and off bed entrapmenta. Sliding either on abdomen or back through space between upper and lower rails, becoming lodged in the space.4. Increased potential of injury due to fall from calling over the top of the bedside rails or out the end of bed over the footboard.Each of these situations stated above have been known to cause injury and/or even death.Having been informed, I consent to the use of bedside rails as follows:Check one:Upper bed side rails used only. Review of the assessments for Resident #1 from [DATE] to [DATE] reflected no assessment for bed rail safety. Review of the physician orders for Resident #1 from [DATE] to [DATE] reflected no order for bed rails. Review of a death in facility MDS for Resident #1 dated [DATE] reflected that she was discharged from the facility on [DATE] for the reason of deceased . Review of a facility self-reported incident dated [DATE] reflected the following: (CNA H) observed patient (Resident #1) on the floor and reported her position to (LVN A). Upon assessment, (LVN A) observed the patient seated on the floor on the right side of the bed, off the mattress, with her head resting between the side rail and the bed mattress. The patient was unresponsive; CPR was initiated. EMS arrived onsite and assumed care. The patient was pronounced deceased . Review of a written statement from LVN A on [DATE] reflected: Approximately 5 AM CNA came out of room and reported that (Resident #1) was on floor. Upon entering room, this writer observed resident lying on floor on right side of bed. This nurse observed (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	resident body position in a sitting position on right side of bed with head resting between side rail and bed mattress. This nurse immediately called for help and CPR was initiated after resident was placed on floor in position to perform CPR. EMS was notified immediately. Review of a written statement from CNA H on [DATE] reflected the following: ADM interviewed CNA to discuss incident on 3/29. He stated he made a round at approximately 2 AM and patient was observed resting calmly. He rounded again close to 5 AM and observed the patient partially out of bed with her head pinned between the assist bar and the mattress, he notified LVN charge nurse and CPR was initiated. During an interview on [DATE] at 10:18 AM, the county ME stated her understanding was that Resident #1 was found with her head and neck wedged between the mattress and the bed rails. She stated the ME office's investigator went to the scene, but Resident #1 had already been moved when the staff and EMS gave her CPR. The ME stated she found bruising and abrasions around Resident #1's neck and jawline during the autopsy and two spots of hemorrhaging in the neck muscle. She stated these injuries were consistent with being trapped between the mattress and the bed rails. She stated she would not be able to make a final determination of cause of death until all the pathology results came back, but it was likely that she would determine the cause of death to be strangulation on the bed rails or asphyxiation on the mattress. During an interview on [DATE] at 10:36 AM, a FM for Resident #1 stated he received a call from the ADM on Sunday morning [DATE] very early, probably before 06:00 AM. He stated the ADM said he was sorry about what had happened and notified him that Resident #1 had become entangled in the bed frame, and they were unable to revive her. He stated the police officer at the scene told him something about the scene did not look right but he did not specify. The FM stated he spoke to the ME investigator and got her card but was told he would not know the outcome of the autopsy for several weeks. He stated he had signed a consent for bed rails when Resident #1 first admitted to the facility, but she had not had any bed rails on her bed at that time. An attempt was made to interview LVN A by phone on [DATE] at 12:18 PM. A voicemail was left but not returned as of [DATE]. Observation on [DATE] at 12:43 PM revealed Resident #1's room was empty and her bed had a sign on it with the words DO NOT USE printed five times. The 1/3 bed rails were the same make and model as the bed frame, and a low air loss mattress was on the bed frame. The rails were not loose or ill-fitting, and there was very little space between the mattress and the rails. However, the mattress could be compressed so much due to being an air mattress, that significant space could be made between the mattress and the rails. During an interview on [DATE] at 12:48 PM, the MAINT stated he thought he had installed the bed rails on Resident #1's bed about two weeks ago, but he was not sure and did not have the date documented anywhere. He stated he was told to install the rails by a charge nurse, but he did not remember who. He stated he received a work order for a low air loss mattress for Resident #1 on [DATE], and he thought the bed rail installation might have been around that time, but he was not sure. The MAINT stated the normal procedure for adding bed rails was they got the consent from the resident or responsible party, the resident was assessed by therapy and the rest of the clinical team, and then a physician order for the bed rails, and then he got a work order. He stated in the case of Resident #1's bed rails, he had not thought it had occurred differently than normal. He stated he had thought all the clinical steps had been accomplished by the time the nurse asked him to install the bed rails. He stated he ensured bed rails were installed safely by checking the policy and the manufacturer's instructions. He stated there was a maximum allowable distance between the rails and the mattress, depending on the manufacturer, and he measured every time he installed them. He stated there was also a maximum weight capacity, but not a minimum. He stated Resident #1 was not at all overweight and did not come close to the maximum capacity. He stated he checked all bed rails in the facility monthly during a walk through. He stated the potential negative outcome of the bed rail policy and procedure not being followed was injury and ultimately even death could happen. He stated after Resident #1's death, he was in-serviced on making sure the process went as it should. He now had to receive instructions to install bed rails directly from the IDT (DONs, ADON, DOR, SW) and there was a specific work order he would receive only if the IDT made (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the request. He stated he was made aware that he could no longer install bed rails based on word-of-mouth requests. He stated he also received the facility policy on bed rails and a facility policy on abuse/neglect/exploitation and took a quiz indicating knowledge of those topics. During an interview on [DATE] at 01:22 PM, the DON stated she had worked at the facility for eight months. She stated the procedure that should have happened before bed rails were installed was there should have been an assessment for safety from entrapment and to make sure that the bed rails would only be for bed mobility and not to prevent falls. She stated the facility did not use bed rails to prevent falls. She stated the facility had revamped their process for installing bed rails. She stated the first step in the change was to ensure the bed did not have rails installed when it was made ready for a new resident. She stated the process for approving bed rails would be exclusively for the IDT from here on out and would never be done at the level of the charge nurse. She stated the process did not happen as it should for Resident #1's bed rails. She stated the risk of entrapment assessment was not conducted, there was no physician order, and the bed rails focus was not added to Resident #1's care plan. She stated the IDT, which included nursing, therapy, and maintenance, should have met and done the assessment and obtained a physician order. She stated part of the procedure was to attempt alternatives to bed rails prior to installation, and they did not attempt other alternatives. She stated the rails were for bed mobility, though, so there would not be other appropriate alternatives. She stated after investigating, she thought the bed rails were installed entirely because they were requested by Resident #1's responsible party. The DON stated she did not know exactly what the facility policy said about bed rails, though she did read it. She stated she had been so shaken by what had occurred that she did not remember exactly what the policy stated. She stated her regional leadership had not asked why the failure to utilize the process occurred. The DON stated the first intervention was to start the process from admission by ensuring there were no bed rails on the bed at admission. She stated she in-serviced the nurses on never allowing a new resident to get in a bed with bed rails in it until they got the go ahead from the IDT. The CNAs were also in-serviced, and everyone knew that bed rails were never placed on a resident bed until there was informed consent, an assessment, a physician order, and a care plan item. She stated the issue had been added to the facility QAPI, and they would be monitoring it for several months before it the QAPI concluded their monitoring period. She stated she received in-servicing about the correct procedure from her corporate clinical supervisor. During an interview on [DATE] at 01:45 PM, the ADM stated he had been called at 05:25 AM on [DATE] to be notified that Resident #1 had become entangled in the bed rails and had expired. The ADM stated the facility was full of police officers when he arrived. He stated the police were not accusing anyone of anything, but the medical examiner investigator came out, and he understood they decided to perform an autopsy. He stated they did not know how she passed, but the way they described how she was found, he thought it was possible she was strangled on her bedrails or was trapped and asphyxiated. He stated to his knowledge, Resident #1 did not have an assessment for risk of entrapment, a physician order, or a care plan item for bed rails. He stated after Resident #1's death, they did a full sweep of all residents, auditing to ensure that if they had bed rails, they had all the required elements in place. He stated during the audit, he was not sure how many residents were identified who had bed rails and did not have an assessment for risk of entrapment. The ADM stated he could not say why the procedure did not happen the way it was supposed to, but it was the DON's and his responsibility to ensure it did. He stated he was re-educated by his corporate leadership on the correct procedure for installing bed rails, and they added the failure to their QAPI to ensure it never happened again. He stated he and his DONs had in-serviced everyone at the facility and had procedures in place on their performance improvement plan to address new hires and newly admitted residents. An attempt was made on [DATE] at 02:27 PM to interview CNA H. A voicemail was left but contact was not returned as of [DATE]. Review of facility policy titled Bed Rails and revised [DATE], reflected the following: PolicyIt is the policy of this facility to attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails.DefinitionsEntrapment is an event in which a resident is caught, trapped, or entangled in the space in or about the bed rail.Bed rails are adjustable metal or rigid plastic bars that attached to the bed. They are available in a variety of types, shapes, and sizes ranging from full to 1/2, 1/4, or 1/8 length. Also, some bed rails are not designed as part of the bed by the manufacturer and may be installed on or used along the side of a bed. Examples of bed rails include, but are not limited to:-Side rails, bedside rails, and safety rails; and-Grab bars and assist bars.Procedure:After the facility has attempted alternatives to bed rails and determined that these alternatives failed to meet the residents assessed needs, the facility interdisciplinary team. IDT will assess the resident for risks of entrapment. The risks and benefits regarding the use of bed rails will be considered for each resident.If the use of bed rails is recommended by the IDT, the facility must obtain informed consent from the resident, or if applicable, the resident representative for the use of bed rails prior to installation or use.The facility should maintain evidence that it has provided sufficient information prior to installation so that the resident or resident representative could make an informed decision. Information that the facility must provide to the resident, or resident representative includes, but are not limited to:Before bed rails are installed or used, the facility should: a. Check with the manufacturers or review manufacturer use requirements to verify the bed rails mattress and bed frame are compatible, as in many instances, bed rails and mattresses are or maybe purchased separate separately from the bedframe. Bed rail should be selected and placed to discouraged climbing over the rails to get in and out of bed, which may result in falling over bed rails.when installing and using bed rails, the facility shall: a. Ensure that the bed dimensions are appropriate to accommodate the size (Height and weight) Of the resident. b. Verify the bed rails to be installed are appropriate for the size and weight of the resident using the bed. c. Install bed rails using the manufacturer's instructions and specifications to ensure a proper fit and safe spacing.Update the resident care plan as needed related to the identified and/or ongoing need or resident choice for the use of bed rails. a. If the IDT determines bed rails are no longer needed or appropriate for resident use, discontinue the use of bed rails. Review of an undated QAPI binder related to Resident #1's death reflected the following documents. Review of a QAPI meeting sign-in sheet dated [DATE] reflected the following attendees: physician by phone, DON, ADM, ADON, MDS nurse, treatment nurse, marketing/admissions, dietary, maintenance, social services, human resources, rehab, rehabilitation, business office, and two clinical resource nurses Review of an undated root cause analysis reflected the following Problem IdentificationThe QIT identified deficiencies related to assessment completion, provider, orders, and care planning processes that placed the facility below benchmark expectations.Assessment route causesAssessments are not consistently updated following changes and condition. Risk assessments may lack sufficient detail or are not completed timely limiting early identification of resident risk and intervention.Orders root causeProvider orders are not always obtained or updated promptly upon following assessment findings. Communication delays between nursing staff and provide providers contribute to gaps between assessment findings and corresponding orders.Care planning root causesCare plans are not consistently revised to reflect updated assessments or new provider orders, resulting in interventions being implemented in practice, but not always clearly reflected or individualized in the care plan.Contributing FactorsWorkflow pressures, staffing turnover, competing clinical priorities, and limited interdisciplinary communication contribute to delays an assessment, order, initiation, and care plan updates.Corrective actions implementedTargeted education provide provided on timely assessment completion, provide provider, notification, and care plan updates. Increased DON and unit manager oversight implemented along with weekly audits and real-time feedback.Monitoring and sustainabilityOngoing QIT monitoring, monthly QA review, continued audits, and leadership oversight to ensure sustained compliance and improved outcomes. Review of a QAPI Performance Improvement Plan reflected the following: Item identified/problem and goalPatient bed rail entanglementReduce risk of bed rail-related injuryOngoing (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	monitoring for improvement and review at QAPIIntervention/action planMedical Director notificationOmbudsman notificationAd hoc QAPIDON provided education to trainers regarding abuse and neglectAdmissions processes regarding bed rails reviewed and in-service is completed with DON, ED, and IDT by clinical resourceIn service all nurses involved with admissions process regarding bed railsAudit of bed rails currently in useInspection of bed rails currently in useVerify consent on file for all bed rails in useVerify order and care plan for all bed railsComplete bed rail, safety evaluation for all with bed railsAudit of low air loss mattresses currently in useVerify order and care plan for all LAL mattresses in useComplete fall risk assessment for all with LAL mattressStaff education regarding use of enabler/bed railStaff education regarding use of enabler/bed railStaff education regarding false safetyStaff education regarding LAL mattressAudit admissions for completion weeklyAudit of LL mattress and bedside rails weekly times four then monthly times threeOngoing monitoring for improvement to be reviewed at QAPI monthlyCompletion date/date resolved[DATE] Review of an electronic work order system list of facility wide bed rail checks reflected monthly checks from [DATE] to [DATE].Review of a bed rail inspection checklist dated [DATE] reflected that all rooms were checked for bed rails present and in good condition.Review of in-service dated [DATE] and presented by the ADM reflected the following and were signed by all available employees:admission process regarding bed rails education provided regarding appropriate admission processBed rail safetyAir mattressesFall prevention/identifying high fall risksMobility support barsTwo-hour safety checksReview of a facility-wide audit reflected that all 114 residents had been audited for bed rails and the consents, orders, assessments, and care plans of all residents with bed rails had been verified or updated. Of these, 24 residents had no bed rail safety assessment prior to [DATE].Review of bed rail safety assessments for Residents #2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, and 25 were all dated [DATE]. They were all assessed as safe to use bed rails for mobility.Review of care plans for Residents #2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, and 25 reflected they all had care plans for bed rails updated on [DATE] or [DATE].Review of physician orders for Residents #2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, and 25 reflected they all had orders updated on [DATE].During an interview on [DATE] at 11:49 AM, CNA I stated she worked the 6 AM to 2 PM shift at the facility. She stated she knew that bed rails were for positioning and not to prevent falls. She stated she had received some in-servicing about bed rails and air mattresses when she returned to work on Monday [DATE]. She stated she was trained to observe that residents were not looking like they would get stuck in their bed rails when she did her rounds. She stated she was told that information about bed rail safety was also in the resident care plan. She stated the protocol if she saw a problem with the bed rails was to make sure the resident was safe and then notify the charge nurse. She stated she did know Resident #1, because CNA I was the restorative aide and took the weight measurements on all residents, but she did not work directly with Resident #1. CNA I stated Resident #1 was nervous and agitated a lot. She stated she received some in-servicing related to residents who had dementia and were nervous would be more vulnerable to abuse and neglect. She stated she knew if she had concerns about abuse and neglect she would report to the abuse coordinator, who was the ADM.During an interview on [DATE] at 11:56 AM, LVN B stated she worked the 6 AM to 6 PM shift. She stated she made sure residents were safe with their bed rails by doing checks on each resident every two hours. She stated checking bed rail safety was constant and frequent. She stated there was an enhanced policy and procedure in which only the IDT could decide on bed rails. She stated when she returned to work on Monday [DATE], the facility had removed all the bed rails and was conducting new assessments, adding focus areas to care plans, and making sure there were orders for every set of bed rails used. She stated she was in-serviced on the new procedure before she started working on Monday morning [DATE] as well as on bed rail safety and LAL mattresses. She stated she had heard about Resident #1's death but did not know very much about it, as that occurred on a hall where she did not work.During an interview on [DATE] at 12:04 PM, LVN C stated he worked (continued on next page)

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LVN C stated there was nothing about Resident #1 and her bed that made him concerned about risk of entrapment.During an interview on [DATE] at 12:19 PM, LVN D stated she usually worked the 6 PM to 6 AM shift. She stated she had been in serviced on the new policy and procedure for bed rails. She stated that the new policy and procedure was what usually happened but sometimes the charge nurses took it upon themselves to get bed rails for residents. She stated that they could do the assessment themselves before, and that they could ask for a physician order, but now everything had to go through the IDT. She stated she was also asked to check on residents with bed rails every two hours and make sure that the bed rails and air mattresses were safe.During an interview on [DATE] at 12:20 PM, LVN E stated she worked the 6 AM to 6 PM shift at the facility. She stated she had participated in a review of every single resident in the facility, but she had only reviewed residents on her hall. She had gone through and written down if they had bed rails, and then she checked to see if they had a consent, an assessment, an order, and that bed rails were in the resident care plans. She stated that she cannot remember if any of the residents she looked at did not have bed rail safety assessments in place. She stated from now on only the IDT could determine if a resident can use bed rails. She stated if a resident or responsible party wanted bed rails, she had to let the DON know and that would start the process. During an interview on [DATE] at 12:23 PM, LVN F stated she worked the 6 PM to 6 AM shift regularly. She stated she had been off work and has not been back to work since [DATE], but she got a phone call informing her of the new process. She stated that if a resident was going to have bed rails, they needed to notify somebody on the management team like the director of rehab or the DON. She stated what happened from there was that the IDT gets consent and a physician order, does an assessment, and then added bed rails to the care plan. They were told to make sure to review all the care plans from the list of residents who had bed rails in case there were any interventions they did not know about. They also had an abuse and neglect in-service, but they have those once a month and she was very familiar with the process. They had in-services on bed rail safety and LAL mattresses. She stated when she had to have an in-service, the DON or ADON came in on her shift- usually at the end of the shift, but sometimes at the beginning.During an interview on [DATE] at 12:27 PM LVN G stated she worked the 6 PM to 6 AM shift at the facility. She stated that there was a death related to bed rails, and so the facility had gone over the entire policy and procedure and retrained everybody on a new policy and procedure. She stated that if the resident or their family wanted bed rails, or if she as a nurse thought a resident could benefit from bed rails, they had to either put a note in the 24 hour logbook or report directly to somebody on the IDT, which included the DON, ADONs, Director of rehab and maybe some other people. She stated the IDT took it from there. She stated they were supposed to be rounding on residents every two hours anyway, but they were reminded to look at the bed rails every time they rounded and make sure they were safe. She stated she had not seen or encountered anything that concerned her about bed rails in the facility. During an interview on [DATE] at 12:30 PM CNA J stated he worked the 10 PM to 6 AM shift at the facility. He stated he had never seen any problem bed rails. He stated he took care of Resident #1 sometimes and he did not notice anything unsafe. He stated the procedure for allowing bed rails happened above his level, but he was still trained on the process and now he knows that he could not just ask for bed rails for a resident. He stated they can only have bed rails if they were doing it to help move in bed. He stated they were (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	03/31/2026

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 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	supposed to check on the residents with bed rails and make sure to notice if there are any problems or anything unsafe happening. He stated they were supposed to report to their charge nurse if they see anything that looks unsafe. He has never seen anything like that.During an interview on [DATE] at 12:35 PM CNA K stated she worked the 6 AM to 2 PM shift at the facility. She stated she had to look out for bed rails and air mattresses because the resident can get stuck in there and be hurt. She stated the bed rails should be in the care plan and she looked at care plan sometimes, especially on the point of care system. She stated she always had to notice if the resident was being hurt by the rails, like skin, tears or other injuries or if the resident ever got stuck in the bed rails. She stated that she got some training about bed rails over the last two days and about abuse and neglect prevention and reporting. During an interview on [DATE] at 12:40 PM CNA L stated she worked the 2 PM to 10 PM shift at the facility. She stated bed rails were usually really helpful for residents and staff. She stated they got trained when she came to work yesterday about checking resident bed rails and checking air mattresses and making sure that nothing got stuck. She said they were also trained on rounding every two hours and on abuse and neglect.During an interview on [DATE] at 12:45 PM CNA M stated she worked the 10 PM to 6 AM shift at the facility and worked on the hall where Resident #1 had lived. She stated she had been at the facility the night Resident #1 was found but was not assigned Resident #1 that night. She stated after she came back to work, she had a lot of in-services about bed rails, mattresses, safety, and abuse and neglect. She stated residents were not supposed to have bed rails without an order. She stated they had to check for safety and if they saw anything with residents that was not safe, they had to report it immediately. She stated that was important to the overnight shift, because that was when residents were in bed the most and sleeping.Observation on [DATE] from 02:30 PM to 03:30 PM revealed Residents #2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, and 27 had properly fitted bed rails on 1/3 the length of their beds, and the bed rails were the same make and model as the beds. There were no hazards identified with the bedrails. During these observations, Residents # 2, 3, 4, 5, 8, 10, 13, 14, 15, 16, 20, 21, 22, 24, and 25 were observed in the beds with bed rails, and no obvious hazardous situation was observed for any resident.The noncompliance was identified as Past Noncompliance. The IJ began on [DATE] and ended on [DATE]. The facility had corrected the noncompliance before the survey began.