STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676267	A. BUILDING _____ B. WING _____	03/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0561 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure that the resident had the right to make choices about aspects of his or her life in the facility that were significant to the resident for one of nine residents (Resident #75) whose care was reviewed in that: The facility failed to ensure transportation and assistance for Resident # 75 to obtain medical care from the Vetrans Affairs (VA). This deficient practice could have affected residents who were competent to make their own decisions by contributing to poor self-esteem, lack of information, and unmet needs. Finding include: Review of the Face Sheet for Resident #75 reflected a [AGE] year-old male who was initially admitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #75's Admission MDS dated [DATE] reflected a Brief Interview for Mental Status (BIMS) score of 15 indicating intact/borderline cognition. Review of Section G, functional status, revealed that the resident needs extensive assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. Review of Resident #75 Therapy Assessment progress note dated 01/6/20 reflected under patient's concern section, I'm about the same I don't know if my wound is healing but I will go to the doctor Friday and I'll find out . Review of the Care Plan for Resident # 75 dated 1/20/20 reflected interventions for resident refusing wound care which included to allow resident to make decisions about treatment regime, to provide sense of control. Resident# 75's care plan reflected if possible, negotiate a time for ADLs do that the resident participates in the decision-making process. Review of Resident #75's Therapy Assessment progress note dated 02/5/20 reflected under patient's concern section, I'm supposed to see a doctor at the VA and these people aren't helping me at all to get in touch with them . Review of Resident #75's Therapy Assessment progress note dated 02/13/20 reflected under patient's concern section, It still hasn't happened. They still haven't made me an appointment at the VA. After 5 months, you would think they could pick up the phone and call . Review of Resident #75's Therapy Assessment progress note dated 02/18/20 reflected under patient's concern section, These people won't help me, and they know what to do to get me into the VA. Review of Resident #75's surgical and wound care progress notes dated 02/6/20 and 02/11/20 reflected that resident refused wound care. Further review of surgical and wound care progress notes dated 2/18/29, reflected that resident refused care and that patient only wants care through the VA system. Review of Resident #75's Facility progress note dated 02/25/20 reflected that resident left the facility approximately at 9:00 a.m. for a VA appointment and that he wasn't seen. Resident's appointment was rescheduled for March. Review of facility's appointment binder on 3/04/20 reflected that there was no documentation for Resident # 75's past or future appointments. During an interview conducted on 3/03/20 at 10:35 a.m. Resident #75 stated that the facility cancelled his VA appointments and it was re-scheduled for 03/06/20. He stated that the facility cancelled his appointment for 01/10/20 told him that the VA cancelled, and the facility forced him to no show but that he called the VA and they have him as no show. During an interview with RN conducted by phone on 3/04/20 at 3:52 p.m., RN stated that TD was responsible for keeping track and monitoring the resident's appointments. She stated that on 02/26/20 TD and resident drove to the VA and resident didn't have an appointment, but he was scheduled for 03/06/20. During an interview with LVN conducted on 3/04/20 at 5:56 p.m., LVN stated that TD was responsible for scheduling and keeping track of appointments. She stated that all resident appointments should be in TD's binder. She stated that resident appointments should be documented in point click care (PCC) under orders. She stated that Resident #75 had no future appointments because there was no note in PCC under orders. During an interview with TD conducted on 3/04/20 at 6:20 p.m. TD stated that if the resident had an appointment the staff should put the documentation in her binder. She stated that she was responsible for scheduling and keeping track of all appointments. She stated that if a staff member scheduled the appointment, they should put the documentation in her binder. She stated that she communicates with the nurses when she schedules an appointment. She stated that if the resident's appointment is cancelled or reschedule, it had to be documented in her binder. She stated that on 1/10/20 Resident #75 cancelled his appointment because of bad weather. She stated that she doesn't have documentation for the appointment on 1/10/20 because resident requested to go to the appointment that same day. TD stated that she took the resident to the VA a few weeks ago to schedule an appointment. She stated that she didn't know the day of the future appointment since they get the schedule appointment by mail. During an interview with DON conducted on 3/4/20 at 7:20 p.m., DON stated that the resident or the facility can call the VA to make an appointment and added that the facility would support the resident with transportation. She stated that if the resident's appointment was cancelled, the resident would be informed and provided with alternatives that work for the resident. If a resident's appointment was cancelled or rescheduled, the reason should be reflected at the nurse's progress notes. Requested policy and procedure for resident's doctors' appointments on 3/4/20 at 6:46 p.m., DON stated that there is not policy or procedure for doctor's appointments.
F 0645 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**PASARR screening for Mental disorders or Intellectual Disabilities** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to coordinate with the state agency to ensure residents with mental illness receive care and services for one of eighteen residents (Resident # 87) reviewed for PASRR. The facility failed to correctly complete the PASRR Level 1 Screening form for Resident # 87 with a mental illness diagnosis. This failure could place residents at risk for not receiving specialized care and services to meet their unique needs. Findings include: Review of Resident # 87's face sheet reflected an [AGE] year-old male admitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident # 87's care plan dated 2/26/19 reflected resident has [MEDICAL CONDITION] with interventions to include monitor and address environmental factors. Use of [MEDICAL CONDITION] medications with interventions to include monitor for involuntary movements and repetitive behaviors. ADL deficits with interventions to include assist with personal hygiene, mobility, dressing and transfers. Review of Resident # 87's quarterly MDS dated [DATE] reflected a BIMS of 3 which indicates severe cognitive impairment. Review of Resident # 87's PASRR Level 1 Screening dated 10/08/19 reflected Section C PASRR Screen (Screener), subsection C0100, Mental Illness was marked as No. During an interview on 3/4/2020 at 6:32PM MDS nurse stated that Delusional Disorder is a mental illness and that the PASSRR Level 1 Screening should be completed and submitted correctly. During an interview on 3/4/2020 at 7:03PM DON stated when a resident is admitted , the documentation should be filled out correctly and the resident is to be evaluated and receive PASRR services. During an interview on 3/4/2020 at 7:27PM ADM stated we communicate with an outside entity to provide the services that are agreed upon. ADM stated her expectation is for staff to complete documentation correctly and trigger the system for further evaluation from the outside entity. Facility policy on PASRR requested and was not provided.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.**

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

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.

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F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop a comprehensive person-centered care plan for three residents (#16, #40 and #61) of twenty-two reviewed for care plans. 1. The facility failed to develop a care plan that accurately reflected the assistance needs for Resident #16. 2. The facility failed to develop a care plan that accurately reflected repositioning needs for Resident #61. 3. The facility failed to develop a care plan that accurately reflected oxygen needs for Resident #40. This failure could place the health and safety of all residents at risk for not receiving necessary care and services. Findings include: 1. Review of Resident #16 face sheet reflected a [AGE] year-old male admitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #16 care plan dated 12/02/2019 reflected that Resident #16 has an ADL self-care performance deficit and interventions included 1 staff participation with bathing and toilet use. Further review of care plan reflected that Resident #16 has an ADL self-care deficit related to weakness and [MEDICAL CONDITION] and interventions included that Resident #16 required 2 staff participation with bathing and 2 staff participation with toilet use. Resident #16 care plan reflected two different levels of assistance for bathing and toilet use. Review of Resident #16 quarterly MDS dated [DATE] reflected a BIMS score of 15 indicating no cognitive impairment. Further review of quarterly MDS reflected that Resident #16's physical help is limited to transfer only when bathing and requires one-person physical assist for bathing. Quarterly MDS also reflected that Resident #16 requires one-person physical assistance for toilet use. During an interview on 03/04/2020 at 11:07 AM, Resident #16 stated that only one staff member assisted him when he bathed and used the toilet. Resident #16 stated that he was able to do most of his showering himself and he only required help with toileting when he was finished. During an interview on 03/04/2020 at 11:16 AM, CNA A stated that the staff used Point Click Care to see what assistance with transfers and bathing residents needed. CNA A stated that the aides were also able to ask the nurse. CNA A stated that he asked the nurses at the beginning of his shift and checked point click care for any resident care. CNA A stated that he looks at Point Click Care from the hall kiosk and he stated he looked at the care plan to indicate how much assistance a resident needed. CNA A stated that if there was a discrepancy he clarified with the nurse but would have done the higher level of assistance to be safe. CNA A stated that Resident #16 required one-person assistance with bathing and transfers. During an interview on 03/04/2020 at 11:22 AM, CNA B stated that she checked on Point Click Care to determine what assistance a resident needed for transfers and bathing. CNA B stated that she also looks at the history of bathing assistance and transfers. She stated that she checks to see how the aide before her charted to know what assistance a resident needed, or she asked the nurse. CNA B stated that she did not check the care plan or use the care plan for information. CNA B stated that she did not think that information was available to her on the kiosk. During an interview on 03/04/2020 at 4:18 PM, LVN A stated that the therapists or nurses put any updated information in the computer as an order and that she believes it is the ADON's responsibility for updating that information in the care plan. 2. Review of Resident #61 face sheet reflected a [AGE] year-old female admitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #61 physician orders [REDACTED].#61 care plan date 11/18/2019 reflected that Resident #61 had an unwitnessed fall due to poor balance and unsteady gait, interventions included physical therapy to consult for strength and mobility. Care plan did not include any interventions regarding repositioning Resident #61 in wheelchair due to abnormal posture. Review of occupation therapy, therapy progress report assessment summary, dated 01/28/2020 for Resident #61, reflected that OTA instructed patient and primary caregivers in positioning maneuvers, safety sequencing techniques and safe transfer techniques in order to increase safety and decrease need for assistance with carryover. Review of Resident #61 quarterly MDS dated [DATE] reflected a BIMS score of 14 indicating no cognitive impairment. Further review of Resident #61 MDS, reflected Resident #61 received at least five days of physical therapy in the seven days prior to the completion of the MDS with service dates of 10/28/2019 to 12/24/2019. Observation on 03/03/2020 at 11:34 am revealed Resident #61 leaning over the side of her wheelchair while sitting in the dining room. Further observation revealed Resident #61 had an assistive device on the back of her wheelchair. During an interview on 03/03/2020 at 11:35 am, Resident #61 stated that things are going well her at the facility, but she keeps leaning to the side. Resident #61 stated that she was not currently in any pain and stated she was not sure why she leans to one side. During an interview on 03/04/2020 at 9:54 am, PTA stated that Resident #61 has not had any consultations for physical therapy since December 2019. PTA stated that Resident #61 was receiving physical therapy from 10/28/2019 to 12/24/2019 for abnormal posture and lack of coordination. PTA stated that Resident #61 has had more of occupational therapy services and that last Friday (02/28/2020), Resident #61 received a consultation for a custom assistive device and stated that her abnormal posture is being addressed. During an interview on 03/04/2020 at 10:01 am, OTA stated that a custom manual chair has been ordered for Resident #61 and that the company brought a sample backrest on 02/28/2020 with side supports to test what would be most beneficial for Resident #61. OTA stated that the positioning issues with Resident #61 are physical and behavioral. OTA stated that Resident #61 has lower back pain and leaned to avoid that pain and did not know what her position was in space which caused Resident #61 to lean very far out to one side. OTA stated that during physical and occupational therapy, Resident #61 was provided a lateral pad and staff put the lateral pad on her chair, however, it has not had any effect on her posture. OTA stated that during occupational therapy, Resident #61 worked on her core strength. OTA stated that the CNAs know to reposition Resident #61 or to put her arm on a table near her to help her sit straight. OTA stated that this information is communicated verbally to the staff. During an interview on 03/04/2020 at 11:16 am, CNA A stated that therapy usually adds repositioning information for a resident in the care plan and verbally tells the staff and trains them on the repositioning. CNA A stated that he did not think the care plan information is available on the kiosk they utilize to access point click care and he got this information from the charge nurse. He stated that some days Resident #61 leans more than others and the staff always looked at her positioning. He stated that the charge nurse did not tell him anything about repositioning Resident #61 in her chair to make her sit up straight. During an interview on 03/04/2020 at 1:22 pm with CNA B, she stated that she did not look at the care plan for information. CNA B stated that she has viewed Resident #61 leaning to the side but stated that she just knew to reposition her by having seen her lean to the side. She stated that she asked the nurse before her about resident needs. During an interview on 03/04/2020 at 12:19 pm, OTA stated that she did verbally tell CNA's and Nurses that Resident #61 did need to be repositioned when she was leaning over to the side. OTA stated that she trained the staff to shift Resident #61's hips to her side to help her sit straight and that if that did not help, Resident #61 may have needed to lay down. OTA stated that she told and trained the staff and then documented it in the therapy documentation system. OTA stated that the worked with Resident #61 for occupation therapy from 01/08/2020 to 01/31/2020. OTA stated that she does not remember who she talked to about repositioning of Resident #61, but it would have been the day shift charge nurse. OTA stated that the term caregivers in her documentation regarding training for Resident #61's positioning refers to all nursing staff. During an interview on 03/04/2020 at 4:18 pm, LVN A stated that therapy did not communicate anything to her about Resident #61 needing to be repositioned when leaning over. LVN A stated that all staff were aware that Resident #61 was supposed to be repositioned every two hours which included to sit Resident #61 up straight and reminded her to sit up straight. LVN A stated that she did not get that information verbally and that therapy or the nurse on duty that day was responsible to put information such as repositioning in as an order. 3. Review of Resident #40 face sheet reflected a [AGE] year old woman admitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #40 care plan dated 01/02/2020 reflected no interventions for Resident #40's [DIAGNOSES REDACTED]. Review of Resident #40 quarterly MDS dated [DATE] reflected a BIMS of 0 which indicated severely impaired cognition. Observation on 03/02/2020 at 9:06 AM revealed Resident #40 ambulating in wheelchair with oxygen tank on the back of the wheelchair. Resident #40's nasal canula dragged on the floor and no oxygen was utilized by resident. Observation on 03/02/ at 9:28 AM revealed resident with nasal canula on at 2 liters. Observation on 03/02/2020 at 2:33 PM revealed Resident #40 at nurse's station with oxygen and nasal canula placed. Observation on 03/03/2020 at 7:45 AM revealed Resident #40 in 400 hallway laying in wheelchair asking for help with oxygen in place. Further observation revealed staff assisted resident to room. During an interview on 03/04/2020 at 5:42 pm, the MDS coordinator stated that care plans were updated daily. She stated that any change or update is reflected in the care plan and any changes to care required a care plan update. MDS coordinator stated that the MDS may not match the care plan if the change or update did not meet qualifications for a significant change or if it was not a quarterly or annual review based on RAI qualifications. She stated that if an MDS is updated prior to a care plan, then what is in the MDS should be reflected in the care plan. MDS coordinator stated that facility MDS coordinators are responsible for reviewing the care plan and making sure the MDS and care plan match. She stated that MDS coordinators were responsible for reviewing that care plans were accurate. MDS coordinator stated that charge nurses, ADON's, LVN's and RN's are responsible for updating any change in the care plan once they learn about it and have access to do so. During an

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F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) interview on 03/04/2020 at 7:03 pm, the DON stated that the care plan should have been updated based on what the therapy staff said. The DON stated that all charge nurses have the capability for updating the care plan. The DON stated that the charge nurse made aware of the newly identified resident need was responsible for changing the care plan. The DON stated that if the charge nurse did not know how to update the care plan they could ask the ADON or DON. The DON stated that the MDS coordinators are responsible for ensuring that the care plan matches the MDS, unless there was an update for the care plan and it did not qualify for an MDS change per RAI guidelines. The DON stated that care plans were updated daily and that they were updated as they change all the time. The DON stated that care plans are fluid and were updated daily and routinely. The DON stated that if a resident has an order for [REDACTED]. The DON stated that if a resident has an order for [REDACTED]. ADM stated that when therapy communicates something to nursing and it is a change then it needed to be updated on the care plan quickly so that the information was communicated to staff. ADM stated that the charge nurse is responsible for updating the information when they received it. Review of facility Care Planning policy from Nursing Services Policy and Procedure Manual dated December 2017 reflected that a comprehensive, person-centered care plan is developed and implemented for each resident to meet the resident's physical, psychosocial and functional needs. Further review reflected that the care plan is developed by the care planning and interdisciplinary team which includes, the registered nurse responsible for the resident, the director of nursing, the charge nurse responsible for resident care and nursing assistants.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed ensure that residents who were unable to carry out activities of daily living (ADL) received the necessary services to maintain good grooming and personal hygiene for nine (#16, #51, #85, #17 and #31) of 22 residents reviewed for ADL care. 1. The facility failed to provide Resident #16 with showers/baths. 2. The facility failed to provide Resident #17 with showers/baths. 3. The facility failed to provide Resident #31 with showers/baths. 4. The facility failed to provide Resident #51 with showers/baths. 5. The facility failed to provide Resident #85 with showers/baths. This failure could place residents dependent on assistance with ADL at risk for infections, skin break down and decreased self-worth. Findings include: 1. Review of Resident #16 face sheet reflected a [AGE] year-old male admitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #16 quarterly MDS dated [DATE] reflected a BIMS score of 15 indicating no cognitive impairment. Further review of quarterly MDS reflected that Resident #16's physical help is limited to transfer only when bathing and requires one-person physical assist for bathing. Quarterly MDS also reflected that Resident #16 requires one-person physical assistance for toilet use. Review of Resident #16 care plan dated 12/02/2019 reflected that Resident #16 has an ADL self-care performance deficit and interventions included 1 staff participation with bathing and toilet use. Further review of care plan reflected that Resident #16 has an ADL self-care deficit related to weakness and [MEDICAL CONDITION] and interventions included that Resident #16 required 2 staff participation with bathing and 2 staff participation with toilet use. Review of facility skin care/shower sheets for the month of February 2020 reflected that Resident #16 only received a shower on 02/20/2020. Review of Resident #16 last 30-day shower log reflected that a shower was not-applicable for Resident #16 on 02/05/2020, 02/06/2020, 02/07/2020, 02/10/2020, 02/12/2020, 02/17/2020, 02/22/2020, 02/26/2020, 02/27/2020, 02/28/2020, and 03/02/2020. Options for 30-day shower log coding included shower, tub bath, bed bath, resident not available, resident refused and not applicable. During an interview on 03/02/2020 at 2:54 PM Resident #16 stated that it was hard to get showers. Resident #16 stated that there was always a mix up about shower times and days and he went without showers. Resident #16 stated that the facility needed a touch of consistency. Resident #16 stated that the longest time he went without a shower was three weeks. He stated that he had to talk with the CNAs to see what kind of mood they were in that day and that the mood of the CNA determined whether he would get a shower that day. Resident #16 stated that the facility does not have enough staff and this is another reason he does not get a shower when he was supposed to. 2. Review of Resident #17 face sheet reflected a [AGE] year old female admitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #17 quarterly MDS dated [DATE] reflected a BIMS score of 15 indicating no cognitive impairment. Further review of MDS, section G, indicated that Resident #17 is a total dependence for self-performance during bathing and a two-person physical assist for support provided during bathing. Review of Resident #17 care plan dated 02/25/2020 reflected that Resident #17 has an ADL self-care performance deficit related to limited mobility. Interventions included one staff participation with bathing and to check nail length and trim and clean on bath day as necessary. Review of facility skin care/shower sheets for the month of February 2020 reflected that Resident #17 received a shower on 02/03/2020 and 02/17/2020. Review of Resident #17 last 30-day shower log reflected that a shower was provided on 02/03/2020, 02/05/2020, 02/10/2020, 02/17/2020, 02/19/2020, 02/26/2020, 02/29/2020, 03/03/2020 a tub bath was provided on 02/08/2020 and that a bed bath was provided on 02/29/2020. Further review reflected that Resident #17 was not available for bath on 02/25/2020. Shower log reflected a shower/bath was not-applicable for Resident #17 on 02/11/2020, 02/13/2020, 02/15/2020, 02/18/2020, 02/20/2020, 02/23/2020, 02/24/2020, 02/25/2020, 02/27/2020 and 03/02/2020. Options for 30-day shower log coding included shower, tub bath, bed bath, resident not available, resident refused and not applicable. During an interview on 3/2/2020 at 9:19 AM with Resident #17 stated she did not get a shower Friday (2/28/2020), Saturday (2/29/2020) or Sunday (3/1/2020). Resident #17 stated that she spoke with a staff today and that staff told her she would get one today. During an interview on 3/2/2020 at 2:15 PM Resident #17 stated she did not receive a shower today and that she was told she would get one early tomorrow (03/03/2020) morning. During an interview on 3/3/2020 at 8:32 AM Resident #17 stated she got a shower this morning. 3. Review of Resident # 31 face sheet reflected a [AGE] year-old female admitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #31 quarterly MDS dated [DATE] reflected a BIMS score of 15 indicating no cognitive impairment. Further review of Resident #31 MDS, section G, indicated that Resident #31 is a total dependence for self-performance during bathing and a two-person physical assist for support provided during bathing. Review of Resident #31 care plan dated 12/20/2019 reflected an ADL self-care performance deficit related to weakness, decreased mobility and obesity with interventions including using short, simple instructions during shower to promote independence and to check nail length and trim and clean on bath day as needed. Review of facility skin care/shower sheets for the month of February 2020 reflected that Resident #31 received a shower on 02/03/2020 and 02/09/2020, and a bed bath on 02/17/2020. Review of Resident #31 last 30-day shower log reflected that a shower was provided on 02/05/2020, 02/12/2020, 02/19/2020, 02/21/2020, 02/26/2020, a tub bath on 02/17/2020, and a bed bath on 02/10/2020 and 03/02/2020. Resident #31 reflected that she refused a shower on 02/24/2020. Shower log reflected a shower/bath was not-applicable for Resident #31 on 02/11/2020, 02/13/2020, 02/15/2020, 02/18/2020, 02/20/2020, 02/23/2020, 02/25/2020, 02/27/2020 and 03/02/2020. Options for 30-day shower log coding included shower, tub bath, bed bath, resident not available, resident refused and not applicable. During an interview on 3/2/2020 at 10:08AM Resident #31 stated she had a complaint. Resident #31 stated that her last shower was Wednesday (2/26/2020). Resident #31 stated her shower schedule was Monday, Wednesday, and Friday. Resident #31 stated that was told this morning that she would not get a shower today because there was only one CNA on her hall. During an interview on 03/20/2020 at 2:30 pm, Resident #31stated she received a shower today. 4. Review of Resident #51 face sheet reflected a [AGE] year-old woman admitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #51 quarterly MDS dated [DATE] reflected a BIMS score of 13 indicating no cognitive impairment. Further review of Resident #51 MDS, section G, indicated that Resident #51 requires physical help in part of bathing activity for self-performance during bathing and one-person physical assist for support provided during bathing. Review of Resident #51 care plan dated 12/02/ reflected that Resident #51 ha an ADL self-care performance deficit related to limited mobility, limited range of motion, disease [MEDICAL CONDITIONS], history of [MEDICAL CONDITION], impaired balance along with recent hospital stay, chronic back pain and old ankle fracture. Interventions for bathing include: checking nail length, trim and clean on bath day as necessary, 1-2 staff participation with bathing, 1-2 staff participation with personal hygiene, and to provide a sponge bath when a full bath or shower cannot be tolerated. Review of facility skin care/shower sheets for the month of February 2020 reflected that Resident #51 refused a shower on 02/06/2020, 02/11/2020, 02/15/2020. Further review reflected that Resident #51 received a shower on 02/08/2020. Review of Resident #51 last 30-day shower log reflected that shower/bath was not-applicable for Resident #51 on 02/05/2020, 02/07/2020, 02/08/2020, 02/10/2020,02/12/2020, 02/13/2020, 02/14/2020, 02/17/2020, 02/22/2020, 02/26/2020, 02/27/2020, 02/28/2020, 02/29/2020, 03/02/2020. Further review reflected that Resident #51 refused a shower/bath on 02/06/2020, 02/11/2020 and 03/03/2020. Options for 30-day shower log coding included shower, tub bath, bed

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F 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3) bath, resident not available, resident refused and not applicable. During an interview on 03/02/2020 at 10:13 am, Resident #51 stated that she had concerns about getting her showers. She stated that she is supposed to be showered on Tuesday, Thursday, and Saturday. She stated that the longest she has gone is nine days without a shower. Resident #51 stated that there is only one person on the hall so she could not get a shower. Resident #51 stated that she was getting a really good funk and felt dirty because she was not showered. She stated that she asked staff about her shower and they stated that there is no one to shower her. 5. Review of Resident #85 face sheet reflected a [AGE] year-old male admitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #85 quarterly MDS dated [DATE] reflected a BIMS score of 12 indicating a moderate cognitive impairment. Further review of Resident #85 MDS, section G, indicated that self-performance task during bathing did not occur or staff provided 100% of care during the activity over the last 7 days and that during the support during bathing the task did not occur or staff provided 100% of care during the activity over the last 7 days. Review of Resident #85 care plan dated 02/21/2020 reflected that Resident #85 has an ADL self-care performance deficit related to limited range of motion in bilateral lower extremities. Interventions included that Resident #85 requires moderate assistance by 1 staff with bathing. Review of facility skin care/shower sheets for the month of February 2020 reflected that Resident #85 received a shower on 02/07/2020, 02/10/2020, and 02/14/2020. During an interview on 03/02/2020 at 9:41 am, Resident #85 stated that he is not on a normal shower schedule because staff said there were not enough people. Resident #85 stated that he expected to be on a normal scheduled and get his showers. Review of resident council minutes dated 02/28/2020 reflected that residents asked why there were not enough CNAs to get the job done and that showers were an issue due to lack of staff. Review of Resident council minutes dated 01/17/2020 reflected that residents needed to be informed about what days they are supposed to get showered and that their showers were not being done. Review of facility in-service dated 02/05/2020 reflected summary of training session was to provide showers on scheduled point of care days and to document in point of care and shower sheets. During a confidential group interview with five residents on 03/03/2020 at 2:29 pm, residents stated that their showers days constantly change. Residents stated that they had issues getting showers and getting showers on their scheduled days. Residents stated that staff has told them they do not have enough staff to provide residents with a shower. A resident stated that not having a shower makes her feel disgusting and she does not like when her hair gets dirty from not showering. During an interview on 03/04/2020 at 11:16 AM, CNA A stated that he does not feel there is enough staff to provide resident showers. CNA A stated that he felt like the facility needed more staff, especially on the weekends. He stated that there is only one CAN per hall on the weekends. He stated that not having enough staff has hindered his ability to get his job done, such as showering residents on his shift. CNA A stated that there were days he was not able to get the shower on his shift done and he had to ask the medication aides to help or ask the next shift to shower the resident. During an interview on 03/04/2020 at 11:38 am, CNA D stated that the facility could use more staff. She stated that personally she does not have an issue getting showers done because she asks other staff members for help such as the ADON or the staffing coordinator. During an interview on 03/04/2020 at 11:43 am, CNA C stated that she had issues completing showers on her shift because there was not enough staff. She stated that she has been stuck on the hall by herself and this hinders her ability to get her job completed and shower residents. CNA C stated that she has been forced to tell a resident she cannot shower them because she did not have enough time or staff to help. During an interview on 03/04/2020 at 2:56 pm, LVN B stated that showers are documented in Point Click Care, but state she was unaware of where to document showers in Point Click Care because staff was supposed to use the shower sheets to document showers. When asked why a shower would be coded as not-applicable for a resident, LVN B stated that she was unsure. She stated that she did not know if there was a special circumstance such as family member requesting a resident not be showered. LVN B stated that it meant a resident was not showered if not-applicable was coded. LVN B stated that she was not sure why the correct code for a shower would not have been used if a resident refused. During an interview on 03/04/2020 at 2:46 pm, LVN C stated that not-applicable being coded for a shower meant that hospice gave the shower. LVN C stated that if a resident is not on hospice services, then not-applicable means the possibly did not get a shower. LVN C stated that she was not sure why not-applicable would be used. During an interview on 03/04/2020 at 2:50 pm, LVN D stated that she could not say why non-applicable would be used to code if a resident received a shower. She stated that if it was a hospice patient then it may be marked. LVN D stated that if a resident is scheduled to get a shower on a certain day, they should get a shower. During an interview on 03/04/2020 at 7:03 PM, the DON stated that it is her expectation that showers are documented in Point Click Care and that residents receive showers on their scheduled shower days. The DON stated that if a resident refused a shower, it is her expectation that it be coded as a refusal and not incorrectly coded as not-applicable. The DON stated that the resident should be coded as on the correct day they got a shower for the correct shower type.

F 0756

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on observation, interview and record review the facility failed to ensure when the pharmacist had reported irregularities and or recommendations, the attending physician had documented in the resident's medical record the identified irregularity had been reviewed and what, if any, action was to be taken to address it for one (1) of six (6) residents reviewed for unnecessary medications. The facility did not have evidence the physician had reviewed the record when on 02/10/2020 pharmacy consultation reports for Resident #50 did not reflect the attending physician's documentation of his or her signature, acceptance or decline of pharmacist's recommendations and did not include physicians' rationales in the resident's medical record. Pharmicist recommended medication [MEDICATION NAME] to a lower dose with no documentation and the Pharmacist recommended labs (CMP, CBC, TSH, FLP) be monitored with (TSH) labs not completed and no documentation.

This failure to timely notify the physician and track a response to the pharmacy recommendation could lead to a longer duration of medication/[DIAGNOSES REDACTED].#50's Face Sheet reflected she was a [AGE] year-old female admitted on [DATE]

diagnosed including: [DIAGNOSES REDACTED]. No [DIAGNOSES REDACTED].#50's Quarterly Minimum Data Set ((MDS) dated [DATE]

reflected she had a BIMS score of 13 which indicated cognitively intact, and she required minimum to extensive assistance with her activities of daily living. Resident had no hallucinations/delusions. Resident had no behaviors. The MDS reflected Resident #50 received an antianxiety, antidepressant, antibiotic and diuretic medication seven days of the seven-day observation period. Review of Resident #50's Care plan not dated reflected Resident #50 took an antidepressant medication Extended Release 24-hour 75 MG and [MEDICATION NAME] Tablet 100 MG for Depression. Administer Antidepressant medications as ordered by physician. Monitor/document side effects and effectiveness (every) Q-shift. Review of Resident #50's Order

Summary Report dated 03/04/2020 reflected Behavior monitoring for Antianxiety behavior; Side effect monitoring for antianxiety and antidepressant side effects effective 02/20/2020. In addition, Effective 04/08/2019 [MEDICATION NAME] tablet 175 MCG- give 1 tablet by mouth one time a day for [MEDICAL CONDITION]. Review of Resident #50's Pharmacy Consultation Report dated 02/10/2020 reflected the pharmacist comment: Repeated Recommendation from 01/21/2020: Please respond promptly to assure facility compliance with federal regulations. Recommendation: Due to CrCl<30, consider decrease [MEDICATION NAME] to 20 mg HS. Physicians' response: had no documentation reflecting re-evaluation, rationale or physicians' signature. Review of Resident #50's Pharmacy Consultation Report dated 02/10/2020 reflected the pharmacist comment: Resident #50 receives aspirin, [MEDICATION NAME], potassium, [MEDICATION NAME], iron, and apap. Recommendation; Please consider monitoring (labwork) CMP, CBC, TSH, FLP on the next convenient lab day. Physicians' response: had no documentation reflecting re-evaluation, rationale or physicians' signature. Reviewed 12 months of Pharmacy consultation reports reflected a large amount of missing information through out the reviewed months. There was no documentation reflecting re-evaluation, rationale or physicians' signature. Review of Resident #50 labs collected date: 01/16/2020 and 02/25/2020 did not include [MEDICAL CONDITION] (TSH) labs the pharmacist recommend doing on 02/10/2020. In an interview on 03/04/2020 at 3:00 PM Director of Nursing (DON) stated she could not find anything documented in the resident's medical record which indicated the pharmacist recommendations had been reviewed by the doctor and what, if any, action was to be taken to address it. The DON stated, I called the nurse practitioner today and she (nurse practitioner) stated she did not do the TSH lab at this time, but it was not documented anywhere. DON stated, The consult report is the only signature line I know of. DON stated she was aware of the consult reports (multiple reports) not being signed because her ADON would get a verbal over the phone and then upload the document (consult report) in the residents medical record. If it is not uploaded, then ADON has not gotten to it yet and is probable sitting on their desk. DON also stated there was no time line expectation currently in place for reviewing the pharmacy consult reports. In an interview on 03/04/2020 at 5:35 PM the Administrator stated My expectations are the pharmacy recommendations are to be passed to the doctor. The doctor should answer request, sign off and document rational. It is then given to medical records to be uploaded. She stated, Yes we need to document. In an interview 03/04/2020 at 6:16 PM the DON stated her expectations was the pharmacy consult reports should be passed to the doctor. The doctor would answer the pharmacist request, sign off and document. Medical records would upload in the resident medical record. Review of the policy 9.1 Medication Regimen Review; Facilities Receiving Pharmacy Products and Services from Pharmacy; Effective Date:12/01/07. This Policy 9.1 sets forth procedures relating to the Medication Regimen Review (MRR). Procedure: 1. The Consultant Pharmacist will conduct MRR's if required under a Pharmacy Consultant Agreement. 2. Facility should ensure that the Consultant Pharmacist has access to: 2.1 The resident and/or the resident's Responsible Party; 2.2 The resident's records, in accordance with Applicable Law; 2.3 Resident's laboratory tests; 2.4 Physician/Prescriber progress notes, nurses' notes, and other documents which may assist the Consultant Pharmacist in making a professional judgment as to whether or not irregularities exist in the medication regimen; and, 2.5 Any other necessary information, in accordance with Applicable Law. 3. Facility should inform the Consultant Pharmacist of any physical and/or mental conditions of the resident which are likely to affect his/her medication therapy outcome. 4. Facility should ensure that the Consultant Pharmacist has a quiet, private location to perform MRR's. Electronic medication records may permit the Consultant Pharmacist to perform some aspects of the MRR outside Facility. 5. Facility should independently review each resident's medication regimen directly from the resident's medical chart and with Interdisciplinary Care Team members, resident or Responsible Party, as needed. 6. Facility should ensure that Facility Physicians/Prescribers are provided with copies of the MRR's. 7. Facility should encourage Physician/Prescriber or other Responsible Parties receiving the MRR and the Director of Nursing to act upon the recommendations contained in the MRR. For those issues that require Physician/ Prescriber intervention, Facility should encourage Physician/Prescriber to either (a) accept and act upon the recommendations contained within the MRR, or (b) reject all or some of the recommendations contained in the MRR and provide an explanation as to why the recommendation was rejected. 8. Facility should provide the Medical Director with a copy of the (medication record) and should alert the Medical Director where MRR's require follow-up. 9. Facility should maintain copies of MRR's on file in Facility, either as part of the resident's permanent medical record or in a special file, in accordance with Applicable Law.

F 0812

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.

Based on observation, interview, and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food safety for one of one kitchen reviewed for dietary services. The facility failed to ensure items in the refrigerator and freezer were properly stored, dated, and labeled. These failures could affect all residents who ate food from the facility's kitchen by placing them at risk of foodborne illness. The findings include: Observation of the facility kitchen conducted on 3/02/20 between 09:09 a.m. to 10:00 a.m. revealed the following: -an open bag of cheese in the refrigerator without a label indicating the type of product or the use by date label; -an open package of raw bacon in an open box in the refrigerator without a pan under the box, no label indicating the type of meat, date of when the bacon was pulled from the freezer to thaw, or the open date label; -a box of rotting cucumbers in the refrigerator; -an unsealed bag of fishless tender without label indicating the open and use by date; -an unsealed package of meat patties in an open box in the freezer there was no label indicating the type of meat, the open and use by date label; -an unsealed bag of fish or chicken tenders in the freezer without label indicating the type of product, or the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676267	A. BUILDING _____ B. WING _____	03/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) open and use by date label; -an unsealed bag of unidentifiable meat without label indicating the type of meat or the open and use by date label; -an unsealed bag of chicken without label indicating the type of meat or the open and use by date label; -a plastic bag with meat without label indicating the type of product or the open and use by date label; -an unsealed bag of green peas in an open box in the freezer During an interview on 3/02/20 at 9:15 a.m. KM stated that the meat patty at the freezer was not supposed to be open and unlabeled. She stated that the cucumbers should be thrown away. She stated that the open food was supposed to be covered or sealed and labeled with the open and use by date and type of product. During an observation on 3/02/20 at 9:54 a.m. revealed KM throwing bags of meat from the freezer to the trash can. During an interview on 3/04/20 at 12:10 p.m., the DM stated that the he expected the products in the freezer and refrigerator to be sealed and labeled. He stated that the staff did not use the rotting cucumbers and threw them away. During an interview on 3/04/20 at 2:36 p.m., ADM stated that she expected that all the food and items that were in the refrigerator and freezer should be sealed, labeled with the open date and use by date. Review of facility, Food Storage Policy dated 2018 read in part: a.All refrigerated foods are dated, labeled and tightly sealed, including left overs, using clean, nonabsorbent, covered, containers that are approved for food storage. b.Frozen foods are stored in moisture-proof wrap or container that are labeled and dated.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain clinical records on each resident that were complete and accurate, in accordance with accepted professional standards and practices, for three of eighteen residents (Resident # 31, Resident # 87, and Resident # 85) whose records were reviewed for accuracy and completeness in that: 1. The facility failed to document Resident # 31's [DIAGNOSES REDACTED]. 2. The facility failed to document Resident #87's [DIAGNOSES REDACTED]. 3. The facility failed to document Resident #85's [DIAGNOSES REDACTED]. This failure could place all residents at risk of having incomplete and inaccurate records and subsequent poor care. Findings Include: 1. Review of Resident # 31's face sheet reflected a [AGE] year-old female initially admitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident # 31's quarterly MDS dated [DATE] reflected a BIMS of 15 which indicates no cognitive impairment. Review of Resident # 31's care plan dated 12/01/19 reflected resident is dependent on staff for meeting emotion, intellectual, physical and social needs with interventions to include staff to assist resident with showers, mobility, transfers and for staff to educated resident on the purpose, side effects of medications. Review of Resident # 31's pharmacy orders reflected order dated 12/20/19 for [MEDICATION NAME] tablet 1mg, give 1 tablet by mouth at bedtime for [MEDICAL CONDITION] disorder. Review of Resident # 31's Pharmacy Consult report dated January 1, 2020 through January 22, 2020 reflected comments noting resident receives [MEDICATION NAME] 1mg at bedtime for [MEDICAL CONDITION] disorder, but this is not a diagnosis, and recommendation to clarify diagnosis. Review of Resident # 31's Pharmacy Consult dated February 1, 2020 through February 12, 2020 reflected repeated recommendation from 1/22/2020 to respond promptly to assure facility compliance with Federal regulations. Resident receives [MEDICATION NAME] 1mg at bedtime for [MEDICAL CONDITION] disorder, but this is not a diagnosis, and recommendation to clarify diagnosis. 2. Review of Resident # 87's face sheet reflected an [AGE] year-old male admitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident # 87's quarterly MDS dated [DATE] reflected a BIMS of 3 which indicates severe cognitive impairment. Review of Resident # 87's care plan dated 2/26/19 reflected resident has [MEDICAL CONDITION] with interventions to include monitor and address environmental factors. Use of [MEDICAL CONDITION] medications with interventions to include monitor for involuntary movements and repetitive behaviors. ADL deficits with interventions to include assist with personal hygiene, mobility, dressing and transfers. Further review of care plan reflected resident has behavior and communication problems related to dementia with interventions to monitor behavior episodes and attempt to determine underlying cause. Review of Resident # 87's pharmacy orders reflected order dated 11/15/19 for [MEDICATION NAME] HCL tablet 50mg, give 1 tablet by mouth at bedtime for antidepressant. 3. Review of Resident # 85's face sheet reflected a [AGE] year-old male admitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident # 85's quarterly MDS dated [DATE] reflected a BIMS of 12 which indicates moderate cognitive deficit. Review of Resident # 85's care plan dated 1/30/18 reflected resident is diabetic with indications to administer hypoglycemic medications as ordered, educate resident and/or family members on the disease, complications and management. Monitor food and fluid intake and for signs and symptoms of hyper/[DIAGNOSES REDACTED]. Monitor resident's blood sugar values as ordered. Review of Resident # 85's pharmacy orders reflected order dated 11/15/19 for [MEDICATION NAME] HCL ER (anti-diabetic) tablet 500mg. Review of Resident # 85's pharmacy orders reflected order dated 11/21/19 to check blood sugar one time a day every Thursday. During an interview on 3/4/2020 at 7:03PM DON stated a resident is receiving medication and/or nursing services for a medical issue all [DIAGNOSES REDACTED]. During an interview on 3/4/2020 at 7:27PM ADM stated if a resident is receiving medications or diabetic services like blood glucose monitoring the [DIAGNOSES REDACTED]., physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident condition and response to care.