Printed: 03/17/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675118	A. Building B. Wing	11/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brush Country Nursing and Rehabilitation	6500 Brush Country Rd Austin, TX 78749

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (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

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 03/17/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675118	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/11/2025
NAME OF PROVIDER OR SUPPLIER Brush Country Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 6500 Brush Country Rd Austin, TX 78749	

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 2 of 9 (Resident #1 and Resident #2) residents reviewed for pharmacy services.The facility failed to order Resident #1's Percocet with Oxycodone timely to ensure Resident #1 did not run out on 11/09/2025. The facility failed to order Resident #2's Oxycodone timely to ensure Resident #2 did not run out on 11/10/2025. This failure could place residents at risk of not receiving the therapeutic benefits of medications which could lead to increased pain, and diminished quality of life. Findings Included:Resident #1 face sheet dated 11/11/2025 revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1's diagnoses included congenital malformation of nervous system (birth defects that affect the structure and function of the brain and spinal cord), somatization disorder (significant focus on physical symptoms, such as pain, weakness or shortness of breath, to a level that results in major distress and/or problems functioning), and fusion of the spine. Record review of Resident #1's quarterly MDS dated [DATE] revealed Resident #1 had a BIMS of 15 indicating cognitive responses. Record review of Resident #1's care plan dated 11/03/2025 revealed Resident #1 was diagnosed with Somatization disorder defined as a mental health condition where a person experiences significant physical symptoms, such as pain, that cause distress and interfere with daily life, despite a lack of clear medical explanation. Interventions were Monitor for s/s of high levels of anxiety and administer medication as ordered. Notify MD when resident complained of pain. Record review of Resident #1's physician orders dated 7/11/2025 revealed Percocet oral tablet 2.5-325mg (oxycodone w/ acetaminophen) give one tablet by mouth four times a day for chronic pain. Record review of Resident #1's MAR dated 10/2025 revealed Resident #1 was last administered Percocet on 11/09/2025 at 9:00pm. Resident #1 has missed 18 doses of her Percocet from 11/07/2025 to 11/11/2025 at 9:00a.m., 3:00p.m., 9:00p.m., and 3:00am. Resident #1's MAR indicated Other see progress notes. As to why it was not given. During an interview with Resident #1 on 11/11/2025 at 9:32a.m., revealed she was calm, laying on her back on her phone. Resident stated she was fine. Resident also said she had not gotten Percocet since Friday. She said she has extreme headaches, and a sore throat to where she could not talk at one point. She said her eyes are burning and watery. She said that her vagina was burning right now. She said she was having withdrawal from not getting her Percocet. She said her pain level was at a 9/10. She said she had been in pain since 11/4/2025. She also said the facility did offer tramadol once, but she said she does not take the tramadol because it gives her a bad headache. During an interview with Resident #1 on 11/11/2025 at 2:13p.m., revealed that the facility offered her Percocet since the medication came in Resident #1 said that she did not want the medication. She said the NP offered to up her vallum, to give her ibuprofen and Tylenol she said she did not want those medications. She said that the NP said she would find another pain medication for her. Record review of Resident #1's progress notes dated 11/07/2025 revealed Pt called EMS complained of vaginal discomfort. EMS arrived, evaluated pt, spoke with this nurse, and decided pts concern is not an emergency and can be addressed by NP on next business day. This offered pt prn Tramadol but pt refused med. This nurse spoke with NP for the Doctor who stated she will call in triplicate for pts oxycodone. Record review of Resident #1's progress notes dated 10/26/2025 revealed Pt has new complaint stating the oxycodone medication she takes is making her sweat profusely. This nurse points out to pt she is not sweating, and she was dry, but pt persist she is sweating, and it is a side effect of oxycodone.Record review of Resident #1's progress notes dated 10/27/2025 revealed Pt continues with somatic complaints. Pt stating, she has neuropathy, brain malfunctions, kidney malfunctions, vaginal burning, excessive sweating, allergy to Oxycodone, allergy to adult briefs. Pt states psych Dr does not know what he was talking about, NP does not know what she is talking about, and medical drs do not know what they are talking about. Record review of Resident #1's progress notes dated 11/08/2025 revealed Pt complained of vaginal discomfort. This nurse Offered pt her prn Tramadol and Ibuprofen. Pt very adamantly refused with son present stating those medicines make her brain hurt. Pt agreed to take Tylenol only. Record review of Resident #1's progress notes dated 11/09/2025 revealed NP returned call, stated she sent request for refill over this morning. Record review of Resident #1's progress notes dated 11/09/2025 revealed Pt called her husband and asked him to call 911 because she is stating she stating something is wrong with her voice and she cannot talk. 911 dispatch call here to receive report

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675118	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/11/2025
NAME OF PROVIDER OR SUPPLIER Brush Country Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 6500 Brush Country Rd Austin, TX 78749	

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. (continued on next page)

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 03/17/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675118	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brush Country Nursing and Rehabilitation	6500 Brush Country Rd Austin, TX 78749

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed make sure that drugs are stored properly and only authorized persons have access for 1 of 3 medication carts (MC #1) and the facility's only medication refrigerator reviewed for drug storage.The facility failed to ensure MC #1, was locked, medications secured, and not accessible to other staff, residents, or visitors. The facility failed to ensure the medication refrigerator was at the correct temperature for medications stored in the refrigerator. These failures could place residents at risk of having unauthorized access to medications, decreased effectiveness of medication, or missing medications. Findings included: 1.During an observation on 11/11/2025 at 1:26p.m., revealed medication refrigerator, had glycerin suppositories, Trulicity, Lantus, NovoLog, and Repatha. The temperature in the refrigerator was 52 F. During an interview with LVN A on 11/11/2025 at 1:57p.m., revealed she had been trained on medication storage. She said the policy for medication stored in the medication refrigerator was that staff were to check to daily to ensure the refrigerator was at the correct temperature. She said the night shift was responsible for checking the temperature on the medication refrigerator. She said if medication was not stored at the correct temperature the medication may not be efficient. She said she did not know who monitored to ensure the medication refrigerator was at the correct temperature. She said she did not know why the medication refrigerator was not at the correct temperature. During an interview with ADON on 11/11/2025 at 2:00p.m., revealed she had been trained on medication storage. She said the policy for the medication refrigerator was the temperature was to be checked daily on the night shift. She said the nurses who worked the night shift were responsible for checking the temperature on the MR. She said medication not stored at the correct temperature could cause unwanted side effects. She said she talked with maintenance and was told the facility recently got a new medication refrigerator. She also said 52 F was not acceptable temperature for the medication refrigerator and the facility was working on getting new medications to replace the ones that were not at the correct temperature in the medication refrigerator. During an interview with the DON on 11/11/2025 at 3:03p.m., the policy for storing medication in the medication refrigerator was the temperature was to be checked daily. She said the temperature range the medication refrigerator was supposed to be at was 36 F to 46 F. She said if the medication refrigerator was not within the correct temperature staff were to notify nursing management. She said the new company had not established who was to monitor the medication refrigerator. She said if the medication was not held at the correct temperature the medication would not be affective. She said the facility used the manufacturer's recommendations on the storage of the medication. She did not know why the medication refrigerator was not at the correct temperature. Record review of How to Use Your Lantus Solostar Pen: Lantus Storage not dated revealed Before opening store Lantus in the refrigerator (36 F to 46 F). Record review of Patient Information Repatha Injection not dated revealed Store REPATHA in the refrigerator between 36 F to 46 F. Record review of NovoLog Storage not dated revealed Store unused NovoLog pens and vials in refrigerator at 36 F to 46 F until expiration. 2.During an observation on 11/11/2025 at 3:24p.m., revealed MC #1, was on the 200-hall, was unattended and unlocked. MC #1 was near room [ROOM NUMBER]. There were no staff in sight of MC #1. MC #1 had residents' prescription medications, over the counter medications, and eye drops in MC #1. During an interview with MA B on 11/11/2025 at 3:27p.m., revealed she had been trained on medication storage. She said the policy for the MC was that the MC was to be locked any time staff were away from it. She said the nurses and medication aides were responsible for ensuring the MC were locked. She said the medication carts were to be always locked when not in use. She said if a MC was left unlocked and unattended a resident could get into the MC. She said all staff monitored to ensure staff were locking the MC. She said staff monitored by observations. She said she was going to see a resident, and she thought she had locked the MC. During an interview with the DON on 11/11/2025 at 4:08p.m., revealed she had been trained on medication storage. She said the policy for the MC was that it needed to be locked any time the nurses and medication aides stepped away from the cart. She also said if the cart is not within the nurses' eyesight it should be locked. She said if the medication was left unlocked and unattended a resident could get into the MC and ingest medication. She said leadership monitors to ensure staff are locking the medication carts. She said all managers monitored to ensure MC were locked. She said management monitored through observations. She said she did not know why the MC #1 was unlocked. During an interview with the ADM on 11/11/2025 at 3:48p.m., revealed she had been trained on medication storage