| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455866 | A. Building<br>B. Wing | 12/03/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brookdale Westlake Hills | 1034 Liberty Park Dr<br>Austin, TX 78746 |

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 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep residents' personal and medical records private and confidential.<br><br>(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 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that each resident has a right to secure and confidential personal and clinical records for one (Resident #2) out of 16 residents LVN B was providing care for on 12/03/2024. A. Resident #2's personal health information was left on the unlocked computer screen at the nursing station by LVN B. This failure could result in Resident #2's personal information being exposed to unauthorized individuals. This problem had the potential to affect all 16 residents in care of LVN B on 12/3/2025. The findings included:Record review of Resident #2's face sheet, dated 12/03/2025, revealed an 89-years-old female admitted on [DATE]. Resident's #2's diagnoses included hypothyroidism (underactive thyroid, happens when a thyroid gland doesn't make enough thyroid hormones to meet body's needs), essential hypertension (high blood pressure that is not due to another medical condition), gastro-esophageal reflux disease (a condition in which acidic gastric fluid flows backward into the esophagus, resulting in heartburn), malignant neoplasm of unspecified site of unspecified female breast (breast cancer).Observation on 12/03/2025, at 1:12 p.m. revealed the computer at the nursing station that LVN B was using for reviewing the order for Resident #2 he left unattended without minimizing the screen of the computer leaving the screen open. The computer screen was open with Resident #2's clinical information in Point Click Care (electronic health record system) displayed on the screen. This confidential information was opened for anyone such as visitors or other residents to see. During an interview on 12/03/2025, at 4:21 p.m. with LVN B, he stated that he never minimizes the screen of the computer as it turns off on its own. He said he was not sure how quickly the screen turned off, but he just knew it did. He stated that he was not trained to shut down the computer screen when leaving the nursing station. He stated that he received HIPAA training (Health Insurance Portability and Accountability Act which protects sensitive patient health information from disclosure without consent) at time of hire and annually. He said that he is responsible for closing the computer screen when leaving the nursing station. He stated that leaving a computer without minimizing the computer screen can lead to exposing residents' private medical information to not authorized personnel or public. During an interview on 12/03/2025, at 4:21 p.m. with ADON, she said that the facility's policy was to minimize the computer screen at the nursing station when stepping away from the computer. She stated that if the screen was not minimized someone could have unauthorized access to private clinical information of Resident #2. She said ADON, clinical manager, and ADM monitor the nursing station and nursing carts to ensure the screens are closed. She said they monitor through observation rounds. She said she did not know why the screen was left open at the nursing station. She stated that HIPAA policy in-service was provided to all employees at hire and annually educating them on locking the computer screens. She said that the person who works with residents' private clinical information should lock the screen before walking away. The potential negative effect would be sharing private residents' information with unauthorized personnel. During an interview on 12/03/2025, at 4:39 p.m. with ADM revealed all staff were trained on HIPAA at the time of hire by signing acknowledgements, and at least annually after that. He stated that if a computer is left open, it should be turned off to prevent unauthorized access. He stated that it is the responsibility of whoever works on the computer to make sure it is off before leaving the nursing station. He stated that ADON, clinical manager, and himself monitor the nursing station area all the time to prevent unauthorized personnel behind the nursing station. Record review of facility's staff in-service form dated 10/28/25 and titled: Use and disclosure of protected healthcare information revealed the following instructions to staff: Confidentiality/HIPAA Regulation: The Privacy Policy reflects practices that have been adopted by the facility to protect patients' privacy and security in relation to their Protected Health Information as defined under HIPAA regulation. It is the duty and responsibility of each staff person associated with this facility to be fully familiar with Privacy Policy and to comply with the requirements detailed within it. This in-service was signed by 28 nursing staff members and LVN B attended the training and acknowledged the completion of the HIPAA training. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to provide a safe and sanitary environment to prevent the development and transmission of communicable diseases and infections for 2 (Resident #1, Resident #2) of 7 residents reviewed for infection control. 1. The facility failed to properly use EBP personal protective equipment during wound care for Resident #1 and Resident #2.2. The facility failed to follow hand hygiene procedure during direct care for Resident #1. This failure could place residents at risk for infection transmission, sepsis, and hospitalization. Findings included: Record review of Resident #1's face sheet, dated 12/02/2025, revealed a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included malignant neoplasm of rectum (rectal cancer occurs when cells in the rectum mutate and grow out of control), major depressive disorder (persistently low or depressed mood), colostomy status (surgery to create an opening for the colon (large intestine) through the belly (abdomen) to allows stool and gas to leave your body when they can't pass through anus, essential hypertension (high blood pressure). Observation on 12/03/2025 at 11:06 a.m. revealed LVN A did not put on the personal protective equipment (gown) before starting the wound care, colostomy (surgical opening in the abdomen to allow stool to exit the body when part of the colon is not functioning properly) and urostomy (a surgical diversion that creates an opening (stoma) in the abdomen to redirect urine from the bladder to an external pouch) care for Resident #1. She did not sanitize her hands between change of the gloves and used contaminated gloves when reached for clean wound care supplies after she cleaned the area around the sacral wound (the triangular region at the base of the spine, just above the buttocks). Record review of Resident #1's order dated 11/4/2025, revealed Sacral wound to clean with normal saline. Pat dry. Apply Anapest with collagen powder. Skin prep peri wound. Cover with foam dressing daily and as needed.Record review of Resident's order dated 11/10/2025 revealed this resident was on contact precautions for urine and enhance barrier precautions (used for infection prevention and control intervention designed to reduce transmission of multidrug resistant organisms to other residents in nursing homes).During an interview on 12/03/2025, with LVN A, she stated that she had an in-service on enhanced barrier precautions and contact precautions protocol with infection control policies earlier this year. She said that enhanced barrier precautions include wearing a gown and gloves when conducting all invasive nursing procedures like wound care and stomas (surgical opening in the body). She stated that she was supposed to wear a gown and gloves when completing wound care and colostomy and urostomy care for Resident #1. She stated that it was too hot in the room and that's why she did not wear the gown, but she had it on earlier in the morning with this patient. She stated that she understood that the negative effect of not following proper EBP or contact precautions every time would be spreading infection and cross contamination. She stated that she is aware of the facility policy for sanitizing hands between gloves change. She stated that not sanitizing her hands could lead to spreading the infection. Observation on 12/03/25, at 1:15 p.m., revealed LVN B performed the wound care for Resident #2. He did not put on the personal protective equipment (gown) before the start of wound care procedure.Interview on 12/03/2025, at 1:25 p.m. with LVN B revealed that he was trained on following EBP protocol for all invasive procedures with residents. He had an in-service on EBP today, 12/03/2025. Nurses are responsible for following the policy He stated that he was aware of potential risk if not following the EBP protocol would be cross contamination and passing the infection to other residents which is detrimental for vulnerable populations in long term care facilitates. Record review of Resident #2's face sheet, dated 12/03/2025, revealed an 89-years-old female admitted on [DATE]. Resident's #2's diagnoses included hypothyroidism (underactive thyroid, happens when a thyroid gland doesn't make enough thyroid hormones to meet body's needs), essential hypertension (high blood pressure that is not due to another medical condition), gastro-esophageal reflux disease (a condition in which acidic gastric fluid flows backward into the esophagus, resulting in heartburn), malignant neoplasm of unspecified site of unspecified female breast (breast cancer).Observation on 12/03/25, at 1:15 p.m., revealed LVN B performed the wound care for Resident #2. He did not put on the personal protective equipment (gown) before the start of wound care procedure.Interview on 12/03/2025, at 1:25 p.m. with LVN B revealed that he was trained on following EBP protocol for all invasive procedures with residents. He had an in-service on EBP today, 12/03/2025. 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