STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455866	A. Building B. Wing	02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookdale Westlake Hills	1034 Liberty Park Dr 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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51512 Based on record review and interview, the facility failed to ensure that the resident has the right to be informed of, and participate in, his or her treatment, including the right to be informed in advance of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers for 2 (Residents #8 and #10) of 6 residents reviewed for unnecessary medications. 1. The facility failed to obtain signed consent prior to administering psychotropic medication Depakote for Resident #8. 2. The facility failed to obtain signed consent prior to administering psychotropic medications Trazodone, Depakote, and Seroquel for Resident #10. These failures could place residents at risk of receiving medications without prior consent and without the option choose alternative treatment or decline based on awareness of risk and benefits of the medications. Findings include: 1. Record review of Resident #8's face sheet dated 6/13/2024 revealed resident is [AGE] year old female with relevant diagnoses of cognitive communication deficit (an impairment in the thought processes that can impact a person's ability to think, speak, read, and interact with others); unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (progressive disorder that impairs thought processes, such as memory, thinking, reasoning, and decision-making causing interference with daily life and activities); anxiety disorder, unspecified (mental health condition characterized by excessive worry, fear, and/or nervousness that can significantly interfere with daily life); and depression (mental health condition that can cause persistent sadness, low-self-esteem, and loss of interest in activities affecting a person's thoughts, feelings, and behaviors). Record review of Resident #8's MDS dated [DATE] revealed BIMS of 13, suggesting intact cognition. Diagnoses of dementia, anxiety disorder, and depression (other than bipolar) were documented. (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review on 2/12/2025 of Resident #8's active orders in the electronic medical record included psychoactive medication of Depakote oral tablet delayed release 125mg (Divalproex Sodium), 1 tablet by mouth two times a day for impulsivity/agitation related to unspecified dementia with an order date of 2/4/2025. Further review of Resident #8's medical records revealed that resident had been receiving Depakote as ordered. Record review of Resident #8's medical record reflected a signed consent for medication Depakote was unable to be located. During an interview with DON on 2/14/2025 at 09:08AM, the DON was notified of signed consent for Depakote prescribed for Resident #8 was not able to be located within the electronic medical record. The DON stated that she would look further into the medical record as well as paper records to locate the document but was unable to recall if consent had been obtained prior to medication initiation. The DON stated that the facility process was to obtain informed consent prior to administration of psychoactive medication and that consents were typically obtained after care plan meetings. The DON also stated that she reviewed orders daily through a generated report and would identify orders requiring consent during this process. The DON stated that failure to obtain consent could cause a delay in care for the resident as medications that required consent would not be administered until consent was obtained. The Administrator provided a signed consent for Depakote on 2/14/2025, dated 2/14/2025, (ten days after resident began receiving medication). 2. Record review of Resident #10's face sheet dated 7/25/2022 revealed resident is [AGE] year old male with relevant diagnoses of bipolar disorder, current episode depressed, moderate (mental health condition characterized by periods of extreme depression and elevated mood); schizoaffective disorder, bipolar type [mental health condition that combines symptoms of schizophrenia (chronic mental health condition that causes difficulty distinguishing reality from their own thoughts and affects a person's thoughts, feelings, and behaviors) and bipolar disorder]; major depressive disorder (depression disorder that significantly interferes with daily life); and anxiety disorder. Record review of Resident #10's MDS dated [DATE] revealed BIMS of 15, suggesting intact cognition. Diagnoses of anxiety disorder, depression (other than bipolar), manic depression (bipolar disease), and schizophrenia (e.g., schizoaffective and schizophreniform disorders) were documented. Record review on 2/12/2025 of Resident's #10's active orders in the electronic medical record included psychoactive medications Trazodone HCl Tablet (medication used to treat depression) 50mg, give 0.5 tablet by mouth at night for insomnia (difficulty sleeping) with an order date of 2/7/2025; Trazodone HCl Oral Tablet 100mg, give 1 tablet by mouth at night for insomnia; Seroquel tablet 300mg (antipsychotic medication used to regulate mood/behaviors/thoughts), give 0.5 tablet by mouth at night for bipolar disorder with an order date of 8/1/2022; and Depakote Tablet Delayed Release 500mg with an order date of 7/26/2022, give 1 tablet by mouth twice daily for bipolar disorder. Further record review revealed that effective 10/21/2021, Resident #10 legal guardianship was appointed to third party representative (representative) by [NAME] County Probate Court #1. Representative was given authority to make decisions regarding medical care. The following signed consents were also located within the electronic medical record: (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Seroquel, quantity 1, dosage 150, frequency QHS (time of sleep), start date 07/21/2023. Consent was signed 1/23/2024 with two illegible signatures on signature- Resident or Resident's Representative signature area. There is a handwritten note stating verbal permission unable to sign/tremors indicating that resident provided self-consent, verbally. 2. Texas HHS Form 3713 Consent for Antipsychotic or Neuroleptic Medication Treatment for medications listed as: continue as ordered and risks and benefits listed as continue as ordered/ psych eval & treat. Consent was signed 11/22/2022 by health care professional proposing treatment. There is illegible signature on resident or resident's representative signature area and date of 12/28/2022. As this document did not contain specific names of any medications, it could not be attributed to any physician orders during record review. 3. Consents for Trazodone and Depakote were unable to be located within the electronic medical record. Consent for current dosage of Seroquel was also unable to be located within the electronic medical record. During an interview with DON on 2/14/2025 at 09:08AM, the DON was notified that signed consents for current antipsychotic medications prescribed to Resident #10 were unable to be located the electronic medical record. The DON stated that she would look further into the medical record as well as paper records to locate the document. The DON acknowledged that Resident #10 had legal appointed guardian and consent for treatment, including verbal consent, must be obtained from guardian, not resident. The DON stated that the facility process was to obtain informed consent prior to administration of psychoactive medication and that consents were typically obtained after care plan meetings. The DON also stated that she reviewed orders daily through a generated report and would identify orders requiring consent during this process. The DON stated that failure to obtain consent could cause a delay in care for the resident as medications that required consent would not be administered until consent was obtained. The Administrator provided signed consents on 2/14/2025 for Trazodone and Depakote, both documents were dated 2/14/2025 and indicated verbal consent had been obtained from representative. A signed consent for current dosage of Seroquel was not provided at this time.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47611 Based on observation, interview and record review the facility failed to ensure residents received services in the facility with reasonable accommodation of resident needs for 1 of 8 residents (Resident #24) who were observed for call light placement. The facility failed to ensure the call light was within reach for Resident #24. This deficient practice could affect any resident and keep them from calling for help as needed. The findings were: Record review of Resident #24's face sheet, dated 02/13/2025, revealed he was admitted to the facility on [DATE] with diagnoses which included: fracture, cognitive communication deficit, cerebrovascular disease (condition that affects blood flow to the brain), and muscle weakness. Record review of Resident #24's MDS assessment, dated 12/01/2024, revealed the resident's BIMS score was 7, which indicated severe cognitive impairment. The MDS assessment further revealed Resident #24 required substantial/maximal assistance (helper does more than half the effort) for ADL assistance. Record review of Resident #24's care plan, initiated date of 11/27/2024, revealed Resident #24 is at risk for falls d/t general weakness and severe cognition impairment and Be sure call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Observation on 02/12/2025 at 10:31 a.m. revealed Resident #24 lying in bed with his call light lying between the bed frame and bed mattress, out of view and reach of the resident. During an interview on 02/12/2025 at 4:19 pm LVN C observed the call light was not visible to the resident and the resident was unable to reach it. He stated the potential for harm could be a lack of care due to the resident unable to call for help. During an interview on 02/14/2025 at 10:45 am the DON stated that where the call light was located, the resident would not be able to see it or reach it and it should be within the resident's reach. She stated the potential for harm cold be a lack of care since the resident would be unable to use the call light to call for help. She stated that the resident would benefit from a push call light that is placed within reach and visible. Record review of facility's Safety for Residents policy, implemented date 07/2015, read Residents should have a signal device placed within reach. If the resident cannot utilize the community standard call system, an adaptive signal device should be utilized. If the resident cannot utilize an adaptive signal device, provide frequent monitoring to identify resident (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	needs.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51512 Based on observation, 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 two of two medication rooms (second floor and third floor medication rooms) reviewed for pharmacy services. The facility failed to ensure the second and third floor medication rooms did not contain expired supplies. These failures could place residents at risk of receiving inadequate treatments or results or ingesting medications for which they were not prescribed. The findings included: 1. During an observation on [DATE] at 2:30 PM of the second-floor medication storage room with LVN A, expired luer locks (fittings used to secure needles to syringes) were discovered in the storage drawers. During an interview with LVN A on [DATE] at 2:31 PM, when asked what could happen if expired supplies were used on residents, LVN A stated a resident could get an infection or have an adverse effect. During an observation on [DATE] at 3:15 PM of the third-floor medication storage room with LVN B, expired PICC (peripherally inserted central catheter) line starters, expired collection swabs, and expired luer locks were observed on the storage shelves in the room. During an interview with LVN B on [DATE] at 3:17 PM, when asked what could happen if expired supplies were used on residents, LVN B stated a resident could get false results. Review of the facility's policy titled Storage and Expiration Dating of Medications and Biologicals, dated [DATE] and revised on [DATE], noted the facility personnel should inspect nursing station storage areas for proper storage compliance on a regularly scheduled basis. Review of the facility's policy titled Storage and Expiration of Medications, Biologicals, Syringes and Needles, dated [DATE] and revised on [DATE], noted the facility should ensure that medications and biologicals for each resident are stored in the containers in which they were originally received.

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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. 50760 Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals used in the facility were stored and labeled in accordance with currently accepted professional principles for 1 of 1 medication rooms (third floor medication room) and one of four medication carts (third floor Hall E medication aide cart) assessed for drug storage and labeling, as evidenced by: The facility failed to ensure all medications located inside the third floor Hall E medication aide cart were properly labeled. These failures could place residents at risk of receiving inadequate treatments or results or ingesting medications for which they were not prescribed. The findings included: 2. During an observation on 02/12/25 at 3:00 PM of the E Hall medication aide cart on the 3rd floor with MA A, a dosing cup of 1.5 yellow tablets was observed sitting in the med cart drawer in an unlabeled clear dosing cup. During an interview with MA A on 02/12/25 at 3:01 PM, when asked what could happen if unlabeled pills are left in the med cart, MA A stated I don't know. Review of the facility's policy titled Storage and Expiration Dating of Medications and Biologicals, dated 12/01/07 and revised on 08/1/24, noted the facility personnel should inspect nursing station storage areas for proper storage compliance on a regularly scheduled basis. Review of the facility's policy titled Storage and Expiration of Medications, Biologicals, Syringes and Needles, dated 12/01/07 and revised on 01/01/13, noted the facility should ensure that medications and biologicals for each resident are stored in the containers in which they were originally received.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51512 Based on observations and record review, the facility failed to store food in accordance with professional standards for food service safety. 1. The facility failed to maintain refrigerated storage area free of contaminants and store food off flooring. 2. The facility failed to discard food items that were beyond labeled use-by date. 3. The facility failed to label food items with use-by date and date items were opened. 4. The facility failed to ensure items in the freezer were covered. These failures could place residents at risk for food contamination and foodborne illness. Findings included: Observation and interview on [DATE] at 10:00AM revealed: During tour of walk-in refrigeration area, food items were found underneath storage racks on the floor, including a cracked egg, a portion of sliced cake in plastic clamshell container, and a red onion. Clinical Dietary Manager confirmed these items should not be stored underneath the storage racks on the floor and that area underneath should be free from debris. Individual portions of orange juice with labeled date of ,d+[DATE] were found in refrigerator, indicating that the juices were expired. The Clinical Dietary Manager confirmed the juices were expired and should not be in the refrigerator. Inside of chest freezer, individual portions of ice cream were found in freezer without labeling of date portioned or date that the items were to be used by. The Clinical Dietary Manager confirmed the ice cream was not dated or labeled properly. Inside of chest freezer, 4 of 5 large tubs of ice cream were observed to be stored without sealed covers. The Clinical Dietary Manager confirmed the large tubs of ice cream were not sealed with covers. Record review on [DATE] of facility titled Food Storage- DS-04.013 revised ,d+[DATE], stated the storerooms and walk-ins should be maintained free from dirt, dust, insects, rodents or any potential sources of contamination. The same policy also states all food should be stored on storeroom shelving that is no less than 6 from the floor . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of FDA Food Code 2022 Section ,d+[DATE].17 Ready to Eat/Temperature Control for Safety Food, Date Marking: (A) (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S ,d+[DATE].12, and except as specified in (E) and (F) of this section, refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51512 Based on observations, interview, and record review, the facility failed to maintain an infection prevention control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 4 residents (Resident#40 and Resident #10) reviewed for infection control related to isolation precautions. 1. The facility failed to ensure isolation precaution signage and personal protective equipment (PPE) were in place for Resident #40 who had been identified as requiring enhanced barrier precautions (EBP). 2. The facility failed to ensure CNA A utilized isolation precautions, including PPE and hand hygiene, for Resident #10, who had been identified as requiring contact precautions. These failures could result in the spread of infection to other residents and staff. The findings included: 1. Record review of Resident #40's face sheet dated 1/27/2025 revealed resident [AGE] year-old male with relevant diagnoses of cutaneous abscess of left axilla (an infection of the tissue between the left chest and shoulder, commonly known as the armpit) and benign prostatic hyperplasia (enlargement of the prostate gland that can cause difficulty or inability to urinate). Record review of Resident #40's MDS dated [DATE] revealed BIMS of 12, suggesting moderately altered cognition. MDS also reported that resident had indwelling foley catheter (device inserted externally through urethra into bladder to allow passage of urine) and surgical wound requiring surgical wound care. Record review on 2/12/2025 of Resident #40's active orders in the electronic medical record included orders for ongoing care of indwelling catheter (orders dated 1/28/2025), wound care to wound on left chest (order dated 1/29/2025), and enhanced barrier precautions (EBP) for (foley/wounds) (order dated 1/28/2025). During observation on 2/12/2025 at 10:16AM, it was noted that there was no signage indicating EBP precautions or PPE cart present on exterior of Resident #40's room. During additional observation on 2/12/2025 at 3:20PM, EBP signage and PPE remained absent. Interview with LVN C commenced on 2/12/2025 at 3:24PM. LVN C indicated awareness of Resident #40's order for EBP precautions and was unaware that signage and PPE cart were not in place. LVN C stated that EBP precautions included gown, gloves, and washing hands before taking care of resident to prevent infection. At completion of interview, LVN C placed EBP signage and PPE cart at exterior of resident's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A policy titled Enhanced Barrier Precautions Policy revised 02/2025 was provided by Administrator on 2/13/2025. Relevant text includes: 9. Signs are posted in the door or wall outside the resident room indicating EBP precautions and PPE are required. 10. PPE is available prior to entering the resident rooms. During interview with DON on 2/14/2025 at 09:08AM, DON reported awareness of absent EBP and PPE cart for Resident #40 on 2/12/2025. DON stated that the required elements for EBP precautions had been in place previously and was unsure why items were not present on that date. DON stated that the need for EBP precautions is typically discovered during interdisciplinary care plan meetings and then implemented immediately. DON stated that all staff have been trained on the required elements of EBP precautions and are expected to always adhere to requirements to prevent infection. 2. Record review of Resident #10's face sheet dated 7/25/2022 revealed resident is [AGE] year old male with diagnosis of need for assistance with personal care. Record review on 2/12/2025 of Resident #40's active orders in the electronic medical record included order dated 2/6/2025 stating place Pt on contact isolation whilst under tx for MRSA UTI (place patient on contact isolation whilst under treatment for methicillin-resistant staphylococcus urinary tract infection). Additional order was present that stated contact isolation for MRSA in urine dated 2/12/2025. During observation on 2/12/2025 at 10:09AM, Resident #40 was noted to have signage present on exterior wall indicating contact precautions and PPE cart near doorway. CNA A was observed entering resident's room without performing hand hygiene and without donning PPE. CNA A took the breakfast tray from resident's bedside table and then exited room with tray without performing hand hygiene. Dual interview with CNA A and CNA B commenced on 2/12/2025 at 10:45AM. CNA A stated that she was aware of contact precautions in place for Resident #40. CNA A stated that contact isolations included wearing a gown, gloves, and mask at all times when in resident's room. CNA B stated that hand sanitizer should be used when you enter the room. CNA A stated that she should not have entered the room without donning PPE but that she felt it was acceptable because she was just grabbing the tray. CNA A stated that not using precautions can cause infection. During interview with DON on 2/14/2025 at 09:08AM, DON stated that all staff have been trained on isolation precautions, including donning PPE on entry if the type of isolation requires it. DON was then notified of observation on 2/12/2025 of CNA A entering Resident #40's room without following contact isolation procedure, and DON indicated that she was already aware of the incident. DON stated that CNA A is not usually on the floor and coming here to help but is now aware of requirements.