

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2024
NAME OF PROVIDER OR SUPPLIER Brookdale Lakeway Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 1917 Lohmans Crossing Rd Lakeway, TX 78734	

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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47795</p> <p>Based on interviews, and record review, the facility failed to ensure each resident's person-centered comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment for 2(Residents #14, and # 58) of 16 residents reviewed for care plans.</p> <p>The facility failed to ensure Resident #14's comprehensive care plan was updated when wound care was ordered to his left knee.</p> <p>The facility failed to ensure Resident # 58's comprehensive care plan was updated when the external feeding was discontinued.</p> <p>This failure could place residents at risk of receiving inadequate or unnecessary interventions not individualized to their health care needs.</p> <p>The Findings included:</p> <p>Record review of Resident # 14's Quarterly MDS dated [DATE] revealed an [AGE] year old male admitted to the facility on [DATE] and 08/13/2020 with diagnoses that included Acquired Absence of Kidney (surgical removal of Kidney), Epilepsy (a brain condition that causes recurring seizures due to abnormal electrical signals) Dementia (long term brain disorder causing personality changed and impaired memory, reasoning, and social function) and a BIMS score of 15 (cognitively intact). No R wounds were coded as the wound were found after the assessment and submission date.</p> <p>Record review of Resident # 14's Physician's orders dated 7/10/2024 revealed an order for clean left knee wound with wound cleaner, pat dry, and cover with padded dressing on Monday, Wednesday, Friday and as needed.</p> <p>Record review of Resident #14's Physician progress noted dated 7/9/2024 read: small abrasion today-no sign of infection, cover with padded dressing on shower days.</p> <p>Record review of Resident #14's Care plan updated on 07/05/2024 revealed no indication of wound to left knee.</p> <p>(continued on next page)</p>

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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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident # 58 Quarterly MDS dated [DATE] section A revealed a [AGE] year-old male admitted [DATE]. Section I revealed diagnoses that include unspecified nondisplaced fracture of sixth cervical vertebra (a break in the bones of the spinal cord), Dysphagia Pharyngoesophageal phase (difficulty with the swallowing reflex and squeezing down into the throat). Section C revealed a BIMS score of 13 (Cognitively intact). Section K revealed no feeding tube present.</p> <p>Resident # 58's Physician's orders printed 7/31/2024 revealed Bolus feeding Peptamen 1.5-250 ml bolus x 5 per day discontinued on 5/7/2024. Regular diet started on 5/3/2024.</p> <p>Record review of Resident # 58's Nurse Practitioner Notes dated 7/5/2024 read, resident was tolerating regular diet.</p> <p>Record review Resident # 58's care plan revised on 5/18/2024 revealed focus for nutritional risk need for tube feeding. Interventions were updated with diet and dc of feedings.</p> <p>Interview on 07/31/24 at 09:45 AM with LVN C stated the nurses do have the ability to update care plans in the computer system but she does not do that. She stated if she had an order to remove a line/tube, she would remove it and document in the notes that she had removed it. She stated for new wounds she was responsible for the order and the wound care. She stated she would not update the care plan. She stated the MDS nurse or DON was responsible for updating care plans.</p> <p>07/31/24 09:54 AM MDS Nurse, stated she was responsible for care plans, but the clinical supervisors and other nurses also help. But ultimately, she was responsible for the CPs. She stated when a line/tube is removed, the care plan should be updated at that time, or any change that requires a care plan update. She stated she tried to update CPs as soon as she was aware of a change. She stated if a there was a change in the resident condition, the CP should be updated the same day or at least the next day. She stated they have clinical team meetings weekly - the team includes DON A</p> <p>Clinical supervisor, and herself. Not updating the CP, resident may not get needed care. She stated the IDT -dietary, DON MDS, SS, DC planners, Act. Dir review care plans and orders. It does not meet her expectations that a PEG tube that was removed in May was still on the Care Plan on July 30th. Regarding a new wound not on the care plan, it should be reflected on the care plan. Adverse/negative outcome? - Don't get proper care.</p> <p>Interview on 07/31/24 at 02:22 PM with DON B said when MDS got notified of changes in the resident care the care plan it should be updated. When orders reviewed it should have come off the chart. Morning meeting, Care plans not reflecting the actual care doesn't meet expectations as they wouldn't receive the care they needed.</p> <p>Interview with the ADM on 07/31/24 at 03:04 PM, the ADM stated the care plans not reflecting the residents need does not meet expectation. The care plan should be updated as soon as possible but at least at the weekly clinical meeting. The MDS nurse updates and the IDT over sees the process. Residents cannot receive the care they need or deserve if the care plan was not updated.</p> <p>Review of the Policy Comprehensive Care Plan - SOM revised 08/2009</p> <p>5. The Care Plan process assesses and is developed to meet the resident's medical, nursing, mental and psychosocial needs.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>9. Care plans will be revised as information about the resident and the resident's condition changes.</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44317</p> <p>Based on interview and record review, the facility failed to ensure a resident who entered the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates the catheterization is necessary for 1 of 5 residents (Resident #22) reviewed for incontinent and catheter care.</p> <p>The facility failed to obtain physician orders for Resident #22's indwelling catheter, catheter care, and maintenance.</p> <p>This failure could place residents at risk of infection or accidental dislodgement.</p> <p>Findings included:</p> <p>Review of Resident #22's 5-day MDS assessment, dated 07/13/24, Section A (Identification Information) reflected an [AGE] year-old male originally admitted to the facility 04/18/24 and readmitted on [DATE]. Section I (Active Diagnoses) reflected his current diagnoses included cancer, iron deficiency anemia due to blood loss - chronic (lack of red blood cells in the blood), coronary artery disease (the blood vessels supplying blood to the heart are blocked), end stage renal disease (loss of function of the kidneys), and obstructive uropathy (urine cannot drain due to blockage). Section C (Cognitive Patterns) reflected a BIMS score of 14 indicating intact cognition. Section GG (Functional Abilities) reflected he was able to feed himself and perform his own oral hygiene but was dependent for all other ADL care. Section H (Bladder and Bowel) reflected an indwelling catheter.</p> <p>Review of Resident #22's comprehensive care plan revised 05/08/24, reflected in part, Focus: Resident has indwelling catheter r/t obstructive uropathy. Goal: Resident will be/remain free from catheter-related trauma through review date. Interventions/Tasks: Catheter care per policy. Change catheter as per MD orders. Check tubing for kinks. Monitor and document intake and output as ordered .Secure catheter to reduce friction.</p> <p>Review of Resident #22's Bladder Continence task from 07/18/24 to 07/30/24 reflected 12 entries of Continence not rated due to indwelling catheter.</p> <p>Review of Resident #22's clinical physicians orders printed 07/29/24 reflected no orders for an indwelling catheter and no orders for indwelling catheter care or maintenance.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 07/31/24 at 9:45 AM, LVN C stated Resident #22 had an indwelling catheter. She stated she had provided catheter care and placed the drainage bag inside a privacy bag before she sent the resident to the acute hospital on 07/30/24. She stated she expected to see physician orders for anyone with an indwelling catheter. She stated there were batch orders for catheters that included catheter care and maintenance. She stated the orders appeared on the TAR (treatment administration records) where the nurses recorded the care provided. LVN C pulled up the electronic medical record for Resident #22 but was not able to locate an order for the indwelling catheter or for the care and maintenance of the catheter. She stated, Maybe the orders fell off the record when he recently returned from the acute hospital. She stated if there was not an order for the catheter or for care of the catheter, staff may not have known he had a catheter and then not provided proper care. She stated not caring for a catheter could lead to infection.</p> <p>During an interview on 07/31/24 at 9:54 AM, the MDS Nurse stated, there needed to be a physician order for and indwelling catheter. She stated if there was a resident with a catheter but no order, the physician should have been contacted to clarify if the catheter should remain or removed. If the catheter remained, there should have been orders for care and maintenance. She stated the admitting nurse was responsible to clarify the order.</p> <p>During an interview on 07/31/24 at 10:20 AM, MA H stated she had assisted Resident #22 many times. She stated the resident had an indwelling catheter and he had recently told her the catheter was pulling a little bit. She stated she reported the pulling to the nurse.</p> <p>During an interview on 07/31/24 at 10:41 AM, CNA D stated Resident #22 had a catheter, and he always used the drainage bag as he did not like to use a leg beg. She stated she provided catheter care and documented it in the electronic medical record in the ADL charting. She stated the resident always used a stabilization device to keep the catheter from pulling. She stated she had to wear PPE when providing care to Resident #22 because he had a catheter. She stated not wearing PPE or not providing catheter care could lead to the spread of infection.</p> <p>During an interview on 07/31/24 at 2:22 PM, interim DON B stated it was her expectation that orders for catheters were in place and the care documented on the TAR. It did not meet her expectation that there was no order for Resident #22's indwelling catheter. She stated that both her and the other interim DON should have monitored for physician orders. She stated without catheter orders and proper care, residents were at risk of infection.</p> <p>During an interview on 07/31/24 at 3:04 PM, the ADM deferred clinical questions to interim DON A.</p> <p>During an interview on 07/31/24 at 3:07 PM, interim DON A stated it was her expectation that there was an order for an indwelling catheter that included the size of the catheter and the care required. She stated if there was not an order for the catheter, staff may not have known it was present and not provided the correct care. She stated if proper care were not provided, it could have led to infection. She stated all orders should have been reviewed in the supervisor huddle meetings.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy Procedure: Urinary Catheter Care revised August 2023, reflected in part, General Guidelines: 1. Determine if the resident is on intake or output before discarding urine. 2. Check urine for unusual appearance. Record findings. 3. Maintain a daily record of resident's daily fluid intake and output, as indicated. Preparation: 1. Verify that there is a healthcare provider's order for this procedure . Documentation: The following information should be recorded in the resident's medical record: 1. The date catheter care was given. 3. How resident tolerated the procedure .</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Post nurse staffing information every day.</p> <p>44317</p> <p>Based on observation, interview, and record review the facility failed to ensure the nurse staffing information was posted on a daily basis and included the total number and the actual hours worked by licensed and unlicensed nursing staff for 3 of 5 days (07/26/24, 07/27/24, and 07/28/24) reviewed for nurse staffing and the facility failed to maintain the posted daily nurse staffing data for a minimum of 18 months.</p> <p>1</p> <p>The facility failed to ensure the Daily Staffing log contained the total number and actual hours worked of licensed and unlicensed nursing staff directly responsible for resident care per shift for registered nurses, licensed practical or vocational nurses, and certified nurse aides on 07/26/24, 07/27/24, and 07/28/24.</p> <p>2</p> <p>The facility failed to maintain the nurse staffing data from February 2023 through July 31, 2024.</p> <p>These failures could place residents and visitors at risk of not knowing the current staffing and not being able to request the daily nurse staffing data record for the last 18 months.</p> <p>Findings included:</p> <p>An observation on 07/29/24 at 9:01 AM revealed the staffing information posted at the reception desk. The date on the posted information was 07/25/24. The form did not contain the number of actual hours worked by licensed and unlicensed nursing staff.</p> <p>During an interview on 07/31/24 at 12:30 PM, the ADM stated she had some staffing sheets for the last 18 months, but they did not have all of the forms. She stated some of the forms had been lost or maybe thrown out. She provided documents they had for the last 18 months.</p> <p>During an interview on 07/31/24 at 1:37 PM, the Scheduler stated she had been in her current position since late June, and she was responsible for posting the staffing information. She stated she posted the forms daily. She stated she initiated the documents in advance for the weekends and the receptionist was responsible for ensuring to display the correct form to match the date. She stated she did not know why the form for 07/25/24 was posted on 07/29/24. She stated she was responsible to update the actual hours worked on the form depending on the shift. After hours, the charge nurse was supposed to update the hours worked. She stated the director of clinical services monitored the posted staffing. She stated it the forms were not posted daily the families would not know how many staff were on hand and how their loved ones were cared for.</p> <p>(continued on next page)</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 07/31/24 at 2:22 PM, interim DON B stated she expected the staffing to be posted with the correct information at the start of the day. She stated the actual hours worked would have been updated each shift. She stated the scheduler was responsible to post the information. Interim DON B stated the nursing supervisor was responsible to post the information. She stated it did not meet her expectations that the posting on 07/29/24 was dated 07/25/24 and the actual hours worked were not updated. She stated it was important to post the information so visitor and family would know how many staff were working.</p> <p>During an interview on 07/31/24 at 2:54 PM, the Receptionist stated she was aware of the staffing numbers because they were in a frame on the reception desk. She stated the plan was to have the prepared staffing sheets in the frame then on the weekends the receptions would display the form to match the current date. The receptionist stated she worked on 07/27/24 and 07/28/24. She stated she had not changed the form over the weekend because she did not have any prepared forms available.</p> <p>During an interview on 07/31/24 at 03:04 PM, the ADM stated she expected the staffing was posted daily in a visible location. She expected the scheduler reviewed the forms for changes and updated as needed. She expected the forms to be retained, in one location, for at least 18 months. She stated knowledge is power and residents and visitor should have the staffing information available for understanding of staffing.</p> <p>Review of retained posted staffing documents for the last 18 months reflected, from 02/01/24 through 06/30/24, there were forms for only 25 days.</p> <p>Review of the policy titled Benefits Improvement Protection Act Daily Associate Posting, revised 02/23, reflected in part, 1. On a daily basis, a designated associate should post the community-specific number of direct caregivers scheduled for each shift in a 24-hour period by categories of nursing associates employed by the community . 5. Data from the forms must be retained for 18 months.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44317</p> <p>Based on observation, interviews and record reviews, the facility failed to ensure that residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record for 1 (Resident #56) of 5 residents reviewed for unnecessary medications.</p> <p>The facility failed to ensure Resident #56 had a preexisting mental illness for which an antipsychotic medication (Seroquel) would be warranted.</p> <p>This failure could place residents at risk for unnecessary psychotropic drug use.</p> <p>Findings included:</p> <p>Review of Resident #56's admission MDS assessment dated [DATE], Section A (Identification Information) reflected a [AGE] year-old female admitted to the facility on [DATE]. Section I (Active Diagnoses) reflected diagnoses including hypertension (high blood pressure), urinary tract infection, hyperlipidemia (abnormally high level of fats in the blood), thyroid disorder, non-Alzheimer's dementia, anxiety disorder (intense and excessive worry and fear), depression, and metabolic encephalopathy (a group of conditions that cause brain dysfunction). Section C (Cognitive Patterns) reflected a BIMS score of 3 indicating severely impaired cognition. This section also reflected disorganized thinking was continuously present. Section E (Behavior) reflected no hallucinations or delusions. This section also reflected no physical, verbal, or other behavioral symptoms present and there was no rejection of care or wandering. Section N (Medications) reflected the resident was taking antipsychotic and antidepressant medications.</p> <p>Review of Resident #56's physician's orders reflected an order dated 07/09/24, Seroquel oral tablet 25mg give 1 tablet by mouth two times a day for behaviors.</p> <p>Review of Resident #56's MAR and TAR for July 2023, reflected nursing administered the Seroquel as ordered. The MAR and TAR reflected nursing monitored the resident each shift for side effects. From 07/09/24 through 07/31/24, nursing documented confusion as a side effect on three shifts. The MAR and TAR reflected nursing monitored the resident each shift for behaviors. From 07/09/24 through 07/31/24, nursing documented behaviors on two shifts.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #56's comprehensive care plan initiated on 07/09/24, reflected in part, Focus: Resident has impaired cognitive function/dementia or impaired thought process. Goal: Resident will maintain current level of cognitive function through the review date. Interventions/Tasks: Communicate with Resident/family/caregivers regarding resident capabilities and needs. Explain care and procedures to resident prior to beginning. Focus: Resident uses psychotropic medications. Goal: Resident will be/remain free of drug related complications . Interventions/Tasks: Administer medications as ordered. Monitor/document for side effects and effectiveness. Discuss with MD, family of ongoing need for use of medication. Monitor/record/report to MD side effects and adverse reactions of psychoactive medications . On 07/27/24, a problem was initiated, Focus: Resident is/has potential to demonstrate verbally abusive behaviors r/t dementia . Goal: Resident will demonstrate effective coping skills through review date. Interventions/Tasks: Assess and anticipate needs . Assess resident's coping skills and support system. Assess resident's understanding of the situation .</p> <p>Review of Resident #56's nurse practitioner note dated 07/25/24, reflected in part, 3. Cognitive impairment: Patient likely has dementia - BIMS 3- severe range. Refer to behavioral services. Currently on Seroquel - easily agitated, refusing labs, refusing to wear c-collar at times per staff report.</p> <p>Review of the Pharmacist Consultation Report dated 07/10/24, reflected in part, Resident was recently admitted with an order for an antipsychotic medication Quetiapine 25mg po bid. Antipsychotics have a BOXED WARNING (a safety warning required by the FDA due to serious side effects) for increased risk of mortality in older adults with psychosis related to dementia. Additionally, they are associated with other potentially serious adverse effects including movement disorders, metabolic abnormalities, and orthostatic hypotension. Please provide a diagnosis for use . Rationale for recommendation: CMS requires the resident's medical record include documentation of adequate indications for medication use and the diagnosed condition for which a medication is prescribed. On the form, the doctor provided the diagnosis of acute encephalopathy.</p> <p>An observation and interview on 07/29/24 at 10:45 AM revealed Resident #56 sitting quietly in a wheelchair in her room. She stated she thinks she had been at the facility for about a month. She stated the staff treated her well, but she hoped to go home soon.</p> <p>During an interview on 07/31/24 at 2:22 PM, interim DON B stated when there was an order for a psychotropic medication, they ensured there was consent for the medication and they monitored the resident for behaviors and side effects. She stated nursing documented the behaviors and side effects on the TAR. She stated all medications needed an indication for why it was given. She stated the diagnosis of behaviors was not an appropriate diagnosis for an antipsychotic medication. She stated the pharmacy consultant monitored psychotropic medications monthly. She stated they coordinated with the nurse practitioner to determine the need for psychotropic medications. DON B stated the pharmacy recommendations were given to the providers and the clinical supervisor was responsible to monitor the process. She stated giving unnecessary antipsychotic medications could cause lethargy or movement disorders.</p> <p>During an interview on 07/31/24 at 3:07 PM, interim DON A stated the clinical supervisor was mostly responsible for monitoring the pharmacy recommendations. She stated neither behaviors or acute encephalopathy was a proper diagnosis for an antipsychotic medication. She stated residents were given the lowest dose necessary of psychotropic medications to reduce the risk of side effects.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 07/31/24 at 4:41 PM, the Clinical Supervisor provided documentation of Resident #56's behaviors. She stated on one occasion the resident was yelling and screaming. On another occasion the resident refused lunch and refused to wear her c-collar. She stated the nurse practitioner notes reflected a diagnosis of dementia with severe agitation. She stated the resident did not have a specific diagnosed condition for an antipsychotic medication, but the resident was admitted already on the medication.</p> <p>Review of the Psychotropic Drug Management Policy, revised October 2022, reflected in part, Policy Overview .To avoid the use of unnecessary drugs and their associated adverse drug effects, psychotropic medications will be used only after non-drug interventions alone have failed to manage behavioral symptoms associated with dementia and a medication is used to treat a specific condition as diagnosed and documented in the clinical record . Policy Detail . 2. The psychotropic medication order shall include the following information: a. Appropriate diagnosis for the medication. B. Manifestations of the disorder treated (e. g., auditory hallucinations, hitting others) . 3. The health care provider shall write a progress note describing the behaviors and the reason for ordering the psychotropic drug and include a risk versus benefit statement . Nursing Responsibilities . 2. The nurse shall implement non-drug interventions to help modify the resident's behavior in accordance with the care plan . Interdisciplinary Team 1. The resident's interdisciplinary care plan shall include the reason for the medication and describe the behaviors the medication was prescribed to treat . 2. The interdisciplinary team will review psychotropic medications as needed in the collaborative care meeting - appropriate diagnosis of medication - manifestations for the medication .</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2024
NAME OF PROVIDER OR SUPPLIER Brookdale Lakeway Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 1917 Lohmans Crossing Rd Lakeway, TX 78734	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>49048</p> <p>Based on observations, interviews, and record reviews the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for food storage and labeling in that:</p> <p>The facility failed to ensure foods were safely stored, labeled, and dated in the refrigerator.</p> <p>This failure could place residents at risk of foodborne illness.</p> <p>The findings include:</p> <p>Observation on 7/29/2024 at 9:13 am in the kitchen of the refrigerator revealed an unsealed Ziploc bag containing food items that resembled croutons. This item was labeled and dated but unsealed.</p> <p>Observation on 7/29/2024 at 9:15 am in the kitchen of the refrigerator revealed an unsealed Ziploc bag containing food items that resembled romaine lettuce. This item was labeled and dated but unsealed.</p> <p>Observation on 7/29/2024 at 9:16 am in the kitchen of the refrigerator revealed a large, unsealed, clear, plastic bag containing food that resembled uncooked bacon This food item was not labeled or dated.</p> <p>Interview on 7/31/2024 at 2:20pm with DC-F revealed they had been employed by the facility for two years. They stated every person working in the kitchen was responsible to ensure that food was stored and labeled properly. They stated they were trained by the previous Dietary Manager and had read the facility's policy for Labeling and Storage. They identified potential adverse outcomes for the residents as infection, intoxication (DC-F speaks Spanish) and illness.</p> <p>Interview on 7/31/2024 at 2:30pm with DC-G revealed they had been employed by the facility for two years. They stated the cook was responsible for labeling the items when they used the food. They stated they used to be a Dietary Manager on the assisted living side of the facility. They stated they had read the facility's policy for Labeling and Storage. They identified potential adverse outcomes for the residents as bacteria, diarrhea and vomiting in the elderly.</p> <p>Interview on 7/31/2024 at 2:10pm with the CD revealed they had been employed with the facility or two years. They stated everyone in the kitchen was responsible to ensure food was stored and labeled properly. They identified potential adverse outcomes could have been illness for the residents and spoiled food. They stated their expectation was that items should be sealed properly.</p> <p>Interview on 7/31/2024 at 3:00 pm with DON-B revealed the CD supervised the staff who were responsible for ensuring food was stored properly. They identified potential adverse outcomes for the residents could have been exposure to bacteria or gastrointestinal (digestion) issues. They stated their expectation was that items should be sealed properly.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2024
NAME OF PROVIDER OR SUPPLIER Brookdale Lakeway Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 1917 Lohmans Crossing Rd Lakeway, TX 78734	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 7/31/2024 at 3:20 pm with the ADM revealed it was the responsibility of all kitchen staff to store items properly and the monitoring was done by dining leadership. They identified potential adverse outcomes could have been gastrointestinal (digestion) issues for the residents, food contamination, spoiled food and/or the food not tasting good.</p> <p>Review of the facility's policy titled Labeling - DS-04.02, effective date 2005, last revised 5/10 revealed.</p> <p>Category/Sub-Function: Safety and Sanitation.</p> <p>Policy Overview: All food items must be labeled and dated before storing.</p>		