STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676131	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookdale Lakeway Snf	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)
F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on observation, interview, and record review, the facility failed to implement its policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption for CR 8 (CR #1, CR #2, CR #3, CR #4, CR #5, CR #6, CR #7, CR #8) of 8 CR reviewed for food and nutrition services. 1. The facility failed to have a system in place for reheating resident food items brought in from outside sources to ensure safe food handling and were not allowing residents to bring in food from outside sources.2. The facility failed to accurately document temperature recordings of nourishment station refrigerators. These failures could place residents at risk for foodborne illnesses.Findings included: Observation on 8/19/25 at 11:30 AM of 2nd floor nourishment station revealed no refrigerator present at station. Observation on 8/19/25 at 12:30 PM of 1st floor nourishment station on hall 3 revealed no refrigerator present at station. Observation on 8/19/25 at 1:00 PM of 1st floor nourishment station on hall 2 revealed no refrigerator present at station. Observation on 8/19/25 at 3:30 PM of 1st floor nourishment station on hall 1 revealed no refrigerator present at station. During a confidential Resident council meeting on 8/20/25 at 10:15 am, a concern regarding resident's right to bring in outside food to store and heat was voiced. Residents stated they no longer have access to the breakroom, fridge, or microwave. On 8/20/25 at 10:15 am A resident in the confidential interview stated about 3 weeks ago they went out to a local restaurant and returned with some leftover pizza. Resident stated she asked a CNA to warm up their pizza and the CNA told her she was not able to warm the pizza for her. Resident stated the CNA told her that residents were no longer able to use the microwave or refrigerator. Resident stated she asked to speak to the ADMIN. Resident stated the ADMIN told Resident that residents could not use the microwave because it could overheat and cause burns. Resident stated she told ADMIN she had been using a microwave for 20-25 years and never had a burn or other incident. Resident asked for a skills test to prove she could use the microwave. Resident stated she asked ADMIN what she was supposed to do with her pizza, she stated he responded, Eat cold pizza. Resident stated they took their privilege away to have food from the outside brought in and they can't have personal refrigerators anymore. It was stated the breakroom was taken away from the residents and given to the staff, a coded lock was added to the door. They advised surveyor it's the room across from the living room. Resident stated they were unsure as to why the changes were implemented. Four of the residents stated they would like to have access to the room for their food they bring in or someone bring them. Observation and interview on 8/20/25 at 11:45 AM, revealed ADMIN provided the facility policy for outside food. The ADMIN stated there has been a mistake and the facility would get refrigerators for the nourishment stations today. ADMIN stated he was mistaken about the facility not providing refrigerators for the residents to put their personal food from outside in. ADMIN stated he had been misled by another staff member about the facility policy regarding outside food and reheating food. ADMIN stated currently the facility was using the staff breakroom refrigerator to label and date resident's food and the staff food. Observation on 8/20/25 at 11:49 AM of 1st floor staff breakroom refrigerator revealed the breakroom refrigerator was observed to contain food and drink items labeled with residents' names and room numbers mixed in with other food and drink items that were unlabeled and undated, making it difficult to distinguish if items belonged to staff or residents. (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 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	There were 5 cartons of vanilla liquid nutrition formula with expiration dates of October 25, 2024, and some snack cheese snack bars with expired dates of June 29, 2025. There were some Shakes indicating for people on dialysis, no names, labels or dates, Med Pass 2.0 nutritional shakes, no label indicating name or date. Also observed box of fast food with no names or date, several plastic bags with food items, no names, no dates. Observation of nourishment station refrigerator on 08/21/25 at 9:26 AM on 1st floor hall 2 revealed refrigerator had 12 half egg salad sandwiches dated 8/20/25 with a discard date of 8/23/25 and 1 pudding cup dated 8/20/25. Temperature log reflected temperature of 36 Fahrenheit recorded at 9:00 AM on day 2 no actual date recorded. Observation of nourishment station refrigerator on 08/21/25 9:30 AM on 1st floor hall 3 revealed refrigerator had 11 half egg salad sandwiches dated 8/20/25 with a discard date of 8/23/25 and 1 bottle of sparkling water black raspberry flavored undated and unlabeled. Temperature log reflected temperature of 12 Fahrenheit recorded at 5:50 PM on day 1 no actual date recorded. Observation of nourishment station refrigerator on 08/21/25 9:41 AM on 1st floor hall1 revealed refrigerator had 11 half egg salad sandwiches dated 8/20/25 with a discard date of 8/23/25. Temperature log reflected temperature of 38 Fahrenheit recorded at 9:00 AM on day 2 no actual date recorded. Observation of refrigerator on 08/21/25 10:41 AM on 1st floor dining room revealed refrigerator had 14 pudding cups, 13 gelatin cups, and 24 prune juice cups. Several individual boxes of various cereals on shelf next to refrigerator. Temperature log reflected last temperature recorded of 35 Fahrenheit dated 8/20/25. No temperature recorded for 8/21/25 at this time. Observation of refrigerator on 08/21/25 10:50 AM on 2nd floor dining room revealed refrigerator to be empty and no temperature log on clipboard. Observation of nourishment station refrigerator on 08/21/25 10:53 AM on 2nd floor revealed refrigerator had 3 half egg salad sandwiches dated 8/20/25 with a discard date of 8/23/25, 7 cans of soda pop, and 2 cartons on ensure supplement beverage. Temperature log reflected temperature of 42 Fahrenheit dated 8/21/25 10:40 AM. Interview on 8/20/25 at 4:49 PM, LVN stated she had worked at the facility previously for 2 months as PRN status and now this was her 3rd day on the floor working. LVN was asked do residents store their food brought in from outside. LVN stated no residents on the 2nd floor bring food in. LVN stated if family brings food it was eaten at that time and then discarded. LVN stated if a resident or family was to bring in food, she will ask the nurse manager on what to do in that situation. When asked about the facility training on outside food policy, LVN stated she has not been trained. Interview on 8/20/25 at 5:19 PM, revealed CNA F stated she had worked for the facility for 8 years, at this location and the sister facility location. She was asked where the outside food was stored when brought in. CNA F stated she has not had that situation occur at this facility. She stated the only food she has seen brought was when a resident has a birthday party, and it was eaten then, and nothing kept. CNA F stated at the sister facility location, there was a refrigerator to store the foods, and they label and date with the resident's names. Interview on 8/20/25 at 5: 35 PM, revealed CNA E stated she has worked for this facility for 8 years. CNA E was asked did she know of the facilities outside food policy. CNA E stated, before today, the facility didn't allow outside food, but today they changed the rule and added refrigerators. CNA E stated they removed the policy 2-3 months ago and brought it back today. CNA E stated they were unsure why the changes had been made. CNA E stated they used the microwave in the kitchen to heat the food. Interview on 8/20/25 at 5:55 PM, the DON was asked about outside food policy, she stated if family brought in food, they the family must label with room number and date it. The DON stated she would print out policy and give it to the family if they have a question on discarding of the foods. The DON was asked where the outside food was stored, she stated usually stored downstairs in the nutrition room but now in the employee breakroom (for a month or so). DON stated it was made an employee breakroom, but residents used to have access to this room. The DON was asked how the resident's food was warmed up. DON stated, the facility struggles with that part (a lot of times facility does not allow reheating of food in the microwave by staff for the residents) she stated it was not easy to do temperature checks. She stated if it was soup then that was easy to do a temp check but anything solid, they do not allow it to be brought in. (continued on next page)

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CNA B stated residents have a 24-48-hour window to consume the items. CNA B was asked where these items are stored, he stated they have new refrigerators that came yesterday for the residents. He stated prior they put the items in the employee breakroom refrigerator for about a year. CNA B stated the 10/6 shift checks the dates on the food and discard after the proper time. In an interview on 08/21/2025 at 6:18 PM with CNA A, she stated the following: residents are allowed to bring in food from outside. Families can bring in food that meet the resident's diet. Facility staff are supposed store the food by dating the food, write the residents name, residents room number, and after 3 days, the food product would be thrown out. The CNAs and Nurses oversee monitoring the food that was stored for the residents. The resident food from outside source was stored in the refrigerator that was in the staff break room, it was the staff and residents' food that were stored together previously. The staff's food was marked with their name to differentiate from resident's food. The resident's food from outside source in terms of reheating has been an issue since the microwaves for the residents were removed approximately 8 months ago and all the facility staff was told not to reheat the resident's food by the Dietary Manager. Prior to the microwaves being removed, all facility staff reheated the resident's food. It effects the resident's quality of life as it interferes with the resident's homelike environment and if the residents need something to be reheated, the residents should be able to. It deprives the residents from their rights if food was brought in from family and the residents can't reheat it. She's been trained to properly store and reheat resident's food. The facility staff underwent in-services yesterday, 08/20/2025, and now facility staff can reheat the resident's food in the kitchen although she thinks it's a cross-contamination issue since the resident's food was coming from outside. Residents can get assistance from facility staff to reheat food in the kitchen microwave, but not the microwave in the staff break room. There was now as of today, 08/21/2025, refrigerators for the residents to store food. The Administrator and Director of Nursing were responsible for ensuring residents had somewhere to store or reheat outside food. In an interview on 08/21/2025 at 6:43 PM with ADON, she stated the following: I have been trained on abuse and neglect. The training for abuse and neglect went over suspecting abuse and neglect to report it, investigate it, keep the residents safe from an unsafe situation, and the types of abuse and neglect. The abuse and neglect coordinator are the Administrator. I have received training on resident rights. Resident rights training went over the right to refuse care, and the right to be involved in their care treatment. Residents are allowed to have food from outside sources. The facility staff just got residents new refrigerators during survey and previously prior to the survey, resident's food was stored in the staff break room refrigerator in which the resident's food was dated and labeled their name. The resident's food was thrown out by the third day. Resident food brought from outside source can be reheated as of now, previously facility staff couldn't reheat due to not being able to properly check the food temperatures for safety. Moving forward, the facility staff are now going to have food reheat stations along with new refrigerator and educate facility staff on how to properly check food temperatures. The facility started to do in-services for reheating residents' food and will have ongoing trainings moving forward. Dietary will oversee conducting the trainings for reheating and storing the resident's food. It was making a negative impact on the residents due to the residents being disappointed on not being able to reheat and store their food. Residents were able to reheat and store their food prior until it was taken away (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	from the residents approximately 4 months ago per her knowledge. ADON stated she was unsure of why the changes were made. Residents not being able to reheat and store their food goes against resident rights due to residents aren't given a choice to reheat food they bring from outside. The nursing staff was responsible for ensuring residents have somewhere to store or reheat outside food. In an interview on 08/21/2025 at 7:24 PM with ADMIN, he stated the following: I have received training on abuse and neglect. The training for abuse and neglect went over mental abuse, physical abuse, isolation, misappropriation, and to whom to report the suspected abuse or neglect. The ADMIN stated the abuse and neglect coordinator was the Administrator, and Corporate. ADMIN stated he had received training on resident rights. Resident rights training went over everything that the residents have rights for such as, activities, right to mail, right to phone calls, and right to privacy. Expectations was for all residents to follow these protocols. Resident's quality of life can be affected if these protocols are not followed such as, lead to depression, start acting out, shutting down, and get angry. The residents are allowed to bring in outside food of choice, and he was misled about it because he was advised by a staff member that they could not reheat food. It has now been changed that they will be reheating food for residents moving forward and educate all staff to be able to appropriately temperature check the food, this goes for all staff as well as they have started to in-service staff and will in-service everyone moving forward. A staff member lied to him about the reheating process for residents and he takes accountability about that since he did not further investigate the matter. The Dietary Manager will oversee reheating food for the residents. The microwave that residents can use will be in the kitchen area moving forward. The refrigerator was not for staff to put food in combined with residents' food, moving forward there will be mini refrigerators for the residents to store their food separately. It was a negative outcome for the residents since they could not reheat the food of choice. It goes against resident's rights and was not a policy that was followed, it was meant to protect the residents for safety but goes against the policy for residents. The Administrator and or the Dietary Manager was responsible for ensuring residents have somewhere to store or reheat outside food. Record review of Storage of Resident Food Brought by Families or Others policy, dated 12/2016 and revised on 07/2017, reflected under heading Policy overview: Taking into consideration resident's personal and cultural food preferences, any food that was brought into the community for resident consumption by families or other individuals would be stored and handled per facility safe food handling standards. Under heading Policy detail:1. Each community will designate a unit refrigerator for the storage of perishable foods unless the resident has his/her own refrigerator in their room.2. The unit refrigerator temperature for food storage shall be recorded daily (32-40F).3. All perishable foods must be stored in re-sealable containers with tight fitting lids in the designated refrigerator. Containers will be labeled with the resident's name, the item, the preparation date, and discard date which was 72 hours or less if required by state and local health code. Intact fresh fruit may be stored uncovered at room temperature. 4. The nursing associate and/or designee will be responsible for discarding perishable foods on or before the discard date.5. Dining services will provide educational materials on safe food handling procedures (such as hot holding or transporting foods containing perishable ingredients at room temperatures above 40 degrees F) to residents and /or visitors bringing food from outside sources.6. Facility associates involved in food storage, handling, or service will follow facility safe food handling standards. Record review of In-service reflected In-service provided to staff on 8/20/25 at 7:00 PM and 8/21/25 at 8:45 AM titled Storage of Resident Food Brought by Families or Others with 25 staff signatures. Attached to in-service sign in logs was the Storage of Resident Food Brought by Families or Others policy. Further review of in-service revealed internal temperature of 165F required for reheating of resident foods.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, record review and interviews, the facility failed to prepare food by methods that conserve nutritive value and flavor for 4 pureed diets of 1 of 1 kitchen reviewed for food and nutrition services.The facility failed to ensure [NAME] G refrained from adding an unmeasured amount of liquid to southwestern style chicken pureed during meal service on August 20, 2025.This failure could place all 4 residents who received a pureed diet at risk for diminished or altered nutritional status and potential weight loss.Findings included: Observation on August 20, 2025, at 4:27 PM, revealed [NAME] G took an unmeasured amount of liquid from a pitcher and added to the southwestern style chicken in the food processor and blended.Interview conducted with [NAME] G on August 20, 2025, at 4:31 PM, revealed she used broth to puree the southwestern style chicken. [NAME] G was asked how many servings of chicken she prepared. She stated four. When asked what amount of bread she used, she replied she was not sure, but stated she used enough so the product would stand on its own like mashed potatoes. [NAME] G stated this was how she had been told to prepare it by a previous supervisor who no longer worked at the facility. When asked if she used the recipe book for pureed and other modified diet textures, she stated she had never been shown how to use the recipe book. [NAME] G was then escorted to the recipe book by surveyor. The DSD intervened and stated they use the recipe cards hanging on the wall. The DSD stated to [NAME] G, we looked at it earlier, remember. [NAME] G reviewed the recipe card which called for 2 ounces of poultry gravy or other gravy mix per 1 serving of chicken. [NAME] G was asked what the potential harm could be if recipes were not followed for specific diets. She stated she did not know. [NAME] G then stated she would begin using the recipes moving forward, stating she had never been shown the recipes for the 4 pureed foods and had been trained by a previous manager who was no longer employed at facility.During an interview on August 20, 2025, 4:48 PM, the pureed food policy was requested from the DSD.Interview with DON on August 20, 2025, at 5:55 PM, the DON was asked if she could explain the facility puree process for the residents ordered pureed diets. The DON stated she does not prepare the food herself. She explained she expected the dietary staff to ensure consistency in the puree foods, and that her understanding was the puree meals should be the same as the regular diet served on the plate. She reported that she had never seen the recipes and relied on what the kitchen staff communicated to her. She stated that the pureed meals appear similar on the trays served as a regular diet. When asked if she knew what should be used to puree food, she stated she was unsure. When asked what could happen if the puree diet recipe was is not followed, she stated that residents could potentially lose calories if too much broth was used. She added that if water was used, the taste and nutritional value of the food may be affected. The DON was asked do dietary staff puree with water, she stated she didn't know. Interview conducted on August 21, 2025, at 10:15AM, [NAME] H stated she was trained on all diet textures. [NAME] H stated they received the recipe cards weekly. She stated she followed the specifications on the recipe card for pureed and other diet textures. [NAME] H stated she mostly used milk for pureed diets.Interview conducted with DSD on August 21, 2025, at 3:25PM. DSD stated she has been working at the facility since July 18, 2025. DSD stated she believed the previous Dietary Service Director trained dietary staff previously on preparing diet textures. DSD stated moving forward it will be her providing the in-services. DSD stated each daily menu has a corresponding recipe with the diet modifications. DSD stated it is the standard to cross train the dietary staff across the nursing facility and the assisted living facility. DSD stated all the dietary staff are trained on both kitchen procedures. DSD stated her expectations is for all dietary staff to follow the recipes. DSD stated if they do not follow the recipe they are not in compliance, and each component is important in following the standard. DSD stated the potential risk of harm from not following the recipe could lead to quality being lost and nutrition can be compromised. Interview conducted with CDM on August 21, 2025, at 4:27PM. CDM stated she has worked at the facility for 3 1/2 years. CDM stated the Dietary Director is responsible for training all (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dietary staff on the different diet textures. When ask the potential risk of harm for not following the recipe, CDM did not provide an answer. Record Review of facility diet order conducted on August 20, 2025, revealed there were 4 residents on pureed diets.The policy /protocol for pureeing food was not provided at the time of exit.

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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 observations, interviews, and record reviews the facility failed to properly store, prepare, and distribute food in accordance with professional standards for food service safety for 1 of 1 kitchen. 1. The facility failed to label and date all food items located in the walk-in refrigerator, freezer and in the dry food pantry area on 8/19/2025, 8/20/2025, and 8/21/2025. 2. The facility failed to discard expired food items located in the walk-in refrigerator and in the dry food pantry area.3. The facility failed to ensure that dietary staff [NAME] G on 8/20/2025 at 3;35 PM, practiced appropriate hand hygiene and glove use when necessary, during food preparation activities, such as between handling raw fish and other foods, to prevent cross-contamination.These failures could place all residents who received meals from the kitchen at risk of foodborne illnesses. The findings included: Observation during the initial tour of the kitchen on 8/19/2025 beginning at 9:30 AM, the following was observed:Walk-in refrigerator:3 Packages of hamburger buns, not labeled or dated.20 1-pound blocks of Margarine, not labeled or dated. 3 -32 oz containers of yogurt, not labeled or dated. 1 can of energy drink (not labeled or dated, assumed to be a staff drink, which was in refrigerator)2 large packages of hot dog buns, (not labeled correctly, only had 8/14, not sure if that is discard date or date placed in refrigerator.Bag of past discard date of Sun-Dried tomatoes (prepared date-7/17/25, use by 8/17/25) 1 -5lb package of thawed Ground Beef past discard date (prepared date-8/14, use by 8/16)4 Cartons pasteurized liquid whole eggs- not labeled or dated. 1 large bag looking resembling chicken breast, not labeled or dated. Freezer:1box of 4 chicken tender fritters, not labeled or dated.2 pizza crust dated 5/10 with expiration date of 8/06/2025. Dry Food Pantry area:1 open bag of powdered sugar with expiration date of 8/16 on package. (CDM took out and said she is discarding the package)3 containers of beef base paste, not labeled or dated.4 bags of green lentils not labeled or dated.3 bags of refried pinto beans, not labeled or dated.1 opened bag of elbow macaroni, not labeled or dated.1 large bin of opened cornmeal with prepared date of 6/16, no year or discard date. Observation of second floor kitchen/dining area on 8/20/2025 beginning at 9:33 AM, revealed in self service area 10 individual packages of toasted oat cereal, five packages were expired dated (2-expired on April 17, 2025, and 3 expired on July 16, 2025). Observation 8/20/2025 at 11:28 AM, observed DSD to be removing the tray of cereal and drinks from the 2nd floor dining self-service section. DSD stated she was rotating out the choices. Observation during follow up tour of kitchen on 8/20/2025 beginning at 3:30PM, the following was observed: A clear plastic 32-ounce container contained fish with water running over it. The container was incorrectly labeled item-cheese, prepared date-8/11/25 and use by date of 8/18/25.Observation on 8/20/2025 at 3:35 PM, [NAME] G, did not use proper hand hygiene while handling raw fish. After removing her gloves, she failed to wash her hands and then proceeded to season the fish.Observation on 8/20/2025 at 3:40 PM, of walk-in refrigerator, freezer and in the dry food pantry area:1 -5lb package of thawed Ground Beef past discard date (prep date-8/14, use by 8/16) remained13-1-pound blocks of Margarine, not labeled or dated3 Tubes of thawing meat that resembled pork loin, labeled incorrectly (item: thawing, prep date: uncooked, discard date: meats)1 large loaf of bread with expiration date of 7/11/2025 from food manufacturer, a written date of 8/18, no year, no indication if it's the received date or discard date)1 large bin of opened cornmeal with prep date of 6/16, no year or discard date.1 7ounce opened container labeled seeds tunnel, (prep date:6/24/25, use date:7//24/25)Observation on 8/20/2025 at 4:05 PM of self-service area revealed the expired cheerios from upstairs self-service area was placed in this area. The previously noted 5 packages expired (2-expired April 17, 2025, 3 expired on July 16, 2025.Observation noted on final visit to kitchen on 8/21/2025 beginning at 10:15 AM, revealed of walk-in refrigerator, freezer and in the dry food pantry area:1 large bin of opened cornmeal with prep date of 6/16, no year or discard date1 -5lb package of thawed Ground Beef past discard date (prep date-8/14, use by 8/16) remained10-1-pound blocks of Margarine, not labeled or dated3 Tubes of (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	thawing meat that resembled pork loin, not labeled or dated. labeled from previous day removed.1 large pan of thawing sliced carrots, with only a prep date of 8/21/25 An interview conducted on 8/20/2025 with DSS at 9:33 AM, revealed the second-floor dining hall was not used. She stated it is only used to deliver trays and the nurses and CNAs would get the food items out of the self-service area for alternative choices.An interview on 8/20/2025 at 11:58 AM, revealed the DSD had been in the position for 3 weeks at the facility. The DSD was asked about the labeling policy of the snack food in adjacent rooms in the dining areas. The DSD stated those areas were considered self-service and the policy was to label with date received, put label on tray when received, and the date it expired. DSD stated the snack items were kept in self-service upstairs and some kept in self-service downstairs. DSD stated she is restocking the tray for the area upstairs since the kitchen is not being used upstairs. DSD was asked what is the potential harm that could occur to the residents if they were to eat the expired foods. DSD stated the food is not expired and that it has a best by date, she stated the two are not the same. DSD stated for dry goods it may not be up to standards regarding taste and quality. She stated cold items are more of a health hazard and they can cause some issues. An interview and observation were conducted with [NAME] G on August 20, 2025, at 3:35 PM. [NAME] G was asked, what was in the container, she stated it was fish thawing. [NAME] G stated she just grabbed a clean container and put the fish in it to thaw. She stated sometimes the labels getting missed during cleaning, it just depends on who is cleaning. [NAME] G then took the container of fish and walked it over to a prep area. She was observed to wash her hands and put on gloves and then she removed the fish from the container and placed on a flat baking sheet. She was observed to remove the gloves and then went back to the fish and started seasoning the fish without washing her hands after removing the gloves. [NAME] G stated she has been trained on proper handwashing and food safety protocols. [NAME] G was asked the correct procedure when using gloves in the kitchen, she responded she is supposed to use the two-finger method to remove the gloves and then wash your hands. [NAME] G was asked why she did not wash her hands after removing the gloves and proceeding to handle the raw fish, she stated she just forgot. [NAME] G was asked the potential harm. that could result from not using proper hand hygiene, she stated it can cause transmission of viruses and diseases. An interview was conducted with DON on 8/20/2025 at 5:55PM. DON was asked if she was familiar with the labeling, dating, and discarding of food policy in the kitchen. She stated that she has not reviewed the policy. DON was asked her expectation of the dietary staff when labeling, dating, and discarding of expired. She stated, I would imagine they will follow up on whatever the policy says. DON was asked the potential risk to residence if the labeling, dating, and discarding of the food products are not followed the DON stated she has an opinion regarding expiration dates. She stated what she thinks and believe is different. She stated items like rice does not really expire and beans last a long time. She stated with meat, milk and cheese products, a person could become sick. She stated, anything else, nothing really happens. DON was asked was she okay with outdated products being served, she stated she expects the dietary staff to discard of outdated products. August 20, 2025, 5:53 PM, kitchen food labeling policies were requested from ADMIN.An interview was conducted with [NAME] G on August 21, 2025, at 10:15 AM. [NAME] G stated she has been working at the facility since June 6, 2025. She stated she was trained on labeling, dating and discarding food policy. She stated all dietary staff are to label all items with received date, open date and discard date. [NAME] G stated the potential harm that could happen to a resident if given outdated food products could lead to illnesses like salmonella, she stated a resident can become hospitalized and sometimes a fatality could happen.Additional Interview conducted with DSD on August 21, 2025, at 3:25PM. DSD stated she has been working at the facility since July 18, 2025, as the Director of Dining Services. DSD stated the standard policy for labeling and dating food products is to label with date received, date opened and dated to be used by. Surveyor showed DSM pictures of the past due ground meat that was observed 3 days in the refrigerator. DSM stated her expectations is for dietary staff to throw out expired meats. DSM was asked the potential harm to residents if consumed. DSD stated (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	expired meat, and dairy products are dangerous, and it would be terrible if residents consumed the expired product. Interview conducted with CDM on August 21, 2025, at 4:27PM. CDM stated she has worked at the facility for 3 1/2 years. CDM was asked the policy and protocol on labeling food products in the kitchen. CDM stated all food products are to be labeled and dated with date received, date opened, and date to discard if opened. DSM stated every single dietary person is trained on labeling of all items. CDM stated meat is to be discarded 3 days after being pulled from the freezer. CDM was asked the potential harm that could happen to residents if the policy is not followed in discarding items timely, CDM stated, I decline to answer that question, clearly we are going to discard. CDM was asked about the hand hygiene protocol in the kitchen when handling meat. CDM stated gloves are to be used when handling the raw meat. CDM stated hands should be washed before putting on gloves and immediately after removing gloves. CDM was asked the potential harm of not following proper handwashing, she stated, clearly cross contamination. Record review of facility policy named Labeling -DS-04.028, effective date of 2005 revealed:Policy Overview-All food items must be labeled and dated before storing.Policy Detail:1. Upon receipt from vendors, all non-perishable food items must be labeled with the receive date (month and year) before putting in dry storage. This should be done, even if the food item has a used by or sell by date marked by the manufacturer.2. All prepared items must have a label with the name of item date, and time prepared, by whom, and discard /used by date. Discard/ used by dates should be no more than 3 days for leftover hazardous foods and 7 days for all other prepared food.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and 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 3 of 5 residents (Resident #42, Resident #20, and Resident #57) reviewed for infection control. 1. The facility failed to ensure CNA A was following prescribed Enhanced Barrier Precautions by not putting on a gown before providing peri-care to Resident #42. 2. The facility failed to ensure CNA B was cleansing male residents properly and conducting hand hygiene and glove change during peri-care for Resident #20. 3. The facility failed to ensure CNA D was conducting proper Foley catheter care for Resident #57. These failures could place the residents at risk of transmission of disease and infection.Findings included: Resident #42 Observation on 08/19/25 at 1:49 PM revealed Resident #42 had Enhanced Barrier Precaution signage on the outside of her door with PPE (gloves, gowns, and masks) available in plastic drawers outside of the room. Observation further revealed Resident #42 had a peg tube. Observation on 08/20/25 at 9:44 AM of CNA A going into Resident # 42's room with a package of briefs to change resident. Further observation revealed Resident # 42 had sign on door for EBP with PPE cart outside of resident room. Observation of CNA A not donning PPE (putting on a gown) before entering Resident # 42's room to perform peri-care (when a resident has soiled their brief and their private area needs to be cleaned). Observation on 08/20/25 at 9:50 AM of CNA A exiting Resident # 42's room with bag containing soiled brief and going into soiled utility room to dispose. Interview on 08/20/25 at 10:30 AM, CNA A stated she had worked at the facility for 9 years. CNA A stated that Resident # 42 was on EBP for her Peg tube. CNA A stated she is aware she messed up earlier this morning when she went in to Resident # 42's room to provide peri-care since she did not put on her PPE. CNA A stated she could not give a reason as to why she did not don her PPE besides she just got in a hurry and forgot. CNA A stated if PPE is not worn it could negatively affect the resident by a contaminant getting into the resident's Peg tube which could lead to an infection. CNA A stated she has been trained on Abuse, Neglect, Resident Rights, and EBP. CNA A stated the facility uses CBT and in person trainings. Review of the Enhanced Barrier Precautions Resident List, dated 08/19/25, reflected Resident #42 was on the list due to having a peg tube. Record review of Resident #42's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included cerebral infarction (stroke), hemiplegia and hemiparesis (weakness and paralysis on affected side due to a stroke), gastrostomy status, dysphagia (difficulty swallowing), neuromuscular dysfunction of bladder (nerves in the bladder no longer communicate with the brain), cognitive communication deficit, atrial fibrillation (irregular heart rate), and presence of cardiac pacemaker (implanted inside chest wall to assist a regular heart rate). Record review of Resident #42's Quarterly MDS assessment dated [DATE] reflected a BIMS Score of 05, which reflected a severe cognitive impairment. The MDS reflected Resident #42 was incontinent of bowel and bladder and needed substantial/maximal assistance with the help of two or more people for all her activities of daily living, including eating, drinking, hygiene, positioning, and toileting. Record review of Resident #42's Care Plan, last revised on 06/18/25, reflected she required use of Enhanced Barrier Precautions related to feeding tube/peg tube. The goal was for Resident #42 to not have adverse psychosocial outcome due to Enhanced Barrier Precautions use during care. The interventions reflected staff were to use PPE (hand hygiene, gloves and gown) when providing high contact care activities, providing direct care, and management of tube feedings. Resident #20Observation on 08/20/25 at 1:15 PM of peri-care for Resident #20 revealed CNA B and CNA D turned her to the left side, brief removed and placed in the trash. CNA B conducted handwashing, and clean gloves were put on. CNA B placed a clean under pad, and Resident #20's bottom was cleansed with wipes. CNA B then touched the clean brief that was on the bedside table with soiled gloves. CNA (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B conducted hand hygiene and changed his gloves. CNA B then placed the contaminated brief to Resident #20, on top of the clean under pad. He then conducted hand hygiene and put on clean gloves and cleansed the peri-area with wipes. CNA D then verbally prompted CNA B to replace the brief on Resident #20. Interview on 08/20/25 at 1:26 PM with CNA B who stated he knew he had touched the clean brief with contaminated gloves, and he knew he was not supposed to do peri-care that way. CNA B stated he had received training on infection control protocols, hand hygiene, and peri-care. Record review of Resident #20's undated face sheet reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included syncope and collapse, hypotension, intracerebral hemorrhage resulting in hemiplegia and hemiparesis, dysphagia, chronic obstructive pulmonary disease, hypertension, low back pain, Alzheimer's disease, and cognitive communication deficit. Record review of Resident #20's Quarterly MDS assessment dated [DATE] reflected a BIMS Score of 03, which reflected a severe cognitive impairment. The MDS reflected Resident #20 had diagnoses of Alzheimer's disease, dementia (memory loss and brain degeneration), and hemiplegia and hemiparesis (weakness and paralysis). Resident #20 was dependent on 2 or more helpers for all her activities of daily living, including eating, drinking, hygiene, positioning, and toileting. Resident #20 was always incontinent of bowel and bladder. Record review of Resident #20's Care Plan, last revised on 08/18/25/25, reflected the potential for impairment to skin integrity. Resident #20 would be free from skin breakdown through review date. Interventions included keeping her skin clean and dry, assist with turning and reposition as needed, reduce friction and shearing with use of lift/transfer sheets, and evaluate skin condition on a daily and weekly basis. The interventions also reflected to assist Resident #20 with activities of daily living and mobility as needed. Resident #57 Observation on 08/20/25 at 1:35 PM of peri-care and urinary catheter care for Resident #57 revealed CNA D cleansed the catheter tubing from the urethra/meatus (opening in body where urine comes out) and out around approximately 3-4 inches with only one wipe. CNA D also did not cleanse Resident #57's peri-area. Interview on 08/20/25 at 2:07 PM with CNA D who stated he knew he was supposed to cleanse the tubing with three wipes, and stated the brief was not wet so she did not need peri-care at that time. CNA B stated he had received training on infection control protocols, hand hygiene, and peri-care. Record review of Resident #57's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included multiple sclerosis (a disease that causes breakdown of the protective covering of nerves, which can cause numbness, weakness, trouble walking, vision changes, and other symptoms), neuromuscular dysfunction of bladder (when communication between the brain and the nerves in the spinal cord that control bladder and bowel function become interrupted), intestinal obstruction, presence of prosthetic heart valve (heart valve replacement), difficulty in walking, hypertension, and atrial fibrillation (irregular heart rate). Record review of Resident #57's Comprehensive MDS assessment dated [DATE] reflected she had a BIMS Score of 15, which reflected no cognitive impairment. The MDS reflected Resident #57 had an indwelling catheter and was occasionally incontinent of bladder. The MDS further reflected diagnoses of multiple sclerosis, urinary tract infection, and presence of prosthetic heart valve. Record review of Resident #57's Care Plan, dated 08/08/25, reflected she had a urinary catheter related to a neurogenic bladder (when an injury or disease interrupts the electrical signals between your nervous system and bladder function). The goal reflected Resident #57 would show no signs and symptoms of urinary infection through the review date and relevant intervention(s) included catheter care per policy. Interview on 08/21/25 at 06:16 PM, CNA A stated she had worked at the facility for 9 years. She stated it was important for staff to perform hand hygiene between residents, so staff members do not transmit any germs from one person to another. CNA A stated if staff members do not follow good hand washing/hand hygiene and infection control protocols, an infection could be passed from one person to another. CNA A stated when providing catheter care to residents, the catheter tubing should be cleansed with 3 wipes from the meatus (urinary opening) and out. CNA A further stated she had been in-serviced on infection control protocols, including handwashing/hand hygiene, enhanced (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	barrier precautions, and catheter care. She stated the prevention of infections included frequent hand washing and hand hygiene, glove changed when going from dirty to clean/front to back, and wear gown and gloves for enhanced barrier precautions. Interview on 08/20/25 at 4:30 PM, the DON stated she had been in the current role for about 4 months. She stated she was hired to be the ADON, had become the interim DON, and now full time DON. The DON revealed she heard about CNA B touching the brief with soiled gloves. The DON stated she would be doing further in-servicing with CNA B on infection control and conducting peri-care. The DON stated CNA B had been a CNA for several years in the facility and performed other duties such as showers, feeding, and transfers. The DON stated overall it was her responsibility for ensuring staff were following infection control measures when providing direct care for the residents. She further stated the ADON was the Infection Preventionist, and the ADON kept up the list of residents who were on Enhanced Barrier Precautions, signage and PPE carts outside of the resident rooms, along with catheters and PICC lines. The DON stated she and the ADON double checked and verified residents with catheters, PICC lines, gastrostomy tubes, etc. The DON stated both she and the ADON monitor how staff were doing with handwashing/hand hygiene, and infection control by conducting spot checks during the workday. The DON further stated she and the ADON would then talk with the staff about their observations and what could be done more efficiently. She further stated the ADON had been doing competencies with staff. The DON stated she was not sure of the policy, but in nursing school they were taught to cleanse the catheter tubing at least three times, and from the meatus and out. She stated when a resident was on EBP her expectation was all staff providing direct care to the resident put on gloves and a gown. The DON stated staff had completed check offs and competencies on infection control, catheter care, and Enhanced Barrier Precautions. She stated the potential negative outcome for residents was they could become sick from cross contamination. Interview on 08/21/25 at 06:45 PM, the ADON/IP stated she had been employed at the facility for 14 years. She stated infection control was a team effort, and the DON and herself were responsible for ensuring staff were doing hand hygiene/following infection control measures when providing care for the residents. She stated she worked in the facility for 40 or more hours per week, and more than 20 hours were spent on Infection Control. The ADON/IP stated she conducted in-services on Infection Control topics with staff, along with other clinical supervisors and the DON. Topics of in-servicing included handwashing/hand hygiene, conducting peri-care, catheter care, and Enhanced Barrier Precautions. The ADON/IP stated she observed and monitored how staff were conducting hand hygiene and following infection control measures by watching staff during their daily routine by showing up in the resident rooms during care, assisted with resident care, and by observing staff members' habits. The ADON/IP stated policy on catheter care included cleansing the tubing with three wipes. During Enhanced Barrier Precautions, staff should put on a gown when administering peg tube feedings or medications, changing residents' clothing, check and change and peri-care, emptying catheter bags and providing catheter bags, and any time it was possible to have contact with the residents' body and body fluids. During peri-care, hand hygiene and glove change should be done when going from dirty to clean, and from front to back. The ADON/IP stated a potential negative outcome for the residents would be the spread of infection to the residents. Interview on 08/21/25 at 07:24 PM with the ADMIN, who stated he had been here for 3 years. The ADMIN stated everyone was responsible for following Infection Control protocols in the community. He further stated the Infection Preventionist was responsible for education, along with the DON. The ADMIN stated everyone was responsible for spot checking while staff were providing resident care, using the restroom, and going from one room to another. He stated the DON, the IP, and himself made resident rounds, monitor, and track and trend any abnormal happenings, antibiotic stewardship, and this was all a part of our Quality Assurance. The ADMIN stated when staff were not conducting handwashing and following Infection Control measure, a potential negative outcome for the residents would be the potential to spread infection from resident to resident. Policies: Review of the facility's Policy and Procedure on Enhanced Barrier Precautions, dated 09/2022, reflected:Policy (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Overview: Enhanced barrier precautions (EBPs) should be utilized to reduce transmission of multi-drug-resistant organisms (MDROs) that employs targeted gown and glove use during high contact resident care activities.Policy Detail:1. Enhanced barrier precautions (EBPs) should be used as an infection prevention and control intervention to reduce the spread of multi-drug-resistant organisms to residents.2. EBP are used in conjunction with standard precautions and expand the use of PPE (personal protection equipment) to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to associate hands and clothing.3. The infection control recommendations for EBP will be determined on the point of care task or activity. Use hand hygiene, gown, and gloves (high-contact activity) when providing care under clothes or dressings, providing bundled AM or PM care including oral care, dressing, bathing, grooming, doing dressing changes, and providing peri-care.4. EBPs are indicated with any of the following: Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO.9. Signs are posted on the door or wall outside the resident room indicating EBP precautions and PPE are required. Review of the facility's Policy and Procedure on Handwashing/Hand Hygiene, dated 01/2021, reflected:Policy Overview: This community considers hand hygiene the primary means to prevent the spread of infections.Policy Detail: C. Hand hygiene products and supplies (sinks, soap, towels, alcohol-based had rub, etc.) shall be readily accessible and convenient for associates use to encourage compliance with hand hygiene policies.G. CDC recommends using Alcohol Based Hand Sanitizer with 60-95% alcohol in healthcare settings. Unless hands are visibly soiled, an alcohol-based hand rub is preferred over soap and water in most clinical situations due to evidence of better compliance compared to soap and water during routine resident care.8. Before moving from a contaminated body site to a clean body site during resident care.9. After contact with a resident's intact skin.10. After contact with blood or bodily fluids. The facility did not provide a policy on providing indwelling catheter care.

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F 0575 Level of Harm - Potential for minimal harm Residents Affected - Many	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. Based on observations and interviews, the facility failed to post, in a form and manner available for all residents and resident representatives, the required contact information for the public and the entire facility including telephone number of the Long-Term Care Ombudsman program for the facility's postings for 1 of 1 facility reviewed for resident rights. The facility did not have the Ombudsman Program sign posted with contact information. This failure could affect resident representatives and place residents at risk of not having access to a written description of their rights, advocacy groups, and a decreased quality of life by not having access to Ombudsman information for resources.Findings included: Observation on 08/20/2025 at 9:12 AM, revealed the Ombudsman posted notice located on the second floor on the wall by the facility entry way of the double doors of the foyer. The posting was posted on the right side of the wall as you exit the building, and facing in front of you to the left as an individual would be entering the double door building. Residents would have to go to the second floor, in and out of the facility entry way of the double doors of the foyer in order to have access to the Ombudsman posted information. In a Confidential Resident Council meeting on 08/20/2025 at 10:15 AM, residents stated they did not know where the Ombudsman's contact information was posted. Residents stated they did not know how to contact the Ombudsman. Residents stated Ombudsman was not present at any Resident Council meeting. Residents reported they do not know the name of the Ombudsman assigned to this facility. Residents stated they had not been told how to contact the Ombudsman. Several Residents stated if information was posted, such as the Ombudsman's information, it is not at their eye level. Residents stated the facility post information at the staff's eye level. Residents stated they do not see things where the facility staff posts them due to the majority of the residents were in wheelchairs. Residents stated they would appreciate if the facility would post things where it is assessable to their eye level. Observation on 08/20/2025 at 11:08 AM, revealed during a walkthrough of the facility, on the first floor, there was no visible posting information for how to contact the Ombudsman on second floor hallways. There was Ombudsman posted information in a glass shadow box near the elevator on the first floor. The posted Ombudsman information was in small lettering out of view for individuals in wheelchairs to read. There were water hydration stations under the glass shadow box that obstructed and prevented individuals from getting closer to read postings. Observation on 08/20/2025 at 11:14 AM, revealed during a walkthrough of the facility, on the second floor, there was no visible accessible information on how to contact the Ombudsman. There was a procedure posting notice located by the nursing station with the Ombudsman's phone number was about 6 and a half feet from the floor in small print, not visible or accessible for residents in wheelchairs or with vision deficits. In an interview on 08/20/2025 at 5:55 PM, the ADMIN stated there was not a facility policy on posted Ombudsman information. In an interview on 08/21/2025 at 12:34 PM, the REM stated she had not provided the residents information on the Ombudsman, nor had she invited the Ombudsman to a Resident Council meeting. She stated that she had started employment at the facility as of July 2025. She stated to not know who the Ombudsman is and does not know where the posted Ombudsman information is located. In an interview on 08/21/2025 at 12:45 PM, the RED stated the following she had never invited the Ombudsman to a Resident Council meeting, but she had spoken to residents about the Ombudsman, mainly when they have a lot of questions. She said she would print the Ombudsman information and provide it to the residents. She stated she did not know the name of the local Ombudsman. She stated she thought the glass shadow box on the first floor near the elevator was accessible to all residents with the Ombudsman information in it. She stated it's the facility management staff responsibility to post Ombudsman information. Observation on 08/21/2025 at 12:54 PM, the RED revealed Ombudsman posted information by the elevator located in a glass shadow box of the first floor approximately five and a half feet high in small lettering print and not easily accessible to individuals in wheelchairs or (continued on next page)

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F 0575 Level of Harm - Potential for minimal harm Residents Affected - Many	with vision deficits. In an interview on 08/21/2025 at 12:56 PM, the RED stated the Ombudsman posted information was not accessible to individuals. She stated she would work on getting bigger signs and placed lower in areas to accommodate residents right to accessibility of Ombudsman information. In an interview on 08/21/2025 at 6:18 PM, CNA A stated she thought the Ombudsman posting information should be in the break room or nursing station. CNA A said had not seen it for sure, but it could be provided should the residents ask the facility staff for it by asking her supervisor or another staff member. She is not sure if residents have access to Ombudsman posted information without having to ask facility staff and believes the Ombudsman leaves the residents business cards if the Ombudsman visits, but she is not sure. She can't say that the residents don't have the information for the Ombudsman, and she isn't sure if it would negatively affect the residents. She states it goes against resident rights if they did not have access to the Ombudsman information. The Administrator is responsible for making sure residents have access to the Ombudsman information. In an interview on 08/21/2025 at 6:43 PM, the ADON stated the Ombudsman posting was near the elevator on each floor, and residents pass by it. She said her opinion, the Ombudsman posting was not accessible to residents in a wheelchair. She would have to ask her supervisor if the Ombudsman posted information was anywhere else in the facility. The ADON said she felt the facility needed a bigger print of the Ombudsman information because it was too small for residents to see. She thought the Ombudsman posted information is on both floors near the elevator but is not sure. She stated residents could be negatively affect if they do not have access to this information including individuals in wheelchairs. It can negatively impact residents and residents should have access to it, but residents can ask staff where it's at. She is not sure if all staff in the facility knows where the Ombudsman posted information is located. Ombudsmen offer additional information or resources, and it's part of the staff's duty to be able to offer Ombudsman information to residents. She is not aware of any additional Ombudsman posting in the glass case near the elevator besides a printout from what she has seen. This goes against resident rights if the residents do not have access to Ombudsman information. Residents have the right to have access to the Ombudsman posted information regardless being in a wheelchair or not. The Administrator is responsible for the Ombudsman posted information to be accessible to all residents in the facility. In an interview on 08/21/2025 at 7:24 PM, the ADMIN stated the Ombudsman posted information is near the elevator downstairs in a glass case and is also located at the entrance of the front door that residents can go to. The residents had access to Ombudsman posted information in his opinion. He honestly can't tell if it is at someone's eye level. He can't tell if it is at resident's eye level based on height and it might be difficult for a resident if in a wheelchair to be able to see the posted Ombudsman information. In terms of it negatively affecting the residents, he states residents have access to the Ombudsman information and it is posted where residents can see it. Staff tell residents where it is and residents are informed of their rights. Administrator oversees making sure the Ombudsman information is posted for the residents with easy accessibility. He doesn't know who the Ombudsman was for the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676131	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookdale Lakeway Snf	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)
F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observations, interviews, and record review. The facility failed to ensure results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to survey were readily available to examine for 1 of 1 facility. The required documents were not posted in a location readily accessible and visible to all residents, their legal representatives, or family members. This failure could place all residents of the facility at risk of limited' rights to access information regarding the facility's compliance with state and federal requirements.Findings included: An observation conducted on August 19, 2025, at 4:02 PM, revealed the facility's survey results book was found in the entry foyer on the second floor. The survey book was noted in an acrylic wall book holder with no signage reflecting where the survey book was located. A brief look at the survey book revealed the last survey results were a complaint investigation dated September 2024 and full book results for years 2024 and 2023.An observation conducted on August 20, 2025, at 9:12 AM, revealed the facility's survey results book remained in the entry foyer on the second floor. There was no sign posted stating the location of the survey results. There were no 2025 survey investigations from, January 15, 2025, February 5, 2025, March 3, 2025, March 17th, 2025, April 7, 2025, May 20, 2025, and June 18, 2025posted in the survey binder. An observation conducted on August 21, 2025, at 10:54 AM and again at 3:56 PM, revealed the facility's survey results book remained in the entry foyer on the second floor, still no sign posted stating the location of the survey results. The book did not include any 2025 complaint surveys. During a confidential group interview conducted on undisclosed date and time, five confidential residents stated they had not known where or how to access the survey results in the facility. They had not understood or been aware the survey book existed or that they were able to review the results. Residents also stated when things were posted it is not at their eye level. They stated they do not see things above because most of them were in wheelchairs. Residents stated they would appreciate if the facility would post things where it was visually accessible. Record Review conducted completed August 20, 2025, at 5:05 PM, revealed the facility completed survey investigations on January 15, 2025, February 5, 2025, March 3, 2025, March 17th, 2025, April 7, 2025, May 20, 2025, and June 18, 2025.August 20, 2025, 5:53 PM, state survey book policy was requested via email from the ADMIN.August 21, 2025, 8:25 AM, during interview, the ADMIN stated there was no facility policy for the survey book.Interview conducted August 21, 2025, 6:19 PM, CNA A stated she had worked at the facility for 9 years. CNA A was asked did she know the location of the facility survey results binder, she responded at the nurse's station. She stated the residents do not have access to the survey book. CNA A was asked did she know what was included in the survey book, she responded she did not know what was inside the survey book. CNA A was asked do she know what the survey book was, she stated, no. CNA A stated she do not recall being trained on the survey book. CNA A stated the ADMIN was probably responsible for the survey book binder.Interview conducted on August 21, 2025, at 6:19 PM, the ADON stated she had worked at the facility for 14 years. The ADON stated the facility survey book was located between the double doors at the front of the facility entrance. The ADON was asked do she know what is required to be in the survey binder, she stated is not sure what is supposed to be in the survey book. The ADON was asked did she think the survey book was readily accessible to residents, family members and legal representatives, she stated, It is right there when you walk in, between the double doors, I think on top of a table, they can just open it up. The ADON stated she would go to the ADMIN if there was a question on the survey book. The ADON was asked whose responsibility is it to notify the residents of the whereabouts of the survey book, she stated, it was all the facility staff's responsibility to inform the residents. The ADON was asked do she think the survey book is accessible for all the residents on the first floor, she stated yes, they can take the elevator up and go to the book. The ADON stated the door is always open leading into the double door (continued on next page)

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	676131	A. Building B. Wing	08/21/2025

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	area, the one leading outside lock at certain times. The ADON stated residents have a right to know the results of the surveys.Interview conducted on August 21, 2025, at 7:30 PM, the ADMIN was asked the location of the facility survey results binder. ADMIN stated when you walk into the vestibule (small entrance area), it's to the left in a cubby hole. The ADMIN stated a sign is there. The ADMIN was asked the location of the sign as one was not observed the last 3 days. The ADMIN stated he just put one up, he stated it's not the prettiest sign but one is there. ADMIN stated it was the administrator's responsibility to maintain and update the survey book. ADMIN stated the survey book should include the past 3 annual surveys and any off-cycle deficiencies. The ADMIN was informed that the 2025 survey investigations were not maintained in the facility's survey binder as required. The ADMIN stated that 2 weeks ago the 2025 survey investigations were present in the book. The ADMIN left to retrieve the survey binder, returned, and stated to the surveyor, you are correct, they are missing. The ADMIN stated he felt the survey book was accessible to residents and all visitors. He further stated there was a sign at the desk indicating that the survey results were available. When the surveyor asked where at the desk the sign was located, the ADMIN responded that he believed it was there. No sign was observed, and the ADMIN did not show surveyor the sign. ADMIN was asked how not the results having readily available could have affected the residents; the ADMIN stated residents have the right to know the results. The ADMIN stated he told family members on tours how to review facility results. The ADMIN stated the survey book was readily accessible to everyone. When asked if he believed it was accessible for all residents on the first floor, he responded, yes.