STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455866	A. Building B. Wing	05/01/2024

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0660 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949 Based on observation, interview, and record review, the facility failed to develop and implement an effective discharge planning process that focused on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions for one (Resident #1) of three residents reviewed for discharges. The facility failed to have a wheelchair and assistant services set up upon Resident #1's discharge to her apartment. She was unable to transfer herself and was found by EMS over 24 hours later laying in the same spot without access to food or water. This failure resulted in an identification of an Immediate Jeopardy (IJ) on 04/29/24 at 2:00 PM and an IJ template was provided to the ADM. While the IJ was removed on 05/01/24 at 7:00 PM, facility remained at a level of no actual harm at a scope of isolated that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. This failure placed residents at risk of harm, injury, rehospitalization , and death. Findings included: Review of Resident #1's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including dislocation of right patella, morbid obesity, need for assistance with personal care, and muscle wasting and atrophy. She was discharged from the facility on 04/25/24. Review of Resident #1's quarterly MDS assessment, dated 03/19/24, reflected a BIMS of 15, indicating she had no cognitive impairment. Section GG (Functional Abilities and Goals) reflected she was dependent for toileting, showering/bathing, and dressing and required maximum assistance with transferring. Section M (Skin Conditions) reflected she had a stage V pressure ulcer. Review of Resident #1's admission care plan, dated 01/11/24, reflected she was at risk for falls with an intervention of providing her safe environment. It further reflected she had an ADL self-care performance deficit with interventions of requiring one staff member for assistance with bathing and dressing and requiring two staff members using a hoyer lift for transfers. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0660 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of an email sent by SW B to an agency (HA) that helps residents apply for Medicaid and locate LTCFs, dated 03/28/24, reflected the following: [Resident #1] is looking for LTC facility, wanting to see if she can apply for Medicaid as well. She is currently discharging to (IL facility) on Monday 4/1 . Review of Resident #1's NOMNC, dated 04/22/24, reflected the effective date coverage of her current skilled nursing services would end on 04/24/24. Review of Resident #1's Physical Therapy Discharge Summary, dated 04/24/24, reflected she could transfer, stand, and walk ten feet with minimal assistance. Review of Resident #1's nursing progress noted, dated 04/25/24 and documented by LVN A, reflected the following: Comprehensive Nursing Note for [Resident #1]: AOX4. Vss. No s/s of distress. Incontinent of B&B . pending d/c @ 3:00 PM today to (independent living facility). Review of Resident #1's Discharge Summary, dated 04/25/24 at 7:48 PM and completed by SW B, reflected no home health services were recommended and a wheelchair was to be provided. Review of an e-mail from a HH agency to SW B, dated 04/25/24 at 3:24 PM (after Resident #1 had been discharged), reflected (HH agency) was able to accept Resident #1. The e-mail chain was started that day. Review of Resident #1's EMS documentation, dated 04/26/24 at 3:28 PM and documented by EMT D, reflected the following: 12/27 seen by EMS for dislocated patella and leg pain, [Resident #1] reports emergency surgery followed by admission into (facility). [Resident #1] she was kicked out of (facility) because she hit the 100 days maximum for Medicare. [Resident #1] states staff made her leave, and she was not assessed by a physician for mobility and safety. [Resident #1] states she never refused LTC. [Resident #1] states staff forced her out of NH. AFD responded for lift assist last night a req C4 follow up today per (doctor). [Resident #1] states she is in the same diaper NH discharged her in because she is unable to get to bathroom or in/out of bed without assistance. [Resident #1] states she slid to the floor and did not fall. [Resident #1] reports last meal was yesterday around noon when she was discharged from (facility). [Resident #1] states she has been snacking on candy she had in bed since then. [Resident #1] found lying in bed, alert to EMS, AO4/GCS15. Assessment recorded above with continuous assessment on scene. [Resident #1] appears in no distress. Poor hygiene with smell of foul urine/feces. [Resident #1] states she has been unable to get out of bed to use the restroom or clean herself since discharge. [Resident #1] has trash and laundry scattered about apartment with rotting food in sink. (continued on next page)

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F 0660 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Consult with C4 on scene for [Resident #1]'s re-admission into NH due to inability to care for self with no caregiver or home health present or planned. No answer with NH and no other options. Unable to leave [Resident #1] on scene, transport to (hospital) . Notified hospital that [Resident #1] cannot be dx home and APS is being contacted. After the documentation there were pictures EMT D took of Resident #1's apartment. Observations of these pictures revealed a heavily soaked/stained mattress and a kitchen sink filled with dishes. Review of Resident #1's hospital records, dated 04/26/24, reflected the following: Primary Diagnosis: acute debility, unable to care for self . [Resident #1] was recently discharged home from (facility) but her wheelchair was not delivered so she was essentially unable to move or care for herself. PT/OT recommending return to SNF. APS is reportedly involved in [Resident #1]'s care During an interview on 04/29/24 at 9:42 AM, SW E stated she as one of two SWs that worked at the facility. She stated the discharge process started when a resident was admitted . They discussed as a team where the resident would be discharged to, and if any DME or services would be needed. She stated upon discharge, the SWs were responsible for issuing a non-coverage form (NOMNC), explaining their right to appeal, setting home health, ordering any DME, and any other resources needed. She stated she was not Resident #1's SW. During an interview on 04/29/24 at 9:49 AM, SW B stated she had been Resident #1's SW while she was at the facility. She stated the social worker's responsibilities were mainly to focus on discharges - setting up home health, care giver support, hospice, and ordering DME. She stated she was Resident #1's SW while she was at the facility. She stated she had used up all of her Medicare days (100 days) and wanted to go back to her IL facility where her belongings were. She stated she had informed Resident #1 that it would not be a safe discharge. She stated she worked closely with HA that helped residents find long-term care facilities and they usually took a week or so until they connected with the resident after discharge. The Surveyor asked how she would care for herself for the initial week and she stated Resident #1 had told her there were caregivers at the IL that assisted two hours a day, but she had not confirmed that with the IL. She stated she told the resident it would be safer to have more assistance, but Resident #1 told her she could not afford it. She stated she was not able to order a wheelchair for her because there was a co-pay of $258 and Resident #1 did not have her wallet with her so she had no way to pay it. She stated Resident #1 told her she would pay the co-pay once she got to her apartment. She stated she even sent an e-mail to Resident #1's family member about the wheelchair so he could make sure she paid the co-pay and he was also supposed to help her apply for Medicaid. (continued on next page)

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F 0660 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 04/29/24 at 9:56 AM, Resident #1's FM F stated he had been contacted by EMT D and was informed of the condition she was in at her apartment and it sure as hell sounded like an unsafe discharge to him. He stated her IL facility does not have care givers or anyone to assist her. He stated he lived in another state and it was hard to assist Resident #1, especially since he was so much older than she was. He stated he had not planned to fly down to assist her because he was not physically able to do so. He stated he received an e-mail from SW E regarding the wheelchair, and Resident #1 did not have a lot of disposable income, so he called the number and paid the co-pay. He stated the wheelchair was supposed to be delivered that day (04/29/24), but it would be useless since she was still in the hospital. He stated SW E did have HA contact him about applying for Medicaid back in March (2024), but Resident #1's laptop (with banking information), wallet, and cell phone had been at her apartment while she was at the facility. He stated he did not have access her banking information and told HA there was nothing they could do until she returned home. He stated it was entirely inappropriate for her to be sent home without the ability to get out of bed or go to the bathroom. He stated, How did SW E expect her (Resident #1) to pay for the wheelchair or access her banking information if she did not have any assistance or a way to get to her wallet, cell phone, or laptop? He stated EMT D had told him she should not be returning to her apartment and he was in total agreeance. During an interview on 04/29/24 at 10:12 AM, the ADM stated the discharge process starts upon admission and the goal was always to communicate with the resident for the most appropriate discharge setting. She stated if the resident requested DME or HH services, the SW was responsible for getting that set up. She stated every situation and resident was different. She stated Resident #1 was alert and oriented times 4, had a BIMS of 15, and continuously stated she wanted to go home and that it was her right to make that choice. She stated the staff had encouraged her to have home health services but she could not afford them. She stated she was told it was not a safe discharge, but in the end, she had the right to choose. She stated Resident #1 had told SW B she had a caregiver at the IL that came for two hours a day but the SW B did not confirm that because the resident was fully competent. She stated Resident #1 told SW B that she would pay the co-pay for the wheelchair as soon as she got home and normally DME was delivered within four hours. She stated Resident #1's FM F had told staff he would be flying down to assist her. She stated they did not see it as an unsafe discharge. During a telephone interview on 04/29/24 at 10:55 AM, EMT D stated Resident #1 had initially contacted the fire department the night before (04/25/24) when she fell after trying to get up to go to the bathroom. He stated the fire department assisted her back into bed and requested that EMS follow-up with her the following day (04/26/24). He stated he was glad they did because the situation was horrible. He stated Resident #1 was able to stand and pivot with assistance but was unable to get herself out of bed or walk on her own. He stated her brief was heavily soiled and the odor of urine and feces was palpable. He stated the apartment itself was deplorable with stains throughout and rotting food in the kitchen. He stated she had access to her medications that were near her bed and she told him she used her saliva to be able to take them as she had no access to food or whatever. He stated Resident #1 showed him her DC paperwork from the facility where it reflected, Recommended LTC but resident requested to go home. He stated Resident #1 was adamant stating that was a lie and no one had talked to her about LTC upon discharge. He stated she told him she initially wanted to go home when she was first admitted , but it was obvious now she was unable to care for herself. He stated Resident #1 was completely with it (mentally) and knew what she wanted. He stated he told the hospital she could not return to her apartment upon discharge as it would be completely unsafe. (continued on next page)

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F 0660 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 04/29/24 at 11:31 AM, PTA G stated he had been working with Resident #1 while she was at the facility. He stated she was independent with bed mobility, rolling from side to side. He stated when transferring from bed to wheelchair, she required minimal assistance while utilizing a grab bar. He stated she was able to walk up to ten steps while utilizing a walker. He stated he had made it known to SW B that Resident #1 would require a wheelchair upon discharge. He stated she should not have been discharged home without a wheelchair and in his opinion, she would not be able to live independently. During an observation and interview on 04/30/24 at 11:20 AM, revealed Resident #1 in a hospital bed. She stated she did initially tell the nursing facility she wanted to go home but she was under the impression she would have the proper medical equipment when she got home. She stated she had a walker at her apartment, but the facility did not ask her if she was able to get around using a walker. She stated the facility did not discharge her with a wheelchair because it had not been paid for. She stated it had been ordered but she owed a co-pay. She stated upon discharge the facility told her everything had been set up and taken care of for her to go home. She began crying and stated when she was alone for 24 hours without the ability to get out of bed, she felt helpless and still felt helpless. She stated she did not believe she could care for herself independently because she could not bear hardly any weight on her leg. Review of the facility's Transfer and Discharge Policy, revised 08/2023, reflected the following: Residents should be transferred and discharged by the Community in accordance with applicable Federal and State regulations. . 1. The resident should receive orientation by the social services director or designee on where he or she is being transferred or discharged and reason to minimize anxiety. The Community's policies and procedures for discharge planning should be following regarding resident preparation, education, and planning prior to transfer from the community unless the transfer is emergent. Review of the facility's Transition Care Policy, dated December 2013, reflected the following: The Transition Care Conference ensures the patient and family member are in agreement with the transfer timelines as well as the patient's status to goal and transfer disposition. An understanding of care, equipment, and home needs prior to their transfer home or an alternative care setting is another objective of this meeting, as well as pertinent discussions are the patients after care. Review of the facility's Transition of Care and Discharge Summary Policy, revised 10/23, reflected the following: When a resident discharge is anticipated, a recapitulation of the stay, final summary, and post-discharge plan should be completed. The ADM was notified on 04/29/24 at 2:00 PM that an Immediate Jeopardy had been identified due to the above failures and an IJ template was provided. The following POR was accepted on 05/01/24 at 3:10 PM and included: (continued on next page)

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F 0660 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/29/2024 an abbreviated survey was initiated at (facility). On 04/29/2024 the surveyor provided an Immediate Jeopardy (IJ) Template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate jeopardy to the health and safety. The notification of Immediate Jeopardy states as follows: F660 - The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. Community Response On 4/29/24, Social Services verified with the Durable Medical Equipment (DME) Company that Resident 1 wheel chair was delivered fully assembled and ready to use at Resident 1's address on 4/29/24 delivery receipt signed by a caregiver. On 4/30/24, the community Healthcare Liaison contacted the hospital case manager and Resident 1 to inquire about discharge planning from the hospital. Resident 1 was offered to return to the community. The resident accepted and is scheduled to admit on 5/1/2024. On 4/29/24, Social Services audited actual planned discharges from 4/22/24 to the present and planned discharges scheduled to occur through 5/6/24 to verify that they include discharge date , location, DME, Home Health, and confirmation of services. Appropriate services were confirmed, and no additional residents were identified to be impacted. On 4/29/24, the Divisional Director of Clinical Operations re-educated the Administrator on the discharge planning process and policies. From 4/29/2024 to 4/30/24, the Administrator and/ or designee re-educated licensed nurses the interdisciplinary team (IDT) members, which include therapy, social services, resident programs, nursing management, and the Registered Dietician on completing the transitions discharge summary. The in-services included the Transition Care Conference policy and Transition of Care and Discharge Summary Policy, which will be re-educated before their next scheduled shift. New staff and agency staff will have the training included in orientation. The Administrator re-educated Social Services on listing the date home health has confirmed services and the planned start of care. Re-education includes notification of Adult Protective Services (APS) and Ombudsman for any discharges identified to be unsafe. This notification will be ongoing as part of a systematic change. Licensed Nurses and IDT members including as needed staff who were not available from 4/29 to 4/30/24 will be re-educated before their next scheduled shift by the Administrator and/ or designee. The training will be documented on an in-service form, and competency will be validated by a post-test. The administrator or designee is responsible for administering the posttest and ensuring compliance. On 4/29/24, the community conducted an impromptu Quality Assurance Process Improvement (QAPI) to review the discharge planning process. In attendance were the Medical Director, Administrator, Executive Director, Regional Director of Operations, Regional RAI Director, and Divisional Director of Clinical Operations. (continued on next page)

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F 0660 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Effective 4/30/24, during the weekly Medicare meeting, the IDT will review the discharge checklist, home health services, and DME as indicated for planned discharges. Social Services will arrange for home health services and order DME as indicated. Social Services will confirm the delivery date of the ordered DME and the start of home health services. The delivery date and start dates will be documented in the medical record. IDT will provide residents with a choice to postpone discharge when services as reported not available greater than 2 days from discharge. This is an ongoing systematic change. Social Services and/ or designee will complete weekly audits of planned discharges for 90 days. The audits will be documented on an audit form and the results will be reported to the monthly QAPI Meeting for 3 months. Audit commenced on 4/29/24. The Survey Team monitored the POR on 05/01/24 as followed: During interviews conducted on 05/01/24 from 2:59 PM - 4:54 PM, with the DRE, MCS, 7LVNs, the DOR, two SWs, and the MDSC (from different shifts) all stated they were in-serviced prior to their shifts on safe discharges. All stated social services team was responsible for coordinating discharges and the facility was responsible for ensuring safe discharges. Each staff member stated they needed to ensure DME (if needed) was delivered and services (if needed) such as home health were in place prior to discharge. They stated if they thought it was going to be an unsafe discharge, they would notify the ADM and DON immediately. They stated if a resident left the facility unsafely, they would notify the Ombudsman and APS. Review of the facility's QAPI agenda, dated 04/29/24, reflected the ED, ADM, DDCO, RDO, RDCS, RRD, and MD were in attendance. Review of an e-mail received by the ADM, dated 04/29/24, reflected the wheelchair had been deliver to Resident #1's apartment on 04/29/24. Review of the facility's in-service entitled Discharge Planning conducted by the ADM, dated 04/30/24 - 05/01/24, reflected all staff from each shift were in-serviced on the following: Transition Care Conference Policy, Transition of Care and Discharge Summary Policy, and Notification of APS and Ombudsman for any discharges identified to be unsafe. Review of Planned Discharge Post-Tests , dated 04/30/24 - 05/01/24, reflected staff were completing the tests after being in-serviced. Review of the facility's resident roster, dated 05/01/24, reflected Resident #1 had been readmitted to the facility. While the IJ was removed on 05/01/24 at 7:00 PM, facility remained at a level of no actual harm at a scope of isolated that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.