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	10/14/2024

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47065 Based on interviews and record reviews, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for one (Resident #1) of four residents reviewed for falls. The facility failed to conduct neurological assessments on Resident #1 per facility protocol after Resident #1 returned from the hospital the same day of her unwitnessed fall at the facility. This failure could place residents at risk of a change in condition and not receiving proper treatment and care in a timely manner. Findings included: Review of Resident #1's face sheet, dated 10/14/24, reflected she was an [AGE] year-old female who was admitted to the facility on [DATE] and discharged home on 10/13/24. Review of Resident #1's medical diagnoses list, dated 10/14/24, reflected she had acute on chronic systolic (congestive) heart failure, generalized muscle weakness, unsteadiness on feet, cognitive communication deficit, need for assistance with personal care, and a presence of a cardiac pacemaker. Review of Resident #1's comprehensive MDS assessment, dated 09/04/24, reflected she had a BIMS score of 9, which indicated she had moderate cognitive impairment. Resident #1 also had no falls since admission and was taking an anticoagulant (blood thinner) medication. Review of Resident #1's comprehensive care plan, dated 09/12/24, reflected she was at risk for falls, had an unwitnessed fall, and staff were required to conduct neurological checks per facility protocol. Resident #1 was also on anticoagulant therapy (Apixaban). Review of Resident #1's MAR, dated 10/14/24, reflected she took one Apixaban Oral Tablet 2.5 MG tablet by mouth on 10/01/24 at 8:00 AM. Review of Resident #1's change in condition evaluation, dated 10/14/24, reflected Resident #1 had a fall in the afternoon on 10/01/24 and was transferred to the hospital for further evaluation. Clinician and family were notified on 10/01/24 at 12:32 PM. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's provider investigation report, dated 10/02/24, reflected Resident #1 fell from her wheelchair to the floor in her room on 10/01/24 at 12:30 PM, which was shortly before lunch meal service. Resident #1 was observed on the floor lying face down, bleeding from skin tears on both arms, had a hematoma and swollen area on the right side of her head. Resident #1 was transported to the hospital on 10/01/24 for assessment and returned the same day (10//01/24) with no major injuries or new orders. Review of Resident #1's A physician's note on 10/01/24 at 11:54 AM that reflected, Resident #1 had a fall in her room today (10/01/24). She was reported sitting in wheelchair and falling asleep and falling to the ground hitting her head. Resident #1 had a large lump right side of head. Resident #1 on Eliquis. EMS called and report given. Resident #1 sent out to hospital. Review of Resident #1's A nursing progress note on 10/01/24 at 10:20 PM that reflected, Resident #1 arrived back from hospital at approximately 10:20 PM. Large black, blue, and purple hematoma to the right side of forehead with bruising across the entre forehead. No new orders received from ER/Hospital. Review of Resident #1's electronic neurological evaluation flow sheet, dated 10/03/24 at 3:42 AM, reflected no electronic evaluations entries were completed. Review of Resident #1's neurological evaluation flow sheet, undated, reflected evaluation times/dates were as listed: -10/01/24 12:30 PM -10/01/24 10-6 -10/02/24 6-2 -10/02/24 2-10 -10/02/24 10-6 -10/03/24 6-2 -10/03/24 2-10 -10/03/24 10-6 Resident #1 missed eight neurological checks that were required to occur every two hours from 10/01/24 through 10/02/24. During an interview on 10/14/24 at 5:48 PM, the ADM stated staff must conduct neurological evaluations every shift because Resident #1 came back from the hospital around 10:00 PM on 10/01/24, which was the same day as Resident #1's unwitnessed fall incident. The ADM stated staff correctly completed the neurological checks on Resident #1. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/14/24 at 6:22 PM, LVN A stated staff were required to conduct neurological checks on residents every 15 minutes for the first hour, every 30 minutes for the second hour, every hour for the next four hours, every two hours for the first 24 hours, and then every shift for the second and third days. LVN A stated residents' health could be at risk because staff would miss or might not notice a resident's change in condition if staff did not conduct neurological evaluations according to facility protocol. LVN A stated nurses on duty conduct neurological evaluations. LVN A stated residents' neurological evaluations were documented on physical flowsheets. During an interview on 10/14/24 at 6:28 PM, the ADON stated floor nurses and nurses who assessed residents were responsible for conducting neurological assessments. The ADON stated she expected staff to follow the suggested frequency on the neurological flow sheet when conducting neurological evaluations on residents. The ADON stated if a resident was not monitored according to facility's protocol, the resident could be at risk of having a brain bleed, altered mental status, repeat fall and change in condition. The ADON stated the facility's IDT team oversaw weekly to ensure neurological monitoring sheets were correctly completed. The ADON stated she was unsure if Resident #1's unwitnessed fall incident was reviewed for neurological evaluations. During an interview on 10/14/24 at 6:33 PM, LVN B stated neuro evaluations were standard. LVN B stated staff were required to conduct neurological evaluations every 15 minutes for the first hour, every 30 minutes for the second hour, every hour for the next four hours, every two hours for the first 24 hours, and then every shift for the second and third days. LVN B stated staff documented neurological evaluations on physical flowsheets. LVN B stated residents could be at risk of death or have a brain bleed, which could lead to stroke, if neurological checks were not frequently completed according to facility protocol. LVN B stated residents could also be at risk of not having their change in condition not immediately noticed by staff. LVN B stated the ADON and the DON oversaw neurological check flowsheets to ensure they were correctly completed. During an interview on 10/14/24 at 6:39 PM, the DON stated she expected staff to start neurological checks and follow checking every 15 minutes for the first hour, then every 30 minutes for the second hour, then every hour for the next four hours, then every two hours for the first 24 hours, and then every shift for the second and third days. The DON stated neurological checks were completed to ensure residents were stable. The DON stated if neurological checks frequencies were not followed, residents could be at risk of a neurological issue. The DON stated Resident #1 went out and was gone the whole day on 10/01/24 and returned the night of 10/01/24. The DON stated staff were required to continue Resident #1's neurological checks from every shift after Resident #1 returned to the facility from the hospital. The DON stated the IDT team reviewed neurological sheets to ensure they were correctly completed. Review of the facility's neurological checks policy, effective 07/2015, reflected, It is the policy of this community to evaluate residents following falls for possible injury and neurological problems. Neurological checks should be done for residents with un-witnessed falls and/or injury to the head. A. Neurological checks should be done as follows: o Check every 15 minutes for the first hour, (continued on next page)

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