

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675937	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2024
NAME OF PROVIDER OR SUPPLIER Sagebrook Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 901 Discovery Blvd Cedar Park, TX 78613	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47065</p> <p>Based on interviews and record reviews, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials for 1 (Resident #1) of 4 residents reviewed for incidents.</p> <p>The facility staff failed to inform the ADM of Resident #1's allegation of neglect from 10/19/24 until 10/22/24, subsequently making the ADM's report late to the SA.</p> <p>This failure could place residents at risk of neglect and receiving substandard quality of care.</p> <p>Findings include:</p> <p>Review of Resident #1's admission record, dated 11/21/24, reflected she was an [AGE] year-old female who was admitted to the facility on [DATE] and had diagnoses including unspecified dementia, major depressive disorder, age-related osteoporosis (a disease that causes bones to become weak and more likely to break), and other specified disorders of bone density and structure.</p> <p>Review of Resident #1's quarterly MDS assessment, dated 10/14/24, reflected she had a BIMS score of 12, which indicated she had moderate cognitive impairment. Resident #1's functional abilities section was blank. Resident #1 frequently had urinary incontinence and always had bowel incontinence.</p> <p>Review of Resident #1's care plan, dated 10/22/24, reflected Resident #1 had an ADL self-care performance deficit and required two CNAs to turn and reposition her in bed.</p> <p>Review of Resident #1's progress notes reflected a note made by LVN A on 10/19/24 at 1:26 PM,</p> <p>Resident was found to have bruising to right thumb down to wrist. NOC shift nurse reported to day shift and was found to be a light blue color. Resident not able to push call light button, but able to move around. Resident stated it happened during a transfer and that its been sore since. Family and weekend supervisor notified.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #1's self-report, dated 10/22/24, reflected Resident #1 made a neglect allegation at an unknown date. Resident #1 alleged the neglect incident happened on 10/16/24 at 1:00pm in her room. The facility reported Resident #1's neglect allegation to the SA on 10/22/24 at 1:10pm. There were no alleged perpetrators and witnesses. Resident #1 alleged a CNA hurt her arm and thumb during repositioning for care on either 10/16/24 or 10/18/24. Resident #1 was assessed head to toe on 10/19/24 at 1:25 PM by LVN A. LVN A found bruising to Resident #1's right thumb down to her wrist. The facility initiated safe surveys and skin checks for all residents on Resident #1's hall and found there were no other signs of abuse/neglect. The facility also initiated education on abuse/neglect and proper methods of repositioning during care. Resident #1 was unable to remember when the incident occurred and give a description of the CNA that performed the care. Resident #1 was consistent that the CNA was providing service and used her arm to reposition her. Resident #1 stated she didn't feel pain during the care and noticed her thumb was sore and some slight bruising. Resident #1 kept repeating the incident happened either on 10/16/24 or 10/18/24. Resident #1's bruising looked consistent with someone locking hands in a helping manner around Resident #1's lower wrist and thumb area. Resident #1 repeated during all her interviews that the incident happened while a CNA was providing care and didn't feel that the action was done intentionally. The facility interviewed all staff that were assigned to Resident #1's room on the alleged days except for an Agency CNA that would not return calls and had not been to the facility since. All other interviewed staff stated they didn't use Resident #1's hand to reposition Resident #1, but used a draw sheet. The investigation findings were unconfirmed.</p> <p>During an interview on 11/21/24 at 8:56 AM, the DON stated Resident #1 didn't immediately report her alleged neglect incident. The DON stated she didn't know when Resident #1 initially reported her alleged neglect incident.</p> <p>During an interview on 11/21/24 at 9:30 AM, CNA B stated he was in-serviced on abuse and neglect. CNA B stated he knew the ADM was the abuse and neglect coordinator. CNA B stated he would immediately report abuse and neglect.</p> <p>During an interview on 11/21/24 at 9:43 AM, CNA C stated she worked at the facility for [AGE] years. CNA C stated she was given orientation training on abuse and neglect. CNA C stated she knew the ADM was the abuse and neglect coordinator. CNA C stated she would immediately report abuse or neglect.</p> <p>An attempt to interview Resident #1 was made on 11/21/24 at 9:48 AM. Resident #1 was sleeping in her room.</p> <p>During an interview on 11/21/24 at 9:50 AM, LVN A stated he worked at the facility for 3.5 years. LVN A stated he was given orientation training on abuse. LVN A stated he knew to notify the ADM, who was the abuse and neglect coordinator, on abuse and neglect. LVN A stated he would immediately report abuse or neglect. LVN A stated he was not working when Resident #1 alleged neglect.</p> <p>During an interview on 11/21/24 at 9:54 AM, the ADON stated she knew the ADM was the abuse and neglect coordinator. The ADON stated she would immediately report abuse and neglect. The ADON stated she was not working when Resident #1 alleged neglect.</p> <p>An attempt to interview Resident #1 was made on 11/21/24 at 10:00 AM. Resident #1 was sleeping in her room.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/21/24 at 10:52 AM, LVN A stated he reported what he wrote in his progress note on 10/19/24 to the weekend supervisor. LVN A stated he couldn't recall who the WS was. LVN A stated he knew it was important to immediately report abuse or neglect to ensure it didn't happen to anyone else. LVN A stated he didn't report directly to the DON and ADM because it wasn't something that he saw, Resident #1 didn't have right mindset with her memory, and he just reported it to the weekend supervisor.</p> <p>During an interview on 11/21/24 at 10:56 AM, the ADM stated he couldn't recall when and who reported Resident #1's alleged neglect incident. The ADM stated on 10/21/24, during a morning meeting, it was brought up about Resident #1's alleged neglect incident. The ADM stated he considered Resident #1's alleged incident as neglect and followed the neglect reporting procedures outlined in the provider letter for reporting neglect to the SA. The ADM stated he went by the within 24 hour timeframe for reporting neglect. The ADM stated all staff were responsible for immediately reporting abuse and neglect to him so he could report to the SA.</p> <p>During an interview on 11/21/24 at 11:22 AM, the DON stated she was notified on 10/21/24 during morning meeting about Resident #1's alleged neglect incident. The DON stated she initiated the neglect reporting protocol because it wasn't suspected abuse and because Resident #1 didn't state that the incident was abuse. The DON stated neglect was reported to the SA within 24 hours. The DON stated neglect was reported to the SA within two hours if staff suspected abuse. The DON stated she knew it was important to report abuse and neglect to the SA because staff can remove the alleged staff member from the resident, ensure resident safety, ensure other residents were not harmed, and initiate an investigation. The DON stated residents could be harmed if staff were not reporting within the required timeframes. The DON stated as soon as she's notified of allegations or suspicions of abuse and neglect, she would report right away. The DON stated she did not know why the WS and LVN A, who wrote the progress notes on 10/19/24, didn't report Resident #1's alleged neglect incident to her and the ADM. The DON stated she believed the WS didn't immediately report because the WS didn't think Resident #1 was in immediate danger.</p> <p>An attempt to contact the WS was made on 11/21/24 at 11:32 AM. A voicemail and call back number were left. The WS didn't return the call before exit.</p> <p>Review of the facility's incident log, from 10/01/24 through 11/21/24, reflected Resident #1's bruise incident was on 10/19/24 at 1:20 PM.</p> <p>Review of the facility's in-services, from 10/01/24 through 11/21/24, reflected staff were trained on the abuse and neglect policy and procedure on 10/03/24. Staff were trained on reporting immediately to the ADM of any allegations and suspicions of abuse and neglect.</p> <p>Review of the SA's provider letter for reporting neglect to the SA, issued 08/29/24, reflected:</p> <p>A facility must report to the SA the following types of incidents, in accordance with applicable state and federal requirements: Neglect</p> <p>Do Report: An incident that does not result in serious bodily injury but that involves any of the following: Neglect: Immediately, but not later than 24 hours after the incident occurs or is suspected.</p>		