STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675937	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sagebrook Nursing and Rehabilitation	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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47065 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 5 residents reviewed for incidents. The facility failed to report within 2 hours to the SA after Resident #1 alleged sexual abuse to her Hospice caretaker on 12/13/24, who subsequently notified the facility on 12/16/24. The facility did not report Resident #1's allegation to the SA until 12/18/24. This failure could place residents at risk of sexual abuse and receiving substandard quality of care. Findings include: Review of Resident #1's admission record, dated 12/19/24, reflected she was an [AGE] year old female who was readmitted to the facility on [DATE] and had diagnoses including unspecified Alzheimer's disease, generalized muscle weakness, dementia, delusional disorders, unspecified depression, and unspecified anxiety disorder. Review of Resident #1's quarterly MDS assessment, dated 11/22/24, reflected she had a BIMS of 3, which indicated she had severe cognitive impairment. Resident #1's functional abilities section was blank. Resident #1 always had urinary and bowel incontinence. Review of Resident #1's care plan, dated 11/13/24, reflected Resident #1 had an ADL self-care performance deficit and required one CNA to extensively assist with toileting. Resident #1 also had impaired cognitive function and used psychotropic medications. There was special instructions on Resident #1's care plan that indicated, Female caregiver only. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/19/24 at 10:05 a.m., the ADM stated Resident #1 reported a sexual abuse allegation to her Hospice caretaker on 12/13/24. The ADM explained the Hospice caretaker didn't report Resident #1's sexual abuse allegation until 12/16/24. The ADM explained the Hospice caretaker reported Resident #1's sexual abuse allegation to the Hospice Agency on 12/16/24, who reported Resident #1's sexual abuse allegation to the facility on [DATE]. The ADM stated the Hospice Agency reported Resident #1 told her Hospice caretaker that she was raped 3 times. The ADM said, Our (him and the DON's) initial reaction was that we felt [Resident #1's] allegation wasn't reportable, but after further reflection, we felt it was reportable. The ADM stated he knew to report abuse allegations within 2 hours to the SA. The ADM stated he knew anyone at the facility could report an abuse allegation to the SA, but he and the DON were responsible for reporting abuse allegations to the SA within 2 hours. The ADM stated he knew it was important to report abuse allegations within 2 hours to the SA and said, To make sure everything else could be accurately portrayed and to make sure the residents were safe. During an interview on 12/19/24 at 10:06 a.m., the DON stated she interviewed the facility staff and residents on 12/16/24 and found no one was aware of Resident #1's sexual abuse allegation. The DON stated her and the ADM's initial reaction was that they felt Resident #1's allegation wasn't reportable, but after further reflected, they felt it was reportable. The DON stated she knew to report abuse allegations within 2 hours to the SA. The DON stated she knew her and the ADM were responsible for reporting abuse allegations to the SA within 2 hours. The DON stated she knew it was important to report abuse allegations within 2 hours to the SA and said, To make sure the residents were safe. During an interview on 12/19/24 at 11:00 a.m., Resident #1 said, I was raped 3 times. 2-3 months ago, I can't remember what happened. I knew who did it. A man had done it. I don't remember when it happened. The man grabbed me here (Resident #1 pointed at her left and right arm) and threw me down and acted like he knew me. There was a woman involved. The female was violent against me because this part (Resident #1 pointed at both her arms again). She was very frightening, hurt my toes, and acted like she was going to kill me. I don't remember what time of day it happened. It happened 3 different times. I don't remember if they work at the same place. I've seen the man and woman recently. It has been very long since I've seen the woman and man. I don't exactly remember when I last saw the man and woman. Resident #1's statement continued to change several times during the interview. At some point in the interview, Resident #1 had no additional information to provide. Attempts to contact Resident #1's Hospice caretaker were made on 12/19/24 at 2:52 p.m. and at 3:59 p.m. A voicemail and call back number was left on both attempts. Resident #1's Hospice caretaker didn't return the calls before exit. During an interview on 12/19/24 at 2:54 p.m., CNA A stated Resident #1 never reported a sexual abuse allegation to her. CNA A stated she was most recently in-serviced on abuse and reporting online 1-2 weeks ago. CNA A stated she knew the ADM was the abuse and neglect coordinator. CNA A stated she knew to immediately report abuse allegations. During an interview on 12/19/24 at 3:19 p.m., CNA B stated Resident #1 never reported a sexual abuse allegation to her. CNA B stated she was trained and most recently in-serviced on abuse and reporting on 12/18/24 and learned to report right away to the charge nurse if she saw or heard any abuse. CNA B stated she didn't know who the abuse and neglect coordinator was. CNA B stated she knew it was important to immediately report abuse allegations and said, So they could be investigated right away and residents may forget if reporting was prolonged. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/19/24 at 3:39 p.m., LVN C stated Resident #1 never reported a sexual abuse allegation to her. LVN C stated she was most recently in-serviced on abuse and reporting on 12/18/24 and learned the ADM was the abuse and neglect coordinator and to immediately report abuse allegations. LVN C stated she would immediately report abuse allegations. LVN C stated she knew it was important to immediately report abuse allegations and said, So they (the facility) could contact the authorities and to make sure the resident was safe. During an interview on 12/19/24 at 4:00 p.m., CNA D stated he didn't work with Resident #1 because female caregivers were required to work with her. CNA D stated he was most recently in-serviced on abuse and reporting in November or December 2024. CNA D stated he knew to report abuse allegations to the abuse and neglect coordinator. CNA D stated he didn't know who the abuse and neglect coordinator was. CNA D stated he knew to immediately report abuse allegations. CNA D stated he knew it was important to report abuse allegations and said, So the resident won't get violated and so the abuse doesn't lead to something else. During an interview on 12/19/24 at 4:14 p.m., CNA E stated Resident #1 never reported a sexual abuse allegation to her. CNA E stated she was most recently in-serviced on abuse and reporting alleged violations on 12/16/24. CNA E stated she would report abuse immediately to the charge nurse, LVN, RN, ADON, DON, and ADM. CNA E stated she knew the ADM was also the abuse coordinator. CNA E stated she knew it was important to report immediately abuse allegations and said, It's very important because no one deserves to be hit, whatever abuse is, needs to be dealt with, investigated, and needed to be looked into. Review of the facility's in-services from December 2024 reflected staff were trained on abuse and neglect reporting by the ADM and DON on 12/16/24. Staff were taught to report suspected abuse or neglect immediately to the appropriate person and the abuse/neglect coordinator was the ADM. Before 12/16/24, staff were in-serviced on the Abuse, Neglect, and Exploitation policy by the DON on 10/03/24. Staff were taught that the abuse coordinator was the ADM. Review of the facility's Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy, revised April 2021, reflected the following, Policy Statement: Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. Policy Interpretation and Implementation: The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: . 9. Investigate and report any allegations within timeframes required by federal requirements. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Abuse, Neglect, Exploitation, Misappropriation of Resident Property and Other Incidents that a Nursing Facility Must Report to the Health and Human Services Commission Provider Letter, issued 08/29/24, reflected the following, A NF must report to CII the following types of incidents, in accordance with applicable state and federal requirements: Abuse . Abuse (with or without serious bodily injury) is to be reported immediately, but not later than two hours after the incident occurs or is suspected . HHSC rules define abuse as: The negligent or willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical or emotional harm or pain to a resident; or sexual abuse, including involuntary or nonconsensual sexual conduct that would constitute an offense under Penal Code S21.08 (indecent exposure) or Penal Code Chapter 22 (assaultive offenses), sexual harassment, sexual coercion, or sexual assault . CMS defines abuse as: The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Review of the facility's Abuse and Neglect Clinical Protocol, revised March 2018, reflected the following: Definitions: 1. Abuse is defined at S483.5 as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology . 3. Sexual abuse is defined at S483.5 as non-consensual sexual contact of any type with a resident.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47065 Based on observations, interviews, and record reviews, the facility failed to ensure that each resident receives adequate supervision and assistance devices to prevent accidents for 1 (Resident #2) of 5 residents reviewed for unwitnessed falls. The facility failed to adjust Resident #2's wheelchair brakes so they locked in place. On 12/19/24, Resident #2 went to the bathroom unsupervised and fell due to wheelchair brakes not properly locking, subsequently leading to soreness and pain. This failure could place residents at risk of falls, bruises, skin tears, fractures, and hospitalization s. Findings include: Review of Resident #2's admission record, dated 12/19/24, reflected he was a [AGE] year old male who was admitted to the facility on [DATE] and had diagnoses including unspecified dementia, mild cognitive impairment of uncertain or unknown etiology, pain in right hip, generalized muscle weakness, difficulty in walking, unsteadiness on feet, unspecified lack of coordination, fracture of superior rim of right pubis (hip bone), age related osteoporosis, other chronic pain, and repeated falls. Review of Resident #2's quarterly MDS assessment, dated 09/21/24, reflected he had a BIMS of 9, which indicated he had moderate cognitive impairment. Resident #2 had no falls since admission. Resident #2 required supervision or touching assistance with toileting hygiene and partial/moderate assistance with toilet transfers. Resident #2 was occasionally urinary and bowel incontinent. Resident #2 also used a wheelchair as his normally used mobility device. Review of Resident #2's care plan, dated 09/23/24, reflected he had an ADL self-care performance deficit and required limited assistance by one CNA for toileting and to move between surfaces. Resident #2 was also at moderate risk for falls and staff were required to anticipate and meet his needs, be sure his call light was within reach, encourage him to use his call light for assistance as needed, required prompt response to all requests for assistance, ensure he was wearing appropriate footwear when ambulating and mobilizing in wheelchair, was evaluated and treated as ordered or as needed, and required a safe environment with even floors from spills and/or clutter, adequate glare-free light, a working and reachable call light, the bed in low position while in bed, side rails as ordered, handrails on walls and personal items within reach. Review of Resident #2's care plan, dated 12/19/24 at 2:34 p.m., reflected staff revised to include they were to supply a grabber for him and review information on past falls and attempt to determine cause of falls. Review of Resident #2's plan of care, dated 12/19/24 at 2:41 p.m., reflected Resident #2 required supervision and set-up only assistance with toilet use on 12/19/24 at 5:09 a.m. There were no other entries until 12/19/24 at 1:03 p.m. in which Resident #2 required one person extensive, physical assistance with toilet use. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #2's progress notes, as of 12/19/24 at 2:24 p.m., reflected the following: *11/23/24 reflected he was on the floor in the bathroom and told staff that he hit his face on the floor when he fell . *10/15/24 reflected he was on the floor in his room, on his buttocks, legs flexed and back to his wheelchair and told staff that he was looking for his phone, then reached for his chair to sit but it was unlocked and he fell . *10/05/24 in which he was found on his knees next to his bed and told staff that he was trying to reach his soda bottle on the floor and slid down. During an observation of Resident #2's hallway on 12/19/24 at 11:20 a.m., there was no staff in the hallway. Resident #2 was yelling, Help me! Help me please! The call light was not on outside Resident #2's room. During an observation of Resident #2's hallway from 12/19/24 11:21 a.m. through 11:29 a.m., there was no staff in the hallway. Resident #2 continued to yell, Help me! Help me please! The call light was not on outside Resident #2's room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation of Resident #2's hallway and interview on 12/19/24 at 11:30 a.m., the surveyor notified CNA F, who walked out the dining area and into the front of Resident #2's hallway, about hearing Resident 2 yelling for help. CNA F and the surveyor walked from the front to back of Resident #2's hallway. The surveyor identified Resident #2's room, whose door was closed. The surveyor and CNA F heard Resident #2 yell inside his closed bathroom, Help me! CNA F opened Resident #2's bathroom door. RN G ran from the front of Resident #2's hallway to Resident #2's room. CNA F, the surveyor, and RN G observed Resident #2's knees on the bathroom floor, his upper body leaning on his wheelchair seat, and his right arm in between the gap of his wheelchair backrest and seat. Resident #2 yelled, I've been calling for help for 30 minutes! I've been waiting for a long time! RN G asked Resident #2 how he fell . Resident #2 yelled, Don't lecture me about falling down and not getting up! I don't want to talk about it! I fell , been face down, and screaming for help for a long time! RN G proceeded to ask Resident #2 if he hit his head. Resident #2 yelled, Enough! RN G asked Resident #2 again if he hit his head during her assessment and Resident #2 denied hitting his head. RN G completed her assessment and determined Resident #2 had no physical injuries. RN G and CNA F helped Resident #2 back into his wheelchair. CNA F left Resident #2's room. RN G asked Resident #2 if he was in any pain. Resident #2 said, Yeah a little bit. I'm sore in this arm (Resident #2 pointed at his left arm). This was the arm I leaned on the wheelchair with. RN G left Resident #2's room to get his pain medication. Resident #2 said, I got up, started using the wheelchair, got up from the wheelchair, it started rolling, and I fell . I've been laying here a long time. I don't call unless it was an emergency. I fell out my wheelchair and couldn't move. I screamed and screamed and screamed. I had a knee on the ground. I was on the ground for a long time. After a while, I thought staff would be here. I think there's several problems at this facility, but one of them is people calling for help because they aren't aware of what they're saying and people like me who call for help and staff don't go and don't answer. Staff do it regularly. It's daily. We don't get any help. To tell you the truth, I was in the position for a while, I made a move and slid down to my knees. My wheelchair brakes were out. I mentioned it to staff that they've gone out a couple times. This happened a hand full of times. The second time I made it to the wheelchair. I'm sorry, it's hard to answer questions, I'm just flustered. I fell into the wheelchair seat with my legs on the ground. RN G returned with Resident #2's pain medication, took Resident #2's blood pressure and pulse, gave him pain medication, and assessed his knees and found no injuries except redness. The DON visited Resident #2's room and asked Resident #2 what happened. The surveyor explained to the DON what occurred. The DON left Resident #2's room. Review of the facility's incident log, dated 12/19/24 at 11:07 a.m., reflected Resident #2's unwitnessed fall was not listed. Review of Resident #2's orders, as of 12/19/24 at 1:54 p.m., reflected no new orders for 12/19/24. The most recent order listed was from 12/09/24. Review of Resident #2's MAR/TAR, as of 12/19/24 at 1:55 p.m., reflected no pain levels documented for 12/19/24. Review of Resident #2's pain level summary, as of 12/19/24 at 1:55 p.m., reflected no pain levels documented for 12/19/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #2's neurological check list, effective on 12/19/24 at 12:24 p.m., reflected his most recent pulse and blood pressure levels were checked on 12/19/24 at 11:10 a.m. and at normal ranges and his most recent temperature and respiration levels were checked on 11/24/24 at 1:10 a.m The remainder of the neurological check list was blank. Review of the facility's work order report, from 10/01/24 through 12/19/24, reflected a high priority order to adjust the right side of Resident #2's wheelchair break was initiated on 12/19/24 at 12:43 p.m. Before 12/19/24, there was a resolved order related to wheelchair brakes for another resident that was initiated on 11/05/24 at 10:27 a.m. During an observation and interview on 12/19/24 at 12:00 p.m., Resident #2 demonstrated to the surveyor and the MS, who visited Resident #2's room, locking his left wheelchair brake, which locked into place when he motioned his wheelchair forwards and backwards. Resident #2 demonstrated to the surveyor and the MS his right wheelchair brake, which dragged when he motioned his wheelchair forward and backwards and said, It doesn't hold like it should. There were two times of it slipping under me. I had the wheelchair for about a year. I was admitted to the facility over a year ago. I went to the bathroom on my own, but I'm thinking I might need staff to start helping me because of this. The first time it happened I was right in front of the room door. This time, I wasn't near the call light. I couldn't reach it. I don't know exactly how long I was on the floor, but I was on the floor for a long time. The MS said, I've adjusted his (Resident #2's) wheelchair a couple times. The MS told Resident #2, I would like to adjust your wheelchair, but I know it's lunchtime, so I'll adjust it after lunch. The MS left Resident #2's room. During an interview on 12/19/24 at 12:15 p.m., the MS said, I don't know if there was a work order submitted, but I know I tightened it (wheelchair wheels) a couple of times. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/19/24 at 12:49 p.m., the MS stated he worked at the facility for 7 years and 4 months. The MS stated he was responsible for tightening residents' wheelchair locks. The MS said, Once brought to my attention, sometimes I can correct it on the spot. If it is a critical area, it depended on the state of the brakes and condition of the wheelchair if it needed to be adjusted. When asked when Resident #2 most recently informed him about experiencing issues with his wheelchair wheels not locking, the MS said, It's been awhile since he last brought it up. I did it one time. I have adjusted it before. With enough force he could move it. It (Wheelchair locks) clicked in place pretty well. Found one work order (from Resident #2) about a year old and put one in today. When asked when he inspected, repaired and/or replaced wheelchair locks, the MS said, That's constant. Will go good for a while, and then will have one (work order) show up where brakes failed. The brakes with enough force can move and require adjustments. I had a monthly task of checking. Best course was to check with the CNAs and ask if they're noticing any issues with residents transferring into wheelchairs. Nurses and CNAs will tell me. I will do a wheelchair wash every 2-3 times a year. I put a whole assembly line to wash and maintenance wheelchairs. I can't tell you if I kept the documentation, but I don't remember if I kept any while we (him and the staff) washed them. There's no work order record system that's kept, but I do a lot of that stuff. There's a monthly task that is 100% check on every single unit and there's random checks done every month so we can identify any issues specific to wheelchairs. Just functionality of all wheelchairs. That's performed monthly. I don't put it into a specific task. I just do the adjustment and cleared the task as complete. CNAs can also input work orders. The MS stated he knew it was important to inspect and maintain wheelchairs and said, It's the safety part and one could roll out from under them (residents). They can get hurt on the next transfer. Anything reported on the wheelchairs are immediately reported. As soon as they (nursing staff) report it, they have residents put in bed, and I adjust wheelchairs accordingly. I put antiroll back kits on them and put them in a prior months' notice. My job is to make sure people are kept safe and secure. Wheelchairs are important. That's why I wanted[Resident #2's] wheelchair, but he was going to lunch and so I'm going to follow up with him later. During an observation and interview on 12/19/24 from 1:11 p.m. through 1:30 p.m., Resident #2 was still using the same wheelchair. When asked if the MS adjusted his wheelchair, Resident #2 said, No. When asked if staff offered to put him in a different wheelchair for the time being, Resident #2 said, No. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/19/24 at 1:2 p.m., RN G stated she was assigned to work Resident #2's hall on 12/19/24 from 6:00 a.m. through 2:00 p.m. RN G stated she was trained on falls. RN G stated she could not recall when she was most recently in-serviced on falls by the facility. RN G stated she defined an unwitnessed fall as a patient on the floor and said, [Resident #2], clearly gravity took him, but he didn't hit his head and nobody saw it. When asked what she was required to do when a resident had an unwitnessed fall, RN G said, I would initiate neuros right then and there, get vitals, and tell them (residents) to call if they understand. I tell him (Resident #2) all the time and he doesn't listen. We are also supposed to ensure his safety and we remind him. He should call, but he doesn't call. He should have 1 assist with minimal intervention, but sometimes he's a max assist. Sometimes he can help you and sometimes he can't. When asked what happened during Resident #2's fall, RN G stated she was walking down the hallway coming from the dining area to give another resident a sandwich, she didn't hear Resident #2 screaming for help, she observed the surveyor and CNA F at Resident #2's room, rushed into Resident #2's bathroom with CNA F, observed Resident #2's arm in back of his wheelchair, his knees on the bathroom floor, his hips leaning on the wheelchair seat, her and CNA F guided Resident #2 down on his knees, gave Resident #2 time to breathe, and while holding wheelchair, guided Resident 2 back to his wheelchair. RN G stated Resident #2 said, I don't need a lecture, when she asked what happened and if he's in any pain. RN G stated she didn't want to move Resident #2 if he was in pain, but Resident #2 was able to move what she asked and her and CNA F were able to move him. RN G stated she was required to check residents' vitals and pain and if they can move all extremities whenever there was a witnessed or unwitnessed fall and said, He (Resident #2) didn't hit his head, so I didn't think to check pupils but I was ready to. If he hit his head, it would've been part of his neuro checks. I didn't want to wait to take his vitals, but I didn't want to do it right then and there, so I waited 10-15 minutes to check his blood pressure and so he could calm down and verbalize what happened. RN G stated Resident #2 told her that he was just getting off the toilet, didn't ask for help, tried to get back into his wheelchair, reached for the wheelchair and said, The darn brakes, I believe he put weight on the wheelchair and fell in, thankfully he fell into the wheelchair and not all the way back. RN G stated Resident #2 never mentioned to her about his wheelchair wheels not locking and said, He (Resident #2) probably mentioned it to maintenance man himself because he was cognitive of who played what role and would've told someone like [The MS or the ADM]. RN G stated Resident #2 told her that he was in pain in his shoulders and neck, gave him Tylenol 500mg and notified the DON, NP and ADM. When asked if she notified Resident #2's family, RN G said, I don't think he has any family, maybe a friend. I was behind on other stuff, but didn't have time to notify the family, but would be someone I would notify. RN G stated she mentioned that Resident #2 was experiencing issues with his wheelchair to the DON and that the wheelchair wheels needed to be fixed. RN G stated staff offered to push Resident #2's wheelchair to the dining room. RN G stated the MS fixed Resident #1's wheelchair wheel brakes after the surveyor left Resident #2's room on 12/19/24 around 1:40 p.m. RN G stated she knew it was important to follow fall protocol and conduct neuro checks and said, So the resident didn't suffer any injuries, not suffer a brain bleed, and had no injuries anywhere that could be exacerbated if not followed. So yeah to prevent any further injury or harm. And if they have a brain bleed, cannot do neuros because they could be dead. When asked when CNAs check on residents, RN G said, CNAs round on residents as soon as they get to the facility and every two hours. Nurses of course also round on residents. Administration always around on residents and are readily available and I do see a lot of them in the halls. RN G stated she didn't have any other residents report concerns about their wheelchair wheels not locking into place. RN G stated she assumed the MS was responsible for checking on residents' wheelchairs. RN G stated if a resident reported wheelchair issues, she would notify the DON, MS and Housekeeping Supervisor and tell the DON to follow-up with the issue. RN G stated she didn't have access to work order system at the facility, would write down maintenance issues and informed other staff. (continued on next page)

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	675937	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sagebrook Nursing and Rehabilitation	901 Discovery Blvd Cedar Park, TX 78613

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An attempt to contact CNA F was made on 12/19/24 at 2:36 p.m. A voicemail and call back number was left. CNA F did not return the call. During an interview on 12/19/24 at 4:34 p.m., the DON stated she in-serviced and hosted an all staff meeting that covered fall protocol, who to report falls to, and what to do when falls occur to reiterate importance. The DON stated she most recently in-serviced staff on falls in November 2024 and taught staff about the types of falls, checking for ROM and vitals, CNA reporting to nurse, notifying her of falls, nurses starting neuros, notifying the doctor, family, ADON, her and the NP, and checking for blood thinners. The DON stated nurses were expected to conduct neuros for 72 hours regardless of if the resident hit their head or not. The DON stated she knew it was important to initiate neuros and said, Because they (residents) can have a change in condition and that way you have a timeline when the change in condition occurred and can address it as needed. The DON said the frequency for neurological checks were, 15 minutes first hour, 30 minutes second hour, once an hour, and then every shift until 72 hours was up. The DON stated if there were any changes in condition, staff would notify her even if it was minor. The DON stated she knew it was important to follow fall protocol and said, Because if the resident had an injury, the injury could be reaggravated, it could cause a change in condition, addressing it in a timely fashion so further injury doesn't occur. The DON stated Resident #2 did not call for help and she believed he was more independent than he was. The DON stated staff were supposed to check on Resident #2 every two hours. The DON stated she recently placed Resident #2 on physical therapy services for mobility and were in process of getting a wheelchair more appropriate for him. The DON stated Resident #2 never reported any concerns about his wheelchair having any issues. The DON stated the MS looked at Resident #2's wheelchair before. The DON stated if there were any maintenance issues, she expected staff to put in an order in the facility's work order system or notify her and ADM to notify the MS. The DON stated she knew it was important to notify wheelchair issues and said, So it wouldn't put him at risk for injury again and so he could have more independent mobility. The DON stated the MS was responsible for inspecting and maintaining wheelchairs. The DON stated she did not know how often the MS was required to maintain and fix wheelchairs. The DON stated she expected staff to notify her, the ADM and MS whenever a resident reported a wheelchair issue. The DON stated she expected staff to assess a resident, conduct vitals and neuros, continue the fall process per fall policy, monitor continuously and document if a resident had an unwitnessed fall. The DON stated she defined an unwitnessed fall as If didn't see it, it was unwitnessed. During an interview on 12/19/24 at 5:33 p.m., the RNC said, There's a difference between witnessed and unwitnessed, which was when conducting neuro checks. Unwitnessed fall is going to be neuro checks no matter what. If you can verify the resident didn't hit their head or not, would still do neuro checks. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/19/24 at 5:58 p.m., the ADM stated he could not recall when he most recently in-serviced staff on falls. The ADM stated staff complete annual educations on falls. The ADM stated he defined an unwitnessed fall as no one saw the fall. The ADM stated he expected staff to quickly as they can go and assist if a resident had an unwitnessed fall. The ADM stated if the resident changed planes, he considered it to be an unwitnessed fall. The ADM stated he expected staff to immediately provide care if a resident was found on the ground, knees on the ground, and leaning on the wheelchairs. The ADM stated he expected any staff to check on residents as needed, whenever residents' press the call light, and roughly every two hours. The ADM stated he knew it was important to follow fall protocol and said, To make sure anything isn't serious and no underlying issues occurred that staff didn't know about. The ADM stated he expected his CNAs and nurses to render aide as quickly as they can if there was an unwitnessed fall. The ADM stated he expected staff to report to the nurse or let the MS know how to handle it or have staff enter work orders directly if residents reported wheelchair issues. The ADM said, Generally speaking, therapy and maintenance staff were responsible for adjusting wheelchairs and swapping out wheelchairs. Adding or fixing would be maintenance. The ADM stated he knew it was important to notify the MS of wheelchair malfunction and said, So they can be fixed as quickly as possible and so they don't quickly malfunction. The ADM stated he never been notified of any issues about Resident #2's wheelchair. The ADM stated Resident #2 told an unknown staff member this or last week about his wheelchair. The ADM stated he expected neuro checks to be completed as soon as staff can after the unwitnessed fall incident. The ADM stated he didn't know what level of assistance Resident #2 required to go to the restroom, but believed Resident #2 might be a 1-person assist. Review of the facility's in-services, from 09/01/24 through 12/19/24, reflected staff were trained on falls and fall risk managing policy on unknown date. Staff were also in-serviced on fall precautions by the DON and ADM on 09/04/24 and were taught to ensure all interventions in place. Staff were also in-serviced on neuro checks by the DON and ADM on 09/03/24 and taught it was the nurses responsibility to initiate neuro checks immediately when a patient has an unwitnessed fall and or a witnessed fall with hitting their head and if a neuro check is abnormal to call on-call NP not leave a message in PCC in communications or in NP box. Review of the facility's Logbook Documentation Mobility Aids: Conduct wheelchair inspection, from 09/01/24 through 12/19/24, reflected the MS inspected, repaired, and replaced wheelchairs on 11/05/24, 10/07/24, and 09/11/24. There was no documentation for December 2024. The MS was required to completed the following steps, Inspect wheelchairs for damaged or missing components 1. After lock out or repair work order Is issued, Inspect and or repair (Just a note lock out of a manual wheelchair is not needed) o Check wheelchairs for the following: o Brakes . o Wheels 2. Repair or replace as necessary (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	o Check wheelchair for proper operation 1. Tighten all adjustment points o Items identified as poor condition should be removed from service. Review of the facility's neurological evaluation flow sheet, undated, reflected staff were required to conduct neurological checks according to the following suggested frequency: Complete checks: every 15 minutes x 1 hour, every 30 minutes x 2 hours, every 1 hour x 2 hours, every shift x 72 hours. Staff were also required to date, time, initial, use Glasgow Coma scale to complete assessment, and check and document left and right reactions, arms, legs, blood pressure, pulse, respiration, temperature, and sign for each frequency. Review of the facility's Care Path for Falls, 2014-2021, reflected the following, Fall: Unintentional change in position coming to rest on the ground or onto the next lower surface. Take Vital Signs: Temperature, Blood Pressure, Pulse, Respirations, Oxygen Saturation . Manage in Facility: Document fall per facility policy, monitor vitals for 24-72 hours, monitor neuro checks for 24-72 hours, check for pain level, check for new bruising or other evidence of injury, review of orders for medications associated with increased fall risk . Review of the facility's Accidents and Incidents Investigating and Reporting policy, revised July 2020, reflected the following, Policy Statement: Accidents or incidents involving residents, employees, visitor , vendors, etc., occurring on our premises shall be investigated and reported to the Administrator. Policy Interpretation and Implementation: 1. The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident. 2. The following data, as applicable, shall be included in the Risk Management report: a. The date and time the accident or incident took place; b. The nature of the injury/illness (e.g., bruise, fall, nausea, etc.); c. The circumstances surrounding the accident or incident; d. Where the accident or incident took place; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. pain; e. lower extremity weakness; . i. functional impairments; . k. incontinence . 3. Medical factors that contribute to the risk of falls include: .d. neurological disorders; and e. balance and gait disorders; Resident-Centered Approaches to Managing Falls and Fall Risk: .6. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. 7. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable . Review of the facility's Neurological Assessment policy, undated, reflected the following, Purpose: The purpose of this procedure is to provide guidelines for conducting a neurological assessment (neuro checks) on residents with known or suspected head trauma or acute changes in mental or motor function that may be indicative of a neurological event . Steps in the Procedure: 1. Conduct neurological checks as frequently as ordered . 13. Frequency of neurological checks will be (Total of 72hrs): Every 15 minutes x 4 . The remainder of the policy was blank.