

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 05/14/2025
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 3 of 10 residents (Resident #71, Resident #191, and Resident #194) reviewed for rights.</p> <p>The facility failed to ensure PTA and RN A knocked on Resident #71, Resident #191, and Resident #194's doors when going into the residents' rooms.</p> <p>The deficient practice could place residents at risk of feeling like their privacy was being invaded or the facility was not their home.</p> <p>Findings included:</p> <p>Review of Resident #71's Face Sheet dated 05/14/2025 revealed she was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #71's diagnoses included kidney failure, muscle wasting, muscle weakness, difficulty walking, cognitive communication deficit (problems with communication), need for assistance with personal care, respiratory failure, type 2 diabetes mellitus without complications (high blood sugar), morbid obesity, hyperthyroidism (excessive production of thyroid hormones), diarrhea, insomnia (difficulty sleeping), and anxiety (feeling of uneasiness or worry).</p> <p>Record review of Resident #71's admission MDS assessment dated [DATE] revealed Resident #71 had a BIMS score of 14 indicating intact cognitive response.</p> <p>Review of Resident #191's Face Sheet dated 05/14/2025 revealed she was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #191's diagnoses included end stage renal disease (kidney failure), and discitis lumbar region (a rare and serious medical condition that involves inflammation and infection of the intervertebral disc in the spine).</p> <p>Record review of Resident #191's admission MDS assessment dated [DATE] revealed Resident #191 had a BIMS score of 14 indicating intact cognitive response.</p> <p>Review of Resident #194's Face Sheet dated 05/14/2025 revealed she was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #194's diagnoses included cerebral infraction (long term effects of a stroke).</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #194's admission MDS assessment dated [DATE] revealed Resident #194 had a BIMS score of 03 indicating severe cognitive impairment.</p> <p>Observation while talking to Resident #71 on 05/12/2025 at 10:34 a.m., revealed that PTA and RN A both walked into Resident #71's room without knocking before entering.</p> <p>Observation of 100 hall on 05/12/2025 at 11:13 a.m., revealed that RN A walked into Resident 191's room without knocking before entering.</p> <p>Observation of 100 hall on 05/13/2025 at 08:36 a.m., revealed that RN A walked into Resident 194's room without knocking before entering.</p> <p>During an interview with Resident #71 on 05/12/2025 at 10:35 a.m., revealed that staff do not always knock before entering her room. She said that it did not bother her if staff were coming in and out. She said she did not get upset but would like for staff to knock.</p> <p>During an interview with Resident #194's POA on 05/13/2025 at 1:00 p.m., revealed that he visited Resident #194 daily and stayed for up to 8 hours. He said that staff do not always knock. He said it was mainly the nurses that did not knock. He said that it was not necessary for staff to knock. He said staff were not going to walk into anything going on in the room, so it did not bother him if staff knocked or not.</p> <p>During an interview with Resident #191 on 05/13/2025 at 2:26 p.m., revealed staff do not knock. She said that she would like for staff to knock before entering her room because she said there was no telling what position she could be in. She said that it would irritate her sometimes when staff did not knock, and she would tell them to please knock before coming into her room.</p> <p>During an interview with the PTA on 05/13/2025 at 3:34 p.m., revealed he had been trained on resident rights. He said the policy for knocking on the resident's door was knock, ask if can come in, and tell the resident who you are. He said any staff going into the resident's room should knock before they enter. He said there was not a time that staff do not need to knock. He said if staff did not knock then the resident may feel like their privacy was not being respected. He said everyone was responsible for monitoring to ensure staff were knocking. He said staff monitor by visually watching each other. He said he did not know why he did not knock on Resident # 71's door before entering. He said normally he was going back and forth getting things, but he should be knocking all the time.</p> <p>During an interview with RN A on 05/14/2025 at 8:44 a.m., revealed she had been trained on resident rights. She said the policy for knocking on the residents' doors was knock, wait for them to answer before entering. She also said for residents who could not answer your knock to wait a bit, then go in. She said that staff should always knock on the resident's door. She said that everyone should knock before entering. She said the resident may feel like staff are invading one of their rights by entering and not knocking. She said there was not a reason that staff did not need to knock. She said that the charge nurse was responsible for monitoring to ensure staff knocked. She said that knocking was monitored through observations. She said she did not recall walking into Resident #191, Resident #71, and Resident #194's room without knocking.</p> <p>(continued on next page)</p>

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with the DON on 05/14/2025 at 8:52 a.m., revealed that she and staff had been trained on resident rights. She said the policy for knocking on the door was always knock before entering. She said the resident would tell staff if it was okay to come into the room. She also said if the resident was nonverbal staff were to still knock tell them who they were and what the staff member was going to do. She said that staff should always knock on the resident's door prior to entering the room. She said everyone should knock before entering the resident's room. She said the resident may feel like they were not respected by staff, or the staff may make the resident feel like they were not seen as a person. She said that there was no reason why staff did not need to knock on the door before entering. She said that all management were responsible for monitoring to ensure that staff are knocking before entering. She said that management monitored through spot checks, and rounds. She said that if management seen staff not knocking, they address it right away. She said she did not know why staff were not knocking on the residents' doors.</p> <p>During an interview with the ADM on 05/14/2025 at 9:02 a.m. he stated he and staff had been trained on resident rights. He said that the policy was that staff were to knock before entering the resident's room. He said all staff were to always knock before going into the resident's room. He said if staff did not knock before entering the room the resident may feel like their privacy was not being respected. He said the only time staff did not have to knock on the door before entering was in the event of an emergency. He said knocking was monitored by everyone. He said everyone holds each other accountable and that knocking was monitored by doing rounds. He said that he did not know why staff did not knock before entering.</p> <p>Record review of Resident Rights Nursing Facilities Policy dated 04/2019 revealed right to be treated with dignity, courtesy, consideration and respect. A person living in a nursing home had the right to privacy.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**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 8 of 10 residents (Resident #10, Resident #32, Resident #35, Resident #76, Resident #52, Resident #22, Resident #15 and Resident #193) reviewed for infection control.</p> <p>1.</p> <p>CNA A did not conduct hand hygiene between each resident when passing lunch trays on the 400 Hall to Residents #10, #35, #76, #52, #22, and #15.</p> <p>2.</p> <p>During peri-care, CNA B did not sanitize her hands or change gloves when going from the front to the back for Resident #10.</p> <p>3.</p> <p>RN A did not wear a gown for Enhanced Barrier Precautions when administering medications to Resident #193, who had an enteral feeding tube.</p> <p>4.</p> <p>RN B did not conduct hand hygiene with glove changes when providing Foley catheter care and wound care to Resident #32.</p> <p>These failures could place residents at risk of transmission of disease and infection.</p> <p>Findings included:</p> <p>Record review of Resident #10's undated face sheet reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #10 had diagnoses which included Alzheimer's disease, muscle weakness, dysphagia (difficulty swallowing), difficulty in walking, diabetes mellitus type 2, and hypertension (high blood pressure).</p> <p>Record review of Resident #10's Quarterly MDS dated [DATE] reflected Resident #10 had a BIMS Score of 08, which indicated moderate cognitive impairment.</p> <p>Record review of Resident #10's Care Plan, last revised on 02/07/25, reflected a focus on ADL care, and more specifically meal set-up and reminders to eat.</p> <p>Record review of Resident #193's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #193 had diagnoses which included Down's syndrome, gastrostomy status, dysphagia (difficulty swallowing), and muscle weakness.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #193's Quarterly MDS dated [DATE] reflected he had a BIMS Score of 08, which indicated moderate cognitive impairment.</p> <p>Record review of Resident #193's Care Plan, last revised on 05/07/25, reflected he had Enhanced Barrier Precautions related to a PEG tube. Interventions included Enhanced Barrier Precautions will be maintained and resident will not develop an opportunistic infection through review date. Staff to follow Enhanced Barrier Precautions when providing close contact resident care.</p> <p>Record review of Resident #32's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #32 had diagnoses which included acute cystitis with hematuria (a urinary tract infection with microscopic blood in the urine), muscular weakness, neuromuscular dysfunction of the bladder, pressure ulcer of buttock, and need for personal assistance.</p> <p>Record review of Resident #32's Quarterly MDS dated [DATE] reflected he had a BIMS Score of 08, which indicated moderate cognitive impairment. Resident #32 had a Foley catheter, and he required the assistance of two staff members to provide his activities of daily living .</p> <p>Observation on 05/12/25 at 12:08 PM revealed CNA A was not conducting hand hygiene between each resident when passing lunch trays to resident rooms. CNA A was observed coming out of a room, no hand hygiene conducted, and she picked up a lunch tray and brought it to Resident #35. She went to pick up a tray and brought it to Resident #10. No hand hygiene conducted. CNA A then picked up a tray and brought it to Resident #15. No hand hygiene was observed. On 05/12/25 at 12:19 PM a second cart was brought onto the hall, and CNA A brought a tray to Resident #76. She then returned to the cart and picked up a tray and took it to Resident #52. No hand hygiene was observed. She then picked up a tray and brought it to Resident #22, and no hand hygiene was observed.</p> <p>Interview on 05/12/25 at 12:35 PM with CNA A revealed she had forgotten to use hand sanitizer between each resident when passing lunch trays. CNA A further stated she had been trained on hand hygiene and infection control, and an adverse outcome could be passing an infection to another resident.</p> <p>Observation on 05/14/25 at 09:06 AM revealed CNA B did not change gloves or conduct hand hygiene when going from the front to the back when conducting peri-care for Resident #10.</p> <p>Observation on 5/14/25 at 09:18 AM revealed RN A did not put on a gown during medication administration for Resident #193. His medications were administered via enteral feeding tube, which required any staff providing direct care to wear a gown for Enhanced Barrier Precautions.</p> <p>Interview on 5/14/25 at 09:36 AM with RN A revealed she had forgotten to put on a gown due to feeling nervous. RN A stated the importance of putting on a gown for Enhanced Barrier Precautions was to prevent the spread of infections throughout the facility. RN A further stated she had received training on Enhanced Barrier Precautions and Infection Control.</p> <p>Observation on 05/14/25 at 11:06 AM revealed RN B did not conduct hand hygiene with each glove change when providing Foley catheter care and wound care to Resident #32.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 04/14/25 at 03:47 PM with DON revealed her expectation of hand hygiene while providing peri-care to residents was handwashing/hand hygiene and glove change should be conducted when going from dirty to clean. The DON stated Enhanced Barrier Precautions should be followed for any resident identified, and when staff are providing resident care. DON further stated an adverse outcome of staff not following proper hand hygiene with glove change and not following Enhance Barrier Precautions puts the resident at risk of an infection.</p> <p>During an interview on 04/14/25 at 04:15 PM with ADM revealed his expectation for infection control protocol while providing resident care was for staff to conduct handwashing before and after to prevent spread of infection. ADM further stated the potential adverse outcome of staff not following infection control protocol during resident care would be placing residents at risk of infections.</p> <p>A record review of the facility's policy titled Infection Control dated October 2017 reflected, To maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public and To prevent, detect, investigate, and control infections in the facility.</p>		