

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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 07/16/2026
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)		
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review, the facility failed to ensure that residents who require dialysis receive such service, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences, for 1 of 8 (Resident #2) residents reviewed for dialysis care. The facility failed to document Resident #2's post dialysis assessment in the medical record for 04/27/26, 06/23/26, 06/27/26, 07/02/26, 07/07/26, and 07/08/26. This failure could place residents at risk for untreated medical issues and diminished quality of care. Findings included: Record review of Resident #2's face sheet dated 07/15/26 reflected a [AGE] year old female admitted to the facility on [DATE] with diagnoses that included Klebsiella Pneumonia (type of bacteria causing pneumonia or inflammation of air sacs in the lungs) as the cause of diseases classified elsewhere, chronic kidney disease stage 5, renal osteodystrophy (bone disease that occurs in people with chronic kidney disease), acquired absence of kidney, and dependence on renal dialysis. Record review of Resident #2's admission MDS assessment dated [DATE] reflected a BIMS score of 15 indicating cognition intact. Section H for bladder and bowel reflected Resident #2 had an ostomy (including urostomy, ileostomy, and colostomy). Section O for special treatments reflected resident was on dialysis treatments. Record review of Resident #2's care plan last revised 04/27/26 reflected a focus on the resident has an ostomy ileostomy with interventions change ostomy appliance as needed and report illness, inflammation or draining at ostomy site. There was no care plan focus on Resident #2's dialysis treatment, goals, or interventions. There was no interventions included for the assessments of the ostomy appliance prior to dialysis treatments to prevent the rejection of the dialysis center. There was no care plan focus for special dietary needs as it pertained to Resident #2's renal diet order. Record review of Resident #2's orders reflected an order with a start date of 06/18/26 renal diet regular texture, regular consistency, LCS Record review of Resident #2's orders reflected an order with a start date of 06/18/26 dialysis days T-TH-Sat Record review of Resident #2's orders reflected an order with a start date of 06/18/26 dialysis days -tue-thurs-sat @ 1220 to 0620 [dialysis address 1] Record review of Resident #2's orders reflected an order with a start date of 06/18/26 dialysis [dialysis address 2] M-W-F 0630 chair time Record review of Resident #2's orders reflected an order with a start date of 06/18/26 dialysis- monitor av shunt/fistula to (LUE) for thrill & bruit Q shift notify MD/NP for any unusual/ unexpected findings Record review of Resident #2's orders reflected an order with a start date of 06/18/26 dialysis- no blood pressure or venipuncture on extremity with dialysis access site extremity: LUE Record review of Resident #2's orders reflected an order with a start date of 06/18/26 ileostomy care Q shift and PRN Record review of Resident #2's orders reflected an order with a start date of 06/18/26 ileostomy wafer and bag-change q3 days and PRN Record review of Resident #2's progress note reflected a nursing note dated 07/08/26 pt had accident with colostomy in dialysis yesterday and was not able to complete (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 675937 If continuation sheet Page 1 of 27

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	her dialysis tx. Dialysis rescheduled for today. Pt picked up by [family] for tx at dialysis today. Record review of Resident #2's facility dialysis communication form dated 04/27/26 which contained information on assessment before the resident went to dialysis completed by facility staff, assessment and vitals at dialysis completed by dialysis staff, and assessment after returning to the facility to be completed by facility staff. The assessment and vitals section to be completed by nursing home staff upon resident return and placed in the clinical record was left blank. This included vitals, changes in temperature, edema checks (fluid retention), access type and assessment, shunt/thrill and bruit presence, perma cath check, and a section to document other problems or concerns noted on assessment. Record review of Resident #2's facility dialysis communication form dated 06/23/26 which contained information on assessment before the resident went to dialysis completed by facility staff, assessment and vitals at dialysis completed by dialysis staff, and assessment after returning to the facility to be completed by facility staff. The assessment and vitals section to be completed by nursing home staff upon resident return and placed in the clinical record was left blank. This included vitals, changes in temperature, edema checks (fluid retention), access type and assessment, shunt/thrill and bruit presence, perma cath check, and a section to document other problems or concerns noted on assessment. Record review of Resident #2's facility dialysis communication form dated 06/27/26 which contained information on assessment before the resident went to dialysis completed by facility staff, assessment and vitals at dialysis completed by dialysis staff, and assessment after returning to the facility to be completed by facility staff. The assessment and vitals section to be completed by nursing home staff upon resident return and placed in the clinical record was left blank. This included vitals, changes in temperature, edema checks (fluid retention), access type and assessment, shunt/thrill and bruit presence, perma cath check, and a section to document other problems or concerns noted on assessment. Record review of Resident #2's facility dialysis communication form dated 07/02/26 which contained information on assessment before the resident went to dialysis completed by facility staff, assessment and vitals at dialysis completed by dialysis staff, and assessment after returning to the facility to be completed by facility staff. The assessment and vitals section to be completed by nursing home staff upon resident return and placed in the clinical record was left blank. This included vitals, changes in temperature, edema checks (fluid retention), access type and assessment, shunt/thrill and bruit presence, perma cath check, and a section to document other problems or concerns noted on assessment. Record review of Resident #2's facility dialysis communication form dated 07/07/26 which contained information on assessment before the resident went to dialysis completed by facility staff, assessment and vitals at dialysis completed by dialysis staff, and assessment after returning to the facility to be completed by facility staff. The assessment and vitals section to be completed by nursing home staff upon resident return and placed in the clinical record was left blank. This included vitals, changes in temperature, edema checks (fluid retention), access type and assessment, shunt/thrill and bruit presence, perma cath check, and a section to document other problems or concerns noted on assessment. Record review of Resident #2's facility dialysis communication form dated 07/08/26 which contained information on assessment before the resident went to dialysis completed by facility staff, assessment and vitals at dialysis completed by dialysis staff, and assessment after returning to the facility to be completed by facility staff. The assessment and vitals section to be completed by nursing home staff upon resident return and placed in the clinical record was left blank. This included vitals, changes in temperature, edema checks (fluid retention), access type and assessment, shunt/thrill and bruit presence, perma cath check, and a section to document other problems or concerns noted on assessment. During an interview on 07/16/26 at 12:13 PM with LVN A, she stated (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that for resident on dialysis there was a binder which contains communication forms and they were used to assess the site for dialysis and make sure everything was in place before the residents are sent off to treatment. LVN A stated the form also has sections for vitals because they had to check vitals before the resident leaves for dialysis and then once again when they return and document everything. LVN A stated if assessments were not being completed the resident could have a hypertension crisis which is why it was important to ensure everything was stable upon their return from treatment. She stated fluid overload could also be a negative outcome which can be a medical emergency. LVN A stated she did not believe she was completing the last section of the dialysis communication forms which included the assessment for Resident #2's return to the facility vitals. LVN A stated if she took vitals it was only documented in the POC system but may not have made it to the dialysis communication forms. She stated Resident #2 has not had any negative outcomes from any missed vitals. During an interview on 07/16/26 at 01:48 PM with the DON, she stated that it was her expectation that in addition to documenting a residents vitals in the POC system, that nursing staff were responsible for completing the dialysis communication forms which included the final return assessment with vitals and to ensure that was uploaded back into the system. The DON stated that if vitals were missed or not done timely something could be missed after the resident returns from dialysis treatment and could have low blood pressure, bleeding, a temperature, could have fluid retention, or a delayed reaction that could be missed. During an interview on 07/16/26 at 02:42 PM with the ADM, he stated it was the expectation that assessments were completed and documented appropriately. He stated that if they don't have vitals done, or documentation nobody would know if the appropriate steps were taken to resolve a residents condition or concerns. Record review of the policy for charting and documentation last revised July 2017 reflected: All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Documentation of procedures and treatments will include care-specific details, including:a. The date and time the procedure/treatment was provided;b. The name and title of the individual(s) who provided the care;c. The assessment data and/or any unusual findings obtained during the procedure/treatment;d. How the resident tolerated the procedure/treatment;e. Whether the resident refused the procedure/treatment;f. Notification of family, physician or other staff, if indicated; andg. The signature and title of the individual documenting. The policy for Quality of Care was requested from the ADM 07/16/26 at 09:07 AM, per the ADM the facility did not have a Quality of Care policy.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, and record review, the facility failed to ensure that the medication error rate was not five percent or greater. The facility had a medication error rate of 25.93 % based on 7 errors out of 27 opportunities, which involved three residents (Resident #76, Resident#101 and Resident#39) of five reviewed for medication administration. The facility failed to ensure that the analgesic (Medications for relieving pain), anticonvulsant (a drug primarily used to prevent or treat seizures and convulsions) and anti-parkinsonism medications of Resident #101, Resident #39 and Resident#76 were administered within the liberalized scheduled time (6:00am to 10:00am), before 8:00am for medications that were scheduled at 7:00am and before 9:00am that was scheduled at 8:00am, on 07/14/26 as well as the period between 07/01/26 and 07/16/26, as per facility policy and as scheduled by the physician. These failures could place residents at risk of not receiving the intended therapeutic benefits of their medications risking seizure activities, managing pain and aggravated symptoms of Parkinson's disease. The findings included: Resident #76: Record review of Resident #76's face sheet dated 07/16/26 reflected Resident #76 was admitted on [DATE]. She was a [AGE] year-old female diagnosed with epilepsy(seizure) , polyneuropathy(a type of nerve damage affects multiple peripheral nerves) , chronic pain syndrome, contracture(permanent tightening of muscles, tendons, skin, or other tissues) and tremor (shaking of body). Record review of Resident #76's admission MDS dated [DATE] reflected a BIMS score of 15 indicating her cognition was intact. Further review revealed she was taking anticonvulsant and opioid(a class of medications for reducing the intensity of pain) for chronic pain syndrome, polyneuropathy and seizure disorder. Record review of Resident #76's care plan dated 06/13/26 reflected Resident #76 used opioids and anticonvulsants medications r/t Pain Management and Seizures treatment. The relevant intervention was administering the medications as ordered by physician and monitoring for side effects and effectiveness. Record review of Resident #76's physician's order reflected the following: Clonazepam Oral Tablet 0.5 MG (Clonazepam): Give 1 tablet by mouth two times a day related to anxiety disorder, unspecified- -Start Date- 06/29/2026. It was scheduled to be administered between 6am to 10am and 6pm to 10pm. Gabapentin Capsule 400 MG: Give 1 capsule by mouth two times a day for Nerve Pain.-Start Date-06/26/2026 .It was scheduled to be administered at 8am and 4pm. Keppra Tablet 500 MG (Levetiracetam): Give 1 tablet by mouth two times a day for Seizure D/O. -Start Date-05/21/2026 .It was scheduled to be administered between 6am to 10am and 6pm to 10pm. Primidone Tablet 50 MG Give 2 tablet by mouth two times a day for Seizure d/o Give 2 tabs to equal 100 mg.-Start Date-05/21/2026. It was scheduled to be administered between 6am to 10am and 6pm to 10pm. Buspirone HCl Oral Tablet 10 MG (Buspirone HCl): Give 1 tablet by mouth three times a day for anxiety. -Start Date-06/11/2026It was scheduled to be administered at 7:00am and 1:00pm and 7:00pm. During an observation on 07/15/26 at 10:45am, MA F was administering Resident#76's all morning medications, including the above-named medications. Resident #76 accepted the morning medications without complication and stated she was waiting for the medication. During a record review of Resident #76's MAR for July 26 it was revealed that she had 6 medications that were scheduled to be administered between 6:00am and 10:00am and two medications at 9:00am , one medication at 7:00am and one medication at 8:00am. Further review of the July 26 MAR revealed that Resident#76's morning medications on 07/14/26, 07/13/26, 07/12/26, 07/10/26, 07/04/26 and 07/02/26 were administered after 10:45am. Resident #101: Record review of Resident #101's face sheet dated 07/16/26 reflected Resident #101 was admitted on [DATE]. He was a [AGE] year-old (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	male diagnosed with type 2 diabetes, epilepsy, hypertensive heart disease, dementia, chronic kidney disease and shortness of breath. Record review of Resident #101's admission MDS dated [DATE] reflected a BIMS score of 11 indicating her cognition was moderately impaired. Further review revealed that he was taking Anticonvulsant and Opioid for seizure Disorder and chronic pain syndrome. Record review of Resident #101's care plan dated 06/22/26 reflected that The resident was potential for pain r/t disease process. The relevant intervention was anticipating resident's need for pain relief and responding immediately to any and notifying the physician if interventions were unsuccessful or if the complaint had a significant change from resident's experience of pain. Record review of Resident #101's physician's order reflected the following: Keppra Tablet 500 MG (levetiracetam) : Give 1 tablet by mouth two times a day for Seizure d/o. -Start Date-06/16/2026 It was scheduled to be administrated between 6am to 10am and 6pm to 10pm. Acetaminophen Oral Tablet 325 MG (Acetaminophen): Give 2 tablet by mouth three times a day for pain Do not exceed 3 gm in 24 hours from all sources.-Start Date-06/23/2026 It was scheduled to be administrated in the morning, midday and bed time. Lyrica Oral Capsule 50 MG (Pregabalin): Give 1 capsule by mouth threetimes a day for chronic pain -Start Date-06/18/2026. It was scheduled to be administrated in the morning, midday and bedtime. During an observation on 07/15/26 at 11:15 am, MA F was administering Resident #101's all morning medications, including the above-named medications. Resident #101 accepted the morning medications without complication. During a record review of Resident #76's MAR for July 26 it was revealed that he had 11 medications that were scheduled to be administered between 6:00am and 10:00 am and 2 medications at 9:00:am and one medication at 7:00 am. Further review of the July 26 MAR revealed that Resident #101's morning medications on 07/14/26, 07/13/26, 07/12/26, 07/11/26, 07/10/26, 07/09/26 and 07/08/26 were administered between 11:00 am and 12:45pm. Resident #39: Record review of Resident #39's face sheet dated 07/16/26 reflected Resident #39 was admitted on [DATE]. He was a [AGE] year-old male diagnosed with dementia, chronic obstructive pulmonary disease, Parkinson's disease (a progressive nervous system disorder that affects movement), neurocognitive disorder with Lewy bodies (a progressive brain disease caused by abnormal protein deposits called Lewy bodies) and chronic pain syndrome. Record review of Resident #39's quarterly MDS dated [DATE] reflected a BIMS score of 12 indicating her cognition was moderately impaired. Further review revealed he was taking medications for Parkinson's diseases and chronic pain syndrome. Record review of Resident #39's care plan dated 04/20/26 reflected the resident had Parkinson's Disease, neuropathy and seizure d/o. The relevant intervention was administering medications as ordered by the physician and monitoring side effects and effectiveness. Record review of Resident #39's physician's order reflected the following: Amantadine HCl Oral Tablet 100:MG (Amantadine HCl): Give 1 tablet by mouth one time a day for Parkinson's Disease. --Start Date- 04/07/2026 It was scheduled to be administrated between 6am to 10am. Morphine Sulfate Oral Tablet 15 MG (Morphine Sulfate): Give 1 tablet by mouth two times a day for Pain.-Start Date-04/06/2026 It was scheduled to be administrated between 6am to 10am and 6pm to 10pm. Gabapentin Oral Capsule 300 MG (Gabapentin): Give 1 capsule by mouth three times a day for Neuropathy. -Start Date-04/06/2026 It was scheduled to be administrated in the morning, midday and bedtime. During a record review of Resident #39's MAR for July 26 it was revealed that he had 4 medications that were scheduled to be administered between 6:00am and 10:00am. Further review of the July 26 MAR revealed that Resident #39's morning medications on 07/14/26, 07/09/26, 07/07/26 and 07/06/26 were administered after 10:30am. During an interview on 07/14/26 at 12:15 PM, MA F stated that she worked at the facility from 7:00 AM to 7:00 PM as one of the two MAs on the day shift. She stated that medications should be administered within one hour before or after the (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	scheduled time. She further stated that if there was a specific time frame indicated, medications should be given within that period. MA F said that, given there were only two MAs responsible for approximately 90 residents, the medication administration task was very challenging, often resulting in her being late for the last residents in the hallways. She stated she was assigned to Hall 300 and Hall 200, starting with Hall 200. She said , by the time she reached the end of Hall 300, she would be late. She added that this situation occurs most days. MA F stated that administering medications within the scheduled times was important to ensure residents receive the full therapeutic benefit of the medications.During an interview on 07/14/26 at 2:30 PM, MA E stated that he had worked at the facility as an MA for about 15 years. He explained that meeting the scheduled times for medication administration was not always possible due to the number of residents to be attended to by the morning MAs. He said that, previously, there were more MAs available, which made it easier to administer medications on time. He said, however, there are only two MAs responsible for all the residents at the facility. MA E stated that the main challenge in meeting the schedule occurs mainly with morning medications. He reported that he had previously raised this concern with management, but no changes have been implemented so far. MA E stated that delays in medication administration did occur, but not all are due to time constraints. He added, sometimes, residents themselves request the MAs to visit them later for medication administration.During an interview on 07/16/26 at 11:30 AM, the NP stated that administering medications in a timely manner was important; however, the impact of delays varies depending on the medication. She explained that medications taken once daily or twice daily were generally acceptable even if there were minor delays. She said , however, medications such as anti-Parkinsonian drugs, analgesics, and anticonvulsants were time-sensitive and must be given at their scheduled times. She added that these medications were scheduled within a liberal time window, but it was crucial to provide them within the designated timeframe and avoid exceeding the threshold time. She stated if there was a delay in Resident #76, Resident#101 and Resident#39 ?s analgesic, anticonvulsant or anti-parkinsonism medications in a regular pattern was a big concern and should be addressed with immediate effect. She stated she visited them at the facility regularly and had not noticed any harm had occurred so far.In an interview on 07/16/26 at 3:30 PM, the DON stated that the facility follows a liberal medication administration schedule. She explained that some medications are scheduled at specific times, while others are more flexible. The DON stated that medications with a liberal schedule were to be administered within a designated time window, but those scheduled for a particular time could be given one hour before or after the scheduled time. She said that the expectation was for MAs and nurses to adhere to the facility's policies. The DON noted that delayed medication administration could negatively impact residents, depending on the medications they are taking. She said that most delays in medication administration did not pose significant concerns, but certain medications must be administered at prescribed times to ensure effectiveness. She stated she believed , with proper time management two MAs and LVNs could accomplish the task of medication administration in a timely manner.During an interview on 07/16/26 at 2:38pm the ADM stated the facility ensured the staff were following facility policies by making rounds and training programs . Any issues identified would be discussed in QAPI. He stated that the management related to the medications was delegated to the DON and she would be the right person to answer relevant questions.Record review of undated facility policy Medication Administration reflected: Facility staff should take all measures required by Facility Policy, Applicable Law, and the State Operations Manual when administering medications. Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. During medication administration, the facility staff should observe (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the 6 Rights, ensure that the resident is properly positioned, administer medications at the appropriate medication administration time, document scheduled medication administration per facility policy, observe resident privacy rights per applicable law, observe manufacturer medication administration guidelines, and confirm resident consumption of the medication. Medications are administered within 60 minutes before or after the scheduled time, except for orders to administer with meals which must be administered based on mealtimes. Unless otherwise specified by the prescriber, routine medications are administered according to the established medication administration schedule for the facility. This facility follows person centered care for liberalized medication pass. Daily meds medication pass is 6am to 10am. HS medication pass times are 6pm to 10pm.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **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 5 (Resident #42, Resident #61, Resident #78, Resident #81, and Resident #89) of 9 residents reviewed for infection control.1. LVN C failed to use appropriate infection control techniques while providing gastrostomy tube site care for Resident#89, by repeatedly wiping the gastrostomy stoma (opening) back and forth with the same moistened gauze during an observation of care on 07/15/2026 at 9:25 a.m.2. MA E and MA F failed to sanitize the blood pressure monitors on 07/14/26 while obtaining blood pressure on Resident #78, Resident # 81, Resident #61 and Resident #42. These failures increased the risk of spreading infections among residents. Findings included:Record review of Resident #42's face sheet dated 07/16/26 reflected Resident #42 was initially admitted on [DATE] and readmitted on [DATE]. She was a [AGE] year-old female diagnosed with dementia, acute respiratory failure(lungs cannot get enough oxygen) , chronic obstructive pulmonary disease (difficulty to breath) , pain and hypertension.Record review of Resident #42's quarterly MDS dated [DATE] reflected a BIMS score of 15 indicating her cognition was intact. Further review revealed he was diagnosed with hypertension.Record review of Resident #42's care plan dated 3/20/24 reflected that The resident had hypertension. The relevant intervention was administering anti-hypertensive medications as ordered and monitoring for side effects such as orthostatic hypotension and increased heart rate (Tachycardia).Record review of Resident #42's physician's order reflected the following: Amlodipine Besylate Tablet 2.5 MG: Give 1 tablet by mouth one time a day for hypertension. Hold for SBP less than 110.-Start Date-11/12/2025.Record review of Resident #61's face sheet dated 07/16/26 reflected Resident #61 was admitted on [DATE]. He was a [AGE] year-old male diagnosed with parkinsonism (condition with tremors, slowed movement, and muscle stiffness), heart failure, hypotension, chronic obstructive pulmonary disease (Difficulty in breathing), retention of urine and insomnia(lack of sleep) due to medical condition.Record review of Resident #61's quarterly MDS dated [DATE] reflected a BIMS score of 14 indicating his cognition was intact. Further review revealed he was diagnosed with orthostatic hypotension (Low blood pressure when standing up).Record review of Resident #61's care plan dated 10/21/24 reflected that he had hypotension and the relevant intervention was administering medications as ordered.Record review of Resident #61's physician's order reflected the following: Droxidopa Oral Capsule 100 MG (Droxidopa): Give 2 capsule by mouth one time a day for Neurogenic orthostatic hypotension. Hold for SBP >120.-Start Date-08/10/2025.Record review of Resident #78's face sheet dated 07/16/26 reflected Resident #78 was admitted on [DATE]. She was a [AGE] year-old female diagnosed with dementia, hypertension, muscle weakness and obesity.Record review of Resident #78's quarterly MDS dated [DATE] reflected a BIMS score of 10 indicating her cognition was moderately impaired. Further review revealed she was diagnosed with hypertension.Record review of Resident #78's care plan dated 09/15/23 reflected that she had hypertension and the relevant intervention was administering medications as ordered and monitoring for side effects such as orthostatic hypotension and effectiveness.Record review of Resident #78's physician's order reflected the following: Losartan Potassium Oral Tablet 25 MG (Losartan Potassium): Give 1 tablet by mouth one time a day for Hypertension. Hold for SBP < 110.-Start Date-08/23/2023Record review of Resident #81's face sheet dated 07/16/26 reflected Resident #81 was admitted on [DATE]. She was [AGE] year-old female (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	diagnosed with dementia, muscle weakness, hypertension, tachycardia (fast resting heart rate of more than 100 beats per minute), hypertensive heart disease and cerebrovascular disease(stroke).Record review of Resident #81's quarterly MDS dated [DATE] reflected a BIMS score of 03 indicating her cognition was severely impaired. Further review revealed she was diagnosed with hypertension.Record review of Resident #81's care plan dated 04/06/23 reflected that she had cardiac disease r/t hypertension. Relevant intervention was administering medication as per physician orders.Record review of Resident #81's physician's order reflected the following: Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 25 MG (Metoprolol Succinate): Give 25 mg by mouth one time a day for hypertension, tachycardia. Hold for heart rate < 55. Hold for SBP < 110. -Start Date-04/28/2023.Record review of Resident #89's admission MDS assessment dated [DATE] reflected he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included unspecified dementia, protein-calorie malnutrition(low protein and carb level) and , dysphagia (difficulty to swallow) , and gastrostomy(surgical opening made through the abdominal wall into the stomach to place a feeding tube) status. The assessment reflected a BIMS score of 7, indicating severe cognitive impairment. Resident #89 required extensive assistance with dressing, grooming, and personal hygiene and was totally dependent for eating, receiving 51% or more of his nutritional intake through a gastrostomy tube.Record review of the active physician's orders reflected an order dated 07/10/2026 for gastrostomy tube site care to cleanse the site with normal saline, pat dry, and apply split gauze every evening.Record review of Resident #89's comprehensive care plan reflected the resident required tube feeding related to dysphagia. Interventions included providing gastrostomy tube site care as ordered and monitoring for signs and symptoms of infection.In an observation on 07/14/26 at 9:45 a.m., MA E did not sanitize the upper arm blood pressure monitor before using them on Resident #78, between Resident #78 and Resident #81, and after Resident #81. MA E measured Resident #78's blood pressure with the upper arm blood pressure monitor without prior sanitization. He picked up a cuff band (A fabric wrap with a Velcro fastener that goes around the upper arm) from a collection of cuff bands of various sizes in the basket of the blood pressure monitor stand, and after trying it on Resident #78, he changed it to a larger size. After completing the task, he returned the cuff band into the basket without sanitizing it. He then administered medications to Resident #78. After the completion of medication administration to Resident #78 he moved on to Resident #81 and took her blood pressure using the same cuff band, without sanitizing it and stored among other cuffs in the basket without sanitization.In an interview and observation on 07/14/26 at 10:35 a.m., MA E stated that he had been employed at the facility for approximately fifteen years and had received in-service training on infection control on many occasions; however, none of these trainings in the recent past specifically addressed the sanitization of medical equipment. He explained that on this day, he had already administered medications to more than 15 residents, which involved taking their blood pressure. He stated that he did not sanitize the blood pressure monitor at any point during the day. MA E then looked for a sanitizing wipe in various drawers of the medication cart but could not find one. He stated that following his mistake, he recognized the importance of sanitizing blood pressure cuffs between residents, as it helps to reduce the risk of transmitting infectious diseases through contamination.During an observation on 07/14/26 at 10:50 a.m., MA F did not sanitize the wrist blood pressure monitor before using it on Resident #61, between Resident #61 and Resident #42, and after Resident #42. She measured Resident #61's blood pressure with the cuff without prior sanitization. After administering medications, she moved to Resident #42 and took his blood pressure using the same monitor. After completing this, she returned the monitor to the medication cart without sanitizing it.During an interview on 07/14/26 at 11:20 a.m., MA E stated that the monitor was owned (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	by her and that she usually sanitizes it thoroughly after her duties and before taking it home. She said that she had not sanitized the monitor at any point during that day. MA F stated that she had been employed at the facility for approximately two years and could not recall receiving any in-service training specifically on sanitizing medical equipment. She stated that she understood the importance of sanitizing blood pressure cuffs between residents and stated that going forward, she would make a point to sanitize them after every use to help to prevent the spread of contagious diseases through contaminated blood pressure cuffs. In an observation on 07/15/2026 at 9:25 a.m., LVN C performed gastrostomy tube site care on Resident#89. LVN C wiped around the gastrostomy stoma, then repeatedly wiped back and forth across the stoma site multiple times using the same moistened 4 x 4 gauze pad rather than using a clean portion of the gauze or replacing it as needed to avoid contaminating the insertion site. In an interview on 07/15/2026 at 9:47 a.m., LVN C stated the gastrostomy site should be cleansed from the inner portion of the stoma outward. He acknowledged he should not have wiped the stoma multiple times with the same 4 x 4 gauze. He stated he had received in-service education regarding gastrostomy tube care and infection control practices but was unsure whether he had completed a visual competency for gastrostomy tube site care. LVN C stated repeatedly wiping the stoma with the same gauze could place the resident at risk for infection. In an interview on 07/16/2026 at 1:30 p.m., the Director of Nursing (DON) stated nurses were expected to follow facility policy and accepted infection control practices when providing gastrostomy tube site care. The DON stated the nurse should not have wiped repeatedly around the gastrostomy stoma using the same moistened 4 x 4 gauze. She stated annual nursing skills competency validations were completed by the DON and Assistant Director of Nursing (ADON) to ensure nurses were competent in performing gastrostomy tube care. The DON stated improper cleansing technique could result in skin breakdown, infection of the stoma, and pain. In a follow-up interview on 07/16/26 at 3:30 p.m., the DON stated that her expectation was for all staff to sanitize medical equipment, including blood pressure cuffs, between residents. She reported that she observed deficiencies in infection control practices during routine rounds in the facility by her and the ADON. She explained that when deficiencies were identified, staff members were retrained and re-educated accordingly. The DON stated that the facility conducted in-service training on standard precautions at least once a month, which included sanitization practices and the sanitization of medical equipment. She added that she would include additional topics specific to the sanitization of medical equipment in future in-service sessions. Record review of facility policy titled Ostomy Care reflected Cleanse the peristomal skin gently with warm water using gauze pads or washcloth, dry completely. Skin is not scrubbed. Requested wound care policy/procedure 7/15/26 at 12:34p.m. via email to the ADM. Requested wound care policy/procedure 7/16/26 at 11:20a.m. via email to the ADM. Requested wound care policy/procedure 7/16/26 at 1:30p.m. verbally in interview with DON. No wound care policy/procedure provided by facility. Review of the in-service records from 01/04/26 to 07/15/26 revealed there were no in-services on cleaning medical equipment. Record review of facility's policy Cleaning and Disinfection of Resident-Care Items and Equipment revised in September 2022 reflected: Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA Bloodborne Pathogens Standard. Reusable items are cleaned and disinfected or sterilized between residents (e.g., stethoscopes, durable medical equipment).		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure the resident had a right to be treated with respect and dignity for 1 (Resident #25) of 5 residents reviewed for respect and dignity. The facility failed to ensure CNA A did not enter Resident #35's room, to answer their call light, without knocking and/or announcing themselves prior to entry. This failure could place residents at risk of an invasion of their privacy. Findings included: Record review of Resident #35's quarterly MDS assessment dated [DATE], reflected a [AGE] year-old-female admitted to the facility on [DATE]. Her diagnoses included: stroke (a medical emergency that occurs when blood flow to the brain is blocked or a blood vessel in the brain bursts, causing brain cells to die), high blood pressure (when the pressure in your blood vessels is too high), neurogenic bladder (a condition in which nerve damage or dysfunction disrupts communication between the brain, spinal cord, and bladder, leading to impaired bladder control), hemiplegia (complete paralysis) or hemiparesis (partial weakness), depression (common and serious mood disorder), and chronic pain. Resident #35 had a BIMS score of 12, indicating moderately impaired cognition. Record review of Resident #35's comprehensive care plan dated 05/01/2026 reflected Resident #35 had an ADL self-care performance deficit r/t hx of CVA with interventions of requiring substantial assist by 1 staff to turn and reposition in bed. She had contractures of the left and right legs and left arm. She required 2 staff assistance for transfers. In an observation on 07/14/2026 at 11:17 AM, CNA A walked into Resident #35's open room, without knocking on the door/wall or announcing herself to answer Resident #35's call light and change Resident #35's brief. In an interview on 07/14/2026 at 11:37 AM, Resident #35 stated that her and her roommate typically kept their door open, but staff would knock on it and speak before entering. She stated that she was not startled during this occasion due to the surveyor already being in the room, but if someone just walked into her room without saying anything she would wonder what they were doing and feel a sense of apprehension. In an interview on 07/14/2026 at 1:54 PM, CNA J stated that she had been working for the facility for 2 years. She stated she was answering Resident #35's call light, and that typically she was supposed to knock or announce herself before entry. She stated she should do that to provide privacy and let residents know they were there to help and not harm the residents. She stated they received in-servicing on knocking on doors and announcing themselves before entering a residents room, a while ago. In an interview on 07/16/2026 at 1:48 PM, the DON stated that the facility's policy regarding knocking before entering a resident's room was to always knock, introduce oneself, ask respectfully what a resident needed, and meet their needs. She stated that staff were educated on privacy and dignity through in-servicing often which included verbalizing that this was the residents home and the staff work for the residents. She stated this could negatively impact a resident by embarrassing the resident and invading their privacy. In an interview on 07/16/2026 at 1:48 PM, the ADM stated that the facility policy was to always knock before entering a resident's room and to announce oneself before entering. He stated he had not recently received any grievances on this subject, but they had done in-services on it based on complaints. He stated that staff are educated on privacy/dignity through in-services. He stated that he monitors compliance r/t resident dignity and privacy during rounding, if he saw staff not doing the proper procedures he would correct them immediately. He stated that negative impacts to residents would be a lack of privacy. Review of the facility's policy titled 'Resident Rights' dated February 2021 revealed: Employees shall treat all residents with kindness, respect, and dignity. Federal and state (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to:privacy and confidentiality;		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to provide a safe, clean, comfortable, and homelike environment for 1 of 5 residents (Resident #17) reviewed for resident rights. The facility failed on 07/14/2026 at 10:36 AM and 12:29 PM to ensure that Resident #17 had clean bed linens, and the room was free from odors. These failures could place residents at risk for the potential to compromise the resident's dignity, comfort, skin integrity, and quality of life. Findings included: Record review of Resident #17's Quarterly Minimum Data Set (MDS) assessment dated [DATE] reflected he was a [AGE] year-old male admitted on [DATE] with diagnoses that included vascular dementia (a type of dementia caused by reduced or blocked blood flow to the brain), hyperlipidemia (abnormally high levels of lipids in the blood), anxiety disorder (excessive, persistent fear or worry that interferes with daily life), and chronic pain. The assessment reflected a BIMS score of 6, indicating severe cognitive impairment. Resident #17 required substantial to maximal assistance with dressing, grooming, and toileting hygiene and was always incontinent of urine. The Assessment reflected no rejection of care or behavioral symptoms. Record review of Resident #17's comprehensive care plan dated 04/18/2026 reflected the residents had bladder incontinence related to impaired mobility and physical limitations. Interventions included the use of disposable briefs, changing the briefs as needed, and cleansing the perineal area with each episode of incontinence. During an observation and interview on 07/14/2026 at 10:36 a.m., Resident #17 was observed lying in a soiled bed with a strong odor of urine. Yellow-brown urine rings were present on both the top and bottom bed sheets. Resident #17 denied that his bed was wet and stated he could not remember the last time staff had checked on him. He stated he was fine and had no concerns related to his care. During a second observation on 07/14/2026 at 12:29 p.m., Resident #17's bed remained covered with urine-soiled sheets, and a strong urine odor continued to be present in the room. Resident #17 was not in the room at that time. In an interview on 07/14/2026 at 12:35 p.m., CNA D stated Resident #17 had refused to be changed that morning but she had assisted him with a shower and getting up for the day. She stated she knew soiled linens were supposed to be removed from the room and placed in the laundry hamper located outside the room but she had forgotten to remove the urine-soiled sheets. She stated she was responsible for removing soiled linens from the room. CNA D stated leaving soiled linens in the room was not homelike and placed residents at risk for infection and skin irritation. In an interview on 07/14/2026 at 12:45 p.m., LVN C stated residents were checked every two hours and as needed by either nurses or nurse aides. He stated it was not a normal practice for staff to leave urine-soiled linens on a resident's bed and that CNAs were responsible for ensuring soiled linens were removed and placed in the laundry. He stated the potential negative outcomes included skin irritation, infection, decreased morale due to the foul odor, and an environment that was not homelike. In an interview on 07/16/2026 at 1:30 p.m., The DON stated residents should be monitored frequently and that residents remaining on wet sheets should not happen ever. The DON stated administrative staff conducted daily morning rounds to ensure resident rooms were clean and tidy and that CNAs were responsible for changing soiled linens. The DON stated Resident #17 required frequent monitoring and toileting and that failure to promptly change wet linens could result in skin breakdown, infection, and impaired dignity. In an interview on 07/16/2026 at 2:20 p.m., The ADM stated CNAs and nursing staff were expected to monitor residents at least every two hours and change residents immediately when found soiled. If a resident refused care, staff were expected to continue attempting different approaches or (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	involve another caregiver. The ADM stated supervisory staff also conducted morning rounds to identify concerns about the units. The ADM stated prolonged exposure to urine-soiled linens could lead to skin breakdown, decreased quality of life, and loss of dignity. Record review of facility policy titled Homelike Environment dated 2001 reflected Residents are provided with a safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings to the extent possible. The community team members and management maximize, to the extent possible, the characteristics of the community that reflect a personalized, homelike setting. These characteristics include clean, sanitary, and orderly environment; clean bed and bath linens that are in good condition; and pleasant, neutral scents.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure PRN orders for psychotropic drugs were limited to 14 days unless the attending physician or prescribing practitioner believed, and documented, that it was appropriate for the PRN order to be extended beyond 14 days for 1 of 5 resident (Resident #17) reviewed for PRN psychotropic medications, in that: The facility failed to ensure Resident #17 did not have an PRN order for Ativan 0.5 mg after 14 days without a stop date or re-evaluation by the physician to evaluation if the medication was still needed. This failure could place residents at risk for receiving unnecessary psychotropic medications and could result in residents experiencing adverse drug reactions. Findings included: Record review of Resident #17's Quarterly Minimum Data Set (MDS) assessment dated [DATE] reflected he was a [AGE] year-old male admitted on [DATE] with diagnoses that included vascular dementia (a type of dementia caused by reduced or blocked blood flow to the brain), hyperlipidemia (abnormally high levels of lipids in the blood), anxiety disorder (excessive, persistent fear or worry that interferes with daily life), and chronic pain. The assessment reflected a BIMS score of 6, indicating severe cognitive impairment. Resident #17 required substantial to maximal assistance with dressing, grooming, and toileting hygiene and was always incontinent of urine. The Assessment reflected the resident exhibited no rejection of care or behavioral symptoms. Record review of Resident #17's comprehensive care plan dated 04/18/2026 reflected The resident uses anti-anxiety medications related to anxiety disorder interventions included: Monitor/document/report PRN any adverse reactions to anti-anxiety therapy: drowsiness, lack of energy, clumsiness, slow reflexes, slurred speech, confusion and disorientation, depression, dizziness, lightheadedness, impaired thinking and judgment, memory loss, forgetfulness, nausea, stomach upset, blurred or double vision. Record review of Physicians Orders summary dated 7/14/26 reflected an order for Ativan Oral Tablet 0.5 MG (Lorazepam) Give 1 tablet orally every 12 hours as needed for agitation initiated on 6/12/26. There was no stop date on the order. Record review of Physicians' Letter pharmacy review on file dated 6/16/26 included the following recommendation CMS requires evaluation of psychotropic ordered PRN greater than 14 days. Please review continued use of below PRN Ativan order and for possible dose reduction. Please indicate a short-term duration of therapy. In an interview on 07/16/2026 at 1:30p.m., the DON stated the ADONs were responsible for reviewing new orders every morning to ensure diagnosis and stop dates were in place for psychotropic medications. She stated she was not sure why the order was not reviewed and corrected at the time it was received. She stated the order must have been missed. She stated all psychotropic PRN medications should be reviewed every 14 days and as needed. She stated potential negative effects for not reviewing psychotropic medication orders to ensure stop dates were in place included oversedation, the residents may receive medication that was unnecessary and not needed. In an interview on 07/16/2026 at 2:20p.m., the ADM stated PRN psychotropic medications should be reviewed every 14 days. He stated he had no idea why the nurses did not review the order and correct it when it was received. He stated negative effects could be over medication and unnecessary medications. Record review of facility policy titled Psychotropic Medication Use dated 2001 reflected Psychotropic medications are not prescribed or given on a PRN basis unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record. PRN orders for psychotropic medications are limited to 14 days. For psychotropic medications that are NOT antipsychotics: If the prescriber or attending physician believes it is appropriate to extend the (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PRN order beyond 14 days, he or she will document the rationale for extending the use and include the duration for the PRN order.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, which included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 8 residents (Resident #2) reviewed for care plans. The facility failed to ensure Resident #2's comprehensive care plan addressed her dialysis needs and interventions were in place to ensure the ileostomy(surgical opening of the intestine to allow stool to pass without going through the colon or anus) bag was intact and secure before dialysis to prevent from being returned without treatment. This failure could place residents at risk of not having their individual medical and nursing needs being met. Findings included: Record review of Resident #2's face sheet dated 07/15/26 reflected a [AGE] year old female admitted to the facility on [DATE] with diagnosis that included Klebsiella Pneumonia (type of bacteria causing pneumonia or inflammation of air sacs in the lungs) as the cause of diseases classified elsewhere, chronic kidney disease stage 5 (kidney failure needing dialysis or transplant to survive), renal osteodystrophy (bone disease that occurs in people with chronic kidney disease), acquired absence of kidney, and dependence on renal dialysis. Record review of Resident #2's admission MDS assessment dated [DATE] reflected a BIMS score of 15 indicating cognition intact. Section H for bladder and bowel reflected Resident #2 had an ostomy (including urostomy, ileostomy, and colostomy). Section O for special treatments reflected resident was on dialysis treatments. Record review of Resident #2's care plan last revised 04/27/26 reflected a focus on the resident has an ostomy ileostomy with interventions change ostomy appliance as needed and report illness, inflammation or draining at ostomy site. There was no care plan focus on Resident #2's dialysis treatment, goals, or interventions. There was no interventions included for the assessments of the ostomy appliance prior to dialysis treatments to prevent the rejection of the dialysis center. There was no care plan focus for special dietary needs as it pertained to Resident #2's renal diet order. Record review of Resident #2's orders reflected an order with a start date of 06/18/26 renal diet regular texture, regular consistency, LCS Record review of Resident #2's orders reflected an order with a start date of 06/18/26 dialysis days -tue-thurs-sat @ 1220 to 0620 [dialysis address 1] Record review of Resident #2's orders reflected an order with a start date of 06/18/26 dialysis [dialysis address 2] M-W-F 0630 chair time Record review of Resident #2's orders reflected an order with a start date of 06/18/26 dialysis- monitor av shunt/fistula to (LUE) for thrill & bruit Q shift notify MD/NP for any unusual/ unexpected findings Record review of Resident #2's orders reflected an order with a start date of 06/18/26 dialysis- no blood pressure or venipuncture on extremity with dialysis access site extremity: LUE Record review of Resident #2's orders reflected an order with a start date of 06/18/26 ileostomy care Q shift and PRN Record review of Resident #2's orders reflected an order with a start date of 06/18/26 ileostomy wafer and bag-change q 3 days and PRN Record review of Resident #2's progress note reflected a nursing note dated 07/08/26 pt had accident with colostomy in dialysis yesterday and was not able to complete her dialysis tx. Dialysis rescheduled for today. Pt picked up by [family] for tx at dialysis today. During an interview on 07/15/26 at 10:01 AM, Resident #2 stated she gets regular dialysis and the facility helped with transportation to and from appointments. She stated she was concern that she would sometimes have issues with her ostomy bag not being intact and when she would [NAME] the dialysis center, she (continued on next page)		

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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.			
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would not be able get dialysis because the dialysis center will turn her away since they do not care for the ostomy bags. She said this would result in missed treatment days if she was turned away. She stated she would get the treatment rescheduled and had not had any negative outcomes due to missing a day of treatment. During an interview on 07/16/26 at 12:13 PM, LVN A stated the purpose of the care plan was to have somewhere to go that covered the residents goals and overall situation. She stated the care plan included residents needs such as social, medication, health situation. LVN A stated the care plan was to be updated frequently in order to reflect the current care needs of the resident. She stated if a resident had an ostomy or was on dialysis she would expect to see that in the care plan. LVN A stated residents on dialysis are at risk for infection and have a system that is more compromised. She stated if ostomy bags were not taken care of that could also increased the risk of infection and hospitalization. LVN A stated if residents go to dialysis and they do not have their ostomy bag intact they will be sent back from dialysis with their treatment interrupted. She stated failing to get the treatment would then result in increased blood pressure and other health risks. She stated that Resident #2 had been returned as a result of ostomy bags not being intact but she would be rescheduled to make up the missed visit. During an interview on 07/16/26 at 01:48 PM, the DON stated the purpose of the care plan was to paint a picture of the residents needs and promote good care of the resident. She stated it was her expectation that it reflected current behaviors, certain medications, goals and interventions and things that have been successful. She stated it should be up to date and reflect a residents current status. The DON stated that if a resident was on dialysis and had an ostomy bag that she would expect that information to be reflected on the care plan with goals and interventions. The DON stated the purpose of having dialysis on the care plan was to ensure residents were being assessed appropriately and to ensure needs were met. She stated the same for an ostomy, if there are issues they are sent back as it pertained to dialysis. She stated if these items were not care planned it would not be painting an accurate picture of their care. During an interview on 07/16/26 at 02:42 PM, the ADM stated it was his expectation that care plans showed the overall plan for care and any special needs. He stated it should be comprehensive and updated as needed, every 3 months, or on admission or readmission. The ADM stated if a resident had dialysis or ostomy those were areas that should be on the care plan. He stated a potential negative outcome of not having those care areas on the plan of care would be if someone new was working with the resident they would not see everything that is required for their care, new staff would not know to do those things. Record review of the facility policy Care Plans, Comprehensive Person-Centered last revised December 2016 reflected: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The comprehensive, person-centered care plan will: a. Include measurable objectives and timeframes; b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; c. Describe services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; d. Describe any specialized services to be provided as a result of PASARR recommendations; e. Include the resident's stated goals upon admission and desired outcomes; f. Include the resident's stated preference and potential for future discharge, including his or her desire to return to the community and any referrals made to local agencies or other entities to support such desire; g. Incorporate identified problem areas; h. Incorporate risk factors associated with identified problems; i. Build on the resident's strengths; j. Reflect the resident's expressed wishes regarding care and treatment goals; k. Reflect treatment goals, timetables and objectives in measurable outcomes; l. Identify the professional (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	services that are responsible for each element of care;m. Aid in preventing or reducing decline in the resident's functional status and/or functional levels;n. Enhance the optimal functioning of the resident by focusing on a rehabilitative program; [NAME]. Reflect currently recognized standards of practice for problem areas and conditions.Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents who were unable to carry out activities of daily living received necessary services to maintain personal hygiene for 1 (Resident #100) of 5 residents reviewed for bathing. The facility failed to provide Resident #100 with a shower within her first few days of admission, and gave her a bed bath on 07/14/2026 despite Resident #100 preferring, and asking for a shower. This failure could place residents at risk of skin breakdown, infection, and/or mental dissatisfaction related to their self-worth. Findings included: Record review of Resident #100's baseline care plan initiated 07/10/2026 reflected a [AGE] year-old-female who admitted to the facility on [DATE] from another NF. She was admitted for LTC with no discharge anticipated. Resident #100 was alert to person, place, and time and her short- and long-term memory were intact. Her ADL's revealed that she required extensive assistance with transfers and bed mobility. Her intervention for bathing/showering revealed she required extensive assistance by 1 staff with shower. Record review of Resident #100's shower task (bath/shower performed?) question in the POC revealed a check mark under 'Not Applicable' for 7/11/26, 7/12/26, 7/13/26. Review of Resident #100's ADL-bathing task (bathing: self-performance - How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower) question in the POC revealed a check mark under 'Not Applicable' for 7/10/26, 7/11/26, 7/12/26, 7/13/26. In an observation and interview on 07/14/2026 at 10:48 AM with Resident #100, she stated that she was admitted on [DATE] from a long stay in the hospital. She stated that she had not been showered since she was admitted to this facility, and she wanted a shower bad because she was not used to having to wear briefs. Her hair appeared greasy and a bit disheveled, but no foul odors were observed at this time. In a follow-up interview on 07/16/2026 at 9:22 AM with Resident #100 she stated that the staff gave her a bed bath on Tuesday (7/14/2026), she stated that CNA I went into her room and told her she was giving her a bed bath, she did not offer her to go shower. When Resident #100 asked to go to the shower, she was told no. She stated they have not established her shower days yet. She stated that she was discharged from a previous NF to the hospital for 3 weeks, and then to this facility. She stated she felt filthy until she was 'semi-cleaned' on Tuesday. In an interview on 07/16/2026 at 9:53 AM LVN H stated that he had been working at this facility for 5 years. He stated that he was not working on Resident #100's admission day, but he did normally work on Fridays. He stated that they try to give a new admission a shower as long as it was a reasonable time of day, if not on that day, then on Saturday. However, they typically do not shower on Sundays. He stated that typically they try to wait on a PT assessment, but that did not mean that they would not do a bed bath for the residents. He stated sometimes an assessment would come with the resident that showed the staff their transfer status. He stated that Resident #100 would be a M/W/F based on her room # and bed, but if she wanted that changed they could adjust. He stated that sitting there dirty could introduce germs and bacteria and/or insects, it could also mentally impact someone by their sense of self-worth and feeling down about themselves. In an interview on 07/16/2026 at 9:55 AM with CNA G, she stated that she has been working there about 4 months and was working the day after Resident #100's admission. She stated that Resident #100 did not ask for a shower on that day (2nd day of admission). She stated that the expected timeframe to give a new admission a shower was on the day they admitted if they admitted in the morning or early afternoon, but if they admitted later in the day, the bath/shower should be given the next day. She stated that the 'b bed' in resident rooms were scheduled to receive showers in the morning, but at the time Resident #100 admitted, her (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	shower time would have been in the afternoon (a-bed). She stated that if she did not know the new admissions transfer status, she would use observations of the resident, ask the nurse, but she would normally conduct a bed bath, and/or use the mechanical lift and transport the resident to the shower, if that was what they requested. She stated that CNAs were responsible for giving showers. She stated a negative outcome of residents not receiving a shower after being admitted for 4 days could be skin issues such as dry skin, rashes, being stinky, and could make the resident depressed and feel yucky. In an interview on 07/16/2026 at 10:09 AM with the ADON, she stated she had been ADON for about a year. She stated that if a resident was admitted from the hospital the facility tried to get the resident in the shower the day they admitted. She stated if they were coming from another nursing facility they would fall into the posted shower rotation. She stated that it would not be acceptable for a resident to receive a bed bath until Tuesday after a Friday afternoon admission, because showers occur on Saturdays and Mondays. She stated that CNA's were responsible for showering/bathing. She stated that the nurse should be able to tell the CNA the residents' capability. She stated that the CNA could have asked the nurse on duty what the resident's transfer status was. She stated that physically not receiving a shower could harbor bacteria, cause infection, and emotionally the resident could feel nasty. In an interview on 07/16/2026 at 10:14 AM with CNA I, stated that she has been working at the facility for about 3 months. She stated that she recalled giving Resident #100 a bed bath in her room on Tuesday. She stated that there was a nurse working that day and she asked them what Resident #100's transfer status was, she also asked therapy, and neither were able to give her an answer because the resident had not been fully assessed yet. She stated she also asked the resident what her transfer status was, and the resident told her that she could barely move her hips due to a recent fall/hospitalization at a previous facility. CNA I stated that since therapy had not assessed Resident #1, she wanted to prevent an accident. She stated that after the bath the resident verbalized satisfaction. She stated that she asked the resident if she could assist in the upper extremity portion of bed bathing and she said she was still learning how to do that. She stated the day she bathed the resident was her first interaction with the resident. She stated that the resident expresses pain r/t her hips. In an interview on 07/16/2026 at 1:20 PM with the DON, stated that the expectation for a resident to receive a shower or bath within a certain timeframe after admission was that the admitting staff should offer it, but if the resident was coming from another facility, they would resume a similar shower schedule as the previous facility. If the resident was admitted from a hospital or home, they would encourage the resident to get one the day of admission and then roll them into a schedule. She stated it was not written in a policy but was facility procedure. She stated that determination upon admission of a resident's bathing preference was on a shower list by room number, 'a bed' being in morning and 'b bed' in afternoon or something similar, but the resident could be changed to anything they requested, and they would meet the resident's needs. She stated that staff should know when a new admit was due for their first shower/bath through the computer tasks or they would get it in report from the outgoing staff. She stated that Resident #100 was admitted late on a Friday night, and she was not sure why she did not receive the bed bath until the following Tuesday. She stated they were working on education to the CNA's about meeting needs as best as possible. She stated that if a CNA did not know the residents transfer status, the documentation could be viewed on the d/c summary of the residents admission paperwork from the previous facility, but ultimately if the resident preferred a shower, the staff could have worked as a 2 person assist to shower the resident. She stated that a resident could be physically and emotionally negatively affected by feelings of depression from feeling unclean, feeling self-conscious, and skin breakdown. In an interview on 07/16/2026 at 1:30 PM with the ADM, he stated that as far as he knew, the (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	expectation for a new admission to receive a bath/shower was to be put on the next shower rotation day. He was not sure if the expectation was in policy or if it was a facility procedure. He stated he was not sure how the resident's bathing preference was determined upon admission. He stated that the person responsible for communicating resident shower/bath preferences to the CNA's would be whoever did the admission assessment and it was put in the care plan. He stated that staff knew when a new admission was due for their first shower/bath because it should be put in the rotation/system that the resident was due for one. He was not sure why Resident #100 did not receive a shower/bath within the aforementioned expectations after admission. He stated that by not receiving a shower/bath within a reasonable time, a resident's physical and emotional health and happiness could be negatively affected. Review of the facility's policy dated March 2018 and titled, 'Activities of Daily Living (ADLs), Supporting' revealed: Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care);		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interviews, and record review, the facility failed to store all drugs and biologicals in locked compartments under proper temperature controls for 1 of 2 (400 hall cart) medication carts reviewed for pharmacy services. RN B failed to ensure the 400-hall medication cart was locked and medications were secured and not accessible to other staff, residents, or visitors when not in use on 07/14/26. This failure could place residents at risk of having access to unauthorized medications and lead to an increased risk for drug diversion and possible harm. Findings included: During an observation on 07/14/26 at 02:15 PM in the 400 hall a medication cart was observed unlocked. At 02:18 PM RN B was observed coming out of a residents room wearing PPE (gown and gloves) and retrieving wound care supplies from the bottom drawer of the unlocked med cart. After gathering the wound care items RN B was observed returning to the residents room on the 400 hall and closing the door without locking the medication cart. The medication cart remained unlocked, unattended, and out of view of the staff, in the middle of the hall, until 02:32 PM when RN B returned from the residents room and surveyor brought it to her attention. Between 02:15 PM and 02:32 PM there were 2 residents wandering the hall, 2 CNAs, 1 LVN and 1 visitor observed that walked by the unlocked unattended cart. During an observation and interview on 07/14/26 at 02:32 PM, RN B stated it was the facility policy and expectation that if staff are walking away from the medication cart it needed to be locked and secured. She stated she forgot to lock the cart and was not thinking about it. She stated a potential negative outcome of leaving the medication cart unlocked was that residents could take out medication that did not belong to them and they would not know what the medication was for and the side effects. She stated she has worked at the facility for 4 months now and during this time she has been trained on the expectation to secure the medication cart but it was not on her mind. An observation was made of the drawers that were unlocked and accessible and included but not limited to insulin, antidepressant medication, Parkinson's medication (Carbidopa Levodopa), breathing treatments, wound care supplies, needles, and lancets. During an interview on 07/16/26 at 12:13 PM, LVN A stated she assists with medication passes and has been trained on medication security. She stated it was the facility expectation that staff were to never walk away from a medication cart and to leave it open. She stated they need to be locked and safe and nobody else can have access to it. She stated a negative outcome of leaving it unlocked was; there were many residents in the facility that are known wanderers and could take the medication which could put them at risk for negative effects and could also place their nurse license at risk. She stated important medications could go missing. She stated, it would not be good for the nurse or the residents in the building. During an interview on 07/16/26 at 01:48 PM, the DON stated it was her expectation that if nursing staff were away from the medication cart they were locking it and keeping information private. She stated a negative outcome of leaving it unlocked and unattended was patients could open it, take medications and something could happen if they take medication that is not theirs, or hurt themselves with treatment supplies. During an interview on 07/16/26 at 02:42 PM, the ADM stated it was his expectation that medication carts remained locked when not in use or when nursing staff step away from it. He stated a negative outcome of leaving it unlocked, anyone could take the medications, residents included. Record review of the undated facility policy Medication Administration reflected: During the administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. No medications are kept on top of the (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cart. The cart must be clearly visible to the personnel administering medications and all outward sides must be inaccessible to residents or others passing by.		

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, interview, and record review the facility failed to have the results of the most recent survey of the facility posted in a place readily available to residents, family members, and legal representatives for 1 of 1 survey results books. The facility failed to ensure there was a survey binder posted in a place readily available to everyone which contained the results of the most recent health recertification survey or all surveys, certifications, and complaint/ incident investigations during the 3 preceding years and any plan of correction in effect with respect to the facility. This failure placed residents at risk of not having all the information necessary to make decisions about living at the facility. Findings included: During an observation and interview on 07/14/26 at 02:04 PM, the AD stated she did not know where the survey binder was located. The AD and surveyors walked around inside of the facility and attempted to find the binder and were unsuccessful in locating the survey binder containing the 2567's from previous visits. The AD stated she would need to ask the ADM where it was located. During an observation on 07/14/26 at 02:11 PM, the ADM was observed walking around attempting to locate the survey binder and could not find it. The ADM was observed asking nursing staff at the central nurse's station if they had seen the survey binder to which they responded no. During an observation on 07/14/26 at 03:01 PM, a black binder with the title survey results found by the ADM was observed sitting at the central nurse's station. A review of the survey binder reflected that the most recent 2567 from a health visit was dated 05/14/25. Additionally, it included 2567 visits 03/28/24, 11/21/24, 01/26/23, and 08/23/23. The binder did not include the 2567 for the visits from 07/02/25, 07/17/25, 08/06/25, 03/12/26, 05/07/26, or most recently 07/02/26. During a confidential interview with confidential residents, 13 of 13 residents stated they did not know where the survey binder was located or that they had the information available to them. During an interview on 07/16/26 at 12:13 PM, LVN A stated the purpose of the survey binder was that residents, their families, or any visitors knew what was going on in the facility or how well they are doing. She stated she believed the survey binder was supposed to be located somewhere in the front and was supposed to be made available to everyone. She stated that if the survey binder was not available nobody would have access to the information, they needed to make decisions if they considered placing a resident here. She stated she had not recently seen the binder or knew where it was located. During an interview on 07/16/26 at 01:48 PM, the DON stated that the survey binder tracks complaints and past surveys and the purpose of the survey binder was to ensure that information was accessible to everyone. She stated it was the expectation that the binder was placed in a central location and accessible for everyone to see. She stated she believed it migrated due to the renovations the facility was doing but that it should have been placed somewhere accessible where visitors or residents still had access to information like the central nurses station. She stated a negative outcome of not having the binder or information available was visitors would not have an accurate visual of survey or complaints if they are touring or finding a place for their loved one. During an interview on 07/16/26 at 02:42 PM, the ADM stated he located the survey binder in an office near the front lobby. He stated the purpose of the survey binder was to ensure visitors and residents had access to see survey results. He stated the information should have been easily accessible. The ADM stated it was typically stationed at the front, but when they began renovating things were moved to different places. He stated a negative outcome of not making the previous survey results available to the public was they would be in the dark about things that have happened and could affect their choice if they wanted to remain or move in and be cared for here. Record review of the facility policy Resident Rights last (continued on next page)		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	revised February 2021 reflected: Residents should be treated with kindness, respect, and dignity. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the residents right to - examine survey results.		

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 07/16/2026
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)		
F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation and interview, the facility failed to ensure nurse staffing data was posted daily and readily accessible to residents and visitors with all required information for 2 (07/15/2026 and 07/16/2026) of 3 days reviewed for nurse staffing posting. The facility failed to have nurse staffing information prominently posted in a manner that was accessible to residents and visitors on 07/15/2026 and 07/16/2026. This failure could place residents, families, or visitors at risk of not being informed of the census and number of staff working each day to provide care on all shifts. Findings included: In an observation on 07/15/2026 at 2:56 PM of the right-side wall behind the second set of entry doors to the facility revealed a paper with the facility's name, date, census, and total number and actual hours worked per shift for licensed staff responsible for resident care dated 07/15/2026. However, it was approximately 5 feet up the wall, and behind a potted indoor tree. The form was not at eye level of someone in a wheelchair, or viewable from behind the tree. The surveyor had to maneuver around the tree to read what was written. In an observation on 07/16/2026 at 9:15am of the right-side wall behind the second set of entry doors to the facility revealed a paper with the facility's name, date, census, and total number and actual hours worked per shift for licensed staff responsible for resident care dated 07/16/2026. However, it was approximately 5 feet up the wall, and behind a potted indoor tree. The form was not at eye level of someone in a wheelchair, or viewable from behind the tree. The surveyor had to maneuver around the tree to read what was written. In an interview on 07/16/2026 at 9:17 AM with the ADM, a policy request was made that covered nurse staffing postings. He stated that they did not have a policy on this topic, but that they could move the tree out of the way and move the posting down the wall. In an interview on 07/16/2026 at 1:30 PM with the DON she stated that she had been helping with the nurse staffing posting requirement, and the ADM's handle it as well. She stated that the nurse staffing posting should be located on the wall behind the second set of doors, but ever since the remodeling the tree had been put in that area also. She stated they had some residents that grab things and keep them, so they try to keep postings out of reach and off accessible tables or desks. She stated the postings might not be readily accessible to someone in a wheelchair. She stated that residents or visitors would have to ask someone about the staff posting if they could not read it. In an interview on 07/16/2026 at 1:30 PM with the ADM, he stated that any of the nurse managers were responsible for compliance with the nurse staff posting requirement. He stated that the location of the staff posting had always been located that high on the hall, but the tree in front of it used to be in the front lobby and was moved during their renovations. He stated that he thought a resident in a wheelchair could read the sign from the height it was posted. He stated that the process used to ensure compliance with staff posting in the absence of a written policy was that he checked it every day when he arrived, but on weekends, the RN weekend supervisor checked it, and any nurse manager could ensure it was updated. He stated that the expectation was for it to be updated daily and visible to residents, staff, and visitors. The facility did not have a policy regarding posting the nursing staffing information.		