

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676432	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2024
NAME OF PROVIDER OR SUPPLIER Cedar Pointe Health and Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1301 Cottonwood Creek Trail 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 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45937</p> <p>Based on observations, interviews and record reviews, the facility failed to ensure 1 (Resident #1) of 5 residents received necessary treatment and services, consistent with professional standards of practice reviewed for pressure ulcers.</p> <p>A facility staff failed to ensure Resident #1's orders for a low air loss mattress (LAL) to treat an unavoidable pressure ulcer was placed in the resident's electronic health records, and for the mattress to be ordered. Resident #1's pressure ulcers increased in size.</p> <p>This failure could place residents at risk of improper pressure ulcer management, deterioration of existing pressure injuries, infection, and pain.</p> <p>Findings included:</p> <p>Review of Resident #1's face sheet, dated 02/29/2024, revealed an [AGE] year-old-female who was admitted to the facility on [DATE] and discharged on [DATE] with diagnoses of dementia (a medical term used to describe a group of symptoms affecting memory, thinking, and social abilities in people), Parkinson's Disease (a chronic condition and progressive movement disorder that initially causes tremors, stiffness, or slow movement in affected parts of the body.), chronic venous insufficiency (malfunction of venous walls and/or valves in systemic circulation that result in peripheral pooling of blood known as stasis.), anxiety, and lack of coordination.</p> <p>Review of Resident #1's quarterly MDS assessment, dated 02/15/2024, revealed a BIMS of 06 indicating a severe cognitive impairment. Resident #1's MDS revealed that the resident is at risk of developing pressure ulcer/injuries. Further review of Resident #1's MDS revealed skin conditions, other ulcers, wounds, and skin problems: moisture associated skin damage (MASD). Additional review of Resident #1's MDS revealed skin and ulcer/injury treatments as application of non-surgical dressing (with or without topical medications) other than feet and application of ointment/medications other than to feet.</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 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #1's care plan, no date, revealed a focus of a potential for pressure ulcer development r/t (related to) decreased ADL ability, a goal of having intact skin, free of redness, blisters, or discoloration; and interventions/tasks to monitor nutritional status, monitor changes in skin status, notify nurse immediately for any new areas of skin breakdown, and weekly head to toe assessment. Additional review revealed Resident #1 has a focus of potential nutritional problems related to mechanical soft diet and dementia, with a goal to maintain adequate nutritional status; and with interventions to honor resident rights to make personal dietary choices and provide education as needed, monitor and report to MD as needed for any s/s (signs and symptoms) of decreased appetite, unexpected weight loss, stomach pain, and serve diet as ordered.</p> <p>Review of Resident #1's progress note, dated 02/29/2024, revealed on 02/28/2024 a nursing note text:</p> <p>At 0200 (02:00 a.m.) pt (Resident #1) had a T (temperature) 101.3, BP (blood pressure) 139/80, HR (heart rate) 136, O2 (oxygen) 95%, lung sounds clear, all quadrants. On call was notified and NP (nurse practitioner) said to call EMS (emergency medical services). NP notified family.</p> <p>Review of Resident #1's Hospital Records, date 02/29/2024, revealed Resident #1 admitted to the hospital on 02/28/2024 and arrived on 03:30 a.m., ED (emergency department) course revealed patient (Resident #1) arrived with tachycardia (heart rhythm disorder), hypertension (high pressure in the arteries) , and afebrile (often used to describe a fever that is not associated with an infection.) T 98.7 F (not feverish), CMP (comprehensive metabolic panel) unremarkable. CBC with mild anemia (11.6 Hb), right ischial (lower and back part of right hip bone) decubitus (bed sore) with osteomyelitis (infection in bone). Additional review revealed hospital physical exam temperature of 98.7 F, CBC with WBC (white blood cell count) at 10.4 (reference range of 4.4 to 10.8).</p> <p>Review of Resident # 1's physician progress note from wound care specialist, no date, revealed effective 02/21/2024 and created 02/27/2024, [AGE] year old female with Parkinson's disease and dementia who has developed pressure injuries over the coccyx and right buttock. Resident #1's wound exam revealed there are stage 2 sacral pressure injuries measuring 2.1 x 3.0 x 0.1 and 1.5 x 1.1 x 0.2 centimeters with minimal surroundings erythema (redness of the skin). There is an unstageable right ischial pressure injury measuring 2.2 x 1.5 centimeters with slough (dead skin tissue) present to the level of skin. There is minimal surrounding erythema. Plan:</p> <ul style="list-style-type: none"> -Collagen with foam cover over sacral wounds three times a week. Medihoney with foam cover right ischial wound three times a week. -LAL mattress -Frequent Turning -Consider protein supplement <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #1's Skin Pressure ulcer Weekly, no date, revealed pressure ulcer 1 onset date 02/21/2024 in the Coccyx, stage 3, serous exudate type, moderate exudate amount, no odor, undefined edges. Further review revealed, pressure ulcer 2 onset date 02/21/2024 in the right gluteal fold, size 2.2 x 1.5, UTD (underdetermined) depth, serous exudate type, moderate exudate amount, no odor, wound bed normal for skin, undefined wound edges, erythema surrounding tissue. Additional documentation revealed: Resident (Resident #1) is now being followed by Wound Care Doctor, initial visit 2.21.24. no new orders noted. Stage III, previously noted as MASD, noted to Sacrum: 2.1 x 3 x 0.1, 1.5 x 1.1 x 0.2 (wound has progress to 2 adjacent areas. Periwound intact, friable. Edges diffuse, irregular. Wound bed 80 % pink tissue, 20 % epithelium. Moderate serous exudate noted. Unstageable P.U. (pressure ulcer), previously noted as MASD noted to Right Ischium: 2.2 x 1.5 x UTD. Periwound intact, friable. Edges diffuse, friable. Wound bed 40% pink tissue, 60 % yellow, moist, moderately adhered slough noted. Moderate serous exudate noted. Will treat as ordered. signed by LVN A on 02/26/2024.</p> <p>Review of Resident #1's orders, date 02/29/2024, revealed orders:</p> <ul style="list-style-type: none"> -Magic Cup two times a day for supplement. Order status active. Order date 12/20/2023, start date 12/20/2023. -R gluteal fold; cleanse with ns (normal saline), pat dry, apply calcium alginate and cover with a bordered gauze dressing as needed for as needed if soiled, order status discontinued, order date 02/02/2024, start date 02/09/2024. - R gluteal fold; cleanse with ns (normal saline), pat dry, apply calcium alginate and cover with a bordered gauze dressing one time a day for wound care. Order status discontinued, order date 02/02/2024, start date 02/09/2024. -Sacrum opening: cleanse with ns, pat dry, apply calcium alginate and cover with bordered gauze dressing qd (every day) until resolved one time a day for wound care. Order status discontinued, order date 02/09/2024, start date 02/10/2024. -Sacrum: Cleanse with DWC, apply collagen sheet, cover with silicone border foam, every day shift for MASD. Order status discontinued. Order date 02/10/2024, start date 02/11/2024. -Right Ischium: Cleanse with DWC (Dakin's solution or sodium hypochlorite). Apply Medihoney. Cover with adaptic/oil emulsion dressing and silicone border foam. As needed for as needed if soiled. Order status discontinued, order date 02/10/2024, start date 02/10/2024. -Right Ischium: Cleanse with DWC (Dakin's solution or sodium hypochlorite). Apply Medihoney. Cover with adaptic/oil emulsion dressing and silicone border foam. As needed for as needed if soiled. Order status discontinued, order date 02/10/2024, start date 02/11/2024. -Arginaid Oral Packet (Nutritional Supplements) give 1 packet by mouth tow times a day for Wound Healing. Order status active. Order date 02/23/2024, start date 02/23/2024. -Right Ischium: Cleanse with DWC (Dakin's solution or sodium hypochlorite). Apply Medihoney. Cover with adaptic/oil emulsion dressing and silicone border foam. As needed for as needed if soiled. Order status active, order date 02/26/2024, start date 02/26/2024. <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-Right Ischium: Cleanse with DWC (Dakin's solution or sodium hypochlorite). Apply Medihoney. Cover with adaptic/oil emulsion dressing and silicone border foam. Every day shift for pressure ulcer. Order status active, order date 02/26/2024, start date 02/27/2024.</p> <p>-Sacrum: Cleanse with DWC, apply collagen sheet, cover with silicone border foam, every day shift for pressure ulcer. Order status active, Order date 02/26/2024, start date 02/27/2024.</p> <p>-P.T. Clarification order: POC (point of care) to include low frequency non thermal ultrasound mist wound care to sacrum and R ischium, 2x/week as indicated. Order status active. Order date 02/27/2024.</p> <p>-No order for LAL mattress as per wound care specialist plan on 02/21/2024.</p> <p>Review of Resident #1's skin/wound note, no date, revealed a note created on 02/26/2024, LVN A documented the following:</p> <p>Resident (Resident #1) is now being followed by Wound Care Doctor. Initial visit 2.21.24, no new orders noted. Stage III, previously noted as MASD, noted to sacrum: 2.1 x 3 x 0.1, 1.5 x 1.1 x 0.2 (wound has progressed to 2 adjacent areas. Periwound intact, friable. Edges diffuse, irregular. Wound bed 8- % pink tissue, 20 % epithelium. Moderate serous exudate noted. Unstageable P.U., previously noted as MASD noted to Right Ischium: 2.2 x 1.5 x UTD. Periwound intact, friable. Edges diffuse, friable. Wound bed 40% pink tissue, 60 % yellow, moist, moderately adhered slough noted. Moderate serous exudate noted. Will treat as ordered.</p> <p>Review of NP progress note, no date, appointment date and time 02/27/2024 at 10:18 p.m. revealed NP HPI (history of present illness), seen today per nurse request due to constipation. F/u (follow up) wounds on buttock and right thigh. She (Resident #1) is noted to have weight loss as well as wounds recently. Sacral wounds are noted to be worse than prior. She is sitting up in chair as usual. No fever or pain. No change of behavior or mood. Physical Exam, skin:</p> <p>-right ischium about 3.5 cm in diameter with 100% thick grayish slough, no surrounding erythema, no edema, or warmth.</p> <p>-right buttock about 3.3.5 cm dark red wound, small serious drainage, no surrounding erythema, edema.</p> <p>Further review revealed NP assessment/plan:</p> <p>-Pressure injury of sacral region of back-unstageable, seems bigger and worsened this is unavoidable given her age, severe malnutrition/FTT (failure to thrive) and progressive dementia probably not a healable wound, appropriate for palliative care/hospice care f/u wound care MD continue PT to assist wound cleaning with pressure NS wash 2x/week continue wound care daily continue measure to keep pressure off this region-Pressure ulcer of sacral region, unspecific stage.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-Pressure injury of ischial tuberosity region of right buttock-Right Ischium, appears worsened, this unavoidable given her age, severe malnutrition/FTT (failure to thrive) and progressive dementia probably not a healable wound, appropriate for palliative care/hospice care f/u wound care MD continue PT to assist wound cleaning with pressure NS wash 2x/week continue wound care daily continue measure to keep pressure off this region-Pressure ulcer of sacral region, unspecified stage.-Pressure ulcer of unspecified buttock, unspecified stage.</p> <p>Review of Resident #1's TAR and MAR for February, dated 02/29/2024, revealed all discontinued and active orders for treatment and supplements completed with no inconsistencies.</p> <p>Observation and Interview on 02/29/2024 at 08:45 a.m., at the hospital family stated they have seen wound care completed on Resident #1, as well as dressing changes, and they were aware of Resident #1's issue with weight loss and the NP has been in communication. Family did state that Resident #1's likes to stay on her recliner chair in her room. Observation of Resident #1, in bed she does not appear disheveled, no signs of physical or emotional distress. Limited interview with Resident #1, states that the facility staff takes care of her.</p> <p>Interview on 02/29/2024 at 02:08 p.m., Hospital Physician revealed Resident #1's WBC was within the normal range at 10.4, and she believed the fever she initially presented with probably came from the wound, although we do not have any other source as her WBC was normal. The hospital physician added that the resident's weight loss could have played a part in the wound development.</p> <p>Interview on 02/29/2024 at 02:08 p.m., the Wound Care Doctor stated Resident #1 has an unstageable wound in her sacrum is unstageable, and the right ischial wound, I would characterize as it as more severe. The Wound Care Doctor stated we (with LVN A), treated Resident #1's wounds and retrieved measurements, whatever I noted in my notes are the dimensions, and my plan to treat was in the note as well. The Wound Care Doctor stated that the wounds were not bad after assessments, they were the size of a thumbnail and were so shallow without debris, we treated it and I gave orders for treatment with Medihoney, the low air mattress; I ordered the mattress that day (02/21/2024), out of all the orders the most important are the LAL mattress and the repositioning, if those don't get completed then that's when a wound could get worse. The Wound Care Doctor stated he met with LVN A on the 28th (02/28/2024) and spoke on Resident #1, and he was informed the wounds were healing.</p> <p>Observation and Interview on 02/29/2024 at 02:45 p.m., the DON stated the resident was sent to the hospital that day (02/28/2024) due to having an increase in temperature and heat rate, procedures followed, and the NP wanted to send her to the hospital. The DON stated if a MD, NP, or wound care specialist places and order, nurses are to place the orders in POC, you place all pertinent information in the resident's EHR so it can be administered to our residents. The DON did state that she is aware of Resident #1's issue with weight loss, and we have been meeting with the resident's dietician and the NP to intervene. The DON stated that for a mattress needed for wound care, LVN A would inform us in our morning meetings, and CS A will order the item or anything that is needed. The DON stated she is unsure of when they placed the LAL mattress in residents' room. Observation of Resident #1's room revealed no LAL mattress. The DON confirmed that no items have been moved or changed.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 02/29/2024 at 03:24 p.m., CS A stated and confirmed that she orders supplies and specialized mattress for residents. CS A stated that the LAL mattress for Resident #1 was ordered yesterday (02/28/2024) and it was brought to her attention by the DON during the morning meeting, and it should be ready when Resident #1 comes back to the facility. CS A stated she was not informed by LVN A on ordering a LAL mattress for Resident #1 on 02/21/2024, CS A further confirmed that the mattress in Resident #1's room is not a LAL mattress.</p> <p>Interview on 02/29/2024 at 03:34 p.m., LVN A stated he is the wound care nurse for the facility, and he does round with Wound Care Doctor on Wednesdays. LVN A stated that during rounds I document and take notes from the Wound Care Doctor, that is how he processes the information for resident care. LVN A stated he recalls doing rounds with Wound Care Doctor on 02/21/2024 on Resident #1. LVN A stated, we saw the wound that day and I took orders for the Medihoney and foam dressing, the resident (Resident #1) had already had those orders because we were treating her MASD, and that we were supposed to get a LAL mattress for the resident. LVN A stated that the LAL mattress order was not placed in, and further stated, there is no particular reason for me not placing in the order for the mattress, I just dropped the ball on that. LVN A stated he was aware of how important the LAL mattress was for residents, and for Resident #1, if she did not receive it the wound would have deteriorated or gotten worse. LVN A stated he performed wound care on Resident #1 before she went to the hospital and the wounds were better than before.</p> <p>Interview on 03/01/2024 at 08:24 a.m., NP revealed the resident had multiple factors that could have contributed to the Resident #1's wound. NP stated, she (Resident #1) has Parkinson's disease, progressive dementia, she has been losing weight in that we are intervening on as we started talking with the family dietician on supplements to stimulate her appetite. NP further stated, I referred her to the Wound Care Doctor as her MASD gotten worse despite treatment, and there is no evidence that would support that the lack of the mattress contributed to the Resident being admitted to the hospital, the wounds were unavoidable due to her conditions, and despite our treatment, I was not seeing that Resident #1 was absorbing her ordered supplements due to her condition. NP stated, I placed on my notes that her prognosis was poor, and I had placed that the pressure ulcers were unavoidable due to her conditions.</p> <p>Interview on 03/04/2024 at 08:38 a.m., ADM stated that if orders are given by any doctor or NP, they must be executed. The ADM stated that Resident #1 did not spend much time on her bed, Resident #1 wanted to lay on her recliner in her room, we would assure that she would be repositioned, and have the support wedges to alleviate pressure for Resident #1. The ADM stated despite our efforts Resident #1 would be reluctant with her repositioning despite the facility efforts, we would educate her and intervene although her choice was to remain on her recliner.</p> <p>Record Review for sampled Resident #2, 3, 4, and 5 revealed orders, care plans and treatments occurred, with no significant findings.</p> <p>On 02/29/2024 Physician orders were requested from the ADM; no Physician Orders policy was supplied.</p> <p>Review of the facility's Care and Treatment, subject Medication orders policy, revised 05/2007, reflected 2. Documentation of Medication Order:</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A. Each medication orders is documented in the resident's medical record with the date and time, and signature of the persons receiving the order. The order is recorded on the physician order sheet, or telephone order sheet if it is a verbal order and the Medication Administration Record (MAR).</p> <p>B. Clarify the order, enter the orders on the medication order and receipt record.</p> <p>Review of the facility's Wound Care and treatment Guidelines, revised 05/2007, revealed a policy, it is the policy of this facility to provide wound care to promote healing.</p>