STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676432	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Pointe Health and Wellness Center	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)
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 interviews and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that were identified for one (Resident #1) of four residents reviewed for care plans. The facility failed to ensure Resident #1's fall interventions listed in the comprehensive care plan (fall mat at bedside) were in place on 01/23/2026 and failed to ensure Resident #1's brakes were locked when he was not in his wheelchair were added to his comprehensive care plan after his fall on 1/17/2026. This failure could place residents at risk of not receiving appropriate interventions to meet their current needs. Findings include:Review of Resident #1's face sheet reflected a [AGE] year-old-male admitted on [DATE] , with diagnoses of schizoaffective disorder (chronic mental health condition that has symptoms of hallucinations, delusions and or disordered speech), chronic obstructive pulmonary disease (a progressive lung condition characterized by symptoms like shortness of breath, chronic cough), repeated falls, vascular dementia (changes in thinking caused by impaired supply of blood to the brain) , muscle wasting and atrophy (loss of muscle tissue or shrinking muscle mass) and anxiety disorder (group of mental health conditions characterized by excessive fear and worry that interfere with daily life). Review of Resident #1's quarterly MDS dated [DATE] reflected a BIMS score of 14 (which indicated no cognitive impairment) . Review reflected Resident #1 required partial/moderate assistance (helper does less than half the effort) to go from sitting to lying, and lying to sitting on the edge of the bed. Review reflected Resident #1 was dependent (helper does all of the effort) for chair/bed-to-chair transfers. Review reflected Resident #1 had a history of falls with no injury. Review of Resident #1's care plan dated 01/21/2026 reflected Resident #1 had a fall on 01/20/2026 and 01/17/2026 with intervention to implement fall mat at bedside for safety dated 01/19/2026 and bed in lowest position. Review reflected Resident #1 was at risk for falls related vascular dementia and incontinence dated 03/14/2022 with interventions to maintain a clear pathway free of obstacles. Review of Resident #1's Kardex report dated 01/23/2026 reflected under the safety section implement fall mats at bedside for safety. Review of Resident #1's incident report dated 01/17/2026 reflected Resident #1 was found on floor and stated he tried to get to his wheelchair. Review reflected IDT met to discuss fall and fall mats was added and care plan updated. During an observation and interview on 01/23/2026 at 2:29 PM, Resident #1 was observed in bed. Resident stated that he had falls in the past. Resident #1 stated that now he asked for help to get in and out of bed. Resident #1's bed was observed in a low position with wheelchair placed on the left side of the bed. Observation revealed wheelchair brakes was unlocked on both sides of the wheelchair. Observation revealed that Resident #1 did not have a fall mat on either side of his bed. Observation on 01/23/2026 at 3:20 PM, revealed Resident #1 laid in bed. Resident #1's wheelchair was unlocked and had no fall mat at (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

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 01/23/2026
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	

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bedside. During an interview on 01/23/2026 at 2:49 PM, CNA A stated that fall prevention included to keep eyes on a resident, put the resident's bed in low position and to have their call light in reach. CNA A stated if the wheelchair is at bedside, the brakes should be locked. CNA A stated fall mats were usually next to the bed when the resident was in bed. If the resident was up, fall mats would be put away. CNA A stated that she was aware which residents were a fall risk based on what the nurses report or therapy reported. CNA A stated she could go into the Kardex (summary of resident's care) and it showed if residents needed assistance with transfers and if they were a fall risk. During an interview on 01/23/2026 at 2:57 PM, RN B stated that fall prevention included fall mat, frequent rounding and offering to toilet the resident. RN B stated fall mats was supposed to be positioned on the resident's dominate side of the bed, right next to the bed so the resident did not get hurt if they had a fall. RN B stated the brakes should also be locked if the wheelchair was at bedside. During an interview on 01/23/2026 at 3:09 PM, LVN C stated that fall prevention included to ensure wheelchair brakes were locked, call light was within reach, and bed in low position. LVN C stated that fall mats was placed on the floor next to the bed. LVN C stated that you can find if a resident needed a fall mat in their care plan. During an interview on 01/23/2026 at 3:21 PM, CNA D stated fall prevention included rounding on high risk fall residents. CNA D stated Resident #1 was a high fall risk. CNA D stated fall prevention included to put the bed in low position and encourage the resident to use the call button. CNA D stated Resident #1 thought he was independent. CNA D stated that Resident #1 did not have a fall mat, but that his bed was kept in low position and kept wheelchair close by. CNA D stated that wheelchair brakes was supposed to be locked. During an interview on 01/23/2026 at 4:32 PM, the DON stated Resident #1 had an increase in falls. The DON stated some interventions that was put in place for Resident #1 was increase rounding, education to use call light, medical work up and fall mats. The DON stated that staff was made aware of new fall interventions via the Kardex. The DON stated the Kardex listed if a resident needed a fall mat. The DON stated that Resident #1 should have a fall mat at bedside when he was in bed. The DON stated when the ADON added information about the fall mat on the Kardex they also informed staff. The DON stated that the Kardex was trigged by the care plan. The DON stated brakes on the wheelchair can be locked or unlocked as long as they was locked before the resident got into the wheelchair. The DON stated staff and residents was educated on locking the brakes before residents get into the wheelchair. During an interview on 01/23/2026 at 5:21 PM, with utilization of Spanish translator, CNA E stated she was assigned to work with Resident #1 on 01/23/2026 from 6:00 am to 2:00 pm. CNA E stated that she assisted Resident #1 with getting up today and helped him shower. She stated that later she helped him get into bed around 2:00 PM. CNA E stated that Resident #1 had a fall mat in his room and she put it down when she helped him to bed. CNA E stated that she was supposed to lock brakes on the wheelchair when the resident was not using it. CNA E stated that she got information on the resident from the Kardex of the POC (point of care). During an interview n 01/23/2026 at 5:26 PM, the ADM stated that falls was discussed the following day at morning meeting. The ADM stated that it is discussed what interventions needed to be implemented and this could include adding a fall mat for a resident. The ADM stated when a fall mat is added it went into the Kardex and communicated to staff verbally, but often that was not reliable. The ADM stated that anytime Resident #1 was in bed he should have a fall because it is an intervention that is in place. The ADM stated that Resident #1's orientation fluctuates, he is oriented to personal, place and generally time. Review of facility policy titled Fall Management System with revision date of 04/2025 reflected after a fall, summary of the investigation will and recommendations will be documented in the resident's clinical record and the resident's care plan will be (continued on next page)

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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	

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	update and provide each resident with interventions to prevent falls and to minimize complications if falls occur. Review of facility policy titled Comprehensive Person-Centered Care Planning with revision date of 04/2025 reflected the facility shall develop a person centered care plan that meets the residents medical, nursing and psychosocial need. The facility policy reflected interventions were actions, treatments, procedures or activities designed to meet an objective. Review of facility in-services reflected an in-service was conducted on 12/2/2026 with all staff over the topic fall prevention. Further review reflected no in-service specifically addressing Resident #1's increase in falls.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 (Resident #1) of 4 residents reviewed for accidents and hazards. The facility failed to ensure that Resident #1 had a fall mat next to his bed while he was in bed and failed to ensure Resident #1's brakes was locked on his wheelchair 01/23/2026. This failure could place residents at risk of unsafe transfers, injuries, and/or hospitalization. Findings include:Review of Resident #1 face sheet reflected a [AGE] year-old-male admitted on [DATE] with diagnoses of schizoaffective disorder (chronic mental health condition that has symptoms of hallucinations, delusions and or disordered speech), chronic obstructive pulmonary disease (a progressive lung condition characterized by symptoms like shortness of breath, chronic cough), repeated falls, vascular dementia (changes in thinking caused by impaired supply of blood to the brain) , muscle wasting and atrophy (loss of muscle tissue or shrinking muscle mass) and anxiety disorder (group of mental health conditions characterized by excessive fear and worry that interfere with daily life). Review of Resident #1 quarterly MDS dated [DATE] reflected a BIMS score of 14 (which indicated no cognitive impairment). Review reflected Resident #1 required partial/moderate assistance (helper does less than half the effort) to go from sitting to lying, and lying to sitting edge of bed. Review reflected Resident #1 was dependent (helper does all of the effort) for chair/bed-to-chair transfers. Review reflected Resident #1 had a history of falls with no injury. Review of Resident #1 care plan dated 01/21/2026 reflected Resident #1 had a fall on 01/20/2026 and 01/17/2026 with intervention to implement fall mat at bedside for safety dated 01/19/2026 and bed in lowest position. Review reflected Resident #1 was at risk for falls related to vascular dementia and incontinence dated 03/14/2022 with interventions to maintain a clear pathway free of obstacles. Review of Resident #1 incident report dated 01/17/2026 reflected Resident #1 was found on floor and stated he tried to get to his wheelchair. Review reflected IDT met to discuss fall and fall mats was added and care plan updated. Review of Resident #1's Kardex report dated 01/23/2026 reflected under the safety section implement fall mats at bedside for safety. During an observation and interview on 01/23/2026 at 2:29 PM, Resident #1 was observed in bed, he stated that he had falls in the past. Resident #1 stated that now he asked for help to get in and out of bed. Resident #1's bed was observed in a low position with wheelchair placed on the left side of the bed. Observation revealed wheelchair brakes was unlocked on both sides of the wheelchair. Observation revealed that Resident #1 did not have a fall mat on either side of his bed. Observation on 01/23/2026 at 3:20 PM, revealed Resident #1 laid in bed, the wheelchair was unlocked and no fall mat at bedside. During an interview on 01/23/2026 at 2:49 PM, CNA A stated that fall prevention included to keep eyes on a resident, put the resident's bed in low position and to have their call light in reach. CNA A stated if the wheelchair is at bedside, the brakes should be locked. CNA A stated it was important for the brakes to be locked in case the resident went to sit in the chair it could roll out from under them. CNA A stated fall mats was usually next to the bed when the resident was in bed. If the resident was up, fall mats would be put away. CNA A stated that she was aware which residents was a fall risk based on what the nurses report or therapy reported. CNA A stated she could go into the Kardex (summary of resident's care) and it showed if residents needed assistance with transfers and if they were a fall risk. During an interview on 01/23/2026 at 2:57 PM, RN B stated that fall prevention included fall mat, frequent rounding and offering to toilet the resident. RN B stated fall mats was supposed to be positioned on the resident's dominate side of the bed, right next to the bed so the resident did not get hurt if they had a fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN B stated the brakes should also be locked if the wheelchair was at the bedside because it could move and slide away from them and cause the resident to fall. During an interview on 01/23/2026 at 3:09 PM, LVN C stated that fall prevention included to ensure wheelchair brakes was locked, call light was within reach, and bed in low position. LVN C stated that fall mats was placed on the floor next to the bed. LVN C stated it was important that the fall mat be at the bedside in case they fall. LVN C stated that if wheelchair was at bedside, it was supposed to have the brakes locked in case the resident tried to get out because the wheelchair could move and cause the resident to fall. LVN C stated that you can find if a resident needed a fall mat in their care plan. During an interview on 01/23/2026 at 3:21 PM, CNA D stated fall prevention included rounding on high risk fall residents. CNA D stated Resident #1 was a high fall risk. CNA D stated fall prevention included to put the bed in low position and encourage the resident to use the call button. CNA D stated Resident #1 thought he was independent. CNA D stated that Resident #1 did not have a fall mat, but that his bed was kept in low position and kept wheelchair close by. CNA D stated that wheelchair brakes were supposed to be locked. CNA D stated it was important that the brakes were locked in case the resident tried to climb on it. CNA D stated if the wheelchair brakes were locked the wheelchair would not slip out from under the resident. CNA D stated if the brakes were unlocked it could cause the resident to fall during the transfer. During an interview on 01/23/2026 at 4:32 PM, the DON stated Resident #1 had an increase in falls. The DON stated some interventions that were put in place for Resident #1 was increased rounding, education to use call light, medical work up and fall mats. The DON stated that staff were made aware of new fall interventions via the Kardex. The DON stated the Kardex listed if a resident needed a fall mat. The DON stated that Resident #1 should have a fall mat at bedside when he was in bed and was important to have the fall mat there in cause Resident #1 tried to get up. The DON stated when the ADON added information about the fall mat on the Kardex they also informed staff. The DON stated that the Kardex was triggered by the care plan. The DON stated brakes on the wheelchair can be locked or unlocked as long as they were locked before the resident got into the wheelchair. The DON stated staff and residents were educated on locking the brakes before residents get into the wheelchair. During an interview on 01/23/2026 at 5:05 PM, ADON stated that she tried to work with Resident #1 on 01/23/2026, but he needed to be changed and toileted and this was around 11:00 AM. The ADON stated that the safest way to leave brakes on the wheelchair was locked in cause the resident tried to transfer. The ADON stated locked brakes prevented the wheelchair to slide away. During an interview on 01/23/2026 at 5:21 PM, with utilization of Spanish translator, CNA E stated she was assigned to work with Resident #1 on 01/23/2026 from 6:00 am to 2:00 pm. CNA E stated that she assisted Resident #1 with getting up today and helped him shower. She stated that later she helped him get into bed around 2:00 PM. CNA E stated that Resident #1 had a fall mat in his room and she put it down when she helped him to bed. CNA E stated that she was supposed to lock brakes on the wheelchair when the resident was not using it. CNA E stated that she got information on the resident from the Kardex of the POC (point of care). During an interview on 01/23/2026 at 5:26 PM, the ADM stated that falls was discussed the following day at morning meeting. The ADM stated that it is discussed what interventions needed to be implemented and this could include adding a fall mat for a resident. The ADM stated when a fall mat is added it went into the Kardex and communicated to staff verbally, but often that was not reliable. The ADM stated that anytime Resident #1 was in bed he should have a fall because it is an intervention that is in place. The ADOM stated that a fall mat should be used when a resident was in bed. The ADM stated that if staff noticed the fall mat was out of place it should be returned as some residents could move the fall mat. The ADM stated brakes should be locked on the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wheelchair so it did not slide out when the resident attempted to self transfer into it. The ADM stated that Resident #1's orientation fluctuates, he is oriented to personal, place and generally time. The ADM stated Resident #1 was strong willed and does not always ask for help. Review of facility policy titled Fall Management System with revision date of 04/2025 reflected the facility would provide an environment that remains as free of accidents and hazards as possible and provide each resident with interventions to prevent falls and to minimize complications if falls occur. Review of facility in-services reflected an in-service was conducted on 12/2/2026 with all staff over the topic fall prevention. Further review reflected no in-service specifically addressing Resident #1's increase in falls.