STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455917	A. Building B. Wing	09/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Deer Creek of Wimberley	555 Ranch Rd 3237 Wimberley, TX 78676

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and records review the facility failed to ensure that residents (Resident #1) environment remains as free of accident hazards. The facility failed to ensure Resident #1 was free of accidents and hazards, as Resident #1 spilled a hot liquid onto her leg. Resident #1 sustained a second-degree burn to her left thigh. This failure placed residents at risk of serious harm and injuries which could result in hospitalization and a diminished quality of life. Findings included: Observations on 9/26/2025, at 10:00 a.m. revealed no hot water dispensers were observed in the halls of the facility. Observation and interview on 09/26/2025, at 12:25 p.m. revealed Resident# 1 was observed lying in bed and watching TV. Resident#1 stated she expressed that she is doing well overall. While she did mention having a burn on her leg, she said she was not in pain, and that she felt safe in the facility. Resident #1 mentioned that she was aware that the water dispenser provided hot water and had used it in the past without any issues. Additionally, Resident #1 expressed interest in having a coffee machine available for use. Record Review of Resident #1's face sheet, revealed an [AGE] year-old-female, with a current admit date of 01/02/2024. Resident #1's face sheet further revealed diagnoses including senile degeneration of the brain, arthritis, unspecified dementia, and mobility issues. Review of Resident #1's Minimum Data Set (MDS) dated [DATE], for Resident #1 indicated a BIMS score of 10, suggesting moderate cognitive impairment.Record Review of Resident # 1's Provider Investigation Report, reflects on 9/21/2025 the Resident let CMA know she had spilled hot water on her lap. The water machine was immediately unplugged, and the resident was assessed. POA, Physician and DON were notified. Record Review of Resident #1's progress dated and timed 09/22/2025 at 10:04 PM (p.m.), revealed, the resident was seen today after she spilled hot water on her leg causing a burn. The resident was seen sitting in her wheelchair, able to stand to remove pants for assessment. No pain with standing. The exam showed Resident with a second degree burn to Resident #1's thigh and a Left lateral upper leg with 2 open areas from hot water burn. Record Review of Resident #1's wound care notes created and signed by PA-C - 1, date and timed 09/23/2025 at 07:11 PM, revealed, an [AGE] year-old English speaking female was being seen today for wound(s). At the request of a thorough wound care assessment and evaluation was performed today. Exam showed Resident #1 sustained burns to her left thigh on 9/21/25 when she spilled 180 degrees F water onto her lap. Reports moderate pain. Comprehensive wound care orders require the application of Silvadene to wound beds. Layer with xeroform. Secure with dry dressing or bordered dressing. Record review of Resident #1's physician's orders, dated 9/25/2025, revealed Resident #1's injury was being treated with Silvadene External Cream 1 %. Record review for Resident# 1 in the assessment section of PCC revealed a Hot liquid Assessment was not found. Interview on 9/26/2025, at 1:32 pm CNA A stated she had been employed at the facility for 10 years and attended an in-service training session yesterday. She received training on handling hot beverages as well as protocols related to abuse and neglect. CNA A was knowledgeable about the proper reporting procedures for incidents and understood the importance of safety regarding hot beverages. She utilized the EMR to verify which residents were permitted to have hot drinks and knew to consult with the nurse for any further clarification on this matter. Interview on 9/26/2025, at 1:41pm CNA B stated her commitment to resident safety. CNA B participated in monthly in-service training on abuse and neglect and understood the importance of reporting any incidents to the administration. CNA B recently completed training focused on beverage temperatures, ensuring that they remain below 135 F. When a resident requested a hot drink, CNA B took the necessary precautions by holding the item for them and confirming that it was safe. CNA B also checked the computer for any restrictions related to hot items for residents. Interview on 9/26/2025, at 1:53pm RN A stated she actively participated in monthly in-service trainings focused on preventing abuse and neglect and was well-versed on the procedures for reporting incidents to administration. Recently, RN A completed an in-service training session on the safe preparation and serving of hot beverages, including teas and coffee. This training highlighted the importance of checking beverage temperatures to ensure resident safety. She emphasized the necessity of assessing each resident's abilities to determine their safety in performing specific activities. Interview on 9/26/2025, at 1:56pm the DON stated that all staff members received in-service training on abuse and neglect in August of 2025. An upcoming in-service session focused on the safe handling of beverages and snack drinks was scheduled for Monday, October 1, 2025. The DON shared a recent incident in which a Resident # 1 accidentally spilled a drink. Resident# 1 had placed the cup