| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455930 | A. Building<br>B. Wing | 12/17/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Cedar Ridge Rehabilitation and Healthcare Center | 1700 N Washington<br>Pilot Point, TX 76258 |

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 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep residents' personal and medical records private and confidential.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743<br><br>Based on observation, interview, and record review, the facility failed to secure confidential and personal medical records for two (Resident #1 and Resident #2) of two residents reviewed for privacy and confidentiality.<br><br>1. The facility failed to ensure RN A would close, lock, or minimize her laptop's monitor while administering medications to Resident #1 on 12/17/2024.<br><br>2. The facility failed to ensure RN A would close, lock, or minimize her laptop's monitor while providing wound care to Resident #2 on 12/17/2024.<br><br>This failure could place the residents at risk of exposure of their personal and medical information to unauthorized individuals which could cause a loss of dignity.<br><br>Findings included:<br><br>1. Record review of Resident #1's Face Sheet, dated 12/17/2024, reflected the resident was a [AGE] year-old male admitted on [DATE]. Resident #1 was diagnosed with neurocognitive disorder with Lewy bodies (a form of dementia) and hypertension.<br><br>In an observation on 12/17/2024 at 9:30 PM revealed RN A was passing medications in the Memory Care Unit. She prepared Resident #1's medication and then went inside the resident's room. She left her computer open while administering Resident #1's medication. The computer screen displayed Resident #1's name, status, location, gender, date of birth, age, name of physician, latest vital signs, allergies, code status, emergency instructions, and three medications. the screen of the computer was facing the hallway.<br><br>In an interview with RN A at 10:02 AM, RNA stated the monitor of her computer should be locked, minimized, closed every time a staff went somewhere. She said the purpose was to protect the health or personal information of the residents. She said another reason was to prevent access of unauthorized individuals. She said she usually close the screen of her computer everytime she would leave it unattended but did not know what happened that she forgot to close the monitor of the computer she was using. She said she left the monitor open and Resident #1's medications were visible. She said aside from the medications, some personal information about the resident could be seen. She said the information was confidential.<br><br>(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: 455930 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 12/17/2024 |
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| NAME OF PROVIDER OR SUPPLIER Cedar Ridge Rehabilitation and Healthcare Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 1700 N Washington Pilot Point, TX 76258 | |

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| F 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. Review of Resident #2's Face Sheet, dated 12/17/2024, reflected the resident was a [AGE] year-old male admitted on [DATE]. Resident #1 was diagnosed with dementia.<br><br>Observation on 12/17/2024 at 11:17 AM revealed RN A was about to perform wound care to Resident #2. She prepared the things needed and went inside Resident #2's room. She left the monitor of her computer open while providing wound care. The computer screen displayed Resident #2's name, status, location, gender, date of birth, age, name of physician, latest vital signs, allergies, code status, emergency instructions, and the order for wound care. The screen of the computer was facing the hallway.<br><br>In an interview with RN A at 11:31 AM, RN A stated, she did it again. She said it was important that the medical records of the residents were protected as specified in HIPAA. She said only the authorized staff and the responsible party could had access to the information of the rsidents. She said she left the monitor open and the order for Resident #2's wound care. She said aside from the order for wound care, some personal information about the resident could be seen. She said the information was confidential and she was supposed to provide privacy for all residents under her care.<br><br>In an interview with the ADON on 12/17/2024 at 12:15 PM, the ADON stated before leaving the medication cart unattended the staff should close the computer screen. She stated the staff should make sure the screen was not open and showing Resident #1's personal information and medications and Resident #2's personal information and order for wound care. She said the information was confidential and should not be seen by unauthorized individuals. She said some residents might be embarrassed that others would know they had hypertension or a wound to their face. She said she would collaborate with the DON about the issue on privacy and confidentiality.<br><br>In an interview with the DON on 12/17/2024 at 12:29 PM, the DON stated personal and medical information about a resident should not be exposed for everybody to see. She said the health information of a resident should be protected and could not be shared without the permission of the resident or the resident's responsible party. She said all employees were expected to provide full privacy and confidentiality of information for all residents. The DON stated the failure to not protect the resident information could cause poor self-esteem and embarrassment for the resident. The DON stated she would start an in-service about privacy and confidentiality of the residents' information.<br><br>In an interview with the Administrator on 12/17/2024 at 1:04 PM, the Administrator stated the staff must make sure the residents' information was not exposed because it was a violation of the residents privacy and confidentiality of the care they were receiving. She said the expectation was for all the staff to make sure the residents information and treatment were not visible to unauthorized individuals. She said she would collaborate with the DON to do an in-service about privacy and confidentiality.<br><br>Record review of facility's policy, Resident Rights 2001 MED-PASS, Inc. revised February 2021 revealed Policy Statement: Employees shall treat all residents with kindness, respect, and dignity . Policy Interpretation and Implementation . 3. The unauthorized release, access, or disclosure of resident information is prohibited. All release, access, or disclosure of resident information must be in accordance with current laws governing privacy of information issues. |

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| NAME OF PROVIDER OR SUPPLIER Cedar Ridge Rehabilitation and Healthcare Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 1700 N Washington Pilot Point, TX 76258 | |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>47743<br><br>Based on observations, interviews, and record review, the facility failed to ensure that one cart (wound care cart) of five carts observed was kept locked or under direct observation of authorized staff in an area where residents could access it.<br><br>The facility failed to ensure that RN A locked her wound care cart before providing wound care on 12/17/2024.<br><br>This failure could place the residents at risk of accessing/opening the cart causing accidental overdose or misuse of medications.<br><br>Findings included:<br><br>Observation on 12/17/2024 at 11:17 AM revealed RN A was about to perform wound care. She prepared the things needed and went inside the resident's room. She left the wound care cart unlocked. The drawers of the wound care cart were facing the hallway. The drawers contained different types of dressings, different sizes of dressings, wound cleansers, normal saline, ointments, gauze pads, bandages, tongue depressors, and tape measures.<br><br>In an interview with RN A at 11:31 AM, RN A stated the cart should not be left open everytime care was provided. She said she forgot to lock her cart before going inside the resident's room because anybody could open it and could get anything from the cart and accidentally ingest it. She said even though it was a wound care cart, there were ointments inside that could cause adverse reactions. She said she would be mindful next time to always lock the cart everytime she would leave it unattended.<br><br>In an interview with the ADON on 12/17/2024 at 12:15 PM, the ADON stated before leaving the wound care cart unattended, the staff should lock the cart to prevent untoward incidents. She said residents might be able to open it and access or ingest something that they were allergic to. She said, if it was a medication cart that was left unlocked, any resident, staff, or visitor could open it and get some medications. She medicines could be accidently ingested and children could mistake it for candies. She said leaving the cart unlocked was a serious incident and should be addressed immediately. She said she would collaborate with the DON about the issue on locking the cart.<br><br>In an interview with the DON on 12/17/2024 at 12:29 PM, the DON stated any cart should always be locked when left unattended to prevent any residents from opening it and taking something from it. she said the wound care cart had wound cleanser and ointments that could accidentally drank or ingested that could result to allergic reactions. She said if the medication cart was left open, resident could take and ingest some pills, and could cause choking and accidental overdose. She said the expectation was the cart would be always locked and secured. The DON stated she would start an in-service about the importance of locking the cart.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER Cedar Ridge Rehabilitation and Healthcare Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 1700 N Washington Pilot Point, TX 76258 | |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview with the Administrator on 12/17/2024 at 1:04 PM, the Administrator stated should always be locked in protection of the residents. she said it could result to accidental ingestion and overdose, especially if nobody was monitoring the cart. She said the residents could also choke and nobody would know. She said the expectation was for the staff to make sure the carts were locked everytime they leave them. She said she would collaborate with the DON to do an in-service about locking the cart.<br><br>Record review of facility policy, Storage of Medications 2001 MED-PASS, Inc. revised April 2019 revealed Policy Statement: The facility stores all drugs and biologicals in a safe, secure, and orderly manner . Policy Interpretation and Implementation . 9. Unlocked medication carts are not left unattended. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743<br><br>Based observations, interviews, and record review, the facility failed to 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 one (Resident #3) of five residents reviewed for Infection Control.<br><br>The facility failed to ensure that CNA B changed her gloves and performed hand hygiene while providing incontinent care to Resident #3 on 12/17/2024.<br><br>These failures could place the residents at risk of cross-contamination and development of infections.<br><br>Findings included:<br><br>Record review of Resident #3's Face Sheet, dated 12/17/2024, reflected the resident was an [AGE] year-old female admitted on [DATE]. Resident #3 was diagnosed with chronic kidney disease.<br><br>Record review of Resident #3's Comprehensive MDS Assessment, dated 12/01/2024, reflected the resident had a moderate impairment in cognition with BIMS score of 08. Resident #3's Comprehensive MDS Assessment indicated the resident was frequently incontinent for bowel and bladder.<br><br>Record review of Resident #3's Comprehensive Care Plan, dated 10/27/2024, reflected the resident had an ADL self-care performance deficit and one of the interventions was provide assistance with toilet hygiene.<br><br>Observation and interview with CNA B on 12/17/2024 at 10:33 AM revealed CNA B was about to provide incontinent care to Resident #3. CNA B entered the resident's room and put on a pair of gloves. She did not wash her hands before putting on the gloves. She pulled down the resident's pants, unfastened the brief, and pushed it between the resident's legs. CNA B then pulled the trash can near her. She did not change her gloves after touching the trash can. CNA B pulled some wipes and cleaned the resident's perineal area (area between the thighs) using the front to back technique. After cleaning the resident's perineal area, CNA B rolled the resident towards the wall, cleaned the resident's bottom, pulled the brief, and threw the brief in the trash can. After cleaning the resident's bottom, CNA B opened the resident's drawer and pulled a new brief. She did not change her gloves after cleaning the resident's bottom and before touching the new brief. She opened the brief and placed it under the resident. She rolled back the resident, fixed the brief, and fastened it on both sides. CNA B then pulled the resident's pants up. After pulling the pants up, she removed her gloves and washed her hands. She did not change her gloves throughout incontinent care.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview with CNA B on 12/17/2024 at 10:49 AM, CNA B stated hands should be washed before and after doing incontinent care. She said gloves should be changed after touching the trash can, after cleaning the resident's bottom, and before touching the new brief. She said she forgot to wash her hands before performing incontinent care. She also said she also forgot to change her gloves after touching the trash can and after cleaning the resident's bottom. She said her gloves were soiled when she touched the brief rendering the brief also soiled. She said her actions could result in cross contamination and infection. She said she knew the reasons why the staff needed to do hand hygiene and change the gloves, but forgot to do so. She said she had in-services about incontinent care and hand hygiene but failed to practice it.<br><br>In an interview with the ADON on 12/17/2024 at 12:15 PM, the ADON stated the staff should do hand hygiene before and after incontinent care. She said gloves should be changed after touching the trash can, after cleaning the residents' bottom, and before touching the new brief. She said not performing hand hygiene and not changing the gloves could result in cross contamination and probable infections. She said whatever germs from the trash can and from the soiled bottom would be transferred to the brief. She said the expectation was for the staff to do hand hygiene before and after incontinent care and would change their gloves when transitioning from a dirty site to a clean site. She said the expectation was for the staff to be mindful when they performed incontinent care to prevent urinary tract infection. The ADON said she would collaborate with the DON to do in-services about infection control and hand hygiene.<br><br>In an interview with the DON on 12/17/2024 at 12:29 PM, the DON stated hand hygiene was the most efficient way to prevent cross contamination and infection. She said staff should do hand hygiene before and after incontinent care. She also said the gloves should be changed after touching the soiled brief and after touching the trash to prevent transfer of microorganisms to any clean brief. She said the expectation was for the staff to perform hand hygiene before incontinent care and change their gloves when going from dirty to clean. She said she would do an in-service with all staff about infection control and hand hygiene. She said she would personally monitor them and would check on them randomly.<br><br>In an interview with the Administrator on 12/17/2024 at 1:04 PM, the Administrator stated staff should wash their hands and change their gloves when needed to prevent transfer of germs and infection. She said the expectation was for the staff to follow the policy and procedures pertaining to infection control and hand hygiene. She said she would coordinate with the DON to do in-services about hand hygiene and infection control.<br><br>Review of facility policy, Handwashing-Hand Hygiene Policy and Procedures Nexion revised 10-2020 revealed Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infections . 7. Use an alcohol-based hand rub . f. Before donning sterile gloves . h. Before moving from a contaminated body site to a clean body site during resident care . j. After contact with blood or bodily fluids . k. After handling used dressings, contaminated equipment, etc. Applying and removing Gloves . 1. Perform hand hygiene before and after applying non-sterile gloves.<br><br>Review of facility policy, Perineal Care Nexion revised 04/16/2024 revealed Purpose: The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation . Steps in the Procedure . 2. Wash and apply gloves . For a female resident . b. wash perineal area . 10. Remove gloves . 11. Wash and dry hands thoroughly. |