STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455930	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Ridge Rehabilitation and Healthcare Center	1700 N Washington 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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that residents, who needed respiratory care, were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for one (Resident #1) of 4 residents reviewed for respiratory care.The facility failed to ensure Resident #1's oxygen tubing (flexible tube used to deliver oxygen to the nose through two prongs) and nebulizer mouthpiece (device used to deliver medication in a mist form through the mouth) was properly stored when not in use on 09/30/2025.This failure could place residents at risk of respiratory infection and not having their respiratory needs met.Findings include: Record review of Resident #1's Face Sheet, dated 09/30/2025, reflected the resident was a [AGE] year-old female who admitted on [DATE]. Resident #1 had diagnoses which included hypertension (elevated blood pressure) and COPD (chronic inflammatory lung disease that causes obstructed airflow from the lungs).Record review of Resident #1's MDS (tool used to measure health status) Discharge Assessment, dated 09/21/2025, reflected a BIMS (tool used to measure cognitive status) Assessment was not completed for resident #1. The staff assessment for mental status indicated Resident #1's cognition was moderately impaired with making decisions regarding tasks of daily life. Section I (Active Diagnoses) reflected Resident #1 was treated for COPD.Record review of Resident #1's Comprehensive Care Plan, dated 07/30/2025, reflected the resident had COPD related to smoking. One intervention was continuous oxygen via nasal cannula to keep oxygen saturation at 92% - 94%.Record review of Resident #1's Comprehensive Care Plan, dated 07/30/2025, reflected Resident is at risk for infection, due to non-compliance with nasal cannula use.Frequently removes nasal cannula and drops on the floor. Date initiated 06/20/2025. The intervention was Nursing will monitor for canula placement and if found on floor will be replaced immediately. Date Initiated: 06/20/2025.Record review of Resident #1's Physician's Order, dated 07/10/2025, reflected to administer oxygen at 2-5 LPM to maintain oxygen greater than 92% every shift for shortness of breath. Record review of Resident #1's Physician's Orders, dated 07/10/2025, reflected to administer Ipratropium-Albuterol (medication that makes it easier to breathe) Inhalation Solution 0.5-2.5 (3) MG/3 ML. Inhale 1 vial orally three times a day related to COPD with acute exacerbation (sudden worsening of symptoms in chronic conditions). During an observation and interview on 09/30/2025 at 11:22 AM, Resident #1's oxygen tubing was on the resident's bed unbagged. Resident #1's mouthpiece for administration of breathing treatments was on the resident's bedside table unbagged. Resident #1 was not in her room. CNA C was in the hall and stated the charge nurse was responsible for putting the mouthpiece in the bag after the medication was finished. CNA C stated Resident #1 placed the oxygen tubing on her bed until she returned from smoking and put it back in her nose. CNA C stated the mouthpiece used for breathing treatments should have been bagged to keep it clean, but she was not sure about the nasal cannula. During an interview on 09/30/2025 at 11:28 AM, Resident #1 stated a staff member came to get her for smoke breaks. Resident #1 stated she removed the oxygen tubing and placed it on her bed when she went to smoke. She stated the oxygen tubing was usually on the bed when she returned from smoking. Resident #1 stated she usually turned off the nebulizer machine herself and put the nebulizer mouthpiece on the bedside table. Resident #1 stated she had not been told to notify staff when she removed the nasal cannula or nebulizer mouthpiece.During an interview on 09/30/2025 at 11:36 AM, DON A stated the oxygen tubing and respiratory items should have been stored in a bag when not in use. She stated Resident #1 left her oxygen tubing on the bed when she went to smoke. She stated whoever administered medication should ensure the nebulizer mouthpiece was placed in a bag after the breathing treatment. She stated if left exposed, it should be replaced, and placed in a clean bag. DON A stated if respiratory items were dirty or contaminated, the risk to the resident was infection. She stated the facility would provide in-service training related to monitoring the resident to ensure respiratory items were stored in a bag when not in use. During a telephone interview on 10/02/2025 at 9:58 AM, LVN B stated the nasal cannula, and mouthpiece should have been stored in a bag. She stated Resident #1 had a breathing treatment three times daily. She stated sometimes Resident #1 turned off the nebulizer before completing a treatment, and placed the mouthpiece on the bedside table. LVN B stated it was important to monitor the resident and ensure the items were bagged for infection control. Record review of the facility's policy Administering Medications through a Small Volume (Handheld) Nebulizer, revised October 2010, reflected store in a plastic bag with the resident's name and date on it Record review of the facility's policy