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	04/01/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for three of eighteen residents (Resident #10, #37, and #81) reviewed for reasonable accommodation of needs. The facility failed to ensure the call light system in Residents #10, #37, and #81's rooms were in a position that was accessible to the residents on 03/30/2026. This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency.Findings included: Resident #10 Record review of Resident #10's Face Sheet, dated 04/01/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with cerebral infarction (insufficient oxygen in the brain causing stroke) and muscle weakness. Record review of Resident #10's Comprehensive MDS Assessment (assessment used to determine functional capabilities and health needs), dated 02/20/2026, reflected the resident had a severe impairment (resident required significant assistance and support in daily life) in cognition with a BIMS (screening tool used to assess cognitive status) score of 00. The Comprehensive MDS Assessment indicated the resident was dependent on transfer, hygiene, shower, and dressing. Record review of Resident #10's Comprehensive Care Plan, dated 03/03/2026, reflected that the resident was at risk for falls and one of the interventions was to be sure the resident's call light was within reach. During an observation and interview on 03/30/2026 at 9:28 a.m. revealed Resident #10 was in his bed, awake. It was observed that his call light was tucked at the foot side of the bed. When asked where his call light was, the resident shrugged his shoulders. Resident #81 Record review of Resident #81's Face Sheet, dated 04/01/2025, reflected a [AGE] year-old female admitted on [DATE]. The resident was diagnosed with chronic pain (pain that persisted for a long period of time), anxiety (intense or excessive fear or worry), and lack of coordination. Record review of Resident #81's Comprehensive MDS Assessment, dated 03/10/2026, reflected the resident had a severe impairment in cognition with a BIMS score of 00. The Comprehensive MDS Assessment indicated the resident was dependent for hygiene, dressing, transfer, and bed mobility. Record review of Resident #81's Comprehensive Care Plan, dated 03/10/2026, reflected the resident was at risk for falls and one of the interventions was to be sure the call light was within reach. During an observation and interview on 03/30/2026 at 9:31 a.m. revealed Resident #81 was sitting by her sink. It was observed that the resident's call light was behind the resident's headboard. When asked if she could reach her call light, the resident said it would be difficult for her to reach and pull the cord of the call light. She said even though she could walk, she was unable to pull the call light. During an observation and interview on 03/30/2026 at 9:37 a.m., LVN A said call lights were important for the residents because the residents used them to call the staff when they needed something or needed assistance. He said the residents might fall trying to get the call light or trying to do some activities that needed assistance. He went inside Resident #10's room and saw the call light stuck at the foot side of the bed. He pulled Resident #10's call light and placed it within reach. He then went to Resident #81's room and pulled the call light from behind the resident's headboard. He said Resident #81 could ambulate but if was she was having distress, it would be hard for her to pull the call light from behind the headboard. He (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	said he would check also the call lights of the other residents. He said he would also remind the CNAs to make sure that the call lights were within reach of the residents before leaving the room. During an interview on 03/30/2026 at 11:59 a.m., CNA E said he did not notice that Resident #10 and Resident #81's call lights were not within their reach. He said the call lights were important for the residents because the call lights were what they used to call the staff if they needed something or were in distress. He said he would check if the call lights were within reach of the residents. Resident #37 Record review of Resident #37's Face Sheet, dated 04/01/2025, reflected an [AGE] year-old female admitted on [DATE]. The resident was diagnosed with muscle weakness, chest pain, and shortness of breath. Record review of Resident #37's Comprehensive MDS Assessment, dated 03/10/2026, reflected that the resident had a severe impairment in cognition with a BIMS score of 00. The Comprehensive MDS Assessment indicated that the resident needed assistance for hygiene, dressing, and transfer. Record review of Resident #37's Comprehensive Care Plan, dated 03/25/2026, reflected that the resident was at risk for falls and one of the interventions was to maintain the call light within reach. During an observation on 03/30/2026 at 9:50 a.m. revealed Resident #37 was in her bed with eyes closed. It was observed that her call light was on the floor. It was also observed that HK G was about to clean the resident's room. During an observation and interview on 03/30/2026 at 9:56 a.m., LVN B said call lights should always be within the reach of the residents because that was how they would call the staff if they needed something. She said without the call lights, the residents might be upset or might fall if they tried to do things by themselves. She went inside Resident's #37's room and saw the call light was already with the resident. She said somebody must have picked it up and placed it within reach of the resident. During an interview on 03/30/2026 at 10:00 a.m., HK G said she was the one who placed the call light where Resident #37 could reach it so she could call the staff if she needed help. She said it was on the floor when she started cleaning the resident's room. During an interview on 04/01/2026 at 9:18 a.m., the ADON said call lights were for dependent and independent residents. She said even though residents could ambulate, the call light should be in a place easily accessible because if independent residents were having distress, it would be hard for them if they needed to pull out their call lights. She said the staff should make sure that the call lights were with the residents or were easily accessible before they left the room. She said she would coordinate with the DON to do an in-service about call light placement. During an interview on 04/01/2026 at 9:43 a.m., the Corporate Nurse said call lights were inside the residents' rooms so they can call the staff for assistance, for a glass of water, for pain medication, or because they needed to be changed. She said if the call lights were not within reach, their needs would not be met. She said call lights were for all residents, regardless of whether they were dependent or independent. She said all the staff were responsible for the call lights. She said the expectation was for the staff to scan the residents' rooms when they did their rounds and ensure the call lights were within reach of the residents before they left the room. She said the staff could also clip the call lights so they would not fall. She said she would educate the staff about the importance of call lights for the residents. During an interview on 04/01/2026 at 10:23 a.m., the Administrator said call lights should always be within the reach of the residents. He said for some residents, the call lights were their sense of protection that if something happened to them, they could call the staff for help. He said the residents also used the call lights if they needed to be changed, or they needed pain medication. He said the residents might fall trying to get up and get what they needed. He said everybody was responsible for making sure the call lights were with the residents, whether the resident was independent or not. He said he would collaborate with the DON about the issue regarding call lights. Record review of facility's policy Answering the Call Light 2001 MED-PASS, Inc. revised September 2022 reflected Purpose: The purpose of this procedure is to ensure timely responses to the resident's requests and needs . General Guidelines . 5. Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor.