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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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.

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. Based on interview and record review, the facility failed to provide an activities program directed by a qualified professional who was a qualified therapeutic recreation specialist or an activity professional for 85 of 85 residents.The facility's Activity Director was not a qualified therapeutic recreation specialist or an activities professional that met state licensing requirements. This failure could place residents at risk for reduced quality of life due to lack of activities that were individualized to match the skills, abilities, and interests/preferences of each resident.Findings Include: Record review on 04/01/2026 at 9:00 AM, of the facility's Administrative and other licensed professional staff licensure audit, revealed the current Activity Director was not certified. Documents provided for the Activity Director included training certificates confirming the AD completed 3.5 hours of CEUs through Lifetime Wellness that were pre-approved NCCAP for Activity Directors and 7 hours of CEUs through [Employer] that were a 4-part series on Dementia Training over the last 12 months. Also included was a typed letter dated February 1, 2012, signed by ADM H stating, [AD] meets DADS NFR/LMC 19.702 guidelines for qualified activities professional. [AD] has worked in the [facility] social and recreational program since January 2006. [AD] has worked full time managing the [name of facility] activity program starting in February 2011.In an interview on 04/01/2026 at 11:18 AM, AD stated she has always used the letter from ADM as her certification to work as the Activity Director for the facility. AD stated she has worked for 24 years at this facility; 9.5 years as the office manager and assisted with the activities. AD stated that ADM talked her into doing activities only since she enjoyed it and wrote the letter on 2/01/12. AD stated that the letter was accepted in the past as proof of certification. AD stated she had not completed an accredited course for Activity Director, did not have a certification from a recognized accrediting body or licensure as an Occupational Therapist or Occupational Therapist Assistant. AD stated she was unaware of any addendums or changes to criteria for Activity Directors. AD stated she made sure she had more than enough CEUs each year.In an interview on 04/01/2026 at 12:05 PM, the Administrator stated that the AD has worked at the facility for over twenty years. The Administrator stated he had worked at the facility for almost a year and as far as he was aware all staff who were required to have certifications or licenses did and had accepted when the company stated current staff met criteria for their positions. The Administrator stated he felt the AD met the criteria for the position and was more than qualified based on her experience and longevity.Record review of [Employer] Job Description for Position Title: Activity Director, dated March 2017, revealed the AD reports to the Administrator of the facility. The Qualifications section revealed The requirements listed below are representative of the knowledge, skill and/or ability required.Minimum Qualifications:Freedom from illegal use of drugs.Freedom from use of and effects of drugs and alcohol in the workplaceAnyone found guilty by a court of law of abusing, neglecting or mistreating individuals in a health care related setting are ineligible for employment in the position.Education and/or Experience: Has two years of experience in a social or recreational program within the last five years (one of which was full-time in a residential activities program in a health care setting) or has completed a training program approved by the state.Certificates. Licenses, Registration: Certification as a Therapeutic Recreation Specialist desirable.Continuing Education: Attends in-service and educational programs and attends continuing education required for maintenance of professional certification or licensure.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to, in accordance with State and Federal laws, store all drugs and biologicals in locked compartments under proper temperature controls, and permitted only authorized personnel to have access to the keys for five of eighteen residents (Residents #1, #8, #18, #41, and #66) reviewed for medication storage. 1. The facility failed to ensure Resident #1 did not have a tube of zinc oxide inside his room on 03/30/2026. 2. The facility failed to ensure Resident #8 did not have a tube of zinc oxide and topical antibiotic ointment inside his room on 03/30/2026. 3. The facility failed to ensure Resident #18 did not have a tube of zinc oxide inside his room on 03/30/2026. 4. The facility failed to ensure Resident #41's eyedrops inside his room were not accessible to other residents on 03/30/2026. 5. The facility failed to ensure that Resident #66 did not have a tube of topical pain relief gel inside the room on 03/03/2026. These failures could place the residents at risk of accidental overdose, misuse of medications, and possible adverse reactions.Findings included: 1. Record review of Resident #1's Face Sheet, dated 04/01/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with paraplegia (paralysis of the legs and lower part of the body). Record review of Resident #1's Comprehensive MDS Assessment, dated 02/06/2026, reflected that the resident had a moderate impairment in cognition with a BIMS score of 08. The Comprehensive MDS Assessment indicated the resident was incontinent for bladder and bowel. Record review of Resident #1's Comprehensive Care Plan, dated 02/19/2026, reflected that the resident had incontinence and one of the interventions was incontinent care as needed and apply barrier cream. During an observation 03/30/2026 at 9:32 a.m. revealed Resident #1 was not inside his room. It was observed that a tube of zinc oxide (medicated cream used to prevent skin irritation) was on top of the resident's side table. 2. Record review of Resident #8'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). Record review of Resident #8's Comprehensive MDS Assessment, dated 01/24/2026, reflected that the resident had a moderate impairment in cognition with a BIMS score of 10. The Comprehensive MDS Assessment indicated the resident was incontinent for bowel. Record review of Resident #8's Comprehensive Care Plan, dated 03/11/2026, reflected that the resident had bowel incontinence and had the potential for pressure ulcers and one of the interventions was to keep clean and dry. Record review on 03/30/2026 of Resident #8's Physician Order reflected no order for a topical antibiotic ointment. Record review on 03/30/2026 of Resident #8's Clinical Assessment Notes reflected no assessment for self-administration of medications or an assessment that the resident was competent to manage their own medications. During an observation and interview on 03/30/2026 at 9:36 a.m. it was revealed that Resident #8 was in his bed, awake. It was observed that a tube of zinc oxide and a cup with white cream were on top of the sink inside the room of the resident. It was also observed that a tube of an open topical antibiotic ointment was on the resident's side table. The resident said that the staff used the cream every time they changed him. He said he did not know what the topical antibiotic ointment was for because he did not have any skin infection. 3. Record review of Resident #18's Face Sheet, dated 04/01/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with anxiety (intense or excessive fear or worry) and dementia (a condition characterized by loss of memory and ability to reason). Record review of Resident #18's Comprehensive MDS Assessment, dated 02/27/2026, reflected that the resident had a severe impairment in cognition with a BIMS score of 07. The Comprehensive MDS Assessment indicated the resident was incontinent for bladder and bowel. Record review of Resident #18's Comprehensive Care Plan, dated 03/10/2026, reflected that the resident had bladder and bowel (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	incontinence and one of the interventions was to clean peri-area with each incontinent episode. During an observation on 03/30/2026 at 9:48 a.m. revealed Resident #18 was not inside his room. It was observed that a tube of zinc oxide was on top of the sink inside his room. 4. Record review of Resident #66's Face Sheet, dated 04/01/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with legal blindness (vision impairment that affects central or peripheral vision or both) and dementia. Record review of Resident #66's Comprehensive MDS Assessment, dated 01/30/2026, reflected the resident had severe impairment in cognition with a BIMS score of 07. The Comprehensive MDS Assessment indicated that the resident received scheduled pain medication. Record review of Resident #66's Comprehensive Care Plan, dated 03/19/2026, reflected that the resident was at risk for pain and one of the interventions was to administer analgesia (pain relief medication) as per order. Record review on 03/30/2026 of Resident #66's Physician Order reflected that the resident did not have an order for topical pain relief gel. Record review on 04/01/2026 of Resident #66's Clinical Assessment Notes reflected no assessment for self-administration of medications or an assessment that the resident was competent to manage their own medications. During an observation and interview on 03/30/2026 at 9:32 a.m. Resident #66 was in his wheelchair inside his room. It was observed that a tube of topical pain relief gel was on top of the resident's table that was near the entrance of his room. The tube of topical pain relief gel was visible from the hallway. He said it was his pain medication, and it was always on his table so he would know where to get it in case he needed it. During an observation and interview on 03/30/2026 at 9:54 a.m., LVN A said barrier creams with zinc oxide should not be inside the rooms of the residents because confused residents might mistakenly consume them or use them inappropriately. He said the barrier creams should be somewhere not accessible to the residents. He said medications such as topical antibiotics and topical analgesic should not be inside the residents' rooms for the same reason. He said he did not notice the skin barriers with zinc oxide and the topical medications when he did his morning rounds. He went to Resident #66's room and saw the topical analgesic. He talked to Resident #66 and said he would put the topical analgesic inside his cart. He then went to Resident #8's room and saw the tube of zinc oxide, a cup with white cream on it, and the tube of topical antibiotics. He said, most probably, the white cream inside was also zinc oxide. He said Resident #8 did not have any skin issues, so he did not know why he had a topical antibiotic ointment inside his room. He then went to Resident #1 and Resident #18's rooms and took the barrier creams. He said he would also check the rooms of the other residents to see if they had any medications inside their rooms. He said he would check if Resident #66 needed the topical analgesic so he could request an order for it. He said he would also find out why Resident #8 had a topical antibiotic cream. 5. Record review of Resident #41's Face Sheet, dated 04/01/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with a lack of coordination. Record review of Resident #41's Comprehensive MDS Assessment, dated 02/11/2026, reflected the resident was cognitively intact (resident capable of normal cognition and needs little support) with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident had impaired eyes and used corrective lenses. Record review of Resident #41's Comprehensive Care Plan, dated 02/10/2026, reflected that the resident had limited physical mobility and one of the interventions was to re-evaluate safety. Record review of Resident #41's Self-Administration Safety Screen, dated 01/23/2025, reflected that the resident may self-administer his medication unsupervised. Record review of Resident #41's Physician Order, dated 07/14/2026, reflected Cyclosporine Emulsion 0.05 % Instill 1 drop in both eyes two times a day for dry eyes due to inflammation. During an observation on 03/30/2026 at 10:02 a.m. revealed Resident #41 was not inside his room. It was observed that a box of eyedrops were on top of his overbed table. Several eyedrops were also observed inside a plastic cup that was also on top of the overbed table. The eye drops were visible from the hallway. During an observation and interview on 03/30/2026 at 10:05 a.m., LVN C said Resident #41 could self-administer his medications. She said the issue was that eyedrops were accessible to other (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents. She said other residents might go inside his room and might take some of the eyedrops and use them inappropriately. She said she would talk to the resident to find a way to secure the medications. During an interview on 04/01/2026 at 9:18 a.m., the ADON said barrier creams with zinc oxide is a form of topical medication because they were used to prevent skin breakdown and rashes. She said zinc oxide should not be left inside the rooms of the residents and within the reach of the residents because the creams had chemicals in them that could cause irritation and stomach upset. She said they should be inside the carts, and nurses should give the CNAs the creams in a cup when the CNAs needed to use the cream. She said the same with the topical analgesic and the topical antibiotic ointment. She said Resident #41's eye drops should not be within reach of other residents because they might use the eyedrops inappropriately. She said she would coordinate with the DON to do an in-service about medication storage. During an interview on 04/01/2026 at 9:43 a.m., the Corporate Nurse said medications should not be inside the residents' rooms because the residents might use them inappropriately that could result in adverse reactions. She said skin barriers were applied topically and could be harmful when ingested. She said the same rationale applied to the eye drops found inside the room that were accessible to other residents. She said the expectation was for the staff to be vigilant when they entered the residents' room to check for any medications and for staff using the skin barriers to not leave the tubes within reach of the residents. She said she would start an in-service about medication storage. During an interview on 04/01/2026 at 10:23 a.m., the Administrator said the expectation was for the staff to make sure there were no medications inside the residents' rooms the residents might consume them or use them on their eyes causing irritation. He said he was not a clinician and would let the DON take the lead on the issue. Record review of the facility's policy, Medication Administration revised March 05, 2026, reflected Purpose: To ensure medications are prepared, administered, and documented safely, accurately, and in accordance with prescriber orders and accepted nursing standards of practice . General Standards . 1. Only individuals licensed or legally authorized in this state may prepare, administer, and document medications. Record review of the facility's policy Medication and Treatment Orders 2001 MED-PASS, Inc. revised July 2016 reflected Policy Statement: Orders for medications and treatments will be consistent with principles of safe and effective order writing . Policy Interpretation and Implementation . 1. Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state . Drug and biological orders must be recorded on the physician's order sheet in the resident's chart.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Number of residents sampled: Number of residents cited: Based on observation, interviews, and record reviews the facility failed to ensure food was stored, prepared, distributed, and served in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for food storage, labeling, and dating. The facility failed to ensure all food items in the facility's kitchen were dated and discarded prior to their use-by date, were properly sealed, and failed to ensure the main ice machine was free of a brownish and blackish substance. These failures could place residents at risk for food contamination and food-borne illness. Finding included: During observation on 03/30/2026 between 9:10 AM and 9:45 AM in the facility's kitchen revealed: One large bag of marshmallows dated 03/19/26 with no visible expiration date. One large bag of crispy fried onions dated 03/10/26 with a use by date of 03/15/26. One large bag of graham crumbs dated 12/27/25 with no visible expiration date. One gallon bag of cherry cake mix not properly sealed and exposed to air contaminants. One gallon bag containing orange cake mix dated 03/27/26 with no visible expiration date. One 5-gallon bin containing [NAME] dated 02/11/26 with a use by date of 03/11/26. One 22-quart bin containing white beans dated 02/11/26 with a use by date of 03/11/26. One 22-quart bin containing Egg noodles dated 02/11/26 with a use by date of 03/11/26. One 22-quart bin containing Sweet Cornbread mix dated 02/08/26 with no visible expiration date One 5-gallon bin containing Blackeye peas One large bag of noodles dated 02/11/26 with a use by date of 03/11/26. One large bag of noodles dated 03/18/26 with a use by date of 03/23/26. One large bag of spaghetti noodles dated 03/03/26, with no visible expiration date was observed. One 20 lb. box of spaghetti pasta noodles not properly sealed and exposed to air contaminants. One 10 lb. bag of pancake mix not properly sealed and exposed to air contaminants. One large bag containing whole potatoes dated 03/27/26, with no visible expiration date was observed. One large bag of cooked beef patties was dated 03/23/26, with no visible expiration date was observed. One large bag containing cut potatoes was undated and revealed no expiration date. One large bag of premade salad opened, not properly sealed and exposed to air contaminants. One gallon pitcher of Vegetable soup dated 03/15/2026 and revealed no expiration date was observed. One large tray containing assorted sandwiches dated 02/27 and revealed no expiration date. Observation on 3/30/26 at 9:40 AM, the Main Ice Machine in the interior portion had brownish and blackish substance on the top portion of the ice bin. During an interview on 04/01/2026 at 10:40 AM DM stated he was the person overall responsible for ensuring the kitchen was meeting guidelines for food storage and kitchen sanitization. DM confirmed the surveyor observations and stated the listed items would be corrected. DM stated once items were opened, they should be properly sealed and dated. DM stated he was responsible for ensuring policy was followed. DM stated he and kitchen aide were responsible for labeling and making sure that the items were labeled properly. The DM stated the risk to residents if policy was not followed was a health risk to the residents. DM stated the items should be labeled, and the risk of the concerns not being addressed could result in food-borne illnesses. DM stated if food items were not dated when opened then they will not be able to know how long they will last. DM stated he will conduct a full in-service of food rotation and storage pertaining to what the proper procedures were dealing with food rotation and storage. The risk of serving foods that were past use by date or serving food that was not labeled or dated can cause food borne illness. During an interview on 04/01/2026 at 11:45 AM, ADM stated he oversaw all departments, and ensured residents were taken care of. ADM stated the DM made him aware of the concerns observed in the kitchen and had spoken with the DM. He stated that the issues could cause food contamination and this matter would be resolved. If items (continued on next page)

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Cedar Ridge Rehabilitation and Healthcare Center	1700 N Washington Pilot Point, TX 76258

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were expired, they do not want to serve them to residents. The ADM stated the risk of all these concerns observed in the kitchen could result in residents getting sick. The ADM said the policy or procedure for storing food was, everything needed to be dated, and if opened it needed to have an open date and an expiration date. He said the risk to residents if policy was not followed was that they could get sick from food borne illnesses. The ADM stated he would expect the DM to ensure that the kitchen followed all guidelines, including ensuring the food items were labeled properly in the kitchen. The ADM stated he expected staff to ensure they were following policies and procedures of the facility kitchen policy, to protect residents and to deliver good care. ADM stated if foods were not discarded properly, sanitized properly, or heated properly, there was the potential for foodborne illness. The ADM stated the risk of these concerns not being addressed could result in food contamination and residents becoming ill. Record review of the facility's Food Receiving and Storage Policy, dated March 2026, indicated 2. Food Labeling and Dating, to ensure proper food rotation and prevent use of expired products: All food must be dated upon delivery. Food removed from original packaging must be labeled with the product name and date.Prepared foods stored in refrigerators must include a use by date. Opened containers must be sealed or covered and dated. Expired foods must be immediately removed from storage areas. 4. Dry Storage Storage containers. Foods stored in bins must be removed from original packaging and placed in clean labeled binds or kept in the original packaging with proper labeling and dating. 5. Sanitation and Equipment Maintenance. Equipment will be cleaned regularly and sanitized as needed.Supervisors will conduct monthly inspections of refrigeration equipment including Door gaskets, Fans, Rust or corrosion, Condensation, and Mechanical issues. Record review of the U.S. Food and Drug Administration (FDA) Code (2022) revealed, Packaged Food shall be labeled as specified in law, including 21 CFR 101 Food Labeling, 9 CFR 317 Labeling, Marking Devices, and Containers, and 9 CFR 381 Subpart N Labeling and Containers, and as specified under S 3-202.18. Food shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 - 3-306.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to establish and 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 four of eighteen residents (Resident #5, #46, #67, and #82) reviewed for infection control. 1. The facility failed to ensure CNA F performed hand hygiene before assisting the ADON on Resident #5's wound care on 04/01/2026. 2. The facility failed to ensure MA D sanitized the blood pressure cuff while administering medications to Residents #46 and Resident #67 on 03/31/2026. 3. The facility failed to ensure CNA E performed hand hygiene and changed his gloves during Resident #82's incontinent care on 03/30/2026. These failures could place residents at risk of cross-contamination and development of infections.Findings included: 1. Record review of Resident #5's Face Sheet, dated 04/01/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with skin transplant status. Record review of Resident #5's Comprehensive MDS Assessment, dated 01/23/2026, reflected the resident had a moderate impairment in cognition with a BIMS score of 12. The Comprehensive MDS Assessment indicated that the resident had a skin transplant. Record review of Resident #5's Comprehensive Care Plan, dated 02/08/2026, reflected the resident had surgical skin graft to left lower leg/foot and one of the interventions was to keep incision clean and dry. Record review of Resident #5's Physician Order, dated 04/01/2026, reflected skin graft/surgical wound to left heel: cleanse with wound cleanser, pat dry. Apply collagen to wound bed and cover with ABD and wrap with kerlix. Secure with ace wrap. everyday shift for surgical wound AND as needed for soiled or dislodged dressing. During an observation on 04/01/2026 at 8:37 a.m. the ADON was about to do Resident # 5's wound care. Before doing wound care, she asked CNA F to help her. CNA F put on a gown and a pair of gloves. She did not wash or sanitize her hands. During an interview on 04/01/2026 at 9:10 a.m., CNA F said hands should be sanitized before putting on a gown and the gloves to prevent cross contamination and infection. She said she would remember the next time she would provide care to do hand hygiene. 2. Resident #46 Record review of Resident #46's Face Sheet, dated 04/01/2026, reflected an [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with hypertension (high blood pressure). Record review of Resident #46's Comprehensive MDS Assessment, dated 02/10/2026, reflected the resident had severe impairment in cognition with a BIMS score of 06. The Comprehensive MDS Assessment indicated that the resident had hypertension. Record review of Resident #46's Comprehensive Care Plan, dated 03/02/2026, reflected that the resident had hypertension and one of the interventions was to give anti-hypertensive medications. Resident #67 Record review of Resident #67's Face Sheet, dated 04/01/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with hypertension. Record review of Resident #67's Comprehensive MDS Assessment, dated 03/06/2026, reflected that the resident was cognitively intact with a BIMS score of 13. The Comprehensive MDS Assessment indicated that the resident had hypertension. Record review of Resident #67's Comprehensive Care Plan, dated 02/19/2026, reflected that the resident had hypertension and one of the interventions was to give anti-hypertensive medications. Record review of Resident #67's Physician Order, dated 11/21/2025, reflected Metoprolol Succinate ER Tablet Extended Release 24 Hour 50 MG Give 1 tablet by mouth one time a day for HTN related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) HOLD for SBP<110, DBP<60 HR<60. During an observation on 03/31/2026 at 8:12 a.m. MA D was about to prepare Resident #46's medication. She picked up the blood pressure cuff from the top of the medication cart, put it on her wrist, went inside the resident's room, took the blood pressure cuff from her wrist, and placed it on Resident #46's arm. After the blood pressure reading was completed, she placed the blood pressure cuff on top of the medication cart, prepared the medications, and gave the medications to Residents #46. She did not sanitize the blood pressure cuff. She then went to Resident (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#67's room to administer her medications. She picked up the blood pressure cuff, put it on her wrist again, went inside the resident's room, took the blood pressure cuff from her wrist, and placed it on Resident #67's arm. After the blood pressure reading was completed, MA D placed the blood pressure cuff on top of the medication cart, prepared the medications, and gave the medications to Residents #67. She did not sanitize the blood pressure. During an interview on 03/31/2026 at 8:49 a.m., MA D said she did take the blood pressures of the residents who had orders for anti-hypertensive medications, so she would know if she needed to hold medications or not. She said she would put the blood pressure cuff on her wrist before and after taking the blood pressure so she would not forget where she put it. She said she should have sanitized the blood pressure cuff between residents to prevent cross contamination and spread infection. She said one resident might have a skin issue and would be transferred to another resident because the blood pressure cuff was not sanitized. She said, on that note, she should also not put it on her wrist because she might have a skin infection and could transfer it to the residents or the other way around. 3. Record review of Resident #82's Face Sheet, dated 04/01/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with hemiplegia (paralysis of one side of the body). Record review of Resident #82's Comprehensive MDS Assessment, dated 03/13/2026, reflected the resident had moderate impairment in cognition with a BIMS score of 10. The Comprehensive MDS Assessment indicated that the resident was frequently incontinent for bladder and bowel. Record review of Resident #82's Comprehensive Care Plan, dated 03/11/2026, reflected that the resident had incontinence and one of the interventions was to provide pericare after each incontinent episode. During an observation on 03/30/2026 at 11:47 a.m. revealed CNA E was about to do Resident #82's incontinent care. He went inside the resident's room and put on a pair of gloves. He did not wash his hands before putting on his gloves. He took the trash can and placed it near him. He did not change his gloves after touching the trash can and proceeded with incontinent care. He unfastened the brief and cleaned the resident's perineal area (area between the thighs) and then assisted the resident to roll to his side. He then pulled the soiled brief and threw it in the thrash can. He cleaned the resident's bottom and then pulled the soiled draw sheet. After cleaning the bottom, he took the new brief from the overbed table, placed it under the resident, and fixed it. He did not change his gloves after cleaning the bottom and rolling the soiled brief and draw sheet and before touching the new brief. During an interview on 03/30/2026 at 11:59 a.m., CNA E said he was supposed to change his gloves after touching the trash can, after cleaning Resident #82s' bottom, after rolling the soiled brief, and before touching the new brief to prevent using dirty gloves. He said hand hygiene should also be done before doing any care, like incontinent care to prevent cross contamination and urinary tract infection. During an interview on 04/01/2026 at 9:18 a.m., the ADON said hand hygiene should be done before doing any care and before putting on a pair of gloves to make sure the gloves that the staff would be using were clean. She said after touching the trash, the gloves should have been changed, after cleaning the bottom, the gloves should have been changed, after rolling the soiled draw sheet, the gloves should have been changed to avoid transfer of microorganisms to the new brief that could eventually cause infection. She said the blood pressure cuff should be sanitized after each use for the same reason. She said she would coordinate with the DON to do an in-service about hand hygiene and infection control During an interview on 04/01/2026 at 9:43 a.m., the Corporate Nurse said staff should do hand hygiene before, during, and after care. She said hand hygiene was the most effective way to prevent cross contamination that could possibly lead to infection. She said the gloves should have been changed after touching something soiled like the trash can, the resident's bottom, soiled brief, and soiled draw sheet to make sure there was no transfer of microorganisms to the new brief. She said the blood pressure cuff should be sanitized after every use for the same reason. She said the expectation was for the staff to be mindful that they would not be the cause of any infection. She said she would start an in-service about infection control. During an interview on 04/01/2026 at 10:23 a.m., the Administrator said the expectation was for the staff to be mindful not to cause any kind of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	He said he was not a clinician and would let the DON take the lead on the issue of infection control. Record review of the facility's policy Handwashing-Hand Hygiene Policy and Procedures revised October 2020 reflected Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infections . Policy Interpretation and Implementation . 7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations . b. Before and after direct contact with residents; g. Before handling clean or soiled dressings, gauze pads . h. Before moving from a contaminated body site to a clean body site during resident care . i. After contact with a resident's intact skin . j. After contact with blood or bodily fluids . m. After removing gloves . Applying and Removing Gloves . 1. Perform hand hygiene before and after applying non-sterile gloves. Record review of the facility's policy Fundamentals of Infection Control Precautions Infection Control Policy & Procedure Manual 2019 revised March 2024 reflected 6. Resident care equipment and articles . 3. Non-invasive resident care equipment is cleaned daily or as need between use. Record review of the facility's policy Perineal Care revised March 03, 2026, reflected 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 . 4. Wash hands and apply gloves.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents with wounds received care and treatment consistent with professional standards of practice to promote healing and prevent further development of skin breakdown and infection for one of four residents (Resident #5) reviewed for quality of care. The facility failed to ensure that the interim ADON did not clean Resident #5's wound with the gauze used to clean the surrounding skin of the wound on 04/01/2026. This failure could place the residents with wounds at risk of infection.Findings included: Record review of Resident #5's Face Sheet, dated 04/01/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with skin transplant (a surgical procedure that involves taking healthy skin and moving it to cover damaged skin) status. Record review of Resident #5's Comprehensive MDS Assessment, dated 01/23/2026, reflected that the resident had a moderate impairment (resident may need additional support and monitoring) in cognition with a BIMS score of 12. The Comprehensive MDS Assessment indicated that the resident had a skin transplant. Record review of Resident #5's Comprehensive Care Plan, dated 02/08/2026, reflected the resident had surgical skin graft (another term for skin transplant) to left lower leg/foot and one of the interventions was to keep incision clean and dry. Record review of Resident #5's Physician Order, dated 04/01/2026, reflected skin graft/surgical wound to left heel: cleanse with wound cleanser, pat dry. Apply collagen to wound bed and cover with ABD and wrap with kerlix (bandage used for wound care). Secure with ace wrap. Every day shift for surgical wound AND as needed for soiled or dislodged dressing. During an observation on 04/01/2026 at 8:37 a.m. revealed the ADON was about to do Resident # 5's wound care. She sanitized her hands, put on a pair of gloves, and sanitized the resident's overbed table. When the table was dry, she placed some gauze, some normal saline bullets, dressing, collagen sheet, kerlix, ace wrap, and some gloves on the table that she covered with wax paper. She sanitized her scissors, placed them on the table, and taped a plastic bag to the side of the table. She washed her hands and put on a gown and gloves. She took the ace wrap and kerlix off and then took the soiled dressing. She removed her gloves, sanitized her hands, and put on a new pair of gloves. She squeezed the normal saline bullet on a couple of gauzes and started to clean the resident's wound to his left heel. She started by cleaning the surrounding skin of the wound and used the same gauze to clean the inside of the wound. She did it twice. She took off her gloves, sanitized her hands, put on a pair of gloves, and proceeded with wound care. During an interview on 04/01/2026 at 9:12 p.m., the ADON said the gauze used to clean the skin surrounding the wound should not have been used to clean the inside of the wound because germs from the skin surrounding the wound would transfer to the wound itself. She said she was not aware she used the gauze to clean the surrounding skin of Resident #5's wound to clean the inside of the wound. She said she should have discarded the gauze used to clean the surrounding skin of the wound and got another gauze to clean the wound. She said the microorganism accumulated from the surrounding skin of the wound eventually was transferred to the wounds and could cause infections. She said she would be mindful the next time she would do wound care not to use soiled gauze to clean the inside of the wounds again. During an interview on 04/01/2026 at 9:43 a.m., the Corporate Nurse said the gauze should be changed after every stroke and discarded. She said the gauze used to clean the surrounding skin was already soiled and should not be used to clean the inside of the wound. She said the goal was to clean the wound and not to contaminate it. She said if the same gauze was used, microorganisms might be introduced to the wound and could result in infection. She said the expectation was for the staff doing wound care to do the right procedure. She said she would do an in-service about proper techniques in wound care. She said the ADON went ahead and cleaned Resident #5's wound again. During an interview on 04/01/2026 at 10:23 a.m., the Administrator said improper wound care could lead to infection. He said the expectation was to do wound care the right way according to wound care technique. He said he (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would coordinate with the DON about the issue. Record review of the facility's policy Skin Integrity, Prevention, and Treatment Program revised March 05, 2026, reflected Wound Care . c. Adheres to infection control best practices. Policy for wound care policy requested via email to the Administrator on 03/31/2026 and requested verbally to the Corporate Nurse on 04/01/2026 but was not provided prior to exit.

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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. Based on observations, interviews, and record reviews, the facility failed to ensure that residents' environment remained free of hazards as was possible for one of five direct staff (LVN C) reviewed for accident hazard. 1. The facility failed to ensure LVN C did not leave a container of germicidal wipes on top of her cart unattended on 03/30/2026. 2. The facility failed to ensure there were no germicidal wipes on the ledge of the nurse's station, unattended, on 03/30/2026. These failures could prevent the residents from having an environment that was free from toxic chemicals. Finding included: 1. During an observation on 03/30/2026 at 1:05 p.m. LVN C went inside a resident's room to administer medications. She closed the door while administering medications. She left a container of germicidal wipes (substance that destroys germs and microorganism) on top of a cart, unattended, until she finished administering medications. 2. During an observation on 03/30/2026 at 1:26 p.m. a container of germicidal wipes was observed sitting at the nurse's station ledge. It was observed that nobody was in the nurse's station and a resident was sitting near the nurse's station. During an observation and interview on 03/30/2026 at 1:28 p.m., LVN C said she forgot to put the container of germicidal wipes into the drawer of her cart when she went inside a resident's room to administer medications. She said she should have placed the germicidal wipes inside the cart before he closed the door to give medications because residents might be able to get hold of the wipes and use them to clean their faces and eyes that could result in irritations. She took the container of germicidal wipes and put it inside the last drawer of the cart she was using. She then saw the container of germicidal wipes on the ledge of the nurse's station. She took the container and placed it inside the medication room. During an interview on 04/01/2026 at 9:18 a.m., the ADON said the germicidal wipes should be stored inside the cart or the medication room and not where residents could access them. She said residents might pull some and use them to clean their eyes, skin, and private areas. She said it might cause irritation and toxicity if consumed. She said anything that indicated Keep out of reach of children. should be considered harmful because the facility had confused residents that may not know the outcome if the germicidal wipes were used. During an interview on 04/01/2026 at 9:43 a.m., the Corporate Nurse said the containers of germicidal wipes should not be left on top of the cart or on the ledge of the nurse's station unattended because they have chemicals that could cause adverse effects if consumed or had contact with the skin, eyes, and mouth. She said the container of germicidal wipes was closed, but somebody could open it to pull some wipes with their bare hand. She said the wipes were handled with gloves on because they have chemicals on them to eliminate germs on surfaces. She said the containers should be inside the carts when staff were leaving their carts. She said she would start an in-service about not leaving any germicidal wipes, unattended, for resident safety. During an interview on 04/01/2026 at 10:23 a.m., the Administrator said the containers of germicidal wipes should not be within reach of any residents because they might accidentally use them that could result in skin or eye irritation. He said he would collaborate with the DON and the Corporate Nurse regarding the issue. Record review of the facility's policy Safe Storage and Handling of Disinfectant Wipes and Chemical Agents undated, reflected Policy Statement: It is the policy of this facility to ensure that all disinfectant products, including but not limited to germicidal wipes are stored and handled in a manner that prevents resident access, minimizes exposure risk, and maintains a safe environment for residents, staff, and visitors . Purpose: To prevent accidental exposure, ingestion, skin irritation, or other adverse events associated with improper storage or use of disinfectant wipes and chemical agents . Policy Guidelines . Disinfectant wipes must not be left unattended . All chemical agents must be . Stored in secured compartments (locked carts, cabinets; or designated storage rooms) OR maintained under direct staff supervision at all times.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based observation, interview, and record review the facility failed to ensure residents who were incontinent of bladder received appropriate treatment and services to prevent urinary tract infection for one of five residents (Resident #82) reviewed for incontinent care. The facility failed to ensure that CNA E performed the right technique during Resident #82's incontinent care on 03/30/2026. This failure could place the residents at risk of urinary tract infection.Findings included: Record review of Resident #82's Face Sheet, dated 04/01/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with hemiplegia (paralysis of one side of the body). Record review of Resident #82's Comprehensive MDS Assessment, dated 03/13/2026, reflected the resident had moderate impairment in cognition with a BIMS score of 10. The Comprehensive MDS Assessment indicated that the resident was frequently incontinent for bladder and bowel. Record review of Resident #82's Comprehensive Care Plan, dated 03/11/2026, reflected that the resident had incontinence and one of the interventions was to provide pericare (hygiene practices involved in cleaning the area between the thighs) after each incontinent episode. During an observation on 03/30/2026 at 11:47 a.m. revealed CNA E was about to do Resident #82's incontinent care. He put on a pair of gloves and started cleaning the sides and top of the resident's perineal area (area between the legs). He then pulled the skin of the shaft of the resident's penis and cleaned the shaft of the penis downward. With the same wipes he used to clean the shaft of the resident's penis, he cleaned the head of the penis touching the opening of the penis. He did it twice. During an interview on 03/30/2026 at 12:07 p.m., CNA E said he should not have used the wipes to clean the shaft of the penis to clean the head of the penis because the germ from the shaft could enter the opening of the penis and may cause urinary tract infection. During an interview on 04/01/2026 at 9:18 a.m., the ADON said wipes used to clean the shaft of the penis should not be used to clean the head of the penis because microorganisms (organism that is too small to be seen) from the shaft might enter the opening of the penis which was located on its tip. He said the head of the penis should be cleaned with clean wipes. She said she would coordinate with the Corporate Nurse or the DON to do an in-service about the right procedure during incontinent care. During an interview on 04/01/2026 at 9:43 a.m., the Corporate Nurse said that using a soiled wipe to clean the head of the penis could result to urinary tract infection. She said the microorganisms from the shaft could eventually enter the opening of the penis. She said the expectation was for the staff to follow the right procedure in cleaning the penis. She said she would start an in-service about proper procedure in cleaning the penis and would let the DON know about the improper procedure of incontinent care. During an interview on 04/01/2026 at 10:23 a.m., the Administrator said the expectation was for the staff to follow the proper technique of incontinent care to prevent any unwanted outcomes like urinary tract infections. He said he would collaborate with the DON and the Corporate Nurse regarding incontinent care. Record review of the facility's policy Perineal (area between the thighs) Care revised March 03, 2026, reflected 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 . For a male resident . b. Wash perineal area starting with urethra (a tube where urine exits the body) and working outward.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide pharmaceutical services, including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals that met the needs of each resident for two of eighteen residents (Resident #33 and Resident #46) reviewed for pharmaceutical services. The facility failed to ensure LVN I did not leave Resident #33 and Resident #46's medications inside the cart on 03/31/2026, instead of administering their medications to them. This failure could place residents at risk of not receiving medications as ordered resulting in adverse effects such as worsening conditions and inadequate disease control.Findings included: Resident #33 Record review of Resident #33's Face Sheet, dated 04/01/2026, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with hypothyroidism (the thyroid gland does not produce enough thyroid hormones resulting in fatigue). Record review of Resident #33's Comprehensive MDS Assessment, dated 01/05/2026, reflected that the resident had severe impairment in cognition with a BIMS score of 05. The Comprehensive MDS Assessment indicated that the resident had hypothyroidism. Record review of Resident #33's Comprehensive Care Plan, dated 03/02/2026, reflected that the resident had hypothyroidism and the intervention was to administer medications as ordered. Record review of Resident #33's Physician's Order, dated 03/17/2025, reflected Levothyroxine Sodium Oral Tablet 25 MCG (Levothyroxine Sodium) Give 12.5 mcg by mouth in the morning for Hypothyroidism Give half tablet by mouth every day. Record review on 03/31/2026 of Resident #33's Progress Notes reflected no documentation why the medication was not administered.Record review on 03/31/2026 of Resident #33's eMAR reflected levothyroxine was not administered. Resident #46 Record review of Resident #46's Face Sheet, dated 04/01/2026, reflected an [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with hypothyroidism. Record review of Resident #46's Comprehensive MDS Assessment, dated 02/10/2026, reflected the resident had severe impairment in cognition with a BIMS score of 06. The Comprehensive MDS Assessment indicated that the resident had hypothyroidism. Record review of Resident #46's Comprehensive Care Plan, dated 03/02/2026, reflected that the resident had hypothyroidism and the intervention was to administer medications as ordered. Record review of Resident #46's Physician's Order, dated 06/25/2025, reflected Levothyroxine Sodium Oral Tablet 88 MCG (Levothyroxine Sodium) Give 1 tablet by mouth in the morning for hypothyroidism recheck TSH in 6 weeks. Record review on 03/31/2026 of Resident #46's Progress Notes reflected no documentation why the medication was not administered.Record review on 03/31/2026 of Resident #46's eMAR reflected levothyroxine was not administered. During an observation on 03/31/2026 at 8:12 a.m. MA D was preparing medications. When she opened the first drawer of her cart, it was observed that there were two small cups with one pill each inside the drawer. During an observation and interview on 03/31/2026 at 8:49 a.m., MA D said the medications were left by the night nurse. She said the night nurse did not tell her anything about the medications. She said she did not know why it was left inside the cart. It was observed that the cups had Resident #33 and Resident #46's names on them. She took the cups and said she would show them to the DON. During an interview on 03/31/2026 at 3:12 p.m., Resident #33 just shrugged her shoulders when asked if she was given her early morning medication. During an interview on 03/31/2026 at 3:19 p.m., Resident #46 did not reply when asked about his early morning medication. During an interview on 04/01/2026 at 9:18 a.m., the ADON said there should be no medications that were already prepared inside the cart. She said the night nurse should have told the medication aide that she was not able to give the medications and if she could give them. She said the night nurse should have discarded the medications if the residents refused and documented it. She said if the residents were still sleeping, the night nurse should have revisited the resident to give the medications so that the residents would (continued on next page)

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

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not miss any medications. She said another issue with this was that the MA could get confused or distracted and would be able to include the medications that were in the cups that were prepared before her shift. She said this could result to other residents taking medications that were not prescribed to them. During an interview on 04/01/2026 at 9:43 a.m., the Corporate Nurse said she already talked to LVN I about why there were medications left inside the cart with Resident #33 and Resident #46's names on them. According to the Corporate Nurse, one of the residents was still sleeping and the other one refused, that was why she placed the medications inside the cart and planned to go back to the said residents to administer the medications but forgot to do so. She said since it was a missed medication, the residents were assessed, and the NP and the responsible party were notified. During an interview on 04/01/2026 at 10:23 a.m., the Administrator said he was not a clinician and would let the Corporate Nurse and the DON take the lead on the issue. Record review of the facility's policy Medication Administration revised March 05, 2026, reflected Purpose: To ensure medications are prepared, administered, and documented safely, accurately, and in accordance with prescriber orders and accepted nursing standards of practice . During Medication Pass . Missed residents are followed up after completion of the medication pass . Refused, withheld, or rescheduled medications are documented appropriately on the MAR.