STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675929	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Creek Nursing and Rehabilitation Center	159 Montague Ave Bandera, TX 78003

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34957 Based on observation, interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan that includes measurable objectives and time frames to meet a resident's medical and nursing needs to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 4 residents (Residents #1) reviewed for comprehensive care plans in that: The facility failed to develop a plan of care to address Resident #1's multiple wounds. This failure could place residents at risk of not being provided with the necessary care or services and having personalized plans developed to address their specific needs. The findings included: Record review of Resident #1's face sheet dated 2/5/25 revealed an admitted [DATE] and discharge date of [DATE] (transfer to hospital on 1/28/25) with admission diagnoses that included: sepsis (infection in the blood), type 2 diabetes with neuropathy (nerve damage), and peripheral vascular disease (poor blood circulation) especially to the right foot. Resident was a female; age 84. RP was listed as: self. Record review of Resident#1's admission MDS dated [DATE], revealed: the BIMS score was 14 (cognitively intact). In the area of transfer and mobility the resident required total assistance. As for toileting, the resident was incontinent of bowel and bladder. Record review of Resident #1's baseline Care Plan dated 1/3/25, revealed, the goals and interventions included: fall prevention, perform wound care for lacerations and skin tears, and diabetes management. The care plan did not address the presenting diagnosis of peripheral vascular disease especially to the resident's right foot and no interventions were listed for wound care. Record review of Resident#1's hospital record, dated 1/1/25, revealed: severe PAD (peripheral artery disease) status post Angio gram to both legs; lower extremity ulcer with cellulitis with MRSA; dual duodenal ulcers with GI bleed; acute blood loss anemia. Recommendation made for follow-up with a vascular clinic. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of email sent on 2/6/25 at 5:00 PM from the vascular clinic confirmed that Resident #1 had a vascular clinic follow-up 3 months after discharged from the hospital for an arterial duplex of lower extremities. Record review of Resident #1's skin assessment dated [DATE] read in reference to the right leg: Right top foot: 6x7x 0.2 open area .right outer ankle: 2.5x1 open area w/ slough .right toe 1x1 black .right 3rd toe 1x1scab .right outer foot:1.5x1.5 open area w/slough . right heel:6x2 boggy . right distal foot:1x1 scab . right anterior foot:0.5 x 0.5 open area. Record review of Resident #1's skin assessment dated [DATE] read in reference to the right leg: Pressure, venous, arterial, or diabetic ulcer present: Yes; see ulcer assessments for details .Other skin findings present: No . Yes, to arterial issues. Record review of Resident#1 's TAR dated January 2025, revealed, the resident received treatment for arterial wounds as ordered by the physician. Treatment included: cleansing, patting, gel, and wrapping one time a day related to non-pressure chronic ulcer of other part of right foot with fat layer exposed. Record review of Resident #1's Nurse Note dated 1/27/25 authored by LVN A, read: Right foot swelling to affected area; readiness to area; dressing intact. Diabetic foot ulcer. Open lesion and infection to foot. Record review of Resident #1's Nurse Note dated 1/28/25 authored by LVN B: MD notified: tenderness to affected and right big toe turning black. [MD (wound specialist) was present in the facility making rounds with LVN B].[Resident was transferred to the ER]. Record review of Resident #1's ER report dated 1/28/25 reflected resident was admitted for evaluation of right foot due to history of peripheral vascular disease. Resident had undergone angios of the lower extremity in mid-December and had sepsis. The ER report further read: .CT angio demonstrates occlusion of the right mid femoral artery with minimal right constitution of flow in the popliteral artery with inability to evaluate right trifurcation (three) vasculature (blood vessels).likely require AKA (above knee amputation) . The discharge diagnosis was Peripheral vascular occlusive (blockage) disease. Record review of Resident #1's electronic record did not contain a comprehensive patient centered care plan that addressed the resident's peripheral vascular disease and wound care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 2/6/25 at 9:30 AM, Resident #1 was in a hospital bed, alert and oriented to person, place, and time, and eating her breakfast. Resident #1 was sitting on a chair with a Right BKA (below the knee amputation). The resident stated: she received wound care at the NF and was followed weekly by the wound physician. Resident #1 stated that she was admitted to the NF with a chronic history of arterial vascular disease. Resident #1 stated, prior to admission to the facility she had undergone treatments (angiogram) for poor blood circulation to her right foot. Resident #1 stated that at the time of admission to the NF (1/12025) admission to the facility she had a blockage to her right foot. The resident stated that one week prior to 1/28/25, the wound doctor had seen her and had no major concerns about the condition of her right foot. On 1/28/25, the wound doctor saw her again and ordered that she be sent to the ER because the toe had gotten black; she underwent right foot BKA. The resident stated that on 1/27/25 at 11:PM RN C provided wound care. The resident stated that she agreed with the doctor that she suffered an acute arterial vascular issue between 1/27/25 and 1/28/25. During an interview on 2/5/25 at 2:55 PM, LVN B stated that the purpose of the comprehensive patient-centered CP was to tell the staff the goals and interventions involving Resident #1 especially around the presenting problem of peripheral vascular disease. LVN B stated she was not assigned to Resident #1 and no need to check the comprehensive patient-centered CP. LVN B repeated, the comprehensive patient-centered CP would help a nurse know the treatment interventions for a resident. During interview on 2/5/25 at 3:18 PM, the Administrator stated the comprehensive patient-centered CP served to communicate goals and interventions for a resident. The Administrator stated that the comprehensive patient-centered CP, when a resident is admitted from a hospital, needed to capture the discharge instructions and recommendations for a resident. The Administrator stated that he had no explanation why Resident #1's comprehensive patient-centered CP was not completed and did not capture wound care interventions for the resident's arterial vascular disease. The Administrator stated that the comprehensive patient-centered CP was developed by the MDS Nurse from assessments by the interdisciplinary team and was updated quarterly and when any change of condition occurred. The Administrator stated the responsible staff for checking on the comprehensive patient-centered CP was the DON. During interview on 2/5/25 at 4:16 PM, LVN B {MDS Nurse] stated that Resident #1 had severe arterial vascular issues and sepsis and MRSA at admissions on 1/1/25. LVN B stated that there was no comprehensive patient-centered CP in the resident's electronic medical records and did not capture the MD's order for wound care. LVN B states,. I did not get around to do it . LVN B stated that the process for the development of the comprehensive patient-centered CP was the development of a: base line CP done at admissions which was good for 20 days; after admissions the comprehensive CP was done 27 days later. LVN B stated that the 27th day for Resident #1 was 1/27/25 and the comprehensive centered-care plan was not done. LVN B stated that by the 27th day the comprehensive patient centered CP for Resident #1 should have captured interventions for wound care. LVN B stated that the interdisciplinary team does assessments and contributes to the comprehensive patient centered CP done by the MDS nurse. During telephone interview on 2/5/25 at 4:43 PM, LVN A stated the purpose of the comprehensive patient-centered CP was to list the interventions requiring wound care for Resident #1. LVN A stated she was not aware that the comprehensive patient -centered CP had not been completed especially in the area wound treatment. LVN A stated the comprehensive patient-centered CP should have listed the interventions for Resident #1's peripheral vascular disease. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 2/5/25 at 4:57 PM, RN C (former DON) stated the purpose of the CP was to establish goals and interventions for a resident. RN C stated the comprehensive patient- centered CP served as a means for communications with the interdisciplinary team. RN C stated, the MDS nurse developed the baseline CP and comprehensive patient-centered CP was developed after 20 days of admissions. RN A stated she was responsible to check on the goals and interventions around wound care for Resident #1 and the existence of the comprehensive patient-centered CP. RN A stated, I have no excuse [absence of the comprehensive patient-centered CP for Resident #1] .I tried to keep up as a DON and floor nurse. Record review of the facility's Comprehensive Care Planning, undated, read: The facility will develop and implement a comprehensive person-centered care plan for each resident .Developed within 7 days after completion of the comprehensive assessment.