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	02/12/2025

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26869 Based on observations, interview and record review the facility failed to ensure Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records and a right to secure and confidential personal and medical records for 3 of 9 (room [ROOM NUMBER], #47 and resident #76) reviewed for privacy and confidentiality, in that: 1. LVN J did not knock on rooms #55 and #47 before entering rooms. 2. LVN Z left her computer open in the hallway, with people passing by, with resident #76's personal information. This could affect and result in resident privacy being violated. The Findings were: 1. a. Observation on 1/26/2025 at 10:33 AM LVN J went into room [ROOM NUMBER] and did not knock on the door before entering room. b. Observation on 1/26/25 at 10:00 AM LVN J went into room [ROOM NUMBER] and did not knock on the door before entering room. Interview on 1/26/25 at 10:38 AM with LVN J confirmed she did not knock on the 2 doors, and she should have knocked before she entered and will do better. 2. Observation on 1/26/2025 at 12:11 PM to 12:19 PM revealed LVN Z had her computer screen open/on in the hallway, with people passing by, with Resident #76's personal information. Interview on 1/26/2025 at 1:48 PM LVN Z stated she forgot to turn the monitor screen off and got busy. LVN stated she was busy checking resident lunch trays, so she attended to the resident. Interview on 1/28/2025 at 12:04 PM with ADM and DON, did discuss and stated they will educate staff on the concerns with knocking on the door, and staff leaving the computer screen open to residents' personal information. No further response from ADM/DON. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675929	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2025
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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of policy, Dignity dated February 2021 Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. 1. Residents are treated with dignity and respect at all times . 7. Staff are expected to knock and request permission before entering resident's rooms. Record review of policy, Confidentiality of Information and Personal Privacy dated October 2017 was documented Our Facility will protect and safeguard resident confidentiality and personal privacy. 1. The facility will safeguard the persona privacy and confidentiality of all resident personal and medical records . 4. access to resident personal and medical records will be limited to authorized staff and business associates.

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F 0609

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48366

Based on interviews and record reviews the facility failed to ensure that all alleged violations involving abuse, neglect, including injuries of unknown source were reported immediately, but not later than 2 hours after the allegation was made, if the event caused serious bodily injury for 1 of 11 residents (Resident #3) whose records were reviewed for abuse and neglect:

Confidential Staff Members A, B, and H failed to report to the administrator about an allegation of neglect of Resident #3 by RN J.

These deficient practices could affect residents by contributing to further abuse and neglect.

The findings included:

Record review of Resident #3's Admission record reflected a male initially admitted [DATE] with diagnoses to include unsteadiness on feet, muscle wasting and atrophy, lack of coordination, weakness, age-related physical debility, cognitive communication deficit, and abnormalities in gait and mobility.

Record review of Resident #3's quarterly MDS assessment, dated 10/30/24, reflected the resident had a BIMS score of 11 out of 15, indicating moderate cognitive impairment. It was reflected Resident #3 used a walker and wheelchair. It reflected Resident #3 needed supervision or touching assistance from sit to stand and chair/bed to chair transfer. It reflected Resident #3 had occasional pain that limited day to day activities.

Record review of Resident #3's care plan, undated, reflected the following:

Resident has a communication problem r/t requiring extra time to find words and slow thinking with memory loss . with interventions to include Anticipate and meet needs., initiated 09/11/18, and Assist with ADLs as needed., initiated 09/11/18.

I have had numerous actual falls. I continue to practice independence and fail to ask for assistance, this causes me to have falls and I may sustain an injury. Staff cue me r/t safety measures and educate me to ask for assistance . with interventions to include . staff helps with transferring/ambulation, revised 10/18/21, and no interventions about leaving the resident on the floor to pick himself up off the floor by himself.

Resident has potential to demonstrate putting himself on the floor due to anger, poor impulse control, revised 10/11/22 with no intervention about leaving the resident on the floor to pick himself off the floor by himself.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Confidential Staff Member A and Confidential Staff Member B revealed Resident #3 was alert and oriented and was able to tell staff if he fell or not. They revealed RN J started upsetting them because RN J told them she would leave Resident #3 on the floor after his falls, and he would have to get up to his bed on his own. They revealed if Resident #3 fell with them, they would need to get him up off the floor as he was not able to do so by himself. They revealed they reported RN J not helping Resident #3 off the floor (date and time unknown) to DON E and thought it was going to be handled. Interview with Confidential Staff Member H revealed RN J was not a very good nurse. They revealed they reported residents needing care to RN J and RN J would not help with resident care sometime in April of 2024. Confidential Staff Member H revealed they called this type of care neglect and they reported this to the DON during this time in April of 2024. Confidential Staff Member H revealed they thought the DON was going to handle this allegation of neglect and report this to the Administrator. Confidential Staff Member H revealed if this happened again, she now knew to report immediately to the Administrator. Interview on 02/10/25 at 04:10 PM, Resident #3 revealed RN J was normally a good nurse to him, but it was only one incident where RN J had left him on the floor and did not help him when he asked for help, in front of 2 staff members. Resident #3 could not recall these staff members nor the exact time this incident occurred. Interview on 02/11/25 at 12:11 PM, RN J revealed she left Resident #3 on the floor after falls and did not put him back into his bed because this was what he requested. RN J further revealed she would ask Resident #3 if he needed help getting up into bed and he would decline help. Interview on 02/11/25 at 12:44 PM, DON E revealed various CNAs had issues with RN J. DON E revealed she had heard CNAs mention RN J did not help Resident #3 off the floor after a fall, however, she found Resident #3 never fell at the time. DON E could not recall the exact date and time of this incident. DON E revealed she never reported this to the administrator because the fall never happened so there was no neglect that occurred. DON E revealed if Resident #3 had fallen, a staff member would need to help him up to get back to bed because he was unable to do so by himself. DON E further revealed if he declined help, DON E would have to circle back and help him up when he was ready. DON E revealed RN J was a good nurse and DON E never heard of any allegations of abuse, neglect, or exploitation against RN J. DON E revealed they would have reported any allegations of abuse, neglect, or exploitation to the Administrator. Interview on 02/12/25 at 12:30 PM, the Administrator revealed he expected nursing staff to report to him when they heard of any allegations of abuse, neglect, or exploitation. He revealed if nursing staff reported these allegations to the DON, this would have been before he was the administrator at this facility because when he started working at this facility, he had trained the facility staff to report any allegations of abuse, neglect, and exploitation to him. Record review of facility's policy Abuse/Neglect, undated, reflected When a suspected abused, neglected, exploited, mistreated or potential victim of misappropriation of property comes to the attention of any employee, that employee will make an immediate verbal report to the Abuse Preventionist or designee. If the discovery occurs outside of normal business hours, the Abuse Preventionist and/or designee will be called.

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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 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** 26869 Based on observations, interviews and record reviews the facility failed to ensure comprehensive person-centered care plans were developed and implemented for each resident to meet medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment as required for 1 of 1 (Resident #1) resident reviewed for care plans in that: Resident #1's care plan did not have interventions for his left hand contracture to maintain or improve mobility on hand. This could affect all resident with contractures and could result in a decrease in mobility. The Finding were: Record review of Resident's #1's Admission Record dated 2/12/2025 was documented he was admitted on [DATE], readmitted on [DATE] with applied income. Record review of Resident #1 had diagnoses of cerebral infarction, epilepsy, pain, anxiety, restlessness and agitation, cognitive communication deficit, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side and abnormal gait and mobility. Record review of Resident #1's Admission Nurse note dated 9/7/2023 was documented most recent admission, he had hypertension, seizure disorder, oriented x 4, resident had hemiplegia/hemiparesis left upper extremities, he used a wheelchair to mobilize, had contractures or limited range of motion, impairment on one side, with 1 person assistance with mobility/transfer, dressing/hygiene, bathing, and toileting. Record review of Resident's #1's consolidated orders for February 20025 was documented diagnosis of epilepsy, hypertension, pain, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, abnormalities of gait and mobility and cognitive communication deficit. Late entry for 01/31/2024; OT Clarification Order: Occupational Therapy to eval and treat 4 x week for 4 weeks for therapy exercises, therapy active, gait treatment, w/c mobility, modalities prn, pain management, manual therapy, group therapy and discharge planning. Phone Active 02/01/2024; Late entry for 1/2/24: PT Clarification Order: Physical Therapy to eval and treat 5 x week for 4 weeks for therapy exercises, therapy active, gait treatment, w/c mobility, modalities prn, pain management, manual therapy, group therapy and discharge planning. Phone Active 01/19/2024; PT Clarification Order: Physical Therapy to eval and treat 3 x week for 4 weeks for therapy exercises, therapy active, gait treatment, w/c mobility, modalities prn, pain management, manual therapy, group therapy and discharge planning. Phone Active 02/26/2024. no order for device for left hand contracture. Record review of Resident's #1's Quarterly MDS dated [DATE] was documented for BIMS score was 12 out of 15 (cognitively intact), he was impaired on one side, for upper/lower extremity (section for functional limitation in range of motion), he required a wheelchair to mobilize, he had a stroke, hypertension, cerebral infarction, pain, abnormal gait and mobility, lack of coordination, end date of occupational therapy was 3/6/2024, and physical therapy was started on 1/3/2025, no end date. Resident #1 had no restorative nursing program marked. (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident's #1's Care Plan dated 1/16/2025 was documented, Resident #1 had a cerebral vascular accident (stoke) with left sided hemiplegia related to hypertension; Resident #1 will be free from contracture of CVA (stoke), contracture through review date. Resident #1 has a potential for uncontrolled pain secondary to CVA with left sided hemiparesis with contracture and headaches. The interventions were the following: Give medications as ordered by physician. Monitor/document side effects and effectiveness; Monitor/document /report to MD PRN s/sx of depression. Encourage resident to talk about feelings and deficits. Obtain mental health consult if indicated; Monitor/document communication skills. Document baseline. If resident is presenting problems with cognitive function and communication, obtain order for Speech Therapy consult to evaluate and treat; Vital signs as ordered/facility protocol. Document and advise physician of abnormal findings; Administer analgesia as per orders. Give 1/2 hour before treatments or care; Anticipate resident's need for pain relief and respond immediately to any complaint of pain; Monitor/document for side effects of pain medication. Observe for constipation; new onset or increased agitation, restlessness, confusion, hallucinations, dysphoria; nausea; vomiting; dizziness and falls. Report occurrences to the physician. Monitor/record/report to nurse loss of appetite, refusal to eat and weight loss. Monitor/record/report to Nurse resident complaints of pain or requests for pain treatment. Notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain. No care plan interventions for left hand contracture. Observation on 2/12/2025 at 10:22 AM in Resident #1's room revealed he had a left-hand contracture with no towel or device to keep from fingernails from going into skin. Interview on 2/12/2025 at 10:23 AM with Resident #1, stated his left hand would not open all the way and his left leg was not able to move because of stroke. Resident #1 stated staff do not place something in hand, to keep his fingernails from going into his skin. During the interview with Resident #1, stated the staff do not work on his hand for therapy. Interview on at 2/12/2025 at 10:47 AM with CNA B stated Resident #1's left hand was contracted, and he could not move his left leg on his own. Interview with CNA B stated Resident #1 needs help putting socks on, she has not seen device for left hand. CNA B stated there was nothing on her computer task for Resident #1's left hand. Interview on 2/12/2025 at 10:58 AM with LVN D stated Resident #1 had left side paralyzed, and stated he was not therapy at this time, due to maybe money. Interview on 2/12/2025 at 11:13 AM with PT stated Resident #1 had a contracted left hand, and leg. PT stated they did not have restorative aides at the facility. PT stated Resident #1 does not have the finances for therapy but try to evaluate him every quarter. The facility paid for his therapy since he does not have funds to pay for therapy. PT stated Resident #1 received therapy for 5 days of services, at a time (pro [NAME]). PT stated Resident #1 was last seen 11th of January 2025 and he never had a splint/device for left hand contracture. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 2/12/25 at 11:24 AM with MDS stated Resident #1 had a left-hand contraction and was care planned for a CVA and contractors. Interview with MDS stated Resident #1 did not get therapy, GDT-goal directive therapy because he did not have insurance, only Medicaid. Interview with MDS stated Medicaid told her it's an old contracture for Resident #1. Interview with MDS stated the ADM pays for therapy for Resident #1 at times. Interview with MDS stated CNA I used to be the restorative aide at the facility, but since COVID the facility no longer had the restorative program. Interview with MDS stated there was nothing in the care plan for restorative services for Resident #1. Interview on 2/12/2025 at 11:51 AM, BOM stated she was Resident #1's payee for SSI, and he received $30 to spend. The BOM was not sure about his left sided hand contracture and usually the nurses would tell her. BOM stated Resident #1 had $1923.09 in his trust fund. Interview on 2/12/2025 at 12:03 PM with ADM stated Resident #1 confirmed he had a left-hand contracture and he had not observed any devices for his left hand. No other response was given. Asked ADM for polices on restorative/mobility. Not provided before exit. Interview on 2/12/2025 at 1:23 PM with CNA I stated she used to be the restorative aid, but not anymore. CNA I stated she stretched and does exercise on hands when he lets you, once a week or every 2 weeks. CNA I stated Resident #1 goes to therapy, but was not sure if they do anything with his left hand. Record review of Email dated on 2/21/2025 at 1:52 PM to ADM asked for the following policies: restorative/mobility. Record review of policy, Comprehensive Care Planning (no date) was documented The facility will develop and implements a comprehensive person-centered care plan for each resident, consistent with the residents' rights that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychological needs that are identified in the comprehensive assessment. Each resident will have a person -centered comprehensive care plan developed and implemented to meet his other preferences and goals, and address the resident's needs medical, physical, mental and psychological needs. The comprehensive care plan will reflect interventions to enable each resident to meet his/her objectives. Interventions are the specific care and services that will be implemented.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26869 Based on interview and record review the facility failed to ensure A resident who is unable to carry out activities of daily living receives the necessary services to maintain grooming, and personal for 3 of 3 (#1, #4, #5) residents reviewed for ADL care, in that: The showers were not completed due to 1 CNA on the 2-10pm shift on Monday (2/10/2025). 1. Resident #1 did take a shower, after continuous asking of staff. 2. Resident # 4 did not take a shower for the month of January 2025 according to the POC task for CNA's. 3. Resident # 5 did not take a shower for the month of January 2025 according to the POC task for CNA's. This failure could affect residents and result in residents not receiving assistance when needed for daily care. The Findings were: Record review of the shower schedule for Resident #1, #4 and #5 was Monday, Wednesday and Friday in the evening shift (2-10 PM shift). 1.Record review of Resident's #1's Admission Record dated 2/12/2025 documented he was admitted on [DATE], readmitted on [DATE] with applied income. Record review of Resident #1 and diagnoses of cerebral infarction)(a condition where blood flow to the brain is interrupted, leading to tissue death , epilepsy (a neurological condition involving the brain that makes people more susceptible to having recurrent unprovoked seizures) , pain, anxiety, restlessness and agitation, cognitive communication deficit, hemiplegia and hemiparesis (Hemiplegia refers to complete paralysis on one side of the body, while hemiparesis means weakness on one side of the body) following cerebral infarction affecting left non-dominant side and abnormal gait and mobility. Record review of Resident #1's Admission Nurse note dated 9/7/2023 documented most recent admission, he had hypertension, seizure disorder, oriented x 4, resident had hemiplegia/hemiparesis left upper extremities, he used a wheelchair to mobilize, had contractures or limited range of motion, impairment on one side, with 1 person assistance with mobility/transfer, dressing/hygiene, bathing, and toileting. Record review of Resident's #1's Quarterly MDS dated [DATE] documented for BIMS score was 12 out of 15 (cognitively intact), he was impaired on one side, for upper/lower extremity (section for functional limitation in range of motion), he required a wheelchair to mobilize, he had a stroke, hypertension, cerebral infarction, pain, abnormal gait and mobility, lack of coordination, required supervision or touching assistance with shower/bath. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident's #1's Care Plan dated 1/16/2025 revealed, Resident #1 has an ADL Self-Care Performance Deficit secondary to stroke with left side hemiplegia. Interventions was Bathing, resident required extensive assist with staff participation with bathing. Interview on 2/12/2025 at 10:23 AM with Resident #1 stated he did take a shower on Monday. Resident #1 stated he had to beg the staff for a shower, it burns him up, and he should not have to worry about that, not knowing if he will get a shower. 2.Record review of Resident #4's Admission Record dated 2/12/2025 documented she was admitted on [DATE], readmitted on [DATE] with diagnoses of diabetes II, abnormalities of gait and mobility, cognitive communications deficit, age-related physical debility, need for assistance with personal care and muscle weakness. Record review of Resident #4's Annual MDS dated [DATE] documented she had a BIMs score of 12 out of 15 (cognitively intact), required the use of manual wheelchair, and required supervision or touching assistance with shower/bathe. Record review of Resident #4's Care Plan dated 12/12/2024 documented Resident #4 had an ADL Self-Care Performance Deficit. Interventions was Bathing requires staff 1 person assistance. Provide the resident with a sponge bath when a full bath or shower cannot be tolerated. Record review of Resident #4's POC task documented Bathing for the month of February 2025, these dates were marked, 2/1/2025 and 2/8/2025 was documented as activity did not occur. The rest of the month was blank. Interview on 2/11/2025 at 4:25 PM Resident #4 stated she did not take a shower on Monday, by staff. 3.Record review of Resident #5's Admission Record dated 2/12/2025 documented she was admitted on [DATE] with diagnoses of dementia, acute respiratory failure shortness of breath, unsteadiness on feet, muscle weakness, and cognitive communication deficit. Record review of Resident #5's Quarterly MDS dated [DATE] documented a BIMS score of 11 out of 15 (cognitively intact), she had impairment on one side for lower extremity, she used a walker/wheelchair, and required set up or clean up assistance. Record review of Resident #5's Care Plan dated 12/18/2024 documented Resident #5 had an ADL Self-Care Performance Deficit related to pain. Intervention was Bathing: supervise as needed. Record review of Resident #5's POC task documented Bathing for the month of February 2025, the month was blank. Interview on 2/11/2025 at 4:50 PM Resident #5 stated she did not take a shower on Monday, by staff. Interview on 2/11/2025 at 4 PM with Confidential Staff Member H stated she worked the 2-10 PM shift on Monday, and she could not get to resident baths. The residents included #1, #4 and #5. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 2/12/2025 at 10:58 AM with LVN D stated she was aware of residents not being provided showers on the 2-10pm shift, because they only had 1 CNA at times. LVN D stated the confidential staff H had told her no she will not do any resident showers. LVN D stated she notified the ADM and this had been going on since December 2024 LVN D stated she had let the confidential staff know she could watch the halls. Interview on 2/12/2025 at 12:03 PM with the ADM stated the concerns with the resident showers was brought up to him , and he was working on hiring more staff. The ADM stated that confidential staff had gotten a verbal disciplinary action. Record review of Policy Bath/Tub Shower dated 2023, was documented Bathing by tub or shower is done to remove soil, dead cells, microorganisms from the skin, and the body order to promote comfort, cleanliness, circulation and relaxation. Although a daily baht or shower is preferred and necessary for some, the adding skin can be maintained by bathing every two days or with partial bathing as needed. Goal: The resident will be free from soil, odor, dryness. Record review of Job Description Certified Nurse Aide dated 2010 was documented The following is a non-exhaustive criteria that relates to the job of a Certified Nursing Assistant, and it is consistent with the business needs of the facility. These are legitimate measures of the qualifications for a Certified Nursing Assistant and are related to the functions that are essential to the job of a Certified Nursing Assistant. Knowledge Base: Accountable for personal care (bathing) .

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26869 Based on observations, interviews and record review the facility failed to ensure a resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable for 1 of 1 (Resident #1) residents in that: Resident #1 had a left sided hand contracture with no devices to maintain or improve mobility on hand. This could affect resident with contractures and could result in a decrease in mobility. The Finding were: Record review of Resident's #1's Admission Record dated 2/12/2025 was documented he was admitted on [DATE], readmitted on [DATE] with applied income. Record review of Resident #1 had diagnoses of cerebral infarction, epilepsy, pain, anxiety, restlessness and agitation, cognitive communication deficit, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side and abnormal gait and mobility. Record review of Resident #1's Admission Nurse note dated 9/7/2023 was documented most recent admission, he had hypertension, seizure disorder, oriented x 4, resident had hemiplegia/hemiparesis left upper extremities, he used a wheelchair to mobilize, had contractures or limited range of motion, impairment on one side, with 1 person assistance with mobility/transfer, dressing/hygiene, bathing, and toileting. Record review of Resident's #1's consolidated orders for February 20025 was documented diagnosis of epilepsy, hypertension, pain, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, abnormalities of gait and mobility and cognitive communication deficit. Late entry for 01/31/2024; OT Clarification Order: Occupational Therapy to eval and treat 4 x week for 4 weeks for therapy exercises, therapy active, gait treatment, w/c mobility, modalities prn, pain management, manual therapy, group therapy and discharge planning. Phone Active 02/01/2024; Late entry for 1/2/24: PT Clarification Order: Physical Therapy to eval and treat 5 x week for 4 weeks for therapy exercises, therapy active, gait treatment, w/c mobility, modalities prn, pain management, manual therapy, group therapy and discharge planning. Phone Active 01/19/2024; PT Clarification Order: Physical Therapy to eval and treat 3 x week for 4 weeks for therapy exercises, therapy active, gait treatment, w/c mobility, modalities prn, pain management, manual therapy, group therapy and discharge planning. Phone Active 02/26/2024. no order for device for left hand contracture. Record review of Resident's #1's Quarterly MDS dated [DATE] was documented for BIMS score was 12 out of 15 (cognitively intact), he was impaired on one side, for upper/lower extremity (section for functional limitation in range of motion), he required a wheelchair to mobilize, he had a stroke, hypertension, cerebral infarction, pain, abnormal gait and mobility, lack of coordination, end date of occupational therapy was 3/6/2024, and physical therapy was started on 1/3/2025, no end date. Resident #1 had no restorative nursing program marked. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675929	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2025
NAME OF PROVIDER OR SUPPLIER Cedar Creek Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident's #1's Care Plan dated 1/16/2025 was documented, Resident #1 had a cerebral vascular accident (stroke) with left sided hemiplegia related to hypertension; Resident #1 will be free from contracture of CVA (stroke), contracture through review date. Resident #1 has a potential for uncontrolled pain secondary to CVA with left sided hemiparesis with contracture and headaches. The interventions were the following: Give medications as ordered by physician. Monitor/document side effects and effectiveness; Monitor/document /report to MD PRN s/sx of depression. Encourage resident to talk about feelings and deficits. Obtain mental health consult if indicated; Monitor/document communication skills. Document baseline. If resident is presenting problems with cognitive function and communication, obtain order for Speech Therapy consult to evaluate and treat; Vital signs as ordered/facility protocol. Document and advise physician of abnormal findings; Administer analgesia as per orders. Give 1/2 hour before treatments or care; Anticipate resident's need for pain relief and respond immediately to any complaint of pain; Monitor/document for side effects of pain medication. Observe for constipation; new onset or increased agitation, restlessness, confusion, hallucinations, dysphoria; nausea; vomiting; dizziness and falls. Report occurrences to the physician. Monitor/record/report to nurse loss of appetite, refusal to eat and weight loss. Monitor/record/report to Nurse resident complaints of pain or requests for pain treatment. Notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain. No care plan interventions for left hand contracture. Observation on 2/12/2025 at 10:22 AM in Resident #1 room revealed he had a left-hand contracture with no towel or device to keep fingernails from going into skin. Interview on 2/12/2025 at 10:23 AM with Resident #1 stated his left hand would not open all the way and his left leg was not able to move because of stroke. Resident #1 stated staff do not place something in hand, to keep his fingernailsfrom going into his skin. Interview with Resident #1 stated the staff do not work on his hand for therapy. Interview on 2/12/2025 at 10:47 AM with CNA B stated Resident #1's left hand was contracted, and he could not move his left leg on his own. Interview with CNA B stated Resident #1 needs help putting socks on, she has not seen device for left hand. CNA B stated there was nothing on her computer task for Resident #1's left hand. Interview on 2/12/2025 at 10:58 AM with LVN D stated Resident #1 had left side paralyzed, and stated he was not therapy at this time, due to maybe money. Interview on 2/12/2025 at 11:13 AM with PT stated Resident #1 had a contracted left hand, and leg. PT stated they did not have restorative aides at the facility. PT stated Resident #1 does not have the finances for therapy but try to evaluate him every quarter. The facility paid for his therapy since he does not have funds to pay for therapy. PT stated Resident #1 received therapy for 5 days of services, at a time (pro [NAME]). PT stated Resident #1 was last seen 11th of January 2025 and he never had a splint/device for left hand contracture. (continued on next page)

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

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 2/12/25 at 11:24 AM with MDS stated Resident #1 had a left-hand contraction and was care planned for a CVA and contractors. Interview with MDS stated Resident #1 did not he get therapy, GDT-goal directive therapy because he did not have insurance, only Medicaid. Interview with MDS stated Medicaid told her it's an old contracture for Resident #1. Interview with MDS stated the ADM pays for therapy for Resident #1 at times. Interview with MDS stated CNA I used to be the restorative aide at the facility, but since COVID the faciltity no longer had the restorative program. Interview with MDS stated their was nothing in the care plan for restorative services for Resident #1. Interview on 2/12/2025 at 11:51 AM, BOM stated she was Resident #1's payee for SSI, and he received $30 to spend. The BOM was not sure about his left sided hand contracture and usually the nurses would tell her. BOM stated Resident #1 had $1923.09 in his trust fund. Interview on 2/12/2025 at 12:03 PM with ADM stated Resident #1 confirmed he had a left-hand contracture and he had not observed any devices for his left hand. No other response was given. Asked ADM for polices on restorative/mobility. Not provided before exit. Interview on 2/12/2025 at 1:23 PM with CNA I stated she used to be the restorative aid, but not anymore. CNA I stated she stretched and does exercise on hands when he lets you, once a week or every 2 weeks. CNA I stated Resident #1 goes to therapy, but was not sure if they do anything with his left hand. Record review of Email dated on 2/21/2025 at 1:52 PM to ADM asked for the following policies: restorative/mobility. Record review of policy, Comprehensive Care Planning (no date) was documented The facility will develop and implements a comprehensive person-centered care plan for each resident, consistent with the residents' rights that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychological needs that are identified in the comprehensive assessment. Each resident will have a person -centered comprehensive care plan developed and implemented to meet his other preferences and goals, and address the resident's needs medical, physical, mental and psychological needs. The comprehensive care plan will reflect interventions to enable each resident to meet his/her objectives. Interventions are the specific care and services that will be implemented.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 48366 Based on interviews and record reviews, the facility failed to provide a resident environment that was free of pests and rodents for 1 of 1 facility reviewed for effective pest control in that: The facility failed to provide a resident environment that was free of pests This deficient practice could place residents at risk of remaining in an environment that was not free of pests and rodents. The findings included: Record review of grievance log for the past year revealed no grievances about pest control. Record review of pest control log for the past 6 months revealed no mention of cockroaches. Interview on 02/10/25 at 01:33 PM, Complainant C revealed she was at the facility this week, exact date unknown, and there were German cockroaches. She revealed she was aware of what German cockroaches looked like because she has experienced an infestation before and stated if you see one then that means there were more. She revealed their dropping can cause respiratory issues and nasal infections. Interview on 02/10/24 at 01:44 PM, CNA A and CNA B revealed they have a lot of roaches in the facility, but it may be because it was an old facility. They further revealed there have been roaches for about a year. Interview on 02/10/25 at 02:19 PM, LVN D revealed she had seen live roaches. She further revealed she killed roaches and let the Maintenance Director know about the roaches. Interview on 02/11/25 at 12:44 PM, DON E revealed there was an incident where there were mice and they got pest control involved and cleaned out everything in the kitchen storage room. She revealed this family always brought snacks so they had put his food away because he would have his food out. Housekeeping had to keep resident's food in Tupperware. Interview on 02/11/25 at 04:25 PM, Resident #2 revealed his family member saw a roach the other day and was concerned for him. He revealed maybe his family member saw roaches in other parts of the facility too but was unsure. Interview on 02/12/25 at 02:10 PM, the CDM revealed when Pest Control came in there was a roach that was present in the kitchen. He further revealed the pest control found more roaches in the walls and was going to come back to treat the area after hours. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 02/12/25 at 02:25 PM, the ADM revealed the pest control staff member found a roach in the kitchen that came in from the outside. The ADM revealed the cockroaches were in the walls of the facility due to moisture and the recent weather. The ADM revealed he expected staff to document in the pest control log any time they see a pest, but he thought someone may have seen a pest in the kitchen and did not write this in the pest control log so the Maintenance Director was unable to address this issue. He revealed they reviewed the pest control log in the morning meetings so they can address any issues at that time with the maintenance director. Record review of Pest Control's Service Inspection Report, dated 02/12/25, reflected Spoke with Dietary with concerns of German Cockroaches in the kitchen . Kitchen: Heavy German Cockroach activity found in kitchen. Highly recommend after hours targeted service of kitchen equipment . Structural: Kitchen has large gap near entry door. Recommend sealing to prevent access by unwanted pests . Record review of the facility's policy Insect and Rodent Control, dated 2012, reflected The facility will maintain an effective pest control program in order to provide an insect and vermin free food service department . 2. Facility will maintain appropriate screens, close fitting doors, proper sealed water/sewer pipes, structurally maintained walls, baseboards, etc. to prevent entrance access of insects and rodents .