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	03/07/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39075 Based on observation, interview and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 2 of 2 resident units/halls (The Short Hall and Long Hall) reviewed for dignity. 1. The facility failed to ensure Resident #11 was provided privacy when she was administered insulin. 2. The facility failed to ensure Resident #27 was provided privacy when she was administered insulin. This failure could place residents at risk for diminished quality of life, loss of dignity and self-worth. The findings included: 1. Record review of Resident #11's face sheet dated 5/5/25 revealed a [AGE] year-old female admitted to the facility on [DATE] and readmitted [DATE] and 1/1/25 with diagnoses that included type 2 diabetes with ketoacidosis (complication of diabetes that occurs when the body starts breaking down fat too quickly due to a lack of insulin) and need for assistance with personal care. Record review of Resident #11's most recent annual MDS assessment dated [DATE] revealed the resident was moderately cognitively impaired for daily decision-making skills and received insulin injections. Record review of Resident #11's comprehensive care plan with revision date 12/12/24 revealed the resident had a diagnosis of diabetes with interventions that included to administer diabetes medications as ordered by the doctor. Record review of Resident #11's Order Summary Report dated 3/5/25 revealed the following: - Apidra Injection Solution 100 UNIT/ML, Inject as per sliding scale subcutaneously at breakfast, lunch, and supper related to TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA with order date 1/17/25 and no end date (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 3/4/25 at 11:30 a.m. revealed LVN A entered Resident #11's bedroom on the Short Hall while the resident was seen eating lunch from the tray that was placed in front of her on the bedside table. Resident #11 could be seen in full view from the hallway. LVN A, while Resident #11 was eating, instructed Resident #11 to pull up her top to expose the resident's abdomen and injected Resident #11 with the insulin. LVN A did not close the bedroom door or pull the privacy curtain to provide privacy and the resident could be seen in full view from the hallway. During an interview on 3/4/25 at 11:34 a.m., LVN A stated she had given Resident #11 an insulin injection and had not closed the bedroom door or pulled the privacy curtain to provide privacy because she had forgotten. LVN A stated she should have provided privacy so others don't notice, it's kind of a dignity thing. During an interview on 3/4/25 at 11:42 a.m., Resident #11 stated, it did not bother her LVN A did not use the privacy curtain to provide privacy. 2. Record review of Resident #27's face sheet dated 3/7/25 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included type 2 diabetes with hyperglycemia (condition in which a person has excessively high blood sugar levels), bipolar disorder (mental health condition characterized by extreme mood swings that include emotional highs and lows), anxiety and depression. Record review of Resident #27's most recent quarterly MDS assessment, dated 12/25/24 revealed the resident was moderately cognitively impaired for daily decision-making skills, and received insulin injections. Record review of Resident #27's comprehensive care plan with revision date 11/19/24 revealed the resident had diabetes with interventions that included to administer diabetes medications as ordered by the physician. Record review of Resident #27's Order Summary Report dated 3/7/25 revealed the following: - Novolog FlexPen Subcutaneous Solution Pen Injector 100 UNIT/ML, Inject 12 units subcutaneously three times a day related to TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA, hold for glucose less than 100, with order date 6/14/24 and no end date Observation on 3/6/25 at 4:23 p.m. revealed LVN B took supplies into Resident #27's room on the Long Hall and obtained the resident's blood sample via a finger stick to check her glucose level. Resident #27's bedroom door was left open, and the privacy curtain was not utilized as LVN B obtained the blood sample in full view of the hallway. LVN B then left the resident's bedside, prepared the insulin pen to inject Resident #27 with insulin and returned to the resident's bedside. LVN B instructed Resident #27 to lift her top and expose the resident's upper abdomen, where LVN B injected the resident with insulin. LVN B did not provide privacy and left the bedroom door open and did not utilize the privacy curtain leaving the resident exposed in full view of the hallway. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/6/25 at 4:29 p.m., LVN B stated, since Resident #27 did not have a roommate, it would be ok not to close the bedroom door. LVN B further stated, but at least I should have drawn the privacy curtain, for privacy. I wouldn't have any trouble pulling up my shirt to expose my stomach, but I understand. LVN B then stated, I know this resident (Resident #27) and I know she would not mind; she's had stuff done out in the open. She doesn't mind if no one else is around. During an interview on 3/6/25 at 4:33 p.m., Resident #27 stated, they (Nursing Staff) do it all the time, sometimes in the hallway. Resident #27 further stated it did not bother her because that's how they always do it. During an interview on 3/6/25 at 10:29 a.m., the DON stated it was her expectation for the nursing staff, when providing care, to provide privacy and should pull the privacy curtain at a bare minimum and should have closed the door. The DON stated, it is an invasion of privacy, and it is their home, I would not expect you to have the front door open. A policy and procedure was requested in reference to privacy and dignity but was not provided at exit.

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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** 39075 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objective and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 12 residents (Resident #4) reviewed for care plans: The facility failed to develop a person-centered care plan with interventions that addressed Resident #4's physician orders for the use of oxygen therapy. This failure could place residents at risk for not having their needs and preferences met. The findings included: Record review of Resident #4's face sheet dated 5/5/25 revealed a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dementia, heart failure, pneumonia, and shortness of breath. Record review of Resident #4's most recent significant change MDS assessment dated [DATE] revealed the resident was severely cognitively impaired for daily decision-making skills and required oxygen therapy. Record review of Resident #4's Order Summary Report dated 5/5/25 revealed the following: - Check O2 sat every shift and as needed with order date 12/6/24 and no end date - May use oxygen at 2 l/m via nasal canula or mask every shift related to SHORTNESS OF BREATH, with order date 12/12/24 and no end date -Oxygen may be used at 2 liters for O2 sats below 90 percent on RA and shortness of breath every 8 hours as needed for Sats below 90 percent on RA and SOB, with order date 2/6/23 and no end date Record review of Resident #4's comprehensive care plan with revision date 2/11/25 revealed the resident was on oxygen therapy with interventions that included: OXYGEN SETTINGS: (Specify: The resident has, O2 via nasal prongs/mask @ (X) L continuously/(FREQ). Humidified (Specify). Observation on 3/4/25 at 10:43 a.m. revealed Resident #4 sleeping in bed and the oxygen concentrator was operating via a nasal cannula at 3 liters. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/7/25 at 8:28 a.m., the MDS Coordinator stated the development of an MDS, and the comprehensive care plan was a team effort. The MDS Coordinator stated the comprehensive care plan offered a picture of the resident and how to take care of them. The MDS Coordinator stated, Resident #4's comprehensive care plan should have been specific to the resident's use of oxygen and should have been updated when the resident's order for use of oxygen was changed, which was back in December. During an interview on 3/7/25 at 10:35 a.m., the DON stated the purpose of the comprehensive care plan was so that everybody would be aware of how to care for the resident and to catch any risks the resident may have and mitigate and prevent them from occurring. The DON stated, Resident #4's use of oxygen should have been specific to the resident, but it was not. The DON stated, Resident #4's comprehensive care plan did not provide specifics regarding the resident's use of oxygen and should have included the amount of oxygen used, and the duration and/or frequency the oxygen was used. Record review of the policy and procedure titled Comprehensive Care Planning undated revealed in part, . The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment . The comprehensive care plan will describe the following .The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39075 Based on the observation, interview, and record review the facility failed to ensure that the resident's environment remained free of accidents and hazards as was possible and each resident received adequate supervision to prevent accidents for 1 of 6 residents (Resident #4) reviewed for accidents. The facility failed to ensure Resident #4's fall mat was utilized per physician's orders. This failure could place residents at risk for accidents and injuries related to risk for falls. The findings included: Record review of Resident #4's face sheet dated 3/5/25 revealed a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dementia, abnormalities of gait and mobility, muscle wasting, muscle weakness and lack of coordination. Record review of Resident #4's most recent significant change MDS assessment dated [DATE] revealed the resident was severely cognitively impaired for daily decision-making skills and was dependent on staff for bed mobility and transfers. Record review of Resident #4's Order Summary Report dated 3/5/25 revealed the following: - fall mat in place while in bed every shift related to OTHER LACK OF COORDINATION, with order date 1/10/25 and no stop date Record review of Resident #4's comprehensive care plan with revision date 2/11/25 revealed the resident was at risk for falls related to confusion, vision and hearing problems and decline in health, with interventions that included: floor mat on the floor beside bed. During an observation on 3/6/25 at 9:59 a.m., Resident #4 was seen lying in bed, and the fall mat was folded up and leaning against the wall at the foot of the bed. During an observation and interview on 3/6/25 at 10:14 a.m., Resident #4 was seen lying on the bed, and the fall mat was folded up and leaning against the wall at the foot of the bed. A female staff who identified herself as the Hospice Aide stated she was about to provide the resident with a bed bath. CNA C observed Resident #4 in the bed and the fall mat folded up and leaning against the wall at the foot of the bed. CNA C stated she made initial rounds at the beginning of the shift, which began at 6:00 a.m., and rounds included checking for fall mat use. CNA C, while the Hospice Aide was in the resident room believed the Hospice Aide may have removed the fall mat. The Hospice Aide stated the fall mat was folded up against the wall before she entered Resident #4's room. CNA C stated it was the responsibility of the CNA's and the nurses to ensure the fall mat was on the floor to prevent the resident from injury related to falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/6/25 at 11:02 a.m., the DON stated, the whole point of the fall mat was that when the resident was in the bed, the fall mat should be on the floor next to the bed to prevent injury from falls. The DON stated, the CNA staff, nursing staff and all staff in general were responsible for ensuring the fall mats were used, but ultimately the responsibility fell on the DON. A policy and procedure was requested from the DON regarding accidents and hazards but was not provided at the time of exit.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39075 Based on observation, interview, and record review the facility failed to ensure a resident who needed respiratory care, was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals, and preferences for 1 of 1 resident (Resident #4), reviewed for quality of care. Resident #4's oxygen nasal cannula was not covered or protected from the elements when not in use. This failure could place residents who received respiratory care at risk of developing respiratory complications and a decreased quality of care. The findings included: Record review of Resident #4's face sheet dated 3/5/25 revealed a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dementia, hypertension (high blood pressure), heart failure, and shortness of breath. Record review of Resident #4's most recent significant change MDS dated [DATE] revealed the resident was severely cognitively impaired for daily decision-making skills and required oxygen therapy. Record review of Resident #4's Order Summary Report dated 3/5/25 revealed the following: - Administer oxygen as needed for oxygen level less than 92 percent with order date 7/20/24 and no end date. - Change nasal or mask canula (used on the oxygen concentrator) as needed with order date 12/13/24 and no end date. Record review of Resident #4's comprehensive care plan with revision date 2/11/25 revealed the resident used oxygen therapy with interventions that included to provide extension tubing or portable oxygen apparatus for those residents who were ambulatory. Observation on 3/4/25 at 10:43 a.m. revealed Resident #4 was on the bed sleeping and the oxygen concentrator was operating via the nasal cannula. Further observation revealed the tubing attached to the oxygen concentrator with the nasal canula was dated 3/3/25. Observation on 3/5/25 at 8:13 a.m. revealed Resident #4 was not in the bedroom and the oxygen concentrator was operating with the tubing to the nasal cannula attached to the oxygen concentrator on the floor next to the bed. The oxygen concentrator tubing was dated 3/3/25. Observation on 3/5/25 at 2:59 p.m. revealed Resident #4 was sleeping on the bed and the oxygen concentrator was not operating at the time. The tubing attached to the oxygen concentrator with the nasal cannula dated 3/3/2025 was observed stored in a clear plastic bag next to the resident's bed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 3/6/25 at 8:15 a.m., during the medication pass, revealed Resident #4 was on the bed and the oxygen concentrator was operating with the tubing to the nasal cannula dated 3/3/2025 attached to the oxygen concentrator, and the part of the cannula that attaches to the resident's nostrils were inside the top open drawer of the resident's nightstand on the right side of the bed. During an observation and interview on 3/6/25 at 8:46 a.m., the ADON, who was providing medications to Resident #4 noticed the nasal cannula was not being worn by the resident and stated, we have to put the oxygen on you, it's gonna go in your nose, it's your oxygen. The ADON was observed taking the nasal cannula that was inside the top drawer of the resident's nightstand and placed it on the resident's nares. During an interview on 3/6/25 at 9:15 a.m., the ADON acknowledged Resident #4's nasal canula attached to the oxygen concentrator was seen on the top open drawer of Resident #4's nightstand and not stored in a bag. The ADON acknowledged the tubing on the nasal canula was dated 3/3/25. The ADON stated, the oxygen concentrator tubing should have been replaced after it was found on the nightstand and not stored in a bag. The ADON stated the oxygen tubing with the tubing and nasal canula were supposed to be changed weekly and as needed. The ADON stated she made rounds and part of that task was to ensure the oxygen concentrators and tubing were connected and operating according to the prescribed physician's orders and ensure the tubing is off the floor and when not in use, stored in a bag. The ADON stated she needed to change the oxygen tubing with the canula and replace it with a new one. During an interview on 3/6/25 at 10:59 a.m., the DON stated, it was her expectation, the tubing to the nasal canula used on the oxygen concentrator was supposed to be stored in a bag when not in use. The DON further stated, the tubing to the nasal canula was to remain clean and if it was not stored properly could result in the resident getting an infection, or particles of dirt could get into the lungs and result in a respiratory illness. The DON stated, all staff should be looking for proper storage and use of the tubing to the nasal canula when making rounds, but stated it was ultimately her, the DON's responsibility it was being done. Record review of the facility policy and procedure titled, Oxygen Administration with revision date 3/21/23 revealed in part, .Oxygen therapy includes the administration of oxygen (O2) in liters/minute (l/min) by cannula or face mask to treat hypoxemic conditions caused by pulmonary or cardiac diseases .The administration, monitoring of responses, and safety precautions associated with it are performed by the nurse .Attach the tubing to the regulator and the delivery device to be used .Change the tubing (including any nasal prongs or mask) that is in use on one patient when it malfunctions or becomes visibly contaminated .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 39075 Based on observation, interview and record review, the facility failed to ensure all drugs and biologicals were stored in accordance with currently accepted professional principles for 1 of 2 resident units/halls (The Long Hall), and 1 of 3 medication carts reviewed for storage of drugs and biologicals. 1. The facility failed to ensure Resident #22 did not have a jar of mentholated ointment (a topical analgesic and decongestant) at the bedside. 2. The facility failed to ensure the medication cart on The Long Hall was locked and secured. These deficient practices could place residents at risk of medication misuse or drug diversion. The findings included: 1. Record review of Resident #22's face sheet dated 3/6/25 revealed a [AGE] year old female admitted to the facility on [DATE] with diagnoses that included dementia, anxiety disorder (a mental health condition characterized by excessive fear, worry, or nervousness that is persistent and interferes with daily life), acute upper respiratory infection (sudden infection affecting the respiratory system, including the nose, throat, airways, and lungs), chronic pain, and allergic rhinitis (an allergic reaction that causes inflammation of the nasal passages and symptoms like sneezing, runny or stuffy nose). Record review of Resident #22's most recent quarterly MDS assessment dated [DATE] revealed the resident was moderately cognitively impaired for daily decision-making skills. Record review of Resident #22's Order Summary Report dated 3/6/25 revealed the following: - Fluticasone Propionate Nasal Suspension 50 MCG/ACT, 2 spray in both nostrils one time a day related to ALLERGIC RHINITIS, with order date 6/7/23 and no end date - Loratadine Tablet 10 MG, Give 10 mg by mouth one time a day related to ALLERGIC RHINITIS, with order date 11/20/23 and no end date - Ocean Nasal Spray Nasal Solution (Saline), 1 spray in both nostrils one time a day for flush with ocean spray prior to Flonase related to ALLERGIC RHINITIS, with order date 11/20/23 and no end date Record review of Resident #22's comprehensive care plan with revision date 1/22/25 revealed the resident had COPD (Chronic Obstructive Pulmonary Disease; a chronic inflammatory lung disease that causes obstruction of airflow to the lungs with symptoms that include shortness of breath, chronic cough, wheezing and excess mucus production). Further review of Resident #22's comprehensive care plan revealed interventions that included to give medications as ordered by the physician. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 3/4/25 at 10:46 a.m., during initial tour revealed Resident #22, who was not in the bedroom, was observed with a small jar of mentholated ointment in plain view on the resident's nightstand to the left of the bed. During an observation and interview on 3/4/25 at 11:46 a.m., Resident #22 stated she received all her medications from the nurses and was not allowed to administer any medications to herself. The mentholated jar of ointment continued in plain site on Resident #22's nightstand to the left of the bed. Resident #22 could not or would not elaborate on why the mentholated jar of ointment was on the nightstand. Observation on 3/6/25 at 11:27 a.m., revealed Resident #22, who was not in the bedroom, was observed with the same small jar of mentholated ointment in plain view on the resident's nightstand to the left of the bed. During an interview on 3/6/25 at 11:31 a.m., the DON stated there were no residents residing in the facility who were able to self-medicate. The DON further stated, residents were not supposed to have medications at the bedside because they could be taken inappropriately, or used in excess by the residents or other residents could gain access to the medication. The DON stated the facility had residents who wandered. The DON stated it was the responsibility of the nursing staff, the CNA's and anybody making rounds to ensure medications were not left at the bedside. 2. Observation and interview on 3/6/25 at 4:21 p.m. during the medication pass, revealed LVN B notified the State Surveyor she was ready to be observed administering an insulin injection. LVN B was followed from The Short Hall where the State Surveyor was sitting in a room, to the other side of the building to The Long Hall where LVN B's medication cart was parked. As the State Surveyor and LVN B came to the medication cart, the cart could be seen unlocked. LVN B acknowledged the medication cart was unlocked and unattended and stated, any resident might be able to open it and access things; anybody, not just a resident. During an interview on 3/6/25 at 4:36 p.m., the DON stated, she expected the medication carts to remain locked and secured because it was a risk for a wandering resident to take a medication inappropriately. Record review of the facility policy and procedure titled, Storage of Medication, dated 2003 revealed in part, . Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications .Medication rooms, carts, and medication supplies are locked and attended by person with authorized access .

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 41095 Based on observations, interviews, and record review, the facility failed to provide food and drink that was palatable, attractive, and at a safe and appetizing temperature for one of one kitchen. The facility failed to provide palatable food on the sampled foods on test tray: Green beans were cold Turkey was lukewarm Tater tots were overcooked, hard and had no soft potato inside This failure could place residents at risk of not being satisfied with their food or encouraged to increase their personal food intake with an outcome of weight loss and a diminished quality of life. The findings included: During the initial tour on 03/04/25 between 9:15 am and 11:30 am, Residents #11 and #24 complained about the food saying it was usually cold and lacked flavor. Resident #24 complained that the food was not restaurant quality. Confidential interviews during the Resident Meeting confirmed that the food was frequently cold and lacked taste. Several residents at this meeting noted that the meals were frequently late and often the trays sat on the hall in the carts for over 15 minutes before being handed out. The trays that go to the dining room were also delivered on a cart. One resident noted that the carts were the open type, so no insulation was provided for the plates other than the dome covers. During an observation of meal service on 03/06/25, the cook had to reheat several items of food to bring them up to the required temperature on the steam table. The last cart went out at 12:33 pm which was over an hour later than the scheduled meal service time. The cart was observed on the hall. The Administrator was observed checking each plate to ensure the correct diet was present, so the cover of the plate was removed and then placed back on the plate allowing heat to escape. A test tray had been requested for the lunch meal on 03/06/25 and had been placed on the observed cart and was delivered to the state survey room after the other trays had been delivered to the residents which was finished at 12:58 pm. The Dietary Supervisor and the Administrator were present when the food was tasted. The green beans were noted to be cold, and the turkey was lukewarm. The tater tots were noted by one state surveyor to be totally dried out and crumbled when touched with no soft potato inside. The Dietary Supervisor and the Administrator discussed ways they could improve the temperature of the food and stated they will work on this. The Administrator and Dietary Supervisor acknowledged residents could experience weight loss and a diminished quality of life if food was served cold and not palatable thereby making mealtime a less enjoyable experience. (continued on next page)

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Cedar Creek Nursing and Rehabilitation Center	159 Montague Ave Bandera, TX 78003

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The policy titled Daily Food Temperature Control dated 2012 documented We will assure that food is served at a safe temperature. Temperatures of all hot and cold food shall be taken prior to every meal service and recorded on the Temperature Log. This is done to help ensure that food is safe and is served within acceptable rages.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41095 Based on interview and observation, the facility failed to ensure that residents had suitable, nourishing meals and snacks outside of scheduled meal service times. The facility failed to ensure residents were offered snacks at bedtimes. This failure could affect all residents who received meals served from the facility's only kitchen by placing residents at risk for, unplanned weight loss, and side effects from medication given without food, and diminished quality of life. Confidential interviews during the Resident Meeting on [DATE] revealed the facility did not offer snacks at bedtime unless the resident specifically asks for a certain snack. 3 of the 7 residents who attended the meeting and who were diabetic stated they did not receive any snacks with their names on them any time during the day to indicate they needed a snack due to diabetes. During an interview with the Dietary Supervisor (DS) on [DATE] at 12:59 pm, the DS stated they do provide snacks which are kept in the resident refrigerator located in the employee breakroom. The DS showed this refrigerator to the surveyor. Observation of the contents of the refrigerator revealed 1 sandwich with no date, 2 cups of milk dated [DATE], undated containers of what appeared to be mustard and ketchup, and a carton of sour cream with a Best By date of 10 [DATE]. There were also 6 bottles of salad dressing, a half jar of pickles and a plastic bottle of mustard with a resident's name on them along with several other items containing residents' names. The DS threw the undated sandwich and cups of milk away and stated he would have to check to see how long the sour cream should be kept past its Best By date. The refrigerator freezer at the top of the refrigerator had no door on the freezer and was noted to have a couple of inches of ice coating the bottom and sides of the freezer. The shelves of the refrigerator had white circles on them from previously stored foods. When asked who was responsible for cleaning the refrigerator and throwing out expired food, the DS stated he wasn't sure but assumed that since nursing passed out the food, they would be responsible. The DS stated he thought the Maintenance Director would be responsible for defrosting the freezer. An interview with the Maintenance Director on [DATE] at 1:11 pm revealed he thought that nursing was responsible for maintaining the refrigerator. During an interview with the Administrator on [DATE] at 1:12 pm, he stated that Housekeeping should be responsible for maintaining the refrigerator. The ADM stated they had new Housekeeping Supervisor as of [DATE] and would ensure he knew about the refrigerator. The ADM was also informed about the Resident Meeting concerns that snacks were not offered at night. The ADM stated that nursing was responsible for offering snacks but he was not aware of any snacks specifically labeled for diabetic residents or any type of list so staff would know who wanted and/or received a snack. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 5:30 pm, the DON stated that the nurses and CNAs pass the snacks. She stated that some would have names on them if they had been ordered by the physician. A couple of unidentified staff were present during this interview and stated they knew the residents so well, they really didn't need a list since some residents get the same snack every evening such as R #11 and R #28. On [DATE] at 8:12 am, an observation and interview with ADM revealed snacks in the resident refrigerator. There were several sandwiches and cups of yogurt with blueberries viewed in the refrigerator. The ADM stated the snacks are distributed per request but he would go ahead and offer diabetic residents the snacks but could not speak for what the nursing/CNA staff did. During an interview and observation with the DS on [DATE] at 8:16 am, the DS stated Yesterday I asked the new ADON to give me a list of all the diabetics that we have in the building and I do have two residents with weight loss. I have the list in the kitchen. Last night I had the staff make whole sandwiches for all the people on the list, saltine crackers, graham crackers and any extra desserts left from dinner. The residents who are being monitored for weight loss are Resident #3 and Resident #21. The list was provided to the surveyor and then the resident refrigerator was observed. Observation of this refrigerator revealed 12 sandwiches, 6 cups of desserts, and 3 cups of milk. Resident #11 was served her bowl of cereal and Resident #28 was served his peanut butter and jelly (PB and J) sandwich. The DS stated, The diets are liberalized so they all get the same snack except for Resident #11 who always asks for cereal and Resident #28 who always requests a PB and J sandwich. The DS stated that staff should be offering the snacks. The DS also stated that one of his dietary aides works as a C.N.A. on the ,d+[DATE] shift and she has said that most people on the list are already asleep early when snacks are being offered. The DS said he thought the best protocol would be to offer the snack and not just wait for the resident to ask. He also stated that once the snacks are delivered, dietary staff does not go back to see if the snacks were given out or check the refrigerator. The DS stated that Housekeeping was in charge of cleaning out the refrigerator. During an interview with DS on [DATE] at 9:20 am, the DS stated that he was aware the refrigerator was still full of sandwiches this morning. The DS stated they are going to make a check-off list to determine who is actually accepting the snacks. A policy on Cleaning the Refrigerator dated 2012 was provided that stated Refrigerators are maintained in a clean, sanitary condition free of offensive odors. Cleaning of the reach in refrigerator will be done on a daily or as needed basis. Procedure: Interior 1. Remove all leftover food from the shelves. Check with the Dietary Service Manager and sort out and throw away all that is not usable. Store food that will be saved in another refrigeration unit until refrigerator is cleaned and ready to be re-loaded. A policy for snacks was not provided.

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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. 41095 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. 1. The facility dietary staff failed to wash their hands between tasks and before handling food. 2. The cook used his bare hands, which had not been washed prior to meal service, take rolls from the cooking sheet pan and put them on the plates as he served lunch. These failures could place residents at risk for food borne illness. The findings included: 1. The lunch meal service was observed on 03/06/25 beginning at 11:15 am. The cook was observed taking the food temperatures using a different thermometer for each item of food. Some of the items were below the required temperature so he had to place them back in the oven. While he was waiting for items to reheat, he was observed writing some notes on some of the tickets, flipping through pages of information from a folder, gathering serving utensils and washing the thermometers with water to be used to test the temperatures again. At no time during this process, was he observed washing his hands. The evening cook (EC) who was serving as a dietary aide for lunch, was observed preparing dessert items to go on the trays and was covering bowls with plastic wrap. She moved about doing several tasks involving food preparation of the food trays without washing her hands. 2. During an observation on 03/06/25 at 12: 25 pm, the cook was observed taking a roll off the cooking sheet pan and placing it on the plate with his bare hands. An interview with the DS on 03/06/25 at 12:25 pm revealed the facility had a no-glove policy on the steam table. The DS stated the cook should have used tongs to pick up each roll rather than his bare hands. Record review of undated Dietary Department Glove Standard Protocol documented: 1. Per the Texas Food Establishment Rules, there will be no bare hand-to-food contact in the kitchen. Use of tongs, spoons, spatulas, or deli tissue paper will be used whenever possible to avoid touching a ready-to-eat food item with a bare hand. If a glove much be used, such as for sandwich assembly, hands will be washed prior to putting on the glove and immediately after removing it. 4. Gloves will not be worn on tray line. Instead, as much pre-assembly and/or prep work will be completed before meal service to minimize the potential for cross-contamination during service. Record review of the Hand Washing policy dated 2012 documented: We will ensure proper hand washing procedures are utilized. Employees are to frequently perform hand washing as outlined below. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procedure: 1. Hand Washing occurs in sinks provided for that purpose; sink areas provide hot/cold running water, soap in dispensers, and paper towels, and should have a sign posted conspicuously near or above wash basin

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41095 Based on observation , interview and record review, the facility failed to maintain medical records on each resident that were complete and accurately documented for 1 of 1 (Residents #3) residents reviewed for medical records. The facility failed to ensure Resident #3's Letters of Guardianship were maintained current. This deficient practice could place residents at risk of improper care due to inaccurate medical records and lack of authority to provide consent for services. The findings were: Record review of Resident #3's Admission Record dated 03/07/25 documented an [AGE] year-old male most recently admitted to facility on 10/31/23 with an original admitted [DATE]. Resident #3's diagnoses included unspecified dementia (a decline in cognitive function that does not meet the diagnostic criteria for a specific type of dementia), unspecified psychosis not due to a substance or known physiological condition (a mental state characterized by a loss of touch with reality and may involve hallucinations, delusions, disordered thinking and behavioral changes), major depressive disorder (a mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest), anxiety disorder (mental health condition characterized by excessive and persistent worry, fear, and anxiety that significantly interfere with daily life), dysphagia, oropharyngeal phase (a condition characterized by difficulty swallowing during the oropharyngeal phase, which is the second stage of swallowing), and atherosclerotic heart disease of native coronary artery without angina pectoris (a heart disease where the coronary arteries become narrowed or blocked due to plaque buildup - angina pectoris is chest pain that occurs when the heart muscle does not receive enough oxygen-rich blood). The Admission Record also noted that the only emergency contact and responsible party for Resident #3 was a guardian. Record review of Resident #3's Quarterly MDS assessment dated [DATE] documented a BIMS score of 5 which indicates severe cognitive impairment. Record review of Resident #3's Care Plan with most recent revisions dated 02/25/25 documented he requires total assistance with ADLs, is a 2 person transfer, and is receiving a supplement to address weight loss. The care plan also addresses the need for one to one activities as well as encouragement to attend social activities, however, the Focus statement indicates he does not interact well in a group setting and angers easily. Observations of Resident #3 throughout the course of this survey from 03/04/2025 though 03/07/2025 revealed resident ambulating via wheelchair and frequently yelling for no apparent reason. Resident #3 was not interviewable due to cognitive issues. Record review of Guardianship paperwork revealed the last updated guardianship indicated an expiration date of 01/11/25 unless renewed. No renewal was located in the medical record. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Administrator on 03/07/25 at 10:00 am, the importance of keeping the guardianship paperwork up to date was discussed. Since only the guardian could give consent for treatment, without a valid guardianship the validity of the consent could be questioned. The Administrator stated he depended on the social services worker to keep this paperwork up to date. During a phone interview with the part time social services worker on 03/07/25 at 10:10 am, SW indicated that it was her responsibility to ensure that guardianship paperwork was maintained current. SW stated she knew that it had been renewed last December and will contact the guardian to send the new document to the facility.

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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** 39075 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of infections for 3 of 12 residents (Residents #27, #4 and #24) reviewed for infection control. 1. The facility failed to ensure proper hand hygiene was performed and the blood pressure cuff and pulse oximeter were sanitized between resident use. 2. The facility failed to ensure proper hand hygiene was performed, going from a clean area to a dirty area, and the scissors used to provide wound care were sanitized prior to use. These deficient practices could place residents who received medications and wound care at-risk for infections. The findings included: 1. a. Record review of Resident #27's face sheet dated 3/7/25 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included diabetes with hyperglycemia (condition in which blood sugar levels are consistently higher than normal due to the body's inability to properly produce or use insulin), hyperlipidemia (condition characterized by abnormally high levels of fats in the blood), hypertension (high blood pressure), and other specified symptoms and signs involving the circulatory and respiratory systems. b. Record review of Resident #4's face sheet dated 3/5/25 revealed a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dementia, hypertension (high blood pressure), heart failure, and shortness of breath. Observation on 3/6/25 at 8:06 a.m., revealed the ADON was seen entering a resident's room in The Long Hall to administer medications and took the digital wrist b/p (blood pressure) cuff with her. The ADON was then observed exiting the room and placed the digital wrist b/p cuff on the medication cart counter. The ADON did not practice proper hygiene and did not sanitize the digital wrist b/p cuff after use. The ADON then prepared medications for Resident #27 and obtained the resident's blood pressure with the same digital wrist b/p cuff without sanitizing it and obtained the resident's oxygen and pulse reading with a digital pulse oximeter. The ADON then returned to the medication cart and placed the digital wrist b/p cuff, and the pulse oximeter on the medication cart counter without sanitizing it and did not perform proper hand hygiene after administering medications to Resident #27. The ADON then prepared medications for Resident #4 and obtained the resident's blood pressure with the same digital wrist b/p cuff and the resident's oxygen and pulse reading with the same pulse oximeter without sanitizing it prior to use. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/6/25 at 9:15 a.m., the ADON stated she had forgotten to sanitize the digital wrist b/p cuff and the pulse oximeter but realized it was important because it was part of infection control. The ADON stated, a break in infection control to result in residents possibly getting an infection and transmission was always a possibility. The ADON further stated she had also forgotten to wash or sanitize her hands and it was also considered a break in infection control. 2. Record review of Resident #24's face sheet dated 3/5/25 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included pressure ulcer of sacral region stage 4 (wound with full thickness skin and tissue loss located over the lower back near the tailbone), pressure ulcer of left buttock stage 2 (wound partial thickness skin loss), and cervical spina bifida with hydrocephalus (a neural tube defect where the spine does not close properly in the cervical (neck) region during fetal development; hydrocephalus refers to abnormal buildup of cerebrospinal fluid in the brain leading to increased pressure.) Observation on 3/5/25 at 10:38 a.m. revealed LVN A did not perform proper hand hygiene prior to entering Resident #24's room. LVN A was observed placing the treatment cart in Resident #24's room, searched in her pocket for the keys to the medication cart, opened the cart and placed wax paper on top of the medication cart counter. LVN A then, without performing proper hand hygiene and with ungloved hands, took several gloves from a box, the supplies needed for wound care including dry gauze, two tongue depressors, an adhesive bandage and a tube of ointment and placed them on top of the wax paper. LVN A then took a pair of scissors out of her pant pocket and placed it on top of the wax paper without sanitizing it. Resident #24 was observed standing from the wheelchair and used the walker for assistance. LVN A then put on gloves, did not perform proper hand hygiene, pulled Resident #24's wheelchair back with her gloved hands and unfastened the resident's brief to expose his buttock area. LVN A then removed her gloves, did not perform proper hand hygiene and put on a new pair of gloves. LVN A then began wound care and during the care removed and put on new gloves at least 6 times without performing proper hand hygiene. LVN A took the scissors and cut a medicated gauze and placed on the resident's wound. LVN A then was observed removing her gloves, did not perform proper hand hygiene and placed the adhesive bandage over the wound with her ungloved hand. LVN A then put on a new pair of gloves, did not perform proper hand hygiene and disposed of the resident's brief in the trash can. LVN A then moved to the resident's dresser, wearing the same soiled gloves and removed a clean brief from the dresser. LVN A, observed wearing the same soiled gloves, placed the clean brief over the resident, pushed the resident's wheelchair closer to the resident and pulled the walker away from the resident so the resident could sit back down on the wheelchair. LVN A then removed her gloves and gown and placed them in the trash can. LVN A then took the supplies used during care and placed them in the trash can. LVN A then moved the resident's bedside table to the right of the resident's bed and exited the resident's room without performing proper hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/5/25 at 11:01 a.m., LVN A stated she had worked for the facility back in 2020 but then returned in September 2024. LVN A stated she usually washed her hands before care but didn't do it. LVN A stated she had learned to change her gloves as I went, but not trained about washing or sanitizing her hands between glove changes. LVN A stated she had received competency training on infection control last month from the former DON. LVN A stated she had sanitized the scissors used during wound care prior to the State Surveyor observation, but acknowledged placing the scissors back in her pocket after sanitizing it probably would not have kept the scissors clean. LVN A acknowledged she had gone from a dirty area to a clean area wearing the same soiled gloves and should have at the least changed her gloves. LVN A stated, the reason she removed her gloves when applying the adhesive bandage to Resident #24's wound was because the adhesive sticks to the glove and that was the reason I didn't use gloves. LVN A stated, Resident #24 was on enhanced barrier precautions and I know I should have used gloves, but since I only touched the outside of the bandage it was not contaminated. LVN A acknowledged, a break in infection control could result in the resident developing an infection due to cross contamination. During an interview on 3/6/25 at 10:38 a.m., the DON stated it was her expectation for the nursing staff to perform proper hand hygiene between glove changes. The DON further stated, unless the gloves were visibly soiled, then proper hand hygiene would include washing the hands with soap and water. The DON stated, when in doubt sanitize. The DON stated improper hand hygiene could result in an infection, the spread of bacteria, cross contamination, and spread of infection passed on to the next resident. The DON stated, LVN A should not have removed her gloves to apply the adhesive bandage to Resident #24's wound because the bandage has a border specifically made so that it would not stick to the gloves. A competency training was requested on hand hygiene, and infection control for the ADON and LVN A but was not provided at the time of exit on 3/7/25 at 3:00 p.m. Record review of the facility policy and procedure titled, Hand Hygiene, undated revealed in part, .Hand hygiene continues to be the primary means of preventing the transmission of infection. When to perform hand hygiene .Upon and after coming in contact with a resident's intact skin (when taking a pulse or blood pressure) . Record review of the facility policy and procedure titled, Infection Control Plan: Overview, updated 3/2023 revealed in part, .The facility will establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection .The intent of this policy is to assure that the facility develops, implements, and maintains an Infection Prevention and Control Program in order to prevent, recognize, and control, to the extend possible, the onset and spread of infection within the facility .A variety of infection control measures are used for decreasing the risk of transmission of microorganisms in the facility. These measures make up the fundamentals of infection control precautions .Gloving .gloves must be changed between resident contacts, and hands washed after gloves are removed .Wearing gloves does not replace the need for hand washing because gloves may have small inapparent defects or be torn during use, and hands can become contaminated during removal of gloves .Hand Hygiene .When hands are visibly soiled .Before and after direct resident contact .Before and after changing a dressing .After handling soiled equipment .After removing gloves .After completing duty .Resident care equipment and articles. Non-invasive resident care equipment is cleaned daily or as need(ed) between use . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	41095

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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 41095 Based on observations, interviews, and record reviews, the facility failed to maintain effective pest control for 1 of 1 kitchen reviewed for pests. The facility failed to have pest control effectively treat the kitchen for roaches. This deficient practice could place residents at risk of exposure to pests, diseases, infections, and diminished quality of life. The findings include: An observation and interview on 03/06/25 at 12:12 pm, revealed a live roach crawling on the wall near the oven which was next to the steam table. This observation was pointed out to the Dietary Supervisor who immediately caught the roach with a paper towel and removed it from the kitchen. The DS then went to tell the ADM to call the pest control company. The DS stated pest control had come out recently to treat for roaches and other insects. Record review of Pest Control log revealed that the pest control company had come out on 02/12/25 to treat for roaches and other pests and rodents. The Comments section of the report noted: Heavy German Cockroach activity found in kitchen. Highly recommend after hours targeted service of kitchen equipment. There was no documentation that this service was provided. Record review of the policy for Insect and Rodent Control dated 2012 documented: The facility will maintain an effective pest control program in order to provide an insect and vermin free food service department. Procedure: 1. Arrangements are made with a reputable company for regular spraying for insects which includes rodent control when required. 2. Facility will maintain appropriate screens, close fitting doors, properly sealed water/sewer pipes, structurally maintained walls, baseboards, etc. to prevent entrance access of insects and rodents. 3. Sanitation of facility will be maintained per other stated sanitation policies to prevent food sources, breeding places, etc. for insects or rodents.