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	05/08/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure drugs used in the facility were labeled in accordance with currently accepted professional principles and the expiration date for 1 of 2 medication carts (short hall medication cart) reviewed for medication storage.The facility failed to ensure 3 insulin pens and 2 insulin vials were labeled with the expiration date and discarded within 28 days of opening.This failure could result in residents receiving expired insulin and lead to unstable or elevated blood sugar levels. Findings included: In an observation and interview on [DATE] at 10:47 AM with the ADON, the short hall medication cart was observed to contain the following:Novolog insulin (a medication used to manage blood sugar levels) pen dated [DATE]Open Lantus insulin vial, undatedUnopened Novolin insulin vial in the manufacturers box, undatedLantus insulin pen, undatedNovolog insulin pen, undatedThe ADON said all insulin containers should be dated for 28 days when they are removed from the refrigerator and opened, and she was unsure when the 5 insulin containers were removed from the refrigerator. She said it is the nurse's responsibility to maintain the contents of the carts, and the nurse who was responsible for the cart that day had left work early. She was unsure if the labeled date of [DATE] on the Novolog pen was the expiration date or the date the pen was opened. She said the potential harm to residents of not labeling insulin vials was receiving expired and/or ineffective insulin. In an interview with the DON on [DATE] at 2:50 PM, she said all insulin containers should be labeled with the date of expiration by the nurse as soon as they are removed from the refrigerator. She was unsure why the cart contained inaccurately labeled insulin pens/vials. She said the potential harm to residents was receiving ineffective insulin. Record review of the facility policy titled Insulin Pen Use dated 2003/ revised [DATE], reflected the following:Once you take the insulin pen out of cool storage you can use it for up to 28 days. Ensure that the pen is dated when placed into use . Do not use it after this time. Do not use the insulin after the expiration date printed on the label of the pen or on the carton .

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

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

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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident's right to formulate an advance directive for 1 (Resident #40) of 5 residents reviewed for resident rights.The facility failed to ensure a valid MPOA with Resident #40's signature acknowledged before a notary public was on file with Nursing Facility A prior to designating Family Member B as the Responsible Party.The facility failed to establish if Resident #40 wished to designate Family Member B as the Responsible Party at the time of her admission on [DATE] and thereafter when she was alert and oriented and able to make her wishes known.These failures could place residents at risk for a diminished quality of life, loss of dignity and loss of self-worth.Findings included: Record review of Resident #40's admission Record, dated 05/07/2026, revealed a [AGE] year-old female admitted [DATE] and discharged home on [DATE]. Resident #40 was not listed as her own Responsible Party with her [Family Member B] listed as Responsible Party, POA-Medical, and Emergency Contact #1.Record review of Resident #40's Medical Diagnoses, undated and accessed 05/06/2026 at 12:28 p.m., revealed diagnoses including traumatic subdural hemorrhage (a collection of blood that forms between the brain and its outer covering, often due to head trauma) with loss of consciousness of 1 hour to 5 hours 59 minutes and Alzheimer's disease with late onset (characterized by progressive memory loss, cognitive decline, and changes in behavior). Record review of Resident #40's quarterly MDS assessment, dated 11/27/2025 and signed 12/01/2025 as completed, reflected a BIMS score of 06 indicating severe cognitive impairment. Resident #40 was documented as not exhibited any behavioral symptoms, including wandering. Resident #40's functional abilities were documented requiring partial/moderate assistance to set up or clean-up assistance. Resident #40 was documented with active diagnoses including Non-Alzheimer's Dementia and Traumatic Brain Injury (TBI) and was documented as taking antipsychotic medication. Resident #40 was coded as unknown or uncertain of the possibility of leaving this facility and returning to live and receive services in the community with information source documented as Family.Record review of Resident #40's care plan, undated, revealed Resident #40 was resistive to care r/t [related to] wanting to go Home with (Family Member D) and Goal documented that Resident #40 will cooperate with care through next review date with interventions of Allow resident [Resident #40] to make decisions about treatment regime, to provide sense of control. The care plan focus was created and initiated on 11/10/2025 and revised on 12/26/2025. The care plan did not reveal discharge plans for Resident #40 once she stabilized and was able to make her needs and wants known. Record review of Resident #40's progress note, Administrator Note, dated 01/30/2026, revealed [Family Member D] came from out of state to visit resident. Family Member D contacted the Administrator stating that resident [Resident #40] wanted to discharge home with her and explained residents home was in North Carolina. [Family Member D] discussed with Admin [Administrator] that she had the flexibility and means to care for resident [Resident #40] and provide her 24/7 care at residents [Resident #40] home. Resident's [Resident #40] [Family Member B] MPOA, did not agree with resident [Resident #40] discharging home with [Family Member D] however, resident [Resident #40] insisted that she wanted to go home to her house and have her Family Member D help with her care. Admin [Administrator] encouraged [Family Member B] to have a conversation with [Family Member D]and he stated, We do not speak and I do not have anything to say to her. [Family Member D] called [Local Law Enforcement] and they arrived to [Nursing Facility A] and explained this was a civil matter and the MPOA documents clearly state [Family Member B] can make decisions for resident [Resident #40] only if she is deemed incompetent by a physician. [Local Law Enforcement] asked resident [Resident #40] what her wishes were and she stated, I want to go home to North Carolina with my [Family Member D]to my home. Due to no guardianship and resident rights, the physician was notified and resident was Dc'ed [discharged] home with (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[Family Member D] at her request.Record review of Resident #40's admission Agreement. dated 11/06/2025, revealed that Family Member B was documented as the Responsible Party for this agreement and enters into this admission and Financial Agreement with [Nursing Facility A] to provide care for [Resident #40] under the terms and conditions set forth below. If Resident Is Not Own Responsible Party, Resident Authorizes the below to be their agent. Responsible Party Name: [Family Member B]. Responsible Party here in is: (x all that apply).Durable Power of Attorney/Attorney in fact for Resident [Resident #40]was selected for Authority Resident authorizes Responsible Party to make: Financial Decisions. Medical decisions ([Nursing Facility A] has been provided with a durable power of attorney, advance directive or other appropriate instrument). Admission, care, and discharge decisions. Other decisions related to Resident's [Resident #40] personal property and well-being. Primary contact person for this Resident [Resident #40] and signed by only Family Member B and Business Office Manager.Record review of Resident #40's progress notes dated 01/05/2026 - 01/30/2025, revealed Resident #40's Cognitive skills for daily decision making: Organized daily routine and made safe decisions in familiar situations, but experienced some difficulty in decision making when faced with new tasks or situations. Makes self-understood: Difficulty communicating some words or finishing thoughts but is able if prompted or given time. Record review of Resident #40's Psychiatry Initial Evaluation, dated 11/12/2025, revealed Patient [Resident #40] seen for Comprehensive psychiatric evaluation for dementia, insomnia, and Resident #40's mental status exam documented Orientation: Oriented To Person, Oriented To Place, Oriented to Situation. Comprehension/Language: WNL (within normal limits) - Expressive/Receptive Language. Thought Content: Coherent. [and] Thought Process: Linear/Goal-Directed/Logical.Record review of Resident #40's clinical Rehabilitation Notes dated 11/01/2025, revealed Resident #40's Orientation: A&O x4 (indicates a fully intact cognitive function).Record review of Resident #40's Medical Power of Attorney Designation of Health Care Agent (MPOA), dated 08/25/2025, revealed Disclosure Statement. Before Signing This Document, You Should Know These Important Facts: Except to the extent you state otherwise, this document gives the person you name as your agent the authority to make any and all health care decisions for you in accordance with your wishes.when you are unable to make the decisions for yourself. Your agent's authority is effective when your doctor certifies that you lack the competence to make health care decisions for yourself. Once you have signed this document, you have the right to make health care decisions for yourself as long as you are able to make those decisions. This Power of Attorney Is Not Valid Unless: (1) You sign It And Have Your Signature Acknowledged Before A Notary Public; Or (2) You Sign It In The Presence Of Two Competent Adult Witnesses. Signature Acknowledged Before Notary was that of Family Member B and not of Resident #40. Record review of Resident #40's EMR Misc tab on 05/08/2026 did not reveal a valid MPOA document signed by Resident #40 with signature acknowledged before a notary public giving Family Member B the authority to make any and all health care decisions for her.Record review of Resident #40's EMR Physician progress notes tab on 05/08/2026 did not reveal physician certification that Resident #40 lacked the competence to make health care decisions for herself.Record review of Resident #40's EMR Documentation tab on 05/08/2026 did not reveal documentation signed by Resident #40 authorizing Family Member B as their legal guardian or an agent under a medical power of attorney. Record review of Resident #40's EMR social service notes on 05/08/2026 did not reveal there was action taken by the facility's Social Worker [Social Services] to assist with honoring Resident #40's discharge wishes.Record review of Resident #40's EMR progress notes on 05/08/2026 did not reveal there was action to assist with honoring Resident #40's discharge wishes taken by the charge nurses, ADON, DON, or Administrator after they learned of Resident #40's wishes to discharge home to the care of Family Member D.During a telephone interview on 05/05/2026 at 1:00 p.m., the Complainant revealed Resident #40 was back home residing with Family Member D and was doing well since her discharge from Nursing Facility A. She noted that Resident #40 was receiving care at the facility; however, the concern was that Family Member B did (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not have a valid MPOA and Resident #40 did not authorize or designate a Responsible Party to make decisions on her behalf. She noted that Resident #40 was able to express her needs and wants and she was vocal about discharging and returning home with Family Member D.Resident #40 was unavailable for observation or interview as she was discharged home on [DATE].During an interview on 05/08/2026 at 9:29 a.m., CNA E revealed Resident #40's mood was depressed, she would refuse care and medications, and she did not like being at Nursing Facility A and was vocal about wanting to be back home with Family Member D. She stated CNAs reported to the charge Nurse each time Resident #40 expressed wanting to discharge home from Nursing Facility A. She noted Resident #40's behaviors would reduce following a telephone call with Family Member D. She noted the nurse charge was responsible for reporting Resident #40's behaviors and wishes to Social Services. She noted that Resident #40 could make her needs and wants known and over time, with therapy, her cognition improved. She noted all staff, including management, were aware of Resident #40's wishes of returning home with Family Member D.During an interview on 05/08/2026 at 9:39 a.m., Social Services revealed Resident #40 had symptoms of Parkinson's, an unsteady gait, and was confused when she admitted to Nursing Facility A. She noted Resident #40 was admitted into Nursing Facility A following a hospital discharge and was aggressive and paranoid. She noted there was an awkward situation between Family Member B and Family Member D. She noted she was informed by other staff throughout Resident #40's stay of her expressed wishes to return home with Family Member D. She stated there was no formal guardianship paperwork for Resident #40 and recalls notifying Family Member B that he would need to get legal guardianship paperwork as he did not have proper documentation and recommended that he would need Durable Power of Attorney. She noted Resident #40 was able to express her needs and wants and was able to verbalize her expressed wishes to discharge home with Family Member D. She stated she never spoke with Family Member D about Resident #40's expressed wishes to discharge back to the community as Family Member B was the primary contact for Resident #40. Social Services noted that Resident #40 would attend the care plan meetings; however, she could not recall if Resident #40's expressed wishes for discharge were discussed during this meeting or if this was documented in the discharge plan.During an interview on 05/08/2026 at 10:22 a.m., the Activities Director stated Resident #40 engaged in numerous activities, enjoyed participating, verbalizing her needs and wants and her cognition was intact. She stated Resident #40 seemed sad at times and she would talk about missing Family Member D back home. She stated she would report Resident #40's demeanor and statements to the Director of Nursing and Social Services for follow-up and does not recall if this information was documented in the resident's EMR.During an interview on 05/08/2026 at 10:25 a.m., LVN F revealed that Resident #40 was being provided with skilled services, she had dementia, she was always sweet, displayed no behaviors, and sometimes she did refuse medications. She stated there was a big dispute between Resident #40 and her Family Member B regarding him being her Responsible Party. She stated that she did not know all the facts, but that the MDS Coordinator and the Assistant Director of Nursing discovered the guardianship paperwork for Resident #40 was not valid. She stated that Family Member B would direct Nursing Facility A staff to not allow Resident #40 to have contact with Family Member D. She stated this direction was not followed as this was against Resident #40's rights. She stated that it required law enforcement to be contacted for Resident #40 to be discharged .During an interview on 05/08/2026 at 10:37 a.m., the Assistant Director of Nursing stated she provided the nursing staff with Resident Rights training and the impact of not allowing a resident to exercise their rights could affect their quality of life, their self-esteem, and make them feel bad. She stated she recalled Resident #40 required cuing at times, when she admitted she was very sad, she was irritated about being at Nursing Facility A, Family Member B was restricting contact with other family members. She stated Resident #40 was able to express her wants and needs, her cognition was intact, she could answer questions appropriately, and she would say she wanted to return home with Family Member D. She stated Resident #40 constantly verbalized returning home with Family Member D. She stated that (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Family Member B stated he had MPOA over Resident #40, but after she looked over her electronic medical record, she did not recall documentation to support valid MPOA; however, Resident #40 was not allowed to discharge. She stated that she could not recall when she reviewed Resident #40's electronic medical record and she did not document these findings.During an observation and interview on 05/08/2026 at 10:50 a.m., the MDS Coordinator revealed that the impact of not allowing a resident to exercise their rights could affect their mood, making them depressed and miserable wanting to leave. She stated she recalled Resident #40 admitted with verbal and physical aggression behaviors, she was distraught, she would cry often that she wanted to go home with Family Member D. She stated that Resident #40 could express needs and wants clearly, would tell her directly of returning home with Family Member D. She noted that she was forgetful at times, but she knew what she wanted. The MDS Coordinator stated that Resident #40 was not allowed to return home and from what she gathered, Family Member B who provided Nursing Facility A with MPOA was responsible for her discharge. The MDS Coordinator was observed to review Resident #40's MPOA to identify valid Responsible Party documentation and stated the MPOA was not signed by Resident #40. She stated that after reviewing the MPOA that it would not be considered a valid MPOA and was inaccurate.During an interview on 05/08/2026 at 11:30 a.m., the Director of Nursing revealed that she provided the nursing staff with resident rights training and there could be a negative impact on a resident if they were not allowed to exercise their rights. She noted that legal guardianship paperwork was reviewed by the Business Office Manager for accuracy and to determine if it was valid. She noted that Resident #40 was able to make her needs and wants known, she did not believe her cognition was intact, she did not have physical or verbal aggression, she was not displaying depression. She stated on a few occasions she was overheard at the nurse's station talking to Family Member D by telephone and discussing wanting to live with her. She stated she went on leave for a few weeks following her admission and could not provide additional details of Resident #40.During an observation and interview on 05/08/2026 at 11:48 a.m. the Business Office Manager revealed that she transitioned into this role in February 2026 and she has completed resident rights training and that she was responsible for new admissions and reviewing Durable MPOA provided by family members. She noted she was provided training by her corporate office on determining if Durable MPOA, POA, and legal guardianship documents were valid. She stated that for a valid MPOA or POA the resident would need to sign it and this would allow family to speak on their behalf, make decisions on their behalf, and sign consents. The Business Office Manager noted that by not verifying if legal guardianship paperwork was valid, it could prevent a resident from being able to make decisions about their care and could make them confused. The Business Office Manager was observed to review Resident #40's MPOA to identify valid Responsible Party documentation and stated it was not valid as it was not signed by Resident #40.During an observation and interview on 05/08/2026 at 11:49 a.m. the Administrator revealed that she provided the nursing staff with resident rights training and noted that not allowing a resident to exercise their rights could cause them mental anguish and a failure to thrive. She stated that legal guardianship/MPOA was collected within 24 hours of admission. She noted if residents could sign Nursing Facility A's admission documents, then they would sign themselves. She noted that the Business Office Manager and nursing staff were provided with all kinds of training and resources in identifying valid documentation. She noted that not verifying MPOA/guardianship paperwork was valid could negatively impact residents by not fulfilling a resident's wishes. The Administrator stated that she recalled Resident #40 was admitted with some verbal aggression, but when she was discharged , she was very balanced out. She noted that Resident #40 talked about returning home quite a bit. She stated Resident #40 had a valid MPOA in chart and Responsible Party was making decisions on her behalf. She noted that there was some confusion about the MPOA and law enforcement assisted with Resident #40's discharge. The Administrator was observed to review Resident #40's MPOA to identify valid Responsible Party documentation provided at admission and stated she did not realize Resident #40 never signed it. She (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	denied Resident #40 discussing discharge with her and noted upon admission the nursing staff had to lean on Family Member B as Resident was unable to make her needs and wants known. She stated that once Resident #40 stabilized she was coherent and she was able to make her wishes known. She noted discharge plans were discussed during the care plan meeting but stated the nursing staff did not document this in the EMR.Record review of a facility policy titled, Resident Rights, undated, revealed . A facility must 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. The facility must protect and promote the rights of the resident. 1. The facility must ensure that the resident can exercise his or her rights without interference. 2. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. 3. In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. a. The resident representative has the right to exercise the resident's rights to the extent those rights are delegated to the resident representative. 4. The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law. 5. The facility shall not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law. a. In the case of a resident representative whose decision-making authority is limited by State law or court appointment the resident retains the right to make those decision outside the representative's authority. b. The resident's wishes, and preferences must be considered in the exercise of rights by the representative. Record review of a facility document titled, Nursing Facility Resident's Rights, dated 09/01/2025, revealed, Residents of Texas nursing facilities have all the rights, beneˆts, responsibilities, and privileges granted by the Constitution and laws of this state and the United States. They have the right to be free of interference, coercion, discrimination, and reprisal in exercising these rights as citizens of the United States.Freedom of Choice. Make your own choices regarding personal affairs, care, beneˆts and services. Participation in Your Care. Participate in developing a plan of care, to refuse treatment, and to refuse to participate in experimental research. Transfers and Discharges. Discharge yourself from the facility unless you have been determined mentally incompetent. Record review of a facility document titled, admission Agreement, undated, revealed, OBLIGATIONS OF RESIDENT/RESPONSIBLE PARTY. Responsible Party means a person who:. b) has signed an admission agreement with the facility in which the person agrees to provide payment for the resident's care costs from the Resident's income or resources. c) Resident/Responsible Party shall: Abide by [Nursing Facility A] rules and regulations, as provided to Resident/Responsible Party upon admission. vii) Abide by rules and regulations established by licensing and contracting agencies as to charges, refunds, supplies, equipment, and medicine. ENTIRETY OF THIS AGREEMENT This Agreement, and all attachments, supersedes all other agreements, either oral or in writing, between the parties, and contains all the covenants and agreements between the parties. Resident/Responsible Party acknowledge that they have received and reviewed this agreement and the same shall be binding on Resident, Responsible Party, and Resident's heirs, executors and administrators. This Agreement may be amended only by agreement, reduced to writing and signed by both parties.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the development and implementation of an effective discharge planning process that focuses on the resident's discharge goals for 1 of 5 residents (Resident #40) reviewed for discharge planning.The facility failed to ensure Resident #40's discharge planning goals were reviewed and implemented once her health improved and she was able to make her discharge preferences known.This failure could result in loss of residents' autonomy and rights to determine care.The findings included:Record review of Resident #40's admission Record, dated 05/07/2026, revealed a [AGE] year-old female admitted [DATE] and discharged home on [DATE]. Resident #40 was not listed as her own Responsible Party with her [Family Member B] listed as Responsible Party, POA-Medical, and Emergency Contact #1.Record review of Resident #40's Medical Diagnoses, undated and accessed 05/06/2026 at 12:28 p.m., revealed diagnoses including traumatic subdural hemorrhage (a collection of blood that forms between the brain and its outer covering, often due to head trauma) with loss of consciousness of 1 hour to 5 hours 59 minutes and Alzheimer's disease with late onset (characterized by progressive memory loss, cognitive decline, and changes in behavior). Record review of Resident #40's quarterly MDS assessment, dated 11/27/2025 and signed 12/01/2025 as completed, reflected a BIMS score of 06 indicating severe cognitive impairment. Resident #40 was documented as not exhibited any behavioral symptoms, including wandering. Resident #40's functional abilities were documented requiring partial/moderate assistance to set up or clean-up assistance. Resident #40 was documented with active diagnoses including Non-Alzheimer's Dementia and Traumatic Brain Injury (TBI) and was documented as taking antipsychotic medication. Resident #40 was coded as unknown or uncertain of the possibility of leaving this facility and returning to live and receive services in the community with information source documented as Family.Record review of Resident #40's care plan, undated, revealed Resident #40 was resistive to care r/t [related to] wanting to go Home with (Family Member D) and Goal documented that Resident #40 will cooperate with care through next review date with interventions of Allow resident [Resident #40] to make decisions about treatment regime, to provide sense of control. The care plan focus was created and initiated on 11/10/2025 and revised on 12/26/2025. The care plan did not reveal discharge plans for Resident #40 once she stabilized and was able to make her needs and wants known. Record review of Resident #40's progress note, Administrator Note, dated 01/30/2026, revealed [Family Member D] came from out of state to visit resident. Family Member D contacted the Administrator stating that resident [Resident #40] wanted to discharge home with her and explained residents home was in North Carolina. [Family Member D] discussed with Admin [Administrator] that she had the flexibility and means to care for resident [Resident #40] and provide her 24/7 care at residents [Resident #40] home. Resident's [Resident #40] [Family Member B] MPOA, did not agree with resident [Resident #40] discharging home with [Family Member D] however, resident [Resident #40] insisted that she wanted to go home to her house and have her Family Member D help with her care. Admin [Administrator] encouraged [Family Member B] to have a conversation with [Family Member D] and he stated, We do not speak and I do not have anything to say to her. [Family Member D] called [Local Law Enforcement] and they arrived to [Nursing Facility A] and explained this was a civil matter and the MPOA documents clearly state [Family Member B] can make decisions for resident [Resident #40] only if she is deemed incompetent by a physician. [Local Law Enforcement] asked resident [Resident #40] what her wishes were and she stated, I want to go home to North Carolina with my [Family Member D] to my home. Due to no guardianship and resident rights, the physician was notified and resident was Dc'ed [discharged] home with [Family Member D] at her request.Record review of Resident #40's admission Agreement. dated 11/06/2025, revealed that Family Member B was documented as the Responsible Party for this (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	agreement and enters into this Admission.Agreement with [Nursing Facility A] to provide care for [Resident #40] under the terms and conditions set forth below. If Resident Is Not Own Responsible Party, Resident Authorizes the below to be their agent. Responsible Party Name: [Family Member B]. Responsible Party here in is: (x all that apply).Durable Power of Attorney/Attorney in fact for Resident [Resident #40]was selected for Authority Resident authorizes Responsible Party to make: Financial Decisions. Medical decisions [Nursing Facility A] has been provided with a durable power of attorney, advance directive or other appropriate instrument). Admission, care, and discharge decisions. Other decisions related to Resident's [Resident #40] personal property and well-being. Primary contact person for this Resident [Resident #40] and signed by only Family Member B and Business Office Manager.Record review of Resident #40's progress notes dated 01/05/2026 - 01/30/2025, revealed Resident #40's Cognitive skills for daily decision making: Organized daily routine and made safe decisions in familiar situations, but experienced some difficulty in decision making when faced with new tasks or situations. Makes self-understood: Difficulty communicating some words or finishing thoughts but is able if prompted or given time. Record review of Resident #40's Psychiatry Initial Evaluation, dated 11/12/2025, revealed Patient [Resident #40] seen for Comprehensive psychiatric evaluation for dementia, insomnia, and Resident #40's mental status exam documented Orientation: Oriented To Person, Oriented To Place, Oriented to Situation. Comprehension/Language: WNL (within normal limits) - Expressive/Receptive Language. Thought Content: Coherent. [and] Thought Process: Linear/Goal-Directed/Logical.Record review of Resident #40's clinical Rehabilitation Notes dated 11/01/2025, revealed Resident #40's Orientation: A&O x4 (indicates a fully intact cognitive function).Record review of Resident #40's Medical Power of Attorney Designation of Health Care Agent (MPOA), dated 08/25/2025, revealed Disclosure Statement. document gives the person you name as your agent the authority to make any and all health care decisions for you in accordance with your wishes.when you are unable to make the decisions for yourself. Your agent's authority is effective when your doctor certifies that you lack the competence to make health care decisions for yourself. This Power of Attorney Is Not Valid Unless: (1) You sign It And Have Your Signature Acknowledged Before A Notary Public. The signature acknowledged before notary was that of Family Member B and not of Resident #40. Record review of Resident #40's EMR Physician progress notes tab on 05/08/2026 did not reveal physician certification that Resident #40 lacked the competence to make health care decisions for herself.Record review of Resident #40's EMR Documentation tab on 05/08/2026 did not reveal documentation signed by Resident #40 authorizing Family Member B as their legal guardian or an agent under a medical power of attorney. Record review of Resident #40's EMR social service notes on 05/08/2026 did not reveal there was action taken by the facility's Social Worker [Social Services] to assist with honoring Resident #40's discharge wishes.Record review of Resident #40's EMR progress notes on 05/08/2026 did not reveal there was action to assist with honoring Resident #40's discharge wishes taken by the charge nurses, ADON, DON, or Administrator after they learned of Resident #40's wishes to discharge home to the care of Family Member D.Resident #40 was unavailable for observation or interview as she was discharged home on [DATE].During a telephone interview on 05/05/2026 at 1:00 p.m., the Complainant revealed Resident #40 was back home residing with Family Member D and was doing well since her discharge from Nursing Facility A. She noted that Resident #40 was receiving care at the facility; however, the concern was that Family Member B did not have a valid MPOA and Resident #40 did not authorize or designate a Responsible Party to make decisions on her behalf. She noted that Resident #40 was able to express her needs and wants and she was vocal about discharging and returning home with Family Member D.During an interview on 05/08/2026 at 9:29 a.m., CNA E revealed Resident #40's mood was depressed, she would refuse care and medications, and she did not like being at Nursing Facility A and was vocal about wanting to be back home with Family Member D. She stated CNAs reported to the charge Nurse each time Resident #40 expressed wanting to discharge home from Nursing Facility A. She noted Resident #40's (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	behaviors would reduce following a telephone call with Family Member D. She noted the charge nurse was responsible for reporting Resident #40's behaviors and wishes to Social Services. She noted that Resident #40 could make her needs and wants known and over time, with therapy, her cognition improved. She noted all staff, including management, were aware of Resident #40's wishes of returning home with Family Member D.During an interview on 05/08/2026 at 9:39 a.m., Social Services revealed Resident #40 had symptoms of Parkinson's, an unsteady gait, and was confused when she admitted to Nursing Facility A. She noted Resident #40 was admitted into Nursing Facility A following a hospital discharge and was aggressive and paranoid. She noted there was an awkward situation between Family Member B and Family Member D. She noted she was informed by other staff throughout Resident #40's stay of her expressed wishes to return home with Family Member D. She noted Resident #40 was able to express her needs and wants and was able to verbalize her expressed wishes to discharge home with Family Member D. She stated she never spoke with Family Member D about Resident #40's expressed wishes to discharge back to the community as Family Member B was the primary contact for Resident #40. Social Services noted that Resident #40 would attend the care plan meetings; however, she could not recall if Resident #40's expressed wishes for discharge were discussed during this meeting or if this was documented in the discharge plan.During an interview on 05/08/2026 at 10:22 a.m., the Activities Director stated Resident #40 engaged in numerous activities, enjoyed participating, verbalizing her needs and wants and her cognition was intact. She stated Resident #40 seemed sad at times and she would talk about missing Family Member D back home. She stated she would report Resident #40's demeanor and statements to the Director of Nursing and Social Services for follow-up and does not recall if this information was documented in the residents' EMR.During an interview on 05/08/2026 at 10:25 a.m., LVN F revealed that that it required law enforcement to be contacted for Resident #40 to be discharged .During an interview on 05/08/2026 at 10:37 a.m., the Assistant Director of Nursing stated she provided the nursing staff with Resident Rights training and the impact of not allowing a resident to exercise their rights could affect their quality of life, their self-esteem, and make them feel bad. She stated she recalled Resident #40 required cuing at times, when she admitted she was very sad, she was irritated about being at Nursing Facility A, Family Member B was restricting contact with other family members. She stated Resident #40 was able to express her wants and needs, her cognition was intact, she could answer questions appropriately, and she would say she wanted to return home with Family Member D. She stated Resident #40 constantly verbalized returning home with Family Member D. She stated that Family Member B stated he had MPOA over Resident #40, but after she looked over her electronic medical record, she did not recall documentation to support valid MPOA; however, Resident #40 was not allowed to discharge. She stated that she could not recall when she reviewed Resident #40's electronic medical record and she did not document these findings.During an observation and interview on 05/08/2026 at 10:50 a.m., the MDS Coordinator revealed that the impact of not allowing a resident to exercise their rights could affect their mood, making them depressed and miserable wanting to leave. She stated she recalled Resident #40 admitted with verbal and physical aggression behaviors, she was distraught, she would cry often that she wanted to go home with Family Member D. She stated that Resident #40 could express needs and wants clearly, would tell her directly of returning home with Family Member D. She noted that she was forgetful at times, but she knew what she wanted. The MDS Coordinator stated that Resident #40 was not allowed to return home and from what she gathered, Family Member B who provided Nursing Facility A with MPOA was responsible for her discharge. The MDS Coordinator was observed to review Resident #40's MPOA to identify valid Responsible Party documentation and stated the MPOA was not signed by Resident #40. She stated that after reviewing the MPOA that it would not be considered a valid MPOA and was inaccurate.During an interview on 05/08/2026 at 11:30 a.m., the Director of Nursing revealed that she provided the nursing staff with resident rights training and there could be a negative impact on a resident if they were not allowed to exercise their rights. She noted that Resident #40 was able to (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	make her needs and wants known, she did not believe her cognition was intact, she did not have physical or verbal aggression, she was not displaying depression. She stated on a few occasions she was overheard at the nurse's station talking to Family Member D by telephone and discussing wanting to live with her. She stated she went on leave for a few weeks following her admission and could not provide additional details of Resident #40.During an observation and interview on 05/08/2026 at 11:48 a.m. the Business Office Manager revealed that she transitioned into this role in February 2026 and she has completed resident rights training and that she was responsible for new admissions and reviewing Durable MPOA provided by family members. The Business Office Manager noted that by not verifying if legal guardianship paperwork was valid, it could prevent a resident from being able to make decisions about their care and could make them confused. The Business Office Manager was observed to review Resident #40's MPOA to identify valid Responsible Party documentation and stated it was not valid as it was not signed by Resident #40.During an observation and interview on 05/08/2026 at 11:49 a.m. the Administrator revealed that she provided the nursing staff with resident rights training and noted that not allowing a resident to exercise their rights could cause them mental anguish and a failure to thrive. The Administrator stated that she recalled Resident #40 was admitted with some verbal aggression, but when she was discharged , she was very balanced out. She noted that Resident #40 talked about returning home quite a bit. She stated Resident #40 had a valid MPOA in chart and Responsible Party was making decisions on her behalf. She noted that there was some confusion about the MPOA and law enforcement assisted with Resident #40's discharge. The Administrator was observed to review Resident #40's MPOA to identify valid Responsible Party documentation provided at admission and stated she did not realize Resident #40 never signed it. She denied Resident #40 discussing discharge with her and noted upon admission the nursing staff had to lean on Family Member B as Resident was unable to make her needs and wants known. She stated that once Resident #40 stabilized she was coherent and she was able to make her wishes known. She noted discharge plans were discussed during the care plan meeting but stated the nursing staff did not document this in the EMR.Record review of a facility policy titled, Discharge or Transfer, dated 02/12/2025, revealed .This facility may initiate transfers or discharges: B. The Transfer or discharge is appropriate because the resident's health has improved sufficiently. the facility will ensure the discharge planning process addresses each resident's discharge goals and needs.the medical record will show documentation of the basis for transfer or discharge.Discharge planning is the process of creating an individualized discharge care plan, which is part of the comprehensive care plan.and must Be developed by the interdisciplinary team and involve direct communication with the resident. Be re-evaluated regularly and updated when the resident's needs or goals change. Discharge planning must identify the discharge destination, and ensure it meets the resident's health and safety needs, as well as preferences.Record review of a facility policy titled, Resident Rights, undated, revealed . A facility must 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. The facility must protect and promote the rights of the resident. 1. The facility must ensure that the resident can exercise his or her rights without interference. 2. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. 3. In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. 5. The facility shall not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law. Record review of a facility document titled, Nursing Facility Resident's Rights, dated 09/01/2025, revealed, Residents of Texas nursing facilities have all the rights, beneˆts, responsibilities, and privileges granted by the Constitution and laws of this state and (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the United States. They have the right to be free of interference. Freedom of Choice. Make your own choices regarding personal affairs, care, beneˆts and services. Participation in Your Care. Participate in developing a plan of care, to refuse treatment. Transfers and Discharges. Discharge yourself from the facility unless you have been determined mentally incompetent.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure preadmissions screening for individuals with a mental disorder and individuals with intellectual disability for 1 of 6 residents (Resident #6) reviewed for PASARR accuracy. The MDS Coordinator failed to accurately screen Resident #6 for mental illness upon admission to the facility. This failure could place residents at risk of not receiving the necessary care and services.Findings included:Record review of Resident #6's admission Record, dated 05/07/2026, revealed a [AGE] year-old male admitted [DATE] and re-admitted [DATE]. Resident #40 was listed as his own Responsible Party.Record review of Resident #6's Medical Diagnoses, undated and accessed 05/07/2026 at 3:14 p.m., revealed diagnoses including major depressive disorder (serious mental health condition characterized by persistent feelings of sadness, loss of interest in activities, and various emotional and physical problems), recurrent, severe with psychotic symptoms and schizoaffective disorder (rare mental illness that affects how a person thinks, feels, and behaves).Record review of Resident #6's admission MDS assessment, dated 04/02/2026 and signed 04/03/2026 as completed, reflected a BIMS score of 13 indicating cognition intact. Resident #6 was documented as having not exhibited any behavioral symptoms and having active diagnoses of depression and taking antipsychotic and antidepressant medications. Resident #6's functional abilities were documented as requiring supervision or touching assistance to set up or clean-up assistance, He was noted to have a history of schizophrenia (chronic mental health condition that can significantly impair daily functioning and quality of life) and bipolar disorder (mental health condition characterized by significant mood swings) but was not documented as an active diagnosis.Record review of Resident #6's care plan, undated, revealed interventions documented psych services to evaluate and treat as needed. The care plan intervention was initiated on 04/22/2026. Care plan did not document diagnoses of bipolar or schizoaffective disorder.Record review of Resident #6's EMR Diagnosis tab on 05/08/2026 did not reveal documentation of bipolar disorder.Record review of Resident #6's EMR Misc Tab on 05/08/2026 did not reveal documentation of submission of Form 1012 (A determination that a resident with a negative PL1 screening form submitted into the LTC Portal needs further evaluation for MI).Record review of Resident #6's Psychiatry Initial Evaluation, dated 04/29/2026, revealed, Psych History. History of schizophrenia and bipolar disorder (schizoaffective disorder, depressive type) per hospital records.Record review of Resident #6's Psychiatry Initial Evaluation, dated 04/29/2026, revealed, Initial psychiatric evaluation for schizoaffective disorder insomnia anxiety. He has been a patient in this facility in the past. He has a history of schizoaffective disorder, depressive type, from previous admissions and previous collateral review. He does have some delusions and hallucinations but denies depression. He is being treated with fluoxetine 10 mg daily. He refuses other psychotropic medications at this time. Previously, [Resident #6] was last seen for psychiatric care approximately 10 months ago in June 2025. He has a documented history of schizoaffective disorder, depressive type, and major depressive disorder, recurrent. He had been hospitalized for suicidal ideation and depression. No current suicidal or homicidal ideation. Patient is not currently a danger to self or others. No self-harm behaviors.Psych History. History of schizophrenia and bipolar disorder (schizoaffective disorder, depressive type) per hospital records and previous collateral review. Currently experiencing delusions and hallucinations. Denies current depression or mania.Record review of Resident #6's PL 1 Screening, dated 03/31/2026, revealed PASRR Level 1 Screening was coded No for Mental Illness and he was noted to have a Mental Illness but documented as not having one.Record review of Resident #6's Psychiatry Follow-Up, dated 06/26/2025, revealed Patient seen for Comprehensive psychiatric evaluation for MDD, insomnia, anxiety and poor appetite.Review of hospital records indicate history of schizophrenia and bipolar (schizoaffective disorder) . Active Medical Problems MAJOR DEPRESSIVE DISORDER, RECURRENT, MILD SCHIZOAFFECTIVE DISORDER, DEPRESSIVE TYPE .MENTAL STATUS EXAM. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Orientation: Oriented x4. Mood: Anxious, Depressed, Irritable Thought Content: Coherent, Paranoid, Auditory Hallucination, Visual Hallucinations. Assessment/Plan SCHIZOAFFECTIVE DISORDER DEPRESSIVE TYPE.Record review of Resident #6's Order Summary, dated 04/27/2026, revealed Secuado Transdermal Patch 24 Hour 3.8 MG/24HR (Asenapinee) Apply 1 patch transdermally one time a day for schizoaffective disorder, order/start date 4/17/2026, [PMHNP].During an observation and interview of Resident #6 on 05/05/2026 at 11:34 a.m., he was noted to be standing near the doorway to his room, he was dressed well, groomed appropriately, no odors. He stated that he ate breakfast, he had been a resident at Nursing Facility A for a few weeks, he did not want to go to activities today as he felt funky and stated he could not describe this feeling. He stated the care was okay and stated he did not want to talk anymore and closed his room door. Interview ended with Surveyor.During an interview on 05/08/2026 at 10:37 a.m., the Assistant Director of Nursing revealed that Resident #6 gets depressed, he was paranoid and therapy could be offered but does not know if he would benefit from therapy services as he does not like to engage in services.During an observation and interview on 05/08/2026 at 10:50 a.m., the MDS Coordinator revealed that she was responsible for ensuring PASRR Level 1 Screening wasaccurate when received. She stated that by not identifying an inaccurate PL 1 Screening when received could result in a full PASRR Evaluation not being conducted and residents may not receive services they may be eligible for. The MDS Coordinator noted that after reviewing Resident #6's 03/31/2026 PL 1 Screening she found that it was inaccurate and she would move to submit a new PL1 Screening and request for a PASRR Evaluation.Record review of policy titled, PASRR Level 1 Screen, date revised 3-6-2019, revealed, .PASRR is a federally mandated program requiring all states to pre?screen all individuals seeking admission to a Medicaid-certified nursing facility, regardless of payor source or age. The PASRR Program is important because it provides options for individuals to choose where they live, who they live with and the training and therapy they need to live as independently as possible. PASRR Program has 3 Goals: 1. To identify individuals with MI, ID, or DD/RC. 3. To ensure individuals receive the required services for their MI, ID, or DD. [Procedure:] 3. The Facility will review the PL 1 Screening Form for completion and correctness prior to admission and submit the PL 1 form per regulations. If the individuals PE is positive the new PL 1 would remain positive and a new PE will be completed by the LA. An Interdisciplinary Team (IDT) meeting is required and Specialized Services (SS) must be reviewed. For positive Preadmissions only, the LA enters the PL 1 into the portal and this becomes the notification to complete the PE. Both the PL 1 and PE must be completed prior to Admission.Record review of document titled, Form 1012 Policy & Procedure with Instructions, undated, revealed, . Section C. Mental Illness (MI) Indication. 1. Review the medical record for a diagnosis of MI and indicate No or Yes for each MI listed. Examples of MI are: Schizophrenia. Mood Disorder (Bipolar Disorder, Major Depression or other mood disorder) . 5. The NF physician signs and dates Section C of the form attesting to the accuracy of the MI diagnosis information . Section D. Nursing Facility Action - A new PL 1 is needed at this time. A full PASRR Evaluation will be conducted after the NF submits a new positive PL 1.Record review of policy titled, Documentation, undated, revealed .Documentation is the recording of all information, both objective and subjective, in the clinical record of an individual resident and or soft resident file. It may include observations, investigations, and communications of the resident involving care and treatments. It has legal requirements regarding accuracy and completeness. 1. The facility will maintain complete and accurate documentation for each resident on all appropriate clinical record sheets. 2. Ensure that active diagnoses are transferred from hospital forms to the appropriate facility forms. 4. Document completed assessments in a timely manner and per policy.

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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** Based on observation, interview, and record review, in accordance with accepted professional standards and practices, the facility failed to maintain medical records on each resident that were complete, accurately documented, readily accessible, and systematically organized for 2 of 8 residents (Resident #6 and Resident #40) reviewed for clinical records.The facility failed to ensure Resident #6's medical diagnoses report, MDS Assessment, and Care Plan were accurately and completely documented with diagnosis of schizoaffective disorder and bipolar disorder.The facility failed to ensure the EMR contained a complete and accurate MPOA with Resident #40's signature along with a signed admission Agreement. And did not document Resident #40's progress notes with behaviors and statements made during her residence at Nursing Facility A.These failures could place residents at risk of not receiving the care and services needed due to inaccurate or incomplete clinical records. Findings included:1. Record review of Resident #6's admission Record, dated 05/07/2026, revealed a [AGE] year-old male admitted [DATE] and re-admitted [DATE]. Resident #40 was listed as his own Responsible Party.Record review of Resident #6's Medical Diagnoses, undated and accessed 05/07/2026 at 3:14 p.m., revealed diagnoses including major depressive disorder (serious mental health condition characterized by persistent feelings of sadness, loss of interest in activities, and various emotional and physical problems), recurrent, severe with psychotic symptoms and schizoaffective disorder (rare mental illness that affects how a person thinks, feels, and behaves).Record review of Resident #6's admission MDS assessment, dated 04/02/2026 and signed 04/03/2026 as completed, reflected a BIMS score of 13 indicating cognition intact. Resident #6 was documented as having not exhibited any behavioral symptoms and having active diagnoses of Depression and taking antipsychotic and antidepressant medications. Resident #6's functional abilities were documented as requiring supervision or touching assistance to set up or clean-up assistance He was noted to have a history of schizophrenia (chronic mental health condition that can significantly impair daily functioning and quality of life) and bipolar disorder (mental health condition characterized by significant mood swings) not documented as an active diagnosis.Record review of Resident #6's care plan, undated, revealed Resident #6 interventions documented psych services to evaluate and treat as needed. The care plan intervention was initiated on 04/22/2026. Care plan did not document diagnoses of bipolar (mental health condition characterized by significant mood swings) or schizoaffective disorder (mental health condition that typically can affect many different aspects of day-to-day life).Record review of Resident #6's EMR Diagnosis tab on 05/08/2026 did not reveal documentation of bipolar disorder.Record review of Resident #6's PL 1 Screening, dated 03/31/2026, revealed PASRR Level 1 Screening was coded No for Mental Illness and he was noted to have a Mental Illness but documented as not having one.Record review of Resident #6's EMR Misc Tab on 05/08/2026 did not reveal documentation of submission of Form 1012 (A determination that a resident with a negative PL1 screening form submitted into the LTC Portal needs further evaluation for MI).Record review of Resident #6's Psychiatry Initial Evaluation, dated 04/29/2026, revealed Psych History. History of schizophrenia and bipolar disorder (schizoaffective disorder, depressive type) per hospital records and previous collateral review.During an observation and interview of Resident #6 on 05/05/2026 at 11:34 a.m., he was noted to be standing near the doorway to his room, he was dressed well, groomed appropriately, no odors. He stated that he ate breakfast, he had been a resident at Nursing Facility A for a few weeks, he did not want to go to activities today as he felt funky and stated he could not describe this feeling. He stated the care was okay and stated he did not want to talk anymore and closed his room door. Interview ended with Surveyor. 2. Record review of Resident #40's admission Record, dated 05/07/2026, revealed a [AGE] year-old female admitted [DATE] and discharged home on 01/302026. Resident #40 was not listed as her own Responsible Party with her (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 05/08/2026

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.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[Family Member B] listed as Responsible Party, POA-Medical, and Emergency Contact #1.Record review of Resident #40's Medical Diagnoses, undated and accessed 05/06/2026 at 12:28 p.m., revealed diagnoses including traumatic subdural hemorrhage (a collection of blood that forms between the brain and its outer covering, often due to head trauma) with loss of consciousness of 1 hour to 5 hours 59 minutes and Alzheimer's disease with late onset (characterized by progressive memory loss, cognitive decline, and changes in behavior). Record review of Resident #40's quarterly MDS assessment, dated 11/27/2025 and signed 12/01/2025 as completed, reflected a BIMS score of 06 indicating severe cognitive impairment.Record review of Resident #40's care plan, undated, revealed Resident #40 was resistive to care r/t [related to] wanting to go Home with (Family Member D) and Goal documented that Resident #40 will cooperate with care through next review date with interventions of Allow resident [Resident #40] to make decisions about treatment regime, to provide sense of control. The care plan focus was created and initiated on 11/10/2025 and revised on 12/26/2025. The care plan did not reveal discharge plans for Resident #40 once she stabilized and was able to make her needs and wants known.Record review of Resident #40's EMR Misc tab on 05/08/2026 did not reveal a valid MPOA document signed by Resident #40 with signature acknowledged before a notary public giving Family Member B the authority to make any and all health care decisions for her. Record review of Resident #40's EMR Physician progress notes tab on 05/08/2026 did not reveal physician certification that Resident #40 lacked the competence to make health care decisions for herself.Record review of Resident #40's EMR Documentation tab on 05/08/2026 did not reveal documentation signed by Resident #40 authorizing Family Member B as their legal guardian or an agent under a medical power of attorney.Record review of Resident #40's progress note, Administrator Note, dated 01/30/2026, revealed Residents [Resident #40] [Family Member B] has MPOA and he did not agree with resident [Resident #40] discharging home with [Family Member D] however, resident [Resident #40] insisted that she wanted to go home to her house and have her Family Member D help with her care. [Family Member D] called [Local Law Enforcement] and they arrived to [Nursing Facility A] and explained this was a civil matter and the MPOA documents clearly state [Family Member B] can make decisions for resident [Resident #40] only if she is deemed incompetent by a physicianRecord review of Resident #40's admission Agreement. dated 11/06/2025, revealed that Family Member B was documented as the Responsible Party for this agreement and enters into this admission and Financial Agreement with [Nursing Facility A] to provide care for [Resident #40] under the terms and conditions set forth below. If Resident Is Not Own Responsible Party, Resident Authorizes the below to be their agent. Responsible Party Name: [Family Member B]. Responsible Party here in is: (x all that apply).Durable Power of Attorney/Attorney in fact for Resident [Resident #40] was selected for Authority Resident authorizes Responsible Party to make: Financial Decisions. Medical decisions [Nursing Facility A] has been provided with a durable power of attorney, advance directive or other appropriate instrument). Admission, care, and discharge decisions. Other decisions related to Resident's [Resident #40] personal property and well-being. Primary contact person for this Resident [Resident #40] and signed by only Family Member B and Business Office Manager C.Record review of Resident #40's clinical Rehabilitation Notes dated 11/01/2025, revealed Resident #40's Orientation: A&O x4 (indicates a fully intact cognitive function).Record review of Resident #40's Medical Power of Attorney Designation of Health Care Agent (MPOA), dated 08/25/2025, revealed Disclosure Statement. Before Signing This Document, You Should Know These Important Facts:Except to the extent you state otherwise, this document gives the person you name as your agent the authority to make any and all health care decisions for you in accordance with your wishes.when you are unable to make the decisions for yourself. Your agent's authority is effective when your doctor certifies that you lack the competence to make health care decisions for yourself. Your agent's authority is effective when your doctor certifies that you lack the competence to make health care decisions. Once you have signed this document, you have the right to make health care decisions for yourself as long as you are able to (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	make those decisions. This Power of Attorney Is Not Valid Unless: (1) You sign It And Have Your Signature Acknowledged Before A Notary Public; Or (2) You Sign It In The Presence Of Two Competent Adult Witnesses. Signature Acknowledged Before Notary was that of Family Member B and not of Resident #40. Resident #40 was unavailable for observation or interview as she was discharged home on [DATE].During a telephone interview on 05/05/2026 at 1:00 p.m., the Complainant revealed that Resident #40 was able to express her needs and wants and Nursing Facility A did not have a valid MPOA/POA signed by Resident #40 and she did not designate a Responsible Party to make decisions on her behalf.During an interview on 05/08/2026 at 10:22 a.m., the Activities Director stated Resident #40 engaged in numerous activities, enjoyed participating, verbalizing her needs and wants and her cognition was intact. She stated Resident #40 seemed sad at times and she would talk about missing Family Member D back home. She stated she would report Resident #40's demeanor and statements to the Director of Nursing and Social Services for follow-up and does not recall if this information was documented in the residents' EMR.During an interview on 05/08/2026 at 10:25 a.m., LVN F revealed that there was a big dispute between Resident #40 and her Family Member B regarding him being her Responsible Party. She stated that she did not know all the facts, but that the MDS Coordinator and the Assistant Director of Nursing discovered the guardianship paperwork for Resident #40 was not valid.During an interview on 05/08/2026 at 10:37 a.m., Assistant Director of Nursing revealed that Family Member B noted he had MPOA over Resident #40, but after she looked over her electronic medical record, she did not recall documentation to support valid MPOA. During an observation and interview on 05/08/2026 at 10:50 a.m., the MDS Coordinator revealed that Resident #40 could express needs and wants clearly, and would tell her directly of returning home with Family Member D. The MDS Coordinator was observed to review Resident #40's MPOA to identify valid Responsible Party documentation and stated the MPOA was not signed by Resident #40. She stated that after reviewing the MPOA that it would not be considered a valid MPOA and was inaccurate. The MDS Coordinator stated that she is responsible for ensuring medical diagnosis are reflected accurately on a resident's EMR and failure to update could result in residents not receiving the proper care. She noted that she did not review the prior clinicals for Resident #6 and this is an error on her part and Resident 6's medical diagnosis should have been updated to reflect bipolar disorder. She also noted that she is responsible for ensuring PASRR Level 1 Screenings are accurate when received. She stated that by not identifying an inaccurate PL 1 Screening can result in missed services for a resident. During an observation and interview on 05/08/2026 at 11:48 a.m. the Business Office Manager revealed that for a valid MPOA or POA the resident would need to sign it and this would allow family to speak on their behalf, make decisions on their behalf, and sign consents. The Business Office Manager was observed to review Resident #40's MPOA to identify valid Responsible Party documentation and stated it was not valid as it was not signed by Resident #40.During an observation and interview on 05/08/2026 at 11:49 a.m. the Administrator was observed to review Resident #40's MPOA to identify valid Responsible Party documentation provided at admission and stated she did not realize Resident #40 never signed it. She denied Resident #40 discussing discharge with her and noted upon admission the nursing staff had to lean on Family Member B as Resident was unable to make her needs and wants known. She stated that once Resident #40 stabilized she was coherent and she was able to make her wishes known. She noted discharge plans were discussed during the care plan meeting but stated the nursing staff did not document this in the EMR. The Administrator also noted that accuracy of records is necessary to reflect what is going on with a resident, accuracy is how care is provided and the impact on a resident could be that treatment could be missed.Record review of a facility policy titled, Documentation, undated, revealed .Documentation is the recording of all information, both objective and subjective, in the clinical record of an individual resident and or soft resident file. It may include observations, investigations, and communications of the resident involving care and treatments. It has legal requirements regarding accuracy and completeness, legibility and timing. Special forms in the (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	clinical record are utilized in nursing documentation, such as assessment, care plan, nursing progress notes, flow sheets, medication sheets, incident reports, and summary sheets (daily, weekly, monthly, discharge) . 1. The facility will maintain complete and accurate documentation for each resident on all appropriate clinical record sheets. 2. The facility will ensure that information is comprehensive and timely and properly signed. [Procedure] 1. Place all required and appropriately signed forms in the clinical record. Items such as copies of advance directives, consent for treatment, consents for specific procedures. 2. Ensure that active diagnoses are transferred from hospital forms to the appropriate facility forms. 4. Document completed assessments in a timely manner and per policy.