

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676068	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/05/2026
NAME OF PROVIDER OR SUPPLIER  Cedar Manor Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1915 Greenwood St San Angelo, TX 76901	

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)
<p>F 0680</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure the activities program is directed by a qualified professional.</p> <p>Based on interviews and record review, the facility failed to ensure the activities program was directed by a qualified professional who was a therapeutic recreation specialist or an activity professional for 1 of 1 activity director (AD) reviewed for qualifications. The facility failed to ensure the AD was a qualified therapeutic recreation specialist or an activities professional that met state licensing requirements. This failure could place residents at risk for reduced quality of life due to lack of activities that were individualized to match the skills, abilities, and interests/preferences of each resident. The findings included: Interview on 03/05/2026 at 11:05 AM the AD said she had been working at the facility as the AD since April 2025. The AD said she was currently not registered for an activities director course. The AD said there had been some changes in the administration and the previous administration had told her they would assist her with getting registered to take an AD course but since that administration had left she did not get registered. Interview on 03/05/2026 at 4:44 PM the Administrator said they were working on getting the AD enrolled in the AD course and would be working on that. Review of the current Activity Director personnel revealed she was not enrolled in an activity course nor was she a certified AD. Review of the facility's job description for the Activity Director dated 2014 revealed in part: The following is a non-exhaustive criteria that relates to the job of a Activity Director and it is consistent with the business needs if the facility. These are legitimate measures of the qualifications for a Activity Director and are related to the functions that are essential to the job of a Activity Director. Knowledge Base - High school graduate with certification where required by state regulations. Must be certified Activity Director.</p>

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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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>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, for 1 of 1 kitchen as evidence by: The facility failed to ensure:A. Dietary Manager and [NAME] D wore a hair restraint properly covering all of their hair. B. The bottom shelves throughout the kitchen were clean and not soiled.C. The stove and oven were clean and not soiled. D. The vent hood was clean and free of dust.E. The freezer in the pantry was clean and not soiled.F. The shelves in the pantry were clean and free of dust. These failures could place residents at risk for foodborne illness, compromised nutritional health status, and being served food items that may not be fresh, taste stale, or be contaminated.The findings included: In an observation on 03/03/26 at 9:40 AM, during the initial tour of kitchen, the bottom shelves throughout the kitchen, including the shelves that held the dishes, pots and pans, were soiled with food crumbs and dust. The stove and oven were soiled with grease, food crumbs and dried food. The vent hood was covered with a layer of dust. In the pantry, the bottom shelf of the freezer was soiled and food crumbs and frozen foods. The shelf in the pantry that had the plastic covering over the shelves had a layer of dust and food crumbs on them. In a follow-up observation during food preparation on 03/04/26 at 11:15 am, the Dietary Manger's hair net only covered the bun or top part of her hair. [NAME] D had hair coming out of the back of her hairnet. In an interview and observation on 03/05/26 at 10:08 am, the Dietary Manager said that hair nets should be worn to cover all of the hair. She said that her hair net will roll up on top of her head, and she does not realize it. She did not notice that [NAME] D hair was hanging out of the back of her hair net. She said the failure to wear hair nets properly had the potential for residents to have hair in their food. The findings were observed and reviewed with the Dietary Manager, concerning the food crumbs and dirt on the bottom shelves; the stove and oven were soiled with grease, food crumbs and dried food; the vent hood was covered with a layer of dust; the freezer in the pantry bottom shelf was soiled and food crumbs and frozen foods; and the shelf in the pantry that had the plastic covering over the shelves had a layer of dust and food crumbs on them. The Dietary Manager said potential negative outcomes of not keeping the kitchen free of food crumbs, and dirt/dust could attract pests, produce bad smells, hair in the resident's food, and infection control issues. In an interview on 03/05/26 at 3:00 pm, the Administrator was made aware of findings in kitchen. He said it was his expectation for staff to wear hair nets correctly. The kitchen to be cleaned after each meal, including the stove and oven, and freezer/appliances. He said the vent hood is cleaned quarterly by a vendor but should be cleaned by staff in between vendor cleanings. He said the failure had the potential for infection control issues, pests, and hair in resident's food. Record review of the facility policy Infection Control, dated as revised 4.9.25, revealed the following [in part]:We will ensure that all employees practice infection control in the Food and Nutrition Services Department and maintain sanitary food preparation. Procedure: 1b: Clean hair is required. It is to be covered with an effective hair restraint. 5a: All kitchenware and food contact used in the preparation and/or serving of food are cleaned and sanitized before use and cleaned after each meal preparation.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 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 communicable diseases and infections for 2 (Resident #3 and #21) of 5 residents reviewed for infection control. LVN A failed to sanitize the glucometer after she performed a blood sugar test on Resident #21. CNAs B and C failed to use recommended PPE when they assisted Resident #3 with incontinent care and urinary catheter care as the resident was on EBP precautions. These failures could place residents at risk of cross contamination and the spread of infection. Findings include: Observation and an interview on 3/4/2026 at 11:40 AM revealed LVN A went in a Resident #21's room to obtain a fasting blood sugar. The LVN took a small blood sample from the resident's finger and applied it to the test strip that was in the glucometer. After the LVN checked the Resident #21's blood sugar, she exited the resident's room and set the glucometer on the cart without sanitizing it. LVN A stated she used a tissue and hand sanitizer to sanitize the glucometer. She said she was unaware of what she was supposed to use to sanitize the glucometer. Interview on 3/4/2026 at 11:46AM with the DON revealed the glucometers were supposed to be cleaned using bleach wipes. She stated the nurses were trained upon hire and annually on proper disinfection of the glucometers. The DON said the risk of not using the proper solution for sanitizing the glucometers was passing on infections. Record review of Resident #3's admission record dated 03/05/2026 revealed she was admitted to the facility on [DATE] with diagnoses of neuromuscular dysfunction of bladder (is a loss of bladder control caused by nerve damage, resulting in dysfunction of the muscles that store or empty urine) and muscle weakness. She was [AGE] years of age. Record review of Resident #3's care plan dated 12/20/2023 revealed in part: The resident has an Indwelling Catheter: Neurogenic bladder. The resident will show no signs and symptoms of Urinary infection through review date. Resident is on enhanced barrier precautions. There will not be any transmission of infection from or to the resident. Gloves and gown should be donned if any of the following activities are to occur: linen change, resident hygiene, transfer, dressing, toileting/incontinent care, bed mobility, wound care, enteral feeding care, catheter care, trach care, bathing, or other high-contact activity. Record review of Resident #3's MDS assessment dated [DATE] indicated in part: Section H - Bladder and Bowel. Check all that apply: Indwelling catheter. Observation and interview on 03/05/2026 at 09:54 AM CNA B and CNA C performed incontinent care for Resident #3. Both staff entered the resident's room, washed their hands and put on some gloves. They then proceeded to undo Resident #3's brief and it was noted that the resident had a urinary catheter. CNA C then took some wet wipes and wiped the resident's vaginal area and also cleansed the urinary catheter tubing. Both CNA's then turned Resident #3 on her right side and CNA C took some wet wipes and wiped the resident's rectal area and it was noted that the resident had a bowel movement. CNA B then repositioned the resident's urinary catheter on the bed and helped with turning the resident on her back. Both CNAs then fastened a new brief on the resident and they were done with the care. CNA B and CNA C were asked about the EBP posting posted outside of Resident #3's room. Both CNAs said that the posting was to indicate that they were supposed to use PPE such as gloves and a gown when providing personal care for a resident with a urinary catheter such as Resident #3. Both CNAs said they had forgotten to wear a gown while providing the care and they should have worn a gown along with the gloves. Both CNAs said if they did not wear the appropriate PPE then there was a possibility of spread of infections. Interview on 03/05/2026 with the DON and the ADON at 03:34 PM the ADON said staff were expected to wear EBP when providing care for residents that had a urinary catheter. The ADON said the staff had been trained on how and when to use PPE and that the CNAs that performed care for Resident #3's catheter were aware they had to wear PPE but had forgotten. The DON said that if the staff did not wear PPE as indicated it could possibly lead to infections (continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>although it had not been proven yet. Interview and record review on 03/05/2026 at 4:40 PM the Administrator said it was expected for nursing staff to use PPE when care was provided to a resident that was on EBP precautions. The Administrator said that if the correct PPE was not worn it could lead to cross contamination. Review of facility policy labeled glucometer on 3/4/2026 at 1:33PM revealed:4. Maintenance.1. Clean and inspect meter exterior with each use.2. Meter will be cleaned with a germicidal and allowed to air dry between patient testings. Record review of the facility document titled Infection control plan and dated 03/2024 revealed in part: The facility will establish and maintain an infection control program designed to provide a safe, sanitary comfortable environment and to help prevent the development and transmission of disease and infection. The facility will establish an infection control program under which it investigates, controls and prevents infections in the facility. Record review of the facility document titled Enhanced Barrier Precautions and dated 04/01/2024 revealed in part: Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown and glove use during high contact resident care activities. EBP are indicated for residents with any of the following: Wounds and or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. Indwelling medical device example include urinary catheters.</p>		

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<p>F 0914</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide bedrooms that don't allow residents to see each other when privacy is needed.</p> <p>Based on observation and interview, the facility failed to ensure each room was designed or equipped to assure full visual privacy for 6 of 6 dual occupancy rooms reviewed for privacy in the facility. The facility failed to ensure that dual occupancy rooms were provided with ceiling suspended curtains, which extended around the bed, to provide total visual privacy. This failure could lead to a lack of privacy for residents, allow residents' private medical treatment to be observed by roommates or others, and lead to a decline in psychosocial well-being. Findings included: Observation on 03/05/2026 at 2:35 PM of resident rooms 301, 303, 306, 307, 309 and 310 revealed that each room had dual occupancy with an A and B bed in each. The rooms had a single ceiling to floor curtain that divided the center of the room but stopped approximately 24 inches from the door. The curtains did not provide coverage and privacy around the entire beds. Interview on 3/5/2026 at 3:03PM the DON stated she was unaware the curtains failed to provide full visual privacy. The DON stated there was a possibility of residents being exposed during resident care if the door was not closed. Interview on 03/05/2026 at 4:02 PM the Administrator said if there was no full visual privacy in the resident rooms then there was a possibility of the residents being exposed during resident care. The Administrator said that they did not have a policy on full visual privacy curtains.</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to provide a safe and sanitary environment for residents, staff and the public, as evidenced by; An industrial sized garbage can dumpster was seen outside the facility and not on a concrete slab. These failures could affect residents and could result in unsanitary conditions by creating a haven for pests could cause disease for the residents. Findings include: In an observation on 03/04/2026 at 11:02 AM, there was an industrial sized garbage can dumpster that was at the back of the facility. The dumpster was located on the dirt area and not on a concrete slab. Interview on 03/05/2026 at 4:45 PM the Administrator was made aware of the observation of the dumpster not located on top of a concrete slab. The Administrator said they would work on getting that resolved. The Administrator said they did not have a policy for the dumpsters.</p>		