STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676068	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Manor Nursing and Rehabilitation Center	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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 26221 Based on observation, interview, and record review the facility failed to treat each resident with respect and dignity and provide care in a manner that promoted maintenance or enhancement of his or her quality of life for 1 of 2 meals reviewed for resident rights and for 10 of 10 residents in the confidential group interview. The facility failed to serve residents in the female secure unit in a manner that was not institutional-like and serve residents on trays. The facility failed to ensure staff provided care to residents while not on their cell phones causing residents to feel left out. This failure could place residents at risk for decreased meal satisfaction and could result in a diminished quality of life for the identified residents and could affect additional residents by causing a loss of self-esteem and increased isolation. The findings included: Observation on 12/10/24 at 12:17 p.m. of the female locked unit lunch meal revealed the lunch meal arrived on a lunch cart. There were six residents present in the dining room. The staff present took the meal off the cart, checked the card and brought the meal to the resident. The staff placed the meal on the tray in front of all six residents in the dining room. Comparison to the main dining room on 12/10/24 at 12:24 p.m. of the main dining room revealed all residents in the main dining room had their food placed on the table. Interview on 12/10/24 at 12:26 p.m. the DON observed the residents eating in the main dining room and then compared it to the female residents in the secured unit. She stated she could not identify a difference since the food was the same and the staff was sitting. The DON stated she did not eat off a tray at home then asked if it was a dignity issue. CNA A stated the last time she ate off a tray that was not fast-food was probably high school. Observation on 12/10/24 at 4:28 p.m. revealed staff setting up smoking materials while texting. Residents were present at the time of the texting. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the confidential resident council meeting on 12/11/24 10 alert residents stated staff were on the cell phones while providing care. The residents stated it did not matter what shift it was, and it did not make a difference what kind of care the staff was providing. One resident stated staff were on the phone while passing medications. Other residents stated staff were on the phone while in the dining room or doing transfers. The resident stated it made them feel left out and not there. Observation on 12/11/24 at 10:32 a.m. revealed the Activity Director cutting through the dining room on her phone with residents present. Review of the Resident Council Minutes, dated 10/16/24, revealed the residents' reported staff were on their cell phones. Review of the Resident Council Minutes, dated 11/20/24, revealed the residents' reported staff were on their cell phones. Review of the facility's Personnel Handbook dated 2015, on Personal Communication Devices, revealed: use of personal communication devices during scheduled work hours is not permitted at the facility. These devices include but are not limited to cell phones and laptop computers. You may only use your personal communication devices during scheduled lunch/ break times. Communication devices issued by the facility/company are permitted as they are tools of the job and are to be used accordingly. Employees may not bring any forms of audio entertainment devices into the facility. This provision does not apply to designated facility personnel who must use such devices in connection with their positions of employment. For the designated employees that are required to use such devices in connection with their position of employment. For the designated employees that required to use their cell phones in the course of business, the phone may NOT be used in the resident area or used in an unprofessional manner.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26221 Based observations, interviews, and record review, the facility failed to maintain an Infection Prevention and Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for one of one (Resident #15) residents reviewed for wound care. The facility failed to ensure that RN B changed her gloves and performed hand hygiene while providing wound care to Resident #15. This failure could place the residents at risk of cross-contamination and development of infections. Findings included: Review of Resident #15's Admission Record, dated 12/12/24, revealed he was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses including non-pressure chronic ulcer or the left foot. Review of Resident #15's Quarterly MDS Assessment, dated 12/9/24, revealed: Resident # 2? had a mental status exam score of 3 of 15 (indicating severe cognitive impairment) He had 1 venous or arterial ulcer present. Review of Resident #15's Care Plan, initiated 10/18/24, revealed: Focus: The Resident has Venous/Stasis Ulcer related to decreased circulation - ulcer to left 2nd toe. Goal: the resident's ulcer will be healed by review date. Interventions: Document location of wound, amount of drainage, peri-wound (surrounding) area, pain, edema (swelling), and circumference measurements weekly. Evaluate wound for: size, depth, margins (edges). Document progress in wound healing on an ongoing basis, notify physician as indicated. Review of Resident #15's Order Summary, dated 12/12/24, revealed orders dated 11/16/24 Clean venous ulcer to top of 2nd toe of left (foot) with wound cleanser and apply a dry dressing daily and as needed until resolved every day shift. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 12/12/24 at 11:39 a.m. RN B stated Resident #15's orders were to clean, dry and cover with a dressing. RN B opened the cart, gelled her hands with ABHG, donned gloves (put on), and donned PPE. RN B closed the drawer to the cart. RN B pulled out the treatment supplies of wound cleanser spray, a bandage and gauze. RN B took off her gloves washed her hands and returned to the cart. RN B looked around realized she did not clean the bed side table or put a barrier down. RN B donned gloves, cleaned the bed side table and placed wax paper down. RN B brought her wound-care supplies in and placed it on the wax paper. RN B took off her gloves, used ABHG and donned new gloves prior to taking off Resident #15's bandage. Without using any type of hand hygiene. RN B donned new gloves, sprayed Resident #15's toe with wound cleanser and wiped the wound from top to bottom 21 times. RN B took off her gloves, did not use any kind of hand hygiene, and donned a new pair of gloves. RN B wiped the dry gauze across Resident #15's wound 10 times. RN B held the used (dirty) gauze in one hand, took off that glove with the gauze inside of it, and threw away the one glove. With no hand hygiene for the one hand RN B donned a new glove and placed the bandage on Resident #15's toe. RN B changed both gloves, with no hand hygiene and applied lotion to Resident #15's legs. RN B then put the wound cleanser back onto the cart without cleaning it while throwing all other equipment away in a bio-hazard bag. Interview on 12/12/24 at 11:58 a.m. RN B stated she told Resident #15 what she was going to do, gelled her hands, cleaned off the table, laid out her supplies, washed her hands, then reapplied gel. She stated she cleaned the wound well by spraying the wound with wound cleanser and covered it with the bandage, threw everything in a bag and washed her hands. RN B stated she changed her gloves and used alcohol between glove changes on each step. Follow up interview on 12/12/24 at 2:38 p.m. RN B stated when the wound care spray was brought into the room it was considered dirty and she probably did not remember to clean it. RN B stated Resident #15's wound was so small she did not think anything would be accomplished if she did or did not go over the wound repeatedly with the same gauze because there was not any infection to spread. Interview on 12/12/24 at 3:17 p.m. the DON stated her perfect wound care would be for staff to wash their hands, set up a barrier station, get a red bag for biohazard, wash their hands, don glove, remove the soiled dressing, doff gloves, use gel, don new gloves, clean the wound from cleanest to dirtiest, take off gloves, gel, don new gloves, apply the new dressing, take off the gloves and make sure everything went into the red bag. The DON stated by wiping the wound multiple times it re-contaminated the wound. The DON said everyone had wound-care check offs with their annual evaluations, including RN B but she could not remember exactly when RN B's evaluation was. The DON said she did in-services on all thing's infection control including wound care and hand hygiene in July 2024. The DON stated RN B did attend the in-services. Interview on 12/12/24 at 3:39 p.m. the Administrator stated her expectation for wound care was that the wound care be completed appropriately with proper hand hygiene and aseptic technique. The Administrator said wound care was a whole process and the expectation was it be done properly. Review of the facility's policy and procedure on Treatment Table, dated 2003, revealed: Wash hands, put on gloves, Place wax paper on wound care bedside table or small cart (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Gather treatment supplies (i.e. medicine, tape, extra gloves, etc.) Open up and place on top of wax paper. One end will be considered clean, and the other end of the table will be open for dirty (To replace scissors etc. to be cleaned) Place wax paper over top of supplies. On open end place linens, saline, red bag, scissors, pen camera, etc. on top of second cover of wax paper. After treatment place dirty linens, red bags, scissors, pen etc. to be cleaned on open end (considered dirty end of table). Wash hands, take bed side table/cart to treatment cart. Put on gloves. Discard linens, red bags etc. using universal precautions. Clean scissors, pen, etc. with alcohol prep. Clean top of treatment cart, bedside table/cart with disinfectant. Remove gloves. Wash hands.

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F 0910 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure resident rooms meet each resident's needs. 26221 Based on observation, interview, and record review, the facility failed to have certified resident rooms equipped for adequate nursing care, comfort, and privacy for 33 of 85 rooms (Rooms 701-710, 712-714, 717-722, 801-813, and 815). The facility failed to have 38 Title 18 beds in B Building resident ready. The facility failed to have 24 Dually Certified (Title 19/19) beds in B Building resident ready. This failure could affect residents by placing them at risk of residing in rooms without proper furnishings and privacy. The findings included: Review of the facility-completed Form 3740 Bed Classification, completed and signed by the Administrator on 12/10/24, documented the facility identified rooms 701-710, 712, 714, 717-719, and 801-805 as Title 18 Medicare-Only beds for both A and B beds in each room for a total of 38 beds. Form 3740 documented the facility identified rooms 709, 713-A, 720-722, 806, 807, 808-A, 810-A, 811, 812-A, 813, and 815 as dually certified (Title 18/19) for a total of 24 beds. Observation of B Building on 12/11/24 at 3:15 pm revealed 33 rooms that were not in use. All 33 rooms were not resident ready and could not be made resident ready within a reasonable timeframe due to B Building having not been in use for residents since 2020. In an interview on 12/11/24 at 3:35 pm with Corporate Compliance RN stated there was no possibility of getting all 33 rooms livable for residents in 24 hours. He stated it would take deep cleaning and removal of items being stored in the building to make the rooms adequate for housing residents. In an interview on 12/11/24 at 4:55 pm with the Administrator, she stated that the building had been used for storage since before she started working in the facility in 2023. She stated there had been no residents housed in the building in 4 years. The Administrator stated that the corporate plan was to remodel/update the building and use it for a rehabilitation unit, but due to low census, the remodel/renovation had not been priority. She stated that everything in the building was functional, but it needed to be thoroughly cleaned and have some cosmetic repairs done before it would be suitable for residents. She stated that the corporation did not want to lose the rooms and would not allow them to be declassified due to the cost recertifying the beds. In an interview on 12/12/24 at 5:11 pm, the Administrator stated that there was no facility or corporate policy regarding bed classification.