

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676327	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/08/2025
NAME OF PROVIDER OR SUPPLIER  The Springs Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  1500 Cottonwood Creek Trail Cedar Park, TX 78613	

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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>(continued on next page)</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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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 ensure the residents' right to privacy during personal care for one resident ( Resident #1) of three residents reviewed for privacy and confidentiality. The facility failed to ensure the staff provided privacy to Resident #1 by closing the door during bed bath. This failure could place residents at risk of having their bodies exposed to the public, resulting in low self-esteem and a diminished quality of life. The findings include: Record review of Resident #1's face sheet dated 12/08/25 reflected he was initially admitted to the facility on [DATE] and readmitted on [DATE]. He was a [AGE] year-old male with a diagnosis of need for assistance with personal care. Record review of Resident #1' MDS dated [DATE] revealed Resident #1's BIMS was 04 indicating his cognition was severely impaired. It indicated he needed assistance throughout the bathing activity. Record review of Resident#1's care plan dated 11/24/25 revealed Resident #1 had ADL self-care performance deficit r/t weakness and cognitive impairment and required assistance for bathing/showering, at least by one staff as necessary. During an observation on 12/08/25 at 12:10pm it was revealed Resident #1 shared his room with another resident. Resident#1 was lying in his bed awake and alert while CNA A and CNA B providing bed bath in his room. It was observed that the privacy curtain of Resident #1 was drawn, however the door to the room was wide open. Resident #1's fully naked body was visible to the investigator and anyone who approaches Resident #1's bed. During an interview on 12/08/25 at 12:15pm, CNA A stated she and CNA B were from the hospice and at the facility to provide bed bath to Resident#1. CNA A stated, before commencing the bed bath she ensured Resident #1's privacy by closing the door to the room and drawing the privacy curtain. CNA A stated, while they were providing the bed bath CNA C entered the room to give the resident his lunch tray and HK D entered to clean the room. During an interview on 12/08/25 at 12:20pm CNA B stated she was from the hospice and accompanied CNA A from the previous week. She stated she remembered she and CNA A ensured the door and privacy curtain were closed after entering the room. She stated, most likely the facility staff who entered the room might have forgotten to close the door after leaving the room. During an interview on 12/08/25 at 12:30pm HK D stated he entered Resident #1's room about 15 minutes before and at that time the door was already opened. He stated he believed the hospice nurses might have forgotten to close the door before giving Resident #1 the bed bath. HK D stated he never thought of closing the door while the bed bath was being provided and kept the door as it was before, before leaving the room. HK D stated closing the door was important to make sure Resident #1's dignity. He stated he did not remember if he received any in service on privacy. During an interview on 12/08/25 at 1:15pm CNA C stated she entered Resident #1's room to supply lunch. She stated she did not remember if the door was already opened when she entered. CNA C stated when she entered the room CNA A and CNA B were providing bed bath to Resident #1. She stated she did not remember if she closed the door after delivering the lunch to Resident #1 and his roommate. CNA C stated closing the door and drawing the curtain was important while providing personal care to maintain privacy. During an interview on 12/08/25 at 1:30pm LVN E stated she was the charge nurse for Resident #1's hall. She stated she had observed CNA A and CNA B closing the door after they entered the room for giving bed bath to Resident #1. She stated, after that she had not noticed any other staff members entering the room as she was busy with administering medications. During an interview on 12/08/25 at 3:00 p.m., the DON stated that resident's privacy must be maintained during nursing care by closing doors, windows, and privacy curtains. She stated that other staff should not enter the room until care is completed unless urgent, and that any staff entering the room should ensure the door was closed upon entry and exit. The DON stated the facility ensured all the newly hired employees completed skill checks. She added that every nursing staff also had to complete an annual evaluation to ensure their nursing skills and knowledge including competency in privacy/confidentiality. During the review of the undated facility's policy titled Statement of Resident Rights, reflected: . An elderly individual has the right to be treated with dignity and respect for the personal integrity of the individual, without regard to race, religion, national origin, sex, age, disability, marital status, or source of payment. This means that the elderly individual. An elderly individual is entitled to privacy while attending to personal needs and a private place for receiving visitors or associating with other individuals unless providing privacy would infringe on the rights of other individuals.</p>		