STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455618	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Home	631 Lakeview Blvd New Braunfels, TX 78130

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 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** 46677 Based on record review and interview, the facility failed to ensure residents have the right to formulate an advance directive and determine the choice to receive or not receive CPR (cardiopulmonary resuscitation) for 1 of 6 residents (Resident #146) whose records were reviewed for code status. The facility failed to obtain a DNR order for Resident #146 upon admission, [DATE], based on her Living Will, dated [DATE]. This deficient practice could affect any resident who requested a DNR code status and could result in staff providing CPR for a resident who did not want to be resuscitated. The findings were: Review of Resident #146's face sheet, dated [DATE], revealed she was admitted to the facility on [DATE] with diagnoses including Cerebral Infarction and unspecified Atrial Fibrillation. Review of Resident #146's Living Will dated [DATE] reflected she did not want cardiac resuscitation. Review of Resident #146's clinical assessment, dated [DATE], did not reflect Resident #146's code status. Review of Resident #146's Baseline Care Plan, dated [DATE], reflected full code status. Interview on [DATE] at 12:05 PM with RN A revealed physician's orders reflected Resident #146 was full code. She stated usually the Admission Coordinator would talk to the family about the resident's wishes and would pass the information to the SW. The SW would prepare a DNR if that was their wish. The charge nurse would then call the MD to get a new order for a DNR. RN A stated based on Resident #146's Living Will, dated [DATE], staff should have requested a new order for a DNR upon admission. She stated nursing staff would perform CPR as needed because they did not have a DNR order in place as of this date, [DATE]. RN A stated that would be a violation of Resident #146's rights and she would suspect Resident #146 would be upset about being resuscitated which again was not what she wanted. In addition, RN A stated Resident #146, could sustain injuries, like broken ribs, which happened frequently when providing CPR to an elderly person. That would result in Resident #146 enduring unnecessary pain. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LVN/MDS Coordinator B and the SW on [DATE] at 01:15 PM revealed Resident #146's Living Will should have prompted nursing staff to obtain a request for a new order for a DNR. The SW stated typically the Admission Coordinator or the admission nurse would alert her about the resident's and family's wishes. She would then initiate an out of hospital DNR for Resident #146. LVN/MDS Coordinator B revealed a Care Plan meeting was scheduled on [DATE], but the family member did not show up and they would have discussed Resident #146's wishes for code status. Nevertheless, she stated nursing staff should have obtained a DNR physician's orders based on Resident #146's Living Will; as soon as the facility had record of it. The SW stated it was very important to ensure the resident's code status was accurate because it was the resident's life in question and their wishes. They had to ensure they followed the resident's wishes so there would not be any catastrophic consequences. The SW stated she had not been notified of Resident #146's wish for DNR code status and had not talked to the family. Interview on [DATE] at 02:07 PM the DON stated it was very important nursing staff obtained a DNR order in honoring Resident #146's wishes. She stated the facility had multiple safeguards in place to ensure a resident's code status was accurate. The DON also stated the Admission Coordinator would be the first person to discuss the resident's code status with the nurse transferring the resident to their facility. The Admission Coordinator would pass on the information to the SW and the admitting nurse would also discuss the code status with the family upon admission. The family would sign the Admission Agreement which reflected the code status was discussed with the family. The admitting nurse would enter the code status on the admission assessment. The DON stated the family signed the Admission Agreement on [DATE]. The DON stated she understood the code status on the physician's order for [DATE]. The DON stated unfortunately sometimes the family would go against the wishes of the resident. Telephone interview on [DATE] at 2:53 PM with Resident #146's family member revealed nursing staff called today asking her to sign paperwork for the resident's code status. She stated she did not know about Resident #146's Living Will but if Resident #146 wished not to be resuscitated then she would honor the resident's wishes. She stated she had not discussed Resident #146's code status with staff prior to this date, [DATE]. Review of facility policy, Advance Directive Documentation, dated [DATE], reflected in relevant part: All residents and or responsible party, at the time of the admission to the facility, are provided with information related to the resident's right under Texas to make decisions concerning medical care, include the right to accept or refuse medical or surgical treatment and the right to formulate advance directives. This facility respects the implementation of such rights and will follow physician's orders respecting such rights. Without physician's orders, facility staff may be required to institute interventions differ from the advanced directives.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46677 Based on interviews and record reviews the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures, for 1 of 5 residents (Residents #38) reviewed for reporting allegations of abuse and neglect. CNA C failed to report an incident of suspected abuse, from 11/09/2024, to the abuse and neglect coordinator until 11/11/2024 resulting in the allegation not being reported to the State Survey agency (HHSC) within the required 2 hours for suspected abuse. This deficient practice could place residents at risk for continued abuse and neglect. The findings included: Record review of Resident #38's face sheet dated 12/11/2024 revealed resident was an [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE]. Resident #38 had diagnoses that included Alzheimer's disease and unspecified dementia. Record review of the facility provided Provider Investigation Report dated 11/11/2024 revealed the incident was observed on 11/09/2024, time not recorded, and reported to HHSC on 11/11/2024 at 10:40 AM. CNA C reported to the Scheduler that she observed CNA D shoot the finger (flip the resident off with her the middle finger) at Resident #38. Interview with the Administrator on 12/12/2024 at 4:35 PM revealed she was the abuse and neglect coordinator. The Administrator stated all staff received training on when to report abuse and neglect, when they start employment and again annually or in response to incidents. Administrator also stated that there are signs hanging on each unit identifying the administrator as the abuse and neglect coordinator and her phone number. The Administrator stated that CNA C reported an incident that occurred on 11/09/2024 day shift, 6 AM to 2 PM, to the Scheduler on 11/11/2024 via phone. The Administrator stated the Scheduler reported the incident to her right away, she then reported it to HHSC and began the internal investigation. CNA C was counseled on when suspicions of abuse, neglect and exploitation needed to be reported. The Administrator went on to say she completed an in-service with all staff when to report abuse, neglect and exploitation on 11/12/2024 in response to the incident. Interview with the Scheduler on 12/13/2024 at 11:44 AM revealed CNA C called them on 11/11/2024 to report that she witnessed CNA D give Resident #38 the finger while they were providing care to Resident #38 on 11/09/2024. CNA C did not provide the time of the incident. The Scheduler stated CNA C was questioned why the incident was not reported to the Administrator who was the abuse and neglect coordinator. CNA C told them she did not want to get CNA D in trouble. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with CNA D on 12/13/2024 at 12:18 PM revealed CNA D stated she did not flip off Resident #38. She stated that she and other staff had issues with the CNA C. She stated the date in question, she was performing rounds with the nurse and when asked about certain residents and their care, she stated that those residents were on a hall assigned to CNA C. She stated that the nurse was concerned that some of the residents had not received care. She stated that had been an ongoing issue with that CNA not performing her duties and then blaming other staff. CNA D stated that she had since gained employment at another facility, and she was not returning to this facility due to the staff dynamics with CNA C. Interview with CNA C on 12/13/2024 at 1:04 PM revealed she worked the morning shift, 6 AM to 2 PM, on Saturday 11/09/2024 with CNA D. CNA D was assigned to Resident #38. CNA C stated that CNA D reported Resident #38 refused care from CNA D. CNA D asked CNA C to assist changing Resident #38. CNA C stated while she and CNA D were changing the resident, Resident #38 started to make remarks such as President Trump will send you back you your country. CNA C stated CNA D responded to Resident #38 saying I have papers and then flipped the resident the middle finger. CNA C asked CNA D to leave the room while CNA C completed care. CNA C stated the resident was calm and did not react to CNA D's gesture. CNA C discussed the incident with CNA D and told her flipping the middle finger was inappropriate. CNA C stated she did not report the incident to her supervisor or the Administrator right away because she did not want to get CNA D in trouble and Resident #38 was not upset by the incident. CNA C stated she received training on when to report abuse, neglect, and exploitation when she was hired and annually and in response to incident. Record review of facility policy named Abuse Prevention dated 08/29/2019 revealed 1. Reporting of all alleged violations to the Administrator, state agency, and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 Based on observation, interview and record review the facility failed to ensure the assessment must accurately reflect the resident's status for 2 of 6 Residents (Resident #48 and Resident #73) whose records were reviewed for assessments. 1. MDS staff failed to include Resident #48 was diagnosed with Major Depressive Disorder on her most recent quarterly MDS assessment, dated 9/22/24. 2. MDS staff failed to include Resident #73 was diagnosed with Major Depressive Disorder, Post Traumatic Stress Disorder on his most recent quarterly MDS assessment, dated 10/18/24. This deficient practice could affect any resident and could result in Residents not receiving needed care and services. The findings were: 1. Review of Resident #48's face sheet, dated 12/10/24, revealed she was admitted to the facility on [DATE] with diagnoses including Cerebral Infarction (Stroke) and unspecified Dementia. Review of Resident #48's Care Plan, revised on 9/23/24, revealed Resident #48 was scheduled for a psychological evaluation on 1/26/24. The results of the evaluation were not reflected in the Care Plan. Review of Resident #48's psychiatric progress note, not dated, revealed she was being treated for diagnosis to include Major Depressive Disorder. Review of Resident #48's physician's orders for December 2024 revealed an order for Sertraline HCl tablet, 25 MG Give 1 tablet by mouth one time a day for Depression Prescriber Written Active 02/06/2024 02/06/2024. Review of Resident #48's quarterly MDS assessment, dated 9/22/24, revealed her BIMS was 5 indicative of severe cognitive impairment. It did not reflect Resident #48 had a diagnosis of Major Depressive Disorder. Further review revealed she received an anti-depressant. Observation and interview on 12/11/24 at 11:05 AM revealed Resident #48 lying in bed. She engaged in conversation and was able to answer yes and no questions. It was noted she had a flat affect. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/13/24 PM at 01:29 PM with LVN/MDS Coordinator B revealed Resident #48 had a diagnosis of Major Depressive Disorder and was receiving Sertraline, an antidepressant. LVN/MDS Coordinator B stated Resident #48's quarterly MDS assessment, dated 9/22/24, did not reflect that she had MDD or that she was receiving Sertraline. She stated it was important Resident #48's MDS assessment reflect an accurate status of the resident to ensure the resident received needed care and services. 2. Review of Resident #73's face sheet, dated 12/13/24, revealed he was admitted to the facility on [DATE] with diagnoses including Post Traumatic Stress Disorder (PTSD), Chronic and Depression. Review of Resident #73's quarterly MDS assessment, dated 10/18/24, revealed his BIMS was 14 indicative of minimal cognitive impairment. The MDS assessment did not reflect Resident #73 had a chronic diagnoses of PTSD. Review of Resident #73's Care Plan, revised on 4/18/24 revealed the resident used anti-anxiety and anti-depressant medications Buspirone, Sertraline & Depakote related to anxiety, depression and PTSD. Review of Resident #73's psychiatric progress note, dated 12/9/24 revealed the provider was seeing Resident #43 for Major Depressive Disorder and PTSD. It was noted that Resident #43 endorsed a history of recurrent Major Depressive Disorder and PTSD since the 1970's. Observation and interview on 12/11/24 at 10:40 AM with Resident #73 revealed he completed two tours in Vietnam and was 100% disabled. He engaged in conversation and was able to answer surveyor's questions. Interview on 12/13/24 at 01:29 PM LVN/MDS Coordinator B stated Resident #73 had a diagnoses of Major Depressive Disorder and PTSD. She stated those diagnoses were not reflected in Resident #73's quarterly MDS assessment dated [DATE]. LVN/MDS Coordinator B it was important Resident #73's MDS assessment reflected an accurate status of the resident to ensure the resident received needed care and services. Interview on 12/13/24 at 02:07 PM the DON stated it was important that a resident's MDS assessment and care plan accurately reflected their status because nursing staff had access to these tools. She stated staff used them as a guide to help them understand a resident's needs and to provide the care and services based on the assessment and care plan. Review of facility policy, Minimum Data Set 3.0 dated 1/19/14 revealed: An MDS 3.0 will be completed for each [facility name] Resident: on admission, quarterly, annually, and when a significant change in condition occurs. The Medicare MDS will be done per PPS guidelines and time frames. Review of cms.gov website, DEPARTMENT OF HEALTH AND HUMAN SERVICES Centers for Medicare & Medicaid Services dated February 2016 reflected in relevant part: Skilled Nursing Facilities (SNFs) must assess the clinical condition of residents by completing required Minimum Data Set (MDS) 3.0 assessments. The Medicare-required PPS assessment schedule includes 5-day, 14-day, 30-day, 60-day, and 90-day scheduled assessments. Except for the first assessment (5-day assessment), each assessment is scheduled according to the resident's length of stay in Medicare-covered Part A care. Conducting the Assessment: Each assessment must: Accurately reflect the resident ' s status.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 Based on observation, interview and record review the facility failed to coordinate assessments with the pre-admission screening and resident review (PASARR) program for 2 of 6 Residents (Resident #48 and Resident #73) whose records were reviewed. 1. The facility failed to refer Resident #48 to the stated-designated authority after she was diagnosed with Major Depressive Disorder (MDD). 2. The facility failed to refer Resident #73 to the stated-designated authority after he was diagnosed with Major Depressive Disorder (MDD), Post Traumatic Stress Disorder. This deficient practice could affect a resident with a new onset diagnosis of mental disorder, intellectual disability, or a related condition and could result in residents not receiving needed care and services for identified psychiatric problems. The findings were: 1. Review of Resident #48's face sheet, dated 12/10/24, revealed she was admitted to the facility on [DATE] with diagnoses including Cerebral Infarction (Stroke) and unspecified Dementia. Review of Resident #48's quarterly MDS assessment, dated 9/22/24, revealed her BIMS was 5 indicative of severe cognitive impairment. Review of Resident #48's Care Plan, revised on 9/23/24, revealed Resident #48 was scheduled for a psychological evaluation on 1/26/24. The results of the evaluation were not reflected in the Care Plan. Review of Resident #48's most recent psychiatric progress note, not dated revealed she was being treated for diagnosis, Major Depressive Disorder. Observation and interview on 12/11/24 at 11:05 AM revealed Resident #48 lying in bed. She engaged in conversation and was able to answer yes and no questions. It was noted she had a flat affect. Interview on 12/13/24 PM at 01:29 PM with LVN/MDS Coordinator B revealed Resident #48 had a diagnosis of MDD; was receiving Sertraline an antidepressant and psychiatric services. LVN/MDS Coordinator B stated a diagnosis of MDD would prompt them to complete another PASARR screening because it was reflective of mental illness. LVN/MDS Coordinator B stated it was important to submit another PASARR screening to ensure that first of all Resident #48 was in the right placement and to ensure the resident received needed care and services. 2. Review of Resident #73's face sheet, dated 12/13/24, revealed he was admitted to the facility on [DATE] with diagnoses including Post Traumatic Stress Disorder (PTSD), Chronic and Depression. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #73's quarterly MDS assessment, dated 10/18/24, revealed his BIMS was 14 indicative of minimal cognitive impairment. Review of Resident #73's Care Plan, revised on 4/18/24 revealed the resident used anti-anxiety and anti-depressant medications Buspirone, Sertraline & Depakote related to anxiety, depression and PTSD. Review of Resident #73's psychiatric progress note, dated 12/9/24, revealed provider was treating Resident #73 for MDD and PTSD. It was noted that Resident #73 endorsed a history of recurrent Major Depressive Disorder and PTSD since the 1970's. Observation and interview on 12/11/24 at 10:40 AM with Resident #73 revealed he was lying down in bed. He engaged in conversation easily and stated he completed two tours in Vietnam and was 100% disabled. Interview on 12/13/24 at 01:29 PM with LVN/MDS Coordinator B revealed Resident #73 had a diagnoses of MDD and PTSD. She stated a diagnoses of MDD and or PTSD would prompt them to complete another PASARR screening because it was reflective of mental illness. She stated staff should have actually noted the diagnoses upon admission and should have completed another PASARR screening to reflect mental illness. LVN/MDS Coordinator B stated it was important to submit another PASARR screening to ensure that first of all Resident #73 was in the right placement and to ensure the resident received needed care and services. Interview on 12/13/24 at 02:07 PM with the DON revealed it was important to refer residents to PASARR for identified mental illness to ensure the residents received care and services as needed. Review of facility policy, Resident Assessment, Coordination with PASRR Program, dated 3/15/19 reflected in relevant part: Nursing facility coordinates assessments with the Preadmission screening and Resident review (PASRR) program under Medicaid to ensure that individuals with a mental illness (MI), or intellectual disability (ID), development disability (DD), or a related condition receives care and services in the most integrated setting appropriate to their needs. 9. Any resident who exhibits a newly evident or possible serious mental illness . will be promptly referred to the state mental health or intellectual disability authority for additional resident review.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46677 Based on observations, interviews, and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident to meet the resident's medical, nursing, mental and psychosocial needs that were identified in the comprehensive assessment and to ensure that the comprehensive care plan described the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 2 of 6 Residents (Resident #48 and Resident #73) whose records were reviewed. 1. MDS staff failed to include Resident #48 was diagnosed with Major Depressive Disorder (MDD), that she received Sertraline (anti-depressant) and was receiving psychiatric services on her most recent Care Plan, revised 9/23/24. 2. MDS staff failed to include Resident #73 was receiving psychiatric services for diagnoses including Major Depressive Disorder (MDD) and Post Traumatic Stress Disorder (PTSD) on his most recent Care Plan revised on 10/7/24. This deficient practice could affect any resident and could result in residents not receiving needed care and services for identified psychiatric problems. The findings were: 1. Review of Resident #48's face sheet, dated 12/10/24, revealed she was admitted to the facility on [DATE] with diagnoses including Cerebral Infarction (Stroke) and unspecified Dementia. Review of Resident #48's quarterly MDS assessment, dated 9/22/24, revealed her BIMS was 5 indicative of severe cognitive impairment. Review of Resident #48's psychiatric progress note, not dated revealed she was being treated for diagnosis to include Major Depressive Disorder. Review of Resident #48's physician's orders for December 2024 revealed an order for Sertraline HCl tablet, 25 MG Give 1 tablet by mouth one time a day for Depression Prescriber Written Active 02/06/2024 02/06/2024. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #48's Care Plan, revised on 9/23/24, revealed Resident #48 was scheduled for a psychological evaluation on 1/26/24. The results of the evaluation were not reflected in the Care Plan. The Care Plan did not reflect Resident #48 was diagnosed with Major Depressive Disorder of that she was receiving Sertraline (anti-depressant). Further review did not reflect Resident #48 was receiving psychiatric services. Observation and interview on 12/11/24 at 11:05 AM revealed Resident #48 lying in bed. She engaged in conversation and was able to answer yes and no questions. It was noted she had a flat affect. Interview on 12/13/24 PM at 01:29 PM with LVN/MDS Coordinator B revealed Resident #48 had a diagnosis of MDD and was receiving Sertraline, an antidepressant, and psychiatric services. LVN/MDS Coordinator B stated Resident #48's Care Plan revised on 9/23/24 did not reflect she had MDD or that she was receiving Sertraline. She stated it was important Resident #48's Care Plan reflect an accurate status of the resident to ensure the resident received needed care and services. 2. Review of Resident #73's face sheet, dated 12/13/24, revealed he was admitted to the facility on [DATE] with diagnoses including Post Traumatic Stress Disorder (PTSD), Chronic and Depression. Review of Resident #73's quarterly MDS assessment, dated 10/18/24, revealed his BIMS was 14 indicative of minimal cognitive impairment. Review of Resident #73's psychiatric progress note, dated 12/9/24 revealed the provider was treating Resident #43 for MDD and PTSD. It was noted that Resident #43 endorsed a history of recurrent Major Depressive Disorder and PTSD since the 1970's. Review of Resident #73's Care Plan, revised on 4/18/24 revealed the resident used anti-anxiety and anti-depressant medications Buspirone, Sertraline & Depakote related to anxiety, depression and PTSD. Further review did not reveal he was receiving psychiatric services. Interview on 12/11/24 at 10:40 AM with Resident #73 revealed he completed two tours in Vietnam and was 100% disabled. Interview on 12/13/24 at 01:29 PM with LVN/MDS Coordinator B revealed Resident #73 had a diagnoses of MDD and PTSD. She stated the resident's Care Plan, revised 4/18/24, did not reflect he was receiving psychiatric services. LVN/MDS Coordinator B stated it was important Resident #73's MDS and Care Plan reflected an accurate status of the resident to ensure he received needed care and services. Interview on 12/13/24 at 02:07 PM the DON stated it was important that a resident's MDS assessment and Care Plan accurately reflected their status because nursing staff had access to these tools. She stated staff used them as a guide to help them understand a Resident's needs and to provide the care and services based on the assessment and Care Plan. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455618	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Home	631 Lakeview Blvd New Braunfels, TX 78130

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy, Comprehensive Care Plans, dated 3/15/19, reflected in relevant part: It is the policy of [facility name] to develop and implement a comprehensive person-centered care plan for each resident, consistent with residents rights, that includes measurable objectives and timeframe's to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident comprehensive assessment. Policy Explanation and Compliance Guidelines: 1. The care planning process will include an assessment of the resident's strengths and needs. 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. 5. The comprehensive care plan will be reviewed by the interdisciplinary team after each comprehensive and quarterly MDS assessment.