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	03/20/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents who need respiratory care were provided such care, consistent with professional standards of practice for 2 of 2 residents (Resident #91 and Resident #117) and in 1 of 1 oxygen storage rooms reviewed for respiratory care. 1. Resident #91's nasal cannulas for oxygen and BiPAP (bilevel positive airway pressure) mask were not covered in a plastic bag when they were not used on 03/17/2026. 2. The facility failed to ensure Resident #117's oxygen concentrator was set to 2 to 3 liters per minute as ordered by the physician on 03/17/2026 and 03/18/2026. 3. Stored oxygen was not separated -1 oxygen cylinder that was empty was in the full area. 1 oxygen cylinder that was empty was in the full side. This failure could place residents at risk of illness, respiratory complications and accidents. The findings included:3. Observation on 3/18/2026 at 9:19 AM in the oxygen cylinder room, revealed 15 oxygen tanks. There was 1 oxygen cylinder that was empty in the full side and 1 oxygen cylinder that was full on the empty side. Interview on 3/18/2026 at 9:19 AM with RN E confirmed 1 oxygen cylinder that was empty on the full side and 1 oxygen cylinder that was full on the empty side. RN E confirmed all full oxygen cylinders should be on the full side of the room, and all empty cylinders should be on the empty side of the room. Interview on 03/19/2026 at 4:33 PM with the DON stated all the full oxygen cylinders should be in the full side, and the empty cylinders should be in the empty side of the room. DON stated they did not have a policy for the oxygen cylinder room. Interview on 3/20/2026 at 11:11 AM with ADM stated she was not aware the oxygen cylinders were mixed up in the room. Oxygen policy requested from administraor but was not provided prior to exit. Record review of Resident #117's face sheet, dated 03/17/2026, revealed she was admitted to the facility on [DATE] with diagnoses which included: chronic obstructive pulmonary disease, unspecified, atherosclerotic heart disease of native coronary artery without angina pectoris (buildup of plaque inside the artery walls), and generalized anxiety disorder. Record review of Resident #117's Quarterly MDS assessment, dated 02/03/2026, revealed the resident's BIMS score was 11, which indicated moderate cognitive impairment. Section O Special Treatments, Procedures, and Programs revealed C1 Oxygen Therapy was coded for Resident #117's oxygen use while a resident. Record review of Resident #117's care plan, initiated date of 01/01/2026, revealed a focus of The resident has oxygen therapy r/t COPD with an intervention of OXYGEN SETTINGS: O2 @ 2-3 LPM VIA (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	NC AS NEEDED FOR O2 SAT 90%. Record review of Resident #117's physician order summary report, dated, 03/17/2026, revealed a physician order reading O2 @ 2-3 LPM VIA NCAS NEEDED FOR O2 @ SAT<90% every 24 hours as needed for SOB with a start date of 07/31/2025. Observation on 03/17/2026 at 11:02 a.m. revealed Resident #117 lying in bed with the head of bed elevate wearing nasal cannula and oxygen concentrator set at 4 liters per minute. Observation and interview on 03/18/2026 at 9:46 a.m. revealed Resident #117 lying in her bed with the head of the bed elevated, wearing her nasal cannula and oxygen concentrator set at 4 liters per minute. Resident #117 stated she had been using oxygen since she was admitted to the facility about a year ago. Resident #117 further stated the oxygen concentrator should have been set at around 2 liters per minute, then asked what it was set at and she stated 4 liters per minute was rather high. During an interview and observation on 03/18/2026 at 9:57 a.m. RN B stated Resident #117's oxygen concentrator should have been set at 2 liters per minute. RN B was observed checking Resident #117's oxygen concentrator and stated oh, no it's set at 4 liters per minute, and adjusted the oxygen concentrator to 2 liters per minute. RN B stated as long as she had been working with Resident #117 the oxygen concentrator had been set at 2 liters per minute. RN B stated that by not having the oxygen concentrator properly set it could affect Resident #117's oxygenation. RN B further stated by the oxygen concentrator having been set at 4 liters per minute it could have caused a buildup of carbon monoxide. RN B was observed reviewing Resident #117's physician orders and RN B stated Resident 117's physician order was for 2 to 3 liters per minute. RN B stated maybe the oxygen concentrator was turned up due to Resident #117 having been declining but she was not sure. During an interview on 03/19/2026 at 4:09 p.m. the DON stated by not following physician's orders or setting a resident's oxygen concentrator too high it could cause a resident to get too much oxygen and their CO2 levels could be too high. The DON further stated this could cause a resident to become confused. The DON stated the nurses were responsible for making sure the oxygen concentrators were set to the right liters per minute. During an interview on 03/20/2026 at 1:47 p.m. the Administrator stated the nurse was responsible for ensuring oxygen concentrators were set at the proper settings. The Administrator further stated if the oxygen concentrator was too high a person with COPD could possibly have damage to their lungs or if too low it could take the O2 (oxygen) SATS (saturations) down. Record review of facility's policy titled Oxygen Therapy,, dated 03/16/2022, read, Policy: To ensure residents who require oxygen receive it safely according to physician guidelines and orders. 1. Record review of Resident #91's face sheet, dated 03/20/2026, revealed the resident was an 89-years-old male and admitted to the facility on [DATE] with diagnoses of muscle wasting and atrophy (loss of skeletal muscle mass), acute respiratory failure (when fluid leaks from small blood vessels in the lungs and builds up in the air sacs), and chronic obstructive pulmonary disease (common lung disease causing restricted airflow and breathing problems). Record review of Resident #91's admission MDS assessment, dated 01/20/2026, revealed the resident's BIMS score was 15 out of 15 which indicated the resident's cognition was intact and was (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	receiving oxygen therapy and non-invasive mechanical ventilator (BiPAP - bilevel positive airway pressure). Record review of Resident #91's comprehensive care plan, dated 02/23/2026, revealed the resident had the care plans of [Resident #91] has altered respiratory status/difficulty breathing related to chronic obstructive pulmonary disease. For interventions - BIPAP via full-face mask to be worn at night while sleeping and OXYGEN SETTINGS: O2 (oxygen) via NC (nasal cannula) at 3.5 liter per minute continuously and per physician orders. Record review of Resident #91's physician order, starting dated 01/14/2026, revealed the resident had the orders of Bipap to be worn every night while sleeping every night shift, change nebulizer tubing, ensure it is bagged and dated; wipe/clean nebulizer machine with disinfecting wipe every night shift every Friday, change oxygen concentrator/tank tubing, ensure it is bagged & dated; change humidifier water bottle & date it; check & clean oxygen concentrator filter; ensure sign is in place on door; wipe/clean oxygen concentrator with disinfecting wipe every night shift every Friday, and oxygen at 3.5 liter per minute via nasal cannula continuously every shift. Observation on 03/17/2026 at 10:45 a.m. revealed Resident #91 was not in the room, but there was an oxygen concentrator at the bedside, and the nasal cannula was on the concentrator not covered with a plastic bag. There was also a Bipap machine at the nightstand, and the mask connected to the machine was on the nightstand not covered with a plastic bag. In Resident #91's restroom, another nasal cannula was on the walker not covered with a plastic bag. Interview on 03/17/2026 at 11:38 a.m. with RN-G stated Resident #91's nasal cannulas for oxygen and BiPAP mask were not covered in a plastic bag when they were not used. The nurse said they should have been covered with plastic bags to prevent infection, and it was the facility nurse's responsibility. Interview on 03/19/2026 at 3:45 p.m. with the DON said the facility nurses should have covered Resident #91's nasal cannula and Bipap mask with a plastic bag to prevent infection. Record review of the facility policy, titled oxygen therapy, dated 04/19/2018, revealed . 14. Nasal cannula will be cleaned with cotton tipped applicator and normal saline as needed. Replacement of tubing and humidifier will be done weekly, on Friday and dated. Oxygen masks will be cleaned with normal saline and dried as needed and changed and dated weekly. When not in use, nasal cannula or mask will be stored in Ziplock bag and kept in beside drawer.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 out of 2 medication rooms (500-hall medication room), 2 out of 5 medication carts (500-hall B nursing cart and 500-hall A nursing cart), and 2 of 7 residents (Residents #52 and #155) reviewed for pharmacy services. 1. There was one box of refresh plus eye drop lubricant 50 vials that expired 01/2026 found inside the 500-hall medication room on 03/18/2026. 2. There was one bottle of Mucinex 600 mg guaifenesin extended-release that expired 12/09/2025 found inside the 500-hall B nursing cart on 03/18/2026. 3. There was one insulin lispro injection pen of Resident #52 that was opened on 02/09/2026 found inside the 500-hall A nursing cart on 03/18/2026. 4. MA-I took Resident #55's blood pressure and failed to notify the charge nurse of the low blood pressure prior to administering the blood pressure medication. This failure could place residents at risk of inaccurate drug administration and not having appropriate therapeutic effects. The findings included: 1. Observation on 03/18/2026 at 2:34 p.m. revealed inside the 500-hall medication room, there was one box of refresh plus eye drop lubricant eye drops 50 vials, and they were all expired 01/2026. Interview on 03/18/2026 at 2:34 p.m. with RN-B stated there was one box of refresh plus eye drop lubricant eye drops 50 vials, and they were all expired 01/2026. RN-B said the one box of refresh plus eye drop lubricant eye drops 50 vials should have been discarded, but the nurse did not know what reason the medications were still in the 500-hall medication room, and if a nurse used the expired medications, residents might have dry eyes. 2. Observation on 03/18/2026 at 2:46 p.m. revealed inside the 500-hall B nursing cart, there was one bottle of Mucinex 600 mg guaifenesin extended-release, and the medication expired 12/09/2025. Interview on 03/18/2026 at 2:46 p.m. with RN-B stated inside the 500-hall B nursing cart, there was one bottle of Mucinex 600 mg guaifenesin extended-release, and the medication expired 12/09/2025. RN-B said the one bottle of Mucinex 600 mg guaifenesin extended-release should have been discarded, but the nurse did not know what reason the medications were still in the 500-hall B nursing cart, and if a nurse used the expired medications, residents might have mucus. 3. Record review of Resident #52's face sheet, dated 03/20/2026, revealed the resident was a 78-years-old female, originally admitted on [DATE], and readmitted to the facility on [DATE] with diagnoses of displaced bicondylar fracture of right tibia (right knee fracture), type 2 diabetes mellitus (a condition where the body has trouble regulating blood sugar levels, leading to persistently high blood glucose levels), and muscle weakness. Record review of Resident #52's quarterly MDS assessment, dated 03/01/2026, revealed the resident's BIMS score was 11 out of 15 which indicated the resident had moderate cognitive impairment and received insulin injections. Record review of Resident #52's physician order, starting dated 11/23/2025, revealed the resident had the order of Insulin Lispro (1 Unit Dial) Subcutaneous Solution Pen injector 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale: if 150 - 200 = 2 Units; 201 - 250 = 4 Units; 251 - 300 = 6 Units; 301 - 350 = 8 Units; 351 - 400 = 10 Units; 401 more Call doctor, subcutaneously before meals and at bedtime for Diabetes. Observation on 03/18/2026 at 2:53 p.m. revealed inside the 500-hall A nursing cart, there was Resident #52's Insulin Lispro Pen Injector, and it was opened on 02/09/2026. Interview on 03/18/2026 at 2:53 p.m. with LVN-J stated there was Resident #52's Insulin Lispro Pen Injector inside the 500-hall A nursing cart, and it was opened on 02/09/2026. The nurse said per the facility policy, they should have discarded Resident #52's insulin Lispro pen 28 days after it was opened, and the date was 03/09/2026. LVN-J said she used a new insulin Lispro pen for the resident on 03/18/2026, but other nurses might use it and the nurse said she did not know what reason the nurses did not discard it on 03/09/2026, and if a nurse used the expired insulin, residents might not have normal blood sugars. 4. Record review of Resident #155's face sheet, dated 03/20/2026, (continued on next page)

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	455618	A. Building B. Wing	03/20/2026

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

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revealed the resident was a 79-years-old female, originally admitted on [DATE], and readmitted to the facility on [DATE] with diagnoses of arthritis (redness and swelling - inflammation of a joint), type 2 diabetes mellitus (a condition where the body has trouble regulating blood sugar levels, leading to persistently high blood glucose levels), and hypertension (high blood pressures). Record review of Resident #155's admission MDS assessment, dated 03/19/2026, revealed the assessment was still in progress because the resident was admitted to the facility on [DATE]. Record review of Resident #155's physician order, starting dated 03/06/2026, revealed the resident had the order of Enalapril Maleate Tablet 20 milligram - Give 1 tablet by mouth two times a day for BLOOD PRESSURE. Further record review of the resident's physician order revealed there was no specific parameter regarding holding the medications for blood pressures. Observation on 03/19/2026 at 8:39 a.m. revealed MA-I took Resident #155's blood pressure before giving the resident's medications, and the blood pressure was 113/54 and pulse 85 per minute. MA-I gave the medication of Enalapril Maleate Tablet 20 milligram 1 tablet to Resident #155, and the resident took it by mouth. Interview on 03/19/2026 at 8:44 a.m. with MA-I said Resident #155 did not have specific parameter regarding holding blood pressure medications, but MA-I said she generally held Resident #155's Enalapril Maleate if the resident's systolic blood pressure (top number) was less than 100 and reported it to the charge nurse. Further interview on 03/19/2026 at 2:09 p.m. with MA-I said she should have reported Resident #155's blood pressure to the charge nurse because the resident's diastolic blood pressure was 54, and it was a little bit low to normal range, and it was her mistake. Interview on 03/19/2026 at 1:55 p.m. with the DON said Resident #155's primary care physician did not give specific blood pressure parameter regarding the resident's Enalapril Maleate because the physician wanted to know the resident's blood pressure whenever the facility nurses notified if the blood pressures were out of normal ranges. The DON said the facility did not have specific policy regarding blood pressure, but the facility medication aides should take blood pressure before giving blood pressure medications, and if the values were out of normal ranges, medication aides should report to the charge nurse, and the charge nurses should retake the blood pressure with a manual blood pressure cuff. The DON stated the normal blood pressure values were between 110/60 to 140/90. The DON said MA-I should have reported Resident #155's blood pressure to the charge nurse before giving the resident's Enalapril Maleate because the resident's blood pressure was 113/54 to prevent possible adverse effects, and Resident #155 did not have any side effects and cardiac issue. Further interview with the DON on 03/19/2026 at 3:45 p.m. said the facility did not have specific policy regarding expired medication, but the facility never used any expired medication. Interview on 03/19/2026 at 2:07 p.m. with RN-K stated MA-I should have reported Resident #155's blood pressure to the charge nurse before giving the resident's Enalapril Maleate because the resident's blood pressure was 113/54 to prevent possible adverse effects, and if MA-I reported to the nurse, the nurse might retake the resident's blood pressure with a manual blood pressure cuff. The nurse said she retook the resident's blood pressure at 2:00 pm with a manual cuff, and it was normal range 120/80. Record review of the facility policy, titled Insulin Discard After Dates, revised 03/29/2021, revealed Humalog vitals and pen (Lispro) - discard date after opening at room temperature 28 days.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, the facility failed to, in accordance with accepted professional standards and practices, maintain medical records on each resident that were complete for 1 of 6 residents (Resident #105) and the facility failed to safeguard medical record information against loss, destruction, or unauthorized use for 1 of 4 halls (hall#8000), reviewed for Administration. 1. The facility failed to ensure Resident #105's wound care physician visits and notes were documented in the resident's EHR prior to or after the resident's discharge on [DATE]. 2. The facility failed to ensure the Medical Records room/Staff break room was closed and kept private and secure. These failures could place residents at risk of not receiving appropriate follow up care, decreased continuity of care, and loss or unauthorized use of their medical records.The findings were: 1. Record review of Resident #105's face sheet dated 3/17/26 revealed the resident was a [AGE] year-old male admitted to the facility on [DATE]. Resident #105's diagnoses included fusion of spine cervical region (surgical procedure that permanently connects two or more vertebrae in the neck), central cord syndrome at unspecified level of cervical spine (an incomplete spinal cord injury to the neck), muscle wasting and atrophy not elsewhere classified multiple sites (wasting or loss of muscle tissue), and other abnormalities of gait and mobility (abnormal walking pattern and the ability to move freely, coordination). The resident discharged home with home health on 3/9/26. Record review of Resident #105's admission MDS assessment dated [DATE] indicated the resident had clear speech, was understood by others and had clear comprehension. The resident had a BIMS score of 13 of 15 indicating the resident was cognitively intact The resident was Dependent - helper does all of the effort and the resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity for rolling in bed, lying to sitting, sit to stand, and all transfers. The resident had a urinary catheter, was always incontinent of bowel, was at risk for pressure ulcers/injuries but did not have any currently. The resident also had moisture associated skin damage (MASD). Record review of Resident #105's undated care plan revealed a focus initiated on 1/22/26 for the resident was admitted with an unstageable pressure ulcer to his sacral/buttocks and the potential for pressure ulcer development r/t immobility and refusal of use of pressure relieving devices, resident refuses to lay down during the day because laying down hurts his neck/back injury, refused air mattress due to it being too hard and him not being able to tolerate it even on alternating low pressure settings. And added to this focus dated 2/15/26 for a new unstageable pressure ulcer to the left heel, with interventions that included Assess/record/monitor wound healing weekly measure length, width, and depth where possible. Assess and document status of wound perimeter, wound bed, and healing progress. Report improvements and declines to the MD. Record review of Resident #105's weekly wound care nurse wound assessments revealed ten total assessments dated 1/19/26, 1/26/26, 2/2/26, 2/10/26, 2/15/26, 2/17/26, and 2 assessments for each wound on 2/23/26 and 3/4/26 were all created and signed on 3/10/26 by LVN C the day after the resident discharged from the facility. Record review of Resident #105's EHR on 3/19/26 at 11:35 a.m. revealed there were no wound care physician progress notes and no documentation the wound care physician had seen the resident. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #105's EHR on 3/20/26 at 11:00 a.m. revealed there was one physician wound care progress note with an effective date of 2/19/26 that was uploaded on 3/20/26 at 10:58 a.m. In a joint interview on 3/19/26 at 12:43 p.m. with LVN C and LVN D. LVN C stated she had been at the facility for 6 years and was taking over the wound care nurse position from LVN D but LVN D was still assisting as LVN C was still training. LVN C stated she did enter the weekly wound care nurse wound assessments on 3/10/26 in the computer but she had them all documented on paper and had put them all in on the same day on 3/10/26 as she was still learning the system. LVN C and LVN D stated Resident #105 was seen by the wound care physician weekly. LVN D stated his progress visit notes may not be uploaded yet and she would check with medical records and would call the physician for his notes. In an interview on 3/20/26 at 10:50 a.m. LVN D stated she did not know if the physician's wound care progress notes should have been in Resident #105's EHR prior to his discharge on [DATE]. In an interview on 3/20/26 at 11:00 a.m. LVN D stated the wound care physician progress notes had been uploaded to Resident #105's EHR under the miscellaneous tab. LVN D stated the progress note dated 2/19/26 was the only note as that was the only time he saw the resident as the resident was in the hospital one week and the wound care physician did not come another week. In an interview on 3/20/26 at 12:00 p.m. the DON stated it depended on if the physician had sent the facility his progress notes or not as to whether the wound care notes should have been in Resident #105's EHR from 2/19/26 to his discharge on [DATE] or prior to today. The DON was non-responsive when asked to elaborate. The DON stated there were no possible consequences to the resident for his wound care progress notes not being entered in the resident's medical record. Review of the facility policy on medical records dated 11/2/2020 indicated This facility will maintain electronic clinical records for each resident in accordance with acceptable standards of practice. 1. A complete and accurate electronic clinical record will be maintained on each resident and kept accessible and systematically organized for appropriate personnel to deliver the appropriate level of care for each resident. Electronic clinical records will contain at least but are not limited to .c. Physician documentation. Observation on 3/18/2026 at 9:19 AM on the Bluebonnet hall (8000) revealed the staff break room was open, had a microwave, a bathroom, a spa, and had personal resident records on a shelf. The resident charts had their face sheet, orders, miscellaneous records and the hospice resident charts were kept in the room. Interview on 3/18/2026 at 9:20 AM RN E stated this room had always been a break room with residents' personal charts on a shelf. Observation on 3/19/2026 at 10:16 AM revealed the staff break room was open and had resident personal records in the room. (same staff room as above). Interview on 3/19/2026 at 10:19 AM with LVN F stated the open door was a staff break room, had a bathroom, a spa, a microwave and where they kept the resident personal charts. LVN F stated not everyone has access to charts. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 3/19/2026 at 4:33 PM the DON stated she did not see an issue with the staff/personal charts room and the door being opened. The DON stated she could guarantee the residents/family could not go into the staff/personal resident chart room. The DON stated there was minimal information in the resident charts. Interview on 3/20/2026 at 11:11 AM with ADM stated she was not aware the staff/resident chart room was open and the charts contained vital information of residents. Review of the facility policy on medical records dated 11/2/2020 indicated This facility will maintain electronic clinical records for each resident in accordance with acceptable standards of practice. 6. Caution should be used when sharing confidential medical information about residents with employees or other providers from the clinical record. 8. Unauthorized personnel are permitted to review records only with the signed permission of the resident or a legal document allowing such access.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received services in the facility with reasonable accommodation of resident needs for 1 of 8 residents (Resident #117) who were observed for call light placement. The facility failed to ensure the call light which had been placed on Resident #117's oxygen concentrator was within reach for Resident #117. This deficient practice could place residents at risk of not being able to call for help as needed.The findings included: Record review of Resident #117's face sheet, dated 03/17/2026, revealed she was admitted to the facility on [DATE] with diagnoses which included: carcinoma (cancer) in situation of anus and anal canal, generalized anxiety disorder, muscle wasting and atrophy, not elsewhere classified, multiple sites, unsteadiness on feet, other abnormalities of gait and mobility, need for assistance with personal care, and history of falling.Record review of Resident #117's Quarterly MDS assessment, dated 02/03/2026, revealed the resident's BIMS score was 11, which indicated moderate cognitive impairment. The Quarterly MDS assessment further revealed Resident #117 required partial/moderate assistance (helper does less than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) for shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear, personal hygiene, and supervision or touching assistance (helper provides verbal cues and/or touching/steading and/or contact guard assistance as resident completes activity) for chair/bed-to-chair transfer, toilet transfer, and tub/shower transfer.Record review of Resident #117's care plan, initiated date of 08/01/2025, revealed a focus of Fall Risk: Resident is at risk for fall due to disease process with an intervention of Keep call light within easy reach, teach and encourage to use it.Observation and Interview on 03/17/2026 at 11:02 a.m. revealed Resident #117 was observed lying in bed with the head of bed elevated, her covers over her legs and call light hanging through the handle of the oxygen concentrator at the left side of the head of her bed. Resident #117 stated she did use her button when she needed help and felt with her hand the quarter bed rail near the head of the bed and could not locate it. When Resident #117 stated she could not feel it with her hand she stated, I do not know where it is, they usually put it here.Observation on 03/17/2026 at 11:52 a.m. revealed Resident #117's call light remained hanging from her oxygen concentrator through the handle of the oxygen concentrator where she could not reach it. During interview and observation on 03/17/2026 at 12:11 p.m. CNA A stated Resident #117 typically used her call light and Resident #117 had a shower that morning and the hospice helped her back in bed. CNA A further stated Resident #117 had woken up confused that morning and Resident would use her call light sometimes. CNA A stated Resident #117 would not have been able to reach it where it was located and then CNA A wrapped the call light around the quarter rail at the head of the bed within reach of Resident #117. CNA A stated they would usually wrap Resident #117's call light to the side rail so it was close. CNA A stated residents used the call light for getting help and if they needed assistance, to go to the restroom, if they wanted water or anything. CNA A stated by residents not having the call light the staff would not be aware of when a resident needed something.During an interview on 03/19/2026 at 4:02 p.m. the DON stated it was everyone's responsibility, including the hospice who was in there earlier to ensure residents have their call lights. The DON could not answer when staff would go into check on residents after hospice had provided care. The DON stated residents used the call lights to contact staff. During an interview on 03/20/2026 at 1:51 p.m. the Administrator stated everyone was responsible for ensuring call lights were in place. The Administrator stated by Resident #117 not having the call light within reach she could try to get up herself and fall or not be able to call for help. The Administrator stated call lights were used to notify staff when someone needed help or assistance. Record review of facility's Fall Prevention policy, dated 09/16/2020, read Policy: Each resident will be assessed for the risks of falling and will receive care and services in accordance with the level of risk to minimize the likelihood of falls. Policy Explanation and Compliance Guidelines: 5. (continued on next page)

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	455618	A. Building B. Wing	03/20/2026

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Low/Moderate Risk Protocols: a. Implement universal environmental interventions that decrease the risk of resident falling, including, but not limited to: iii. Call light and frequently used items are within reach.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review the facility failed to ensure the resident had the right to and the facility promoted and facilitated resident self-determination through support of resident choice, including the right to make choices about aspects of his or her life in the facility that are significant to the resident for 1 of 8 (Resident #136) residents in that:Resident #136 was not able to eat in her room, which was her preference.This failure could affects the residents' ability to live a dignified life at facility.The findings: .Record review of Resident #136's admission Record dated 3/18/2026 reflected that she was admitted on [DATE], re-admitted on [DATE] with diagnoses of multiple sclerosis (is a chronic autoimmune disease in which the immune system attacks the protective myelin sheath surrounding nerve fibers in the brain and spinal cord, disrupting communication between the brain and the rest of the body), dysarthria following other cerebrovascular disease (motor speech disorder caused by neurological injury, which affects the muscles used for speaking) , anxiety, quadriplegia (symptom of paralysis that affects all a person's limbs and body from the neck down), cognitive communication deficit (condition where a person's ability to communicate effectively is compromised by an underlying impairment in mental processes, rather than a primary problem with language or speech.), need assistance with personal care, dependence on wheelchair, contracture) (affect your skin, muscles, joints, tendons or other soft tissues. It happens when scarring or fibrosis makes the tissues tighten and stiffen. Without swift intervention, contracture can permanently reduce your range of motion) to right elbow, right hand and left hand.Record review of Resident #136's Quarterly MDS dated [DATE] revealed she had a BIMS of 15/15 (cognitively intact), she used an electric wheelchair, she was dependent on staff for all ADLs, she was always incontinent, she had quadriplegia, multiple sclerosis, anxiety, multiple contractures, and speech disturbances.Record review of Resident #136's care plan dated 12/2/2025 revealed she had Multiple sclerosis, hand contractures, she required assistance for all ADLs, at risk for impaired social interaction related to limited mobility, and dependent on staff for meeting emotional, intellectual, physical, and social needs related to depression and MS.Record review of Grievance for Resident #136, dated 1/12/2026, written by the SW stated Residents, [family member] reported that resident was brought to the dining area, approximately 1.5 hours prior to lunch with her bib already in place. {Resident #136's} family stated {Resident #136} informed staff that she did not wish to eat in the dining room: however, she was informed that due to the number of residents requiring assistance with feeding, this would not be possible. The resident stated that she felt embarrassed sitting in the dining area with her bib on for an extended period of time and reported that she had to stare at a wall for approximately 1.5 hours before the meal was served, as there was no TV available for her to watch. Signed and dated 1/13/2026 by SW and ADM. SW informed the ADM on 1/13/2026.Record Review of progress note by RN E dated 1/11/2026 at 2:20 PM, reflectedPatient upset that staff brought her out to dining room for lunch to be fed. Not enough staff on floor to feed everyone in room. Explained to patient the situation. She remained unagreeable. Notified DON of situation and she agreed with bringing patient to dining room. Patient was fed lunch and taken back to room once completed. Observation on 3/17/2026 at 11:58 AM with Resident #136 revealed she required a computer to assist her with communicating and could speak out in phrases but was difficult to understand. Resident #136 was in her electric wheelchair and was moving eyes to type out words and phrases on her computer laptop. Observation on 3/20/2026 at 1:50 PM with Resident #136, revealed was being feed by CNA in her room. Interview on 3/19/2026 at 4:33 PM with the DON stated LVN E did notify her about Resident #136, not wanting to eat in the dining room. DON stated she felt it was safer for Resident #136 to eat in the dining room. DON stated it takes staff an hour to feed Resident #136. Interview on 3/20/2026 at 10:30 AM with SW stated Resident #136's family member, had come (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in and reported Resident #136 had texted her the above grievance. SW stated Resident #136 required assistance with feeding with 1 staff, and that day she was asked to get out of her room to go to the dining room. SW stated Resident #136 does not like coming out of her room. SW stated Resident #136's BIMs level is 15/15, she likes to be in her room, so she could communicate with laptop computer device, and took her time to focus, she was able to type out phrases with her eyes. Interview on 3/20/2026 at 11:28 am with MDS nurse, stated Resident #136 preferred to be in her room, she used the computer to communicate with staff. MDS nurse stated she was not aware of the situation Interview on 03/20/2026 at 2:00 PM with RN E stated they did not have enough staff to feed Resident #136 in her room. RN E called DON and explained situation (Resident #136 wanted to eat in her room, and not enough staff to feed Resident #136 in her room). RN E stated that it would be better if Resident #136 ate in the dining room. RN E stated Resident #136 did not have to wait. RN E stated Resident #136 was ok eating in the dining room. Interview on 3/20/2026 at 11:11 AM with ADM stated she did get the grievance report for Resident #136 , and would have to research it more. ADM stated this incident with Resident #136 was a grievance and not reportable to the state. ADM stated it was Resident #136's preference to stay in her room, she has her computer to communicate with staff/visitors. Record review of policy, Resident Rights, (no date) reflected Residents of Texas nursing facility have all the rights, benefits, responsibilities, and privileges granted by the constitution and laws of the state and 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. Dignity and Respect, you have the right to be treated with dignity, courtesy, consideration and respect. Freedom of Choice, you have a right to make your own choices regarding personal affairs, care, benefits and services.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide a safe, clean, comfortable, and homelike environment for 1 (Resident #156) out of 26 residents reviewed for environmental concerns. Resident #156's toilet seat was dirty with feces, and staff did not flush feces inside the toilet. This failure could place residents at risk of a diminished quality of life due to exposure to an environment that is unpleasant, unsanitary, and unsafe.The findings were: Record review of Resident #156's face sheet, dated 03/20/2026, revealed the resident was an 88-years-old female and admitted to the facility on [DATE] with the diagnoses of muscle weakness, Parkinson's disease (progressive movement disorder of nervous system), and depression (lowering of a person's mood). Record review of Resident #156's admission MDS assessment, dated on 03/20/2026, revealed the MDS assessment was still in progress because the resident was admitted to the facility on [DATE]. Record review of Resident #156's baseline care plan, dated 03/12/2026, revealed the resident had the care plan of Resident has potential for self-care deficit due to impaired mobility and weakness. For intervention - TOILETING: Requires assistance of one staff. Observation on 03/17/2026 at 10:40 a.m. revealed Resident #156 was on the wheelchair and watching TV in her room. The room had a bathroom, and on the toilet seat, there were brown color particles, and it looked like human feces. Further observation revealed inside the toilet, there was a lump of feces. Interview on 03/17/2026 at 10:42 a.m. with Resident #156 stated Resident #156 could not use her bathroom by herself, and staff should help Resident #156 to use the bathroom. Resident #156 said every staff was very nice and helped Resident #156 whenever Resident #156 required and did not know if or not staff cleaned the bathroom. Interview on 03/17/2026 at 11:34 a.m. with RN-G stated there were brown color particles on the toilet seat and it was feces, and there was a lump of feces inside the toilet in Resident #156's bathroom. RN-G said staff did not clean the toilet seat and did not flush the toilet because Resident #156 could not use the bathroom by herself, and staff should put the resident on the toilet seat, clean the resident when the resident finished bowel movements on the toilet, and flush the toilet because the resident could not flush toilet by herself. RN-G said she did not know what reason the staff did not clean and did not flush the toilet, and a dirty bathroom might cause diminished quality of life to the resident. Interview on 03/19/2026 at 3:59 p.m. with DON said staff should have cleaned the toilet seat and should have flushed Resident #156's toilet after helping the resident's bowel movement, and the resident had the right to have a clean and sanitary environment. Record review of the facility policy, titled Resident's Right, dated 11/2021, revealed Dignity and Respect - you have the right to live in safe, decent and clean conditions.

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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** Based on interviews and record reviews the facility failed to ensure the assessment accurately reflected the residents' status for 1 of 8 (Resident #94) residents in that:Resident #94's MDS was not accurate and did not reflect her indwelling catheter.This failure could affect all residents and staff could not know how to provide care to residents.Findings:Record review of Resident #94's admission Record dated 3/20/2026 revealed she was admitted on [DATE] with neuromuscular dysfunction of bladder (refers to what happens when an injury or disease interrupts the electrical signals between your nervous system and bladder function). Record review of Resident #94's consolidated orders for March 2026 revealed she had an order for indwelling foley catheter 16 French (tubing size) for diagnosis of urine retention every shift. May use leg bag while up during day.Record review of Resident #94's Quarterly MDS dated [DATE] revealed she was not marked for have an indwelling catheter.Record review of Resident #94's care plan dated 3/9/2026 revealed she had an indwelling catheter for neurogenic bladder (refers to what happens when an injury or disease interrupts the electrical signals between your nervous system and bladder function).Interview on 3/18/2026 at 10:31 AM with Resident #94 stated she had a leg catheter on at this time.Interview on 3/19/2026 at 11:24 AM with MDS stated it was human error regarding Resident #94's indwelling catheter not being on the MDS. MDS stated they needed to ensure staff are coding correctly and ensure staff are aware of resident care. MDS nurse was responsible for ensuring resident care plan was correct. Interview on 3/19/2026 at 4:33 PM with DON stated the MDS staff had told her she did not code indwelling catheter for Resident #94. DON had no comment.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 (Resident #64) of 5 residents reviewed for incontinence care. When CNA-A was providing incontinent and indwelling urinary catheter care to Resident #64 on 03/19/2026, the CNA did not clean the resident's left buttock area. These failures could place residents who required incontinence care at risk for cross contamination and the development of new or worsening urinary tract infections. The findings included: Record review of Resident #64's face sheet, dated 03/20/2026, revealed the resident was a 91-years-old male, originally admitted on [DATE], and readmitted to the facility on [DATE] with diagnoses of spondylosis (the natural progression of degenerative changes in the spine that occur with aging), weakness, and neuromuscular dysfunction of bladder (when a person lacks bladder control due to brain, spinal cord or nerve problems). Record review of Resident #64's Medicare 5 days MDS assessment, dated 12/15/2025, revealed the resident's BIMS score was 12 out of 15 which indicated the resident had moderate cognitive impairment and had urinary indwelling catheter and was always bowel incontinent. Record review of Resident #64's comprehensive care plan, dated 12/11/2025, revealed the resident had the care plan of The resident has Indwelling Catheter. For intervention - Monitor for signs and symptoms of discomfort on urination and frequency. Observation on 03/19/2026 at 10:41 a.m. revealed CNA-A opened Resident #64's old and dirty brief, cleaned the indwelling urinary catheter, genital area, and groin areas, then turned the resident to right side and cleaned the resident's rectum and right buttock area because the resident had bowel movement. Further observation revealed CNA-A changed her gloves and turned the resident to supine position (lying horizontally with the face and torso facing up), put new and clean brief under the resident, and closed the new and clean brief without cleaning the resident's left buttock area. Interview on 03/19/2026 at 11:09 a.m. with CNA-A stated she was nervous and forgot to clean Resident #64's left buttock area. CNA-A said she should have cleaned Resident #64's left buttock area because the resident had bowel movement and to prevent possible infection and skin breakdown. Interview on 03/19/2026 at 3:45 p.m. with the DON said CNA-A should have cleaned Resident #64's left buttock area to prevent possible infection and skin breakdown, and the DON had responsibility to ensure proper care was provided. Record review of the facility policy, titled Perineal Care Procedure, dated 03/15/2019, revealed . 8. If perineum is grossly soiled, turn resident on side, remove any fecal material and discard. A. Cleanse buttocks and anus, front to back, scrotum to anus in males, using a separate washcloth or wipes. B. Thoroughly dry.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review the facility failed store food in accordance with professional standards for food service safety. for 1 of 3 (Bluebonnet Hall unit pantry) unit pantries in that:The unit pantry refrigerator was out of range temperature; and the apple juice container was not labeled or dated.This could affect residents that used the unit pantry and place residents at risk for food borne illnesses. The Findings:Observation on 3/18/2026 at 9:13 AM in the Bluebonnet Hall unit pantry revealed the refrigerator temperature was at 42 degrees Fahrenheit. The apple juice container was half full and was not dated or labeled.Observation on 3/18/2026 at 10:18 AM in the Bluebonnet Hall unit pantry revealed the refrigerator temperature was 42 degrees Fahrenheit. The apple juice container was half full and was not dated or labeled.Interview on 3/18/2026 at 10:22 AM with RN E confirmed the Bluebonnet Hall unit pantry refrigerator was at a temperature of 45 Degrees Fahrenheit. RN E stated if refrigerator unit was higher than 42 degrees Fahrenheit, it could cause food to spoil. RN E confirmed the apple juice had no label and was not dated. RN E stated this could cause spoilage and was not sure why it was not labeled. The unit refrigerator was used for residents when they needed snacks or hydration. The Temperature was checked daily. The staff using the food item was responsible for labeling and dating open containers. Interview on 3/19/2026 at 4:33 PM with the DON stated she was not sure why the Bluebonnet Hall unit pantry refrigerator temperature was high and stated maybe residents/staff had just opened it.Review of FDA Food Code states for safety, it is important to verify the temperature of the refrigerator. Refrigerators should be set to maintain a temperature of 40 F or below. Record review of Resident Food Services, unit pantry stock, dated 5/95 reflected Policies: Food and Nutrition Services stocks unit pantries with snacks that are available for general resident use and with foods for residents who eat meals at non- traditional mealtimes. All open items must be labeled open and use-by-date. Procedures: Label, date and discard outdated items per food storage policy. Nursing and/or Food and Nutrition Services Designee: The Temperature of the refrigerator and freezer will record at least once daily. Temperature variance out of the acceptable range will be reported.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation, interview and record review the facility failed to dispose of garbage and refuse properly, for 1 of 1 dumpster in that:The garbage container did not have a plug at the bottom.This could affect all residents and could cause debris, foul odors and harborage and feeding of pests.Findings include:Observation on 3/17/2026 at 9:45 AM with FSM, observed the dumpster did not have a plug at the bottom.Interview on 3/17/2026 at 9:45 AM with FSM stated he was not aware that the dumpster did not have a plug and will call the city.Record review of policy, Sanitation and infection preventions, solid Waste disposal dated 5/95, reflected, Policies, Food waste and rubbish in the Food and Nutrition Services Department will be disposed of in an approved manner to prevent contamination of food, clean dishes, or clean working areas.

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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** Based on observations, interviews, and record review, the facility failed to establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development of communicable diseases and infections for 2 of 26 residents (Resident #47 and #153) reviewed for infection control practices. 1. RN-G did not put on gloves and a gown when entering Resident #47's room, and Resident #47 was on contact precautions. 2. When LVN-L changed the dressing of Resident #153's gastrostomy tube site, the LVN-L changed her gloves without sanitizing or washing her hands. The deficient practices could place residents at risk for cross contamination and infections.The findings included: 1. Record review of Resident #47's face sheet, dated 03/20/2026, revealed the resident was a [AGE] year-old female and admitted to the facility on [DATE] with diagnosis of periprosthetic fracture around internal prosthetic right hip joint (fracture associated with an orthopedic implant, whether a replacement or internal fixation device), methicillin resistant staphylococcus aureus infection (caused by a type of staph bacteria that's become resistant to many of the antibiotics used to treat ordinary staph infections), and ESBL (extended spectrum beta-lactamase) in the urine (ESBL producing bacteria cannot be killed by many of the antibiotic that doctors use to treat infections). Record review of Resident #47's admission MDS assessment, dated 02/07/2026, revealed the resident's BIMS score was 15 out of 15 which indicated the resident's cognitive was intact and had multidrug-resistant organism as active diagnoses. Record review of Resident #47's comprehensive care plan, dated 02/02/2026, revealed the resident had the care plan of [Resident #47] has admitted with an infection of MRSA (methicillin resistant staphylococcus aureus) in her surgical wound. Re-cultured on 02/09/2026 by wound care and no longer MRSA positive, culture grew e-coli and proteus mirabilis. For intervention - Maintain CONTACT precautions when providing resident care. Record review of Resident #47's physician's order, starting dated 02/24/2026, the resident had the order of CONTACT ISOLATION PRECAUTIONS FOR ESBL (extended spectrum beta-lactamase) IN THE URINE every shift. Observation on 03/17/2026 at 3:35 p.m. revealed RN-G entered Resident #47's room without putting on gloves and a gown and came out from the room with a lunch tray. RN-G then washed her hands with water. Further observation revealed there was a sign on the door, and the sign reflected, Contact Precaution - wearing gown and gloves before entering the room. Interview on 03/17/2026 at 3:37 p.m. RN-G stated she did not wear gloves and a gown when entering Resident #47's room because she forgot. RN-G said she should have put on a gown and gloves before entering the resident's room to prevent infection, and the resident was on contact precautions. Interview on 03/19/2026 at 3:45 p.m. the DON said RN-G should have put on gown and gloves before entering Resident #47's room to prevent infection, and the resident was on contact precautions. 2. Record review of Resident #153's face sheet, dated 03/20/2026, revealed the resident was a [AGE] year-old male and admitted to the facility on [DATE] with diagnosis of adjustment disorder with depressed mood (feeling of sadness, hopelessness, crying and lack of joy from things that used to bring you pleasure), bacteremia (viable bacteria in the blood), and gastrostomy (surgical procedure used to insert a tube, often referred to as G-tube, through the abdomen and into the stomach). Record review of Resident #153's admission MDS assessment, dated 03/19/2026, revealed the assessment was still in progress because the resident was admitted to the facility on [DATE]. Record review of Resident #153's physician's order, starting dated 03/19/2026, revealed the resident had the order of administer jevity 1.2 calories liquid at 75 milliliters per hour Via gastrostomy-tube for 21 hours with 155 milliliters of water. Flush every 6 hours, off at 9 am and Back on at 12 noon for 3 hour downtime To provide calories and CLEANSE Gastrostomy-TUBE SITE WITH WOUND CLEANSER, PAT DRY, AND APPLY SPLIT SPONGE DRESSING every night shift.' Observation on 03/19/2026 at 8:49 p.m. revealed LVN-L completed administering medications via gastrostomy tube to Resident #153 and changed her gloves without sanitizing or washing hands. Further (continued on next page)

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	455618	A. Building B. Wing	03/20/2026

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observations revealed LVN-L cleaned Resident #153's gastrostomy tube site, changed her gloves without sanitizing or washing hands, and put a new dressing on the site. Interview on 03/19/2026 at 9:05 p.m. with LVN-L said she changed her gloves without sanitizing or washing her hands because she was nervous and forgot. The nurse said she should have sanitized or washed her hands before wearing new gloves to prevent infection. Interview on 03/19/2026 at 3:45 p.m. the DON said LVN-L should have sanitized or washed her hands before wearing new gloves to prevent infection. Record review of the facility policy, titled Nursing-infection control, dated 08/29/2019, revealed . 4. Indications/consideration for PPE (personal protective equipment) use: a. Gloves - perform hand hygiene before donning gloves and after removal. Gloves are not a substitute for hand hygiene.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on interview and record review, the facility failed to ensure abuse, neglect and exploitation training and dementia training for 1 of 5 (CNA-M) employees reviewed for training requirements were completed. The facility failed to ensure abuse, neglect and exploitation training was provided to CNA-M. This failure could place residents at risk of being cared for by staff who have been insufficiently trained. Findings were: Record review of the personnel records for CNA-M revealed a hire date of 11/24/2024. Review of training log provided by human resources revealed no evidence that CNA-M received abuse, neglect and exploitation training. Interview with the Staffing Coordinator on 03/20/2026 at 12:04 PM revealed CNA-M was agency staff and not working at the facility anymore since on 01/19/2026, but the facility should have checked if CNA-M completed abuse, neglect and exploitation training or not before the CNA worked on the floor, and if the CNA did not take the training, the facility should have provided the training to the CNA. The Staffing Coordinator said it was her responsibility if agency staff completed all required trainings, and the Staffing Coordinator did not check if CNA-M completed abuse, neglect and exploitation training or not before the CNA worked on the floor, and it was her mistake. The Staffing Coordinator stated it could lead to mistreatment or neglect of the residents. Record review of the facility policy, titled Abuse prevention, dated 03/16/2022, revealed II. Employee Training. A. New employees will be educated on abuse, neglect, exploitation and misappropriation of resident property during initial orientation.

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed within 14 days after a facility completes a resident's assessment to transmit encoded, accurate, and complete MDS data to the CMS System for 5 of 14 residents (Residents #62, # 86, #107, #123, and #132) reviewed for MDS transmission. 1. Residents #62, #107, #123, and #132's, discharge MDS assessments were not transmitted within 14 days of completion. 2. Resident #86's admission MDS assessment on 03/20/2026 was not completed and not transmitted within 14 days since the resident was admitted to the facility on [DATE]. This deficient practice placed residents at risk of not having completed assessments and not having appropriate care. The findings were: 1. Review of Resident #62's face sheet, dated 03/19/2026, revealed an admission date of 11/05/2025 with diagnoses which included: fracture of unspecified part of right clavicle (a long, slightly curved bone that connects your arm to your body), subsequent encounter for fracture with routine healing, acute and chronic respiratory failure with hypoxia(low levels of oxygen in your body tissues) metabolic encephalopathy (a problem in the brain), muscle wasting and atrophy (waste away), not elsewhere classified, multiple sites, other abnormalities, of gait and mobility, dehydration, unspecified protein-calorie malnutrition, and decreased white blood cell count unspecified. Review of Resident #62's Discharge MDS Assessment, dated 11/17/2025, revealed the assessment had not been transmitted to CMS. Review of Resident #107's face sheet, dated 03/19/2026, revealed an admission date of 11/12/2025 with diagnoses which included: urinary tract infection, site not specified, muscle wasting and atrophy, not elsewhere classified, multiple sites, other abnormalities of gait and mobility, muscle weakness, unsteadiness on feet, chronic diastolic (congestive) heart failure, sleep apnea, unspecified, overactive bladder, hypertension (high blood pressure), and other specified disorders of bone density and structure. Review of Resident #107's Discharge MDS Assessment, dated 11/20/2025, revealed the assessment had not been transmitted to CMS. During an interview and observation on 03/19/2026 at 1:14 p.m. the MDS Coordinator LVN D stated she did not know why Resident #62 and Resident #107's Discharge MDS Assessments had not been transmitted. The MDS Coordinator LVN D reviewed the MDS assessments and they revealed they were locked. The MDS Coordinator LVN D stated they had been locked when the 5-day MDS Assessments were completed due to residents being managed care and would not have transmitted the 5-day MDS Assessments. Review of Resident #123's face sheet, dated 03/19/2026, revealed an original admission date of 10/24/2025 with diagnoses which included: sepsis (life-threatening reaction to an infection) unspecified organism, hypothyroidism(when the thyroid gland doesn't make enough thyroid hormones to meet your body's needs) , unspecified, pure hypercholesterolemia (high cholesterol), unspecified, insomnia unspecified, interstitial pulmonary disease (inflammation and scarring that make it hard for the lungs to get enough oxygen) , unspecified, acute respiratory failure with hypoxia, pain in right shoulder, age-related osteoporosis (disease in which your bones become weak) without current pathological fracture, and age-related physical debility (physical weakness). (continued on next page)

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of Resident #123's Discharge MDS Assessment, dated 01/21/2026, revealed the assessment had not been transmitted to CMS. Review of Resident #132's face sheet, dated 03/19/2026, revealed an admission date of 07/05/2025 with diagnoses which included: multiple fractures of pelvis with stable disruption of pelvic ring, subsequent encounter for fracture with routine healing, other specified fracture of left pubis, subsequent encounter for fracture with routine healing, muscle wasting, and atrophy, not elsewhere classified, multiple sites, other abnormalities of gait and mobility, muscle weakness (generalized), type 2 diabetes mellitus without complications, generalized anxiety disorder and Alzheimer's Disease with late onset. Review of Resident #132's Discharge MDS Assessment, dated 01/06/2026, revealed the assessment had not been transmitted to CMS. During an interview on 03/19/2026 at 1:30 p.m. the MDS Coordinator LVN H stated she was catching up on other MDS assessments and had not completed the Resident #123's and Resident #132's Discharge assessments. The MDS Coordinator LVN H stated Discharge MDS assessments were for CMS compliance and for tracking/trending of residents going to other facilities. During an interview on 03/19/2026 at 4:05 p.m. the DON stated the MDS Coordinators were responsible for completing the MDS Assessments. The DON further stated they had been down one MDS Coordinator for a long time. The DON stated Medical Records was responsible for transmitting the MDS assessment. The DON stated compliance with CMS could be an issue by not transmitting a MDS assessment, but it was not a care issue. The DON stated by not transmitting MDS assessments it could affect the facility getting paid. During an interview on 03/19/2026 at 4:22 p.m. the RCM (Medical Records) stated she would transmit every day and checked every morning to see if their assessments were ready. The RCM stated she would go into the MDS dashboard and check which were export ready. The RCM stated when the RN had signed off on the MDS assessments she was able to see at that point and she was able to export them to SIMPLE (MDS clearing house that transmits the MDS Assessments and its interfaces with CMS). During an interview on 03/20/2026 at 1:30 p.m. the Administrator stated the MDS coordinators were responsible for the MDS assessments completing and transmitting. The Administrator stated the DON would sign off on the MDS Assessments for completion and then it was sent through SIMPLE LTC which was a portal they use. The Administrator further stated the RCM did the billing and would ensure MDS assessments were transmitted for the billing. The DON stated the MDS assessments were used to generate the care and the Discharge MDS assessments were used to ensure it was a safe and complete discharge. The Administrator stated that by not completing these MDS assessments the facility would not get paid and they would not fully address the individual's needs. Record review of the CMS RAI Version MDS 3.0 Manual dated October 2025 revealed in part, Chapter 5: Submission and Correction of the MDS Assessments 5.2 Transmitting Data: Providers must transmit all sections of the MDS 3.0 required for their Stated-specific instrument.Transmission requirements apply to all MDS 3.0 records used to meet both federal and state requirements.-Assessment Transmission: Comprehensive assessment must be transmitted electronically within 14 days of the Care Plan Completion Date. All other MDS assessments must be submitted within 14 days of the MDS Completion Date. (continued on next page)

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	2. Record review of Resident #86's face sheet, dated 03/20/2026, revealed the resident was an 85-years-old female, originally admitted on [DATE], and readmitted to the facility on [DATE] with diagnoses of senile degeneration of brain (a range of neurological disorders characterized by a progressive decline in cognition function, impacting memory, reasoning, and the ability to perform everyday activities), dementia (loss of memory and thinking ability), and type 2 diabetes mellitus (a condition where the body has trouble regulating blood sugar levels, leading to persistently high blood glucose levels). Record review of Resident #86's admission MDS assessment, dated 02/10/2026, revealed the MDS assessment was still in progress on 03/20/2026. Interview on 03/20/2026 at 11:23 a.m. with MDS nurse LVN-H said she did not complete Resident #86's admission MDS assessment because she was very busy due to her workload. The MDS nurse stated she should have completed the resident's MDS assessment and transmitted to CMS at least by 02/18/2026 because the resident was admitted to the facility on [DATE], and it was the MDS nurse's responsibility. The MDS nurse said late completion and transmission might affect billing process and the resident might have lack of care because of late comprehensive care plans. Interview on 03/20/2026 at 3:00 p.m. with the DON stated the MDS nurse LVN-H should have completed Resident #86's MDS assessment and transmitted to CMS at least by 02/18/2026 because the resident was admitted to the facility on [DATE], it was the MDS nurse's responsibility, and the DON said she did not know what reason this MDS assessment was late, and it might affect care to the resident. Record review of the CMS RAI Version MDS 3.0 Manual dated October 2025 revealed in part, Chapter 5: Submission and Correction of the MDS Assessments 5.2 Transmitting Data: Providers must transmit all sections of the MDS 3.0 required for their Stated-specific instrument.Transmission requirements apply to all MDS 3.0 records used to meet both federal and state requirements.-Assessment Transmission: Comprehensive assessment must be transmitted electronically within 14 days of the Care Plan Completion Date. All other MDS assessments must be submitted within 14 days of the MDS Completion Date.