STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455732	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kirkwood Manor	2590 Loop 337 N 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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 MDS assessment accurately reflected the resident's status for 4 residents (Residents #10, #13, #81 and #106) of 24 residents reviewed for MDS assessments. 1. The facility failed to ensure Resident #10 was coded Yes on her Quarterly MDS assessment, signed as completed on 01/14/2026, for Did the resident have a fall anytime in the last 2-6 months prior to admission/entry or reentry? because the resident had fall incident on 01/05/2026. 2. The facility failed to ensure Resident #13 and Resident #81's annual MDS was coded accurately for Preadmission Screening and Resident Review (PASRR). 3. The facility failed to ensure Resident #106's Annual MDS was coded accurately for Preadmission Screening and Resident Review (PASRR). These failures could place residents at risk of not receiving needed care and could result in missed or inappropriate care. The findings included: 2. Record review of Resident #13's face sheet dated 4/8/26 revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE]. Resident #13's diagnoses included major depressive disorder recurrent and moderate (recurring mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life moderate in severity), and PTSD (mental health condition that's caused by being a part of or witnessing an extremely stressful or terrifying event and symptoms may include flashbacks, nightmares, severe anxiety and uncontrollable thoughts about the event). Record review of Resident #13's annual MDS assessment dated [DATE] revealed A1500 Preadmission Screening and Resident Review was coded as the resident did not have a serious mental illness and A1510 Level II Preadmission Screening and Resident Review was left blank. Record review of Resident #13's undated care plan revealed a focus initiated on 12/3/19 and revised on 10/16/24 for potential for psychosocial well-being problem related to diagnoses of depression and PTSD with interventions for psych and social services consults, monitoring, and anticipating needs. Another focus initiated on 10/3/24 for potential for re-traumatization related to the resident's PTSD being triggered by loud noises with interventions that included a revised intervention on 1/30/25 to provide a calm and quiet environment and notify the resident of fire alarm testing prior to alarms going off. Another focus initiated 12/3/19 and revised 10/16/24 for depression with interventions for monitoring and psychiatry consults In an interview on 4/10/26 at 10:57 a.m. LVN B stated Resident #13 did have a serious mental health diagnosis. LVN B stated it was coded incorrectly on the resident's annual MDS assessment dated [DATE] and it should have been coded as a yes and she was unsure how it was overlooked and could possibly delay needed services. Record review of Resident #81's face sheet dated 4/10/26 revealed the resident was a [AGE] (continued on next page)

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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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	year-old female admitted to the facility on [DATE]. Resident #81's diagnoses included Down syndrome (a genetic condition caused by an extra copy of chromosome 21 (Trisomy 21), leading to physical traits like low muscle tone, small stature, and an upward slant to the eyes with mild-to-moderate intellectual disability and developmental delays). Record review of Resident #81's admission MDS assessment dated [DATE] revealed A1500 Preadmission Screening and Resident Review was coded as the resident did not have an intellectual disability or related condition and A1510 Level II Preadmission Screening and Resident Review was left blank. And A1550 Conditions Related to ID/DD Status Down syndrome was checked. The resident had unclear speech and was sometimes understood by others and sometimes understood others. The resident had a BIMS score of 00 indicating the resident was severely cognitively impaired. Record review of Resident #81's undated care plan revealed a focus initiated on 12/15/25 and revised on 1/22/26 for the resident receiving PASRR services, PASRR positive diagnosis: Down syndrome and had the name of the resident's habilitation coordinator listed. The interventions initiated 12/18/25 included IDT meeting to be completed as required, notify local authority of any significant changes, PASRR evaluation to be completed by local authority, and therapy services as ordered. In an interview on 4/10/2026 at 1:50 p.m. LVN B stated Resident #81's admission MDS assessment dated [DATE] was coded incorrectly, and she was unsure how it was overlooked. LVN B stated the MDS being coded incorrectly could delay needed services but the resident was not affected and her specialized services continued without interruption. 1. Record review of Resident #10's face sheet, dated 04/10/2026, revealed the resident was an 84-years-old female, originally admitted on [DATE], and readmitted to the facility on [DATE] with diagnosis of traumatic subdural hemorrhage (it is caused by a traumatic head injury, such as a blow to the head of a fall and bleeding inside the skull), 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 #10's Quarterly MDS assessment, dated 01/14/2026, revealed the resident's BIMS score was 6 out of 15 which indicated the resident had severe cognitive impairment. Section J (Health Conditions), the answered was coded No to the question Did the resident have a fall any time in the last 2–6 months prior to admission/entry or reentry? Record review of Resident #10's comprehensive care plan, dated 01/05/2026, revealed the resident had an actual fall with injury 1/5/26 with interventions 1/5/26 -Install scooped air mattress, fall mat and grab bars and Monitor/document /report to doctor for signs and symptoms: Pain, bruises, Change in mental status, New onset: confusion, sleepiness, inability to maintain posture, agitation. Record review of Resident #10's incident report, dated 01/05/2026, revealed the resident fell from the bed grabbing something on the nightstand without asking help while CNA-C was providing bed bath to the resident on 01/05/2026. During an interview on 04/08/2026 at 12:25 PM, CNA-C stated on 01/05/2026 after dinner time, she was providing a bed bath to Resident #10. CNA-C stated she rolled the resident to the side, and had the resident grab the bed The resident was trying to grab something on the nightstand and suddenly fell from the bed. The CNA called the charge nurse immediately, and the charge nurse started assessing the resident. CNA-C said after the fall on 01/05/2026, the facility updated the care plans to (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	prevent further fall such as fall mat, setting grab bar, scoop mattress, and two persons to assist activities of daily living for just in case, instead of one person. During an interview on 04/10/2026 at 10:22 AM, the MDS nurse LVN-B said Resident #10's quarterly MDS assessment, dated 01/14/2026, was inaccurate regarding coding as No to the question Did the resident have a fall any time in the last 2–6 months prior to admission/entry or reentry? in the Section J (Health Conditions) because the resident fell on [DATE]. The MDS nurse said the answer should have been coded Yes, it was her mistake. She said an inaccurate MDS could cause staff to provide inaccurate care to Resident #10. During an interview on 04/10/2026 at 2:27 PM, the DON said Resident #10 had fallen on 01/05/2026 and because of the incident, the facility had IDT meeting on 01/05/2026 and updated care plans. She said the updated care plans included fall mat, setting grab bar, scoop mattress, and two persons to assist activities of daily living instead of one person. 3. Record review of Resident #106's face sheet dated 04/08/2026, revealed Resident #106 was originally admitted to the facility on [DATE], with an admission date of 04/26/2024 with diagnoses that included: undifferentiated schizophrenia and moderate intellectual disabilities. Record review of Resident #106's Annual MDS assessment, dated 05/04/2025 Section A1500 Preadmission Screening and Resident Review (PASRR) coded 0 (No) for was the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? Record review of Resident #106's care plan, revision date of 01/18/2026, revealed Resident #106 had a focus of Resident receiving PASRR services. PASRR positive diagnosis intellectual disability and developmental disability. Record review of Resident #106's PASRR Level 1 Screening, dated 03/01/2024, revealed, Section C PASRR Screening coded yes for Mental Illness, Intellectual Disability and Developmental Disability. During an interview and observation on 04/10/2026 at 10:40 a.m. LVN B stated Resident #106 was PASRR positive and had services. LVN B reviewed Resident #106's Annual MDS assessment and stated the May 2025 Annual MDS Assessment was coded incorrectly. LVN B further stated it should have been coded yes. LVN B stated Resident #106 had intellectual disability. LVN B stated that miscoding the MDS Assessment could cause a delay in services for residents. LVN B stated it was her responsibility for coding accuracy. LVN B further stated she had overlooked it, and this was why it was miscoded. During an interview on 04/10/2026 at 2:09 p.m. the Administrator stated that by not coding a resident's MDS as PASRR positive could increase the chance they might not have access to the PASRR services that the resident should have access to. The Administrator stated by the MDS Assessment being accurate could change the resident's plan of care and treatments they might get. The Administrator further stated MDS Assessment accuracy was the responsibility of MDS coordinators. Record review of facility's policy titled Resident Assessment and Associated Processes, revised date 12/2023, read, Policy: It is the policy of this facility that resident's will be assessed and the findings (continued on next page)

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Kirkwood Manor	2590 Loop 337 N New Braunfels, TX 78130

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documented in their clinical health record. These will be comprehensive, accurate, standardized reproducible assessment of each resident.Procedure: Comprehensive Assessment: Includes the completion of the MDS (Minimum Data Set) as well as the CAA (Care Area Assessment) process, followed by development and/or review of the comprehensive care plan. Comprehensive MDS assessments include Admission, Annual, Significant Change.An accurate Comprehensive Assessment will be made of the resident's needs, strengths, goals, life history and preferences. Record review of the CMS RAI Version MDS 3.0 Manual dated October 2025 revealed in part, .The OBRA regulations require nursing homes that are Medicare certified, Medicaid certified or both, to conduct initial and periodic assessments for all their residents. The Resident Assessment Instrument (RAI) process is the basis for the accurate assessment of each resident. Section A: Identification Information Intent: The intent of this section is to obtain the reasons for assessment, administrative information, and key demographic information to uniquely identify each resident.Coding instructions for A1550 Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness and/or ID/DD or related condition, and continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life for 1 (Resident #56) of 27 residents reviewed for dignity. The facility failed to ensure CNA-A did not stand next to Resident #56 while assisting the resident to eat during lunchtime on 04/07/2026. These failures could place the residents at risk of not having their right to a dignified existence maintained. Findings included: Record review of Resident #56's Face Sheet, dated 04/10/2026, reflected the resident was an [AGE] year-old female and originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis of dementia (loss of memory and thinking ability), muscle wasting and atrophy (loss of skeletal muscle mass), and extrapyramidal and movement disorder (movement disorders that can develop as side effects of antipsychotic medications and continues spasm and muscle contractions). Record review of Resident #56's Quarterly MDS Assessment, dated 02/13/2026, reflected the resident's BIMS score was 0 out of 15 which indicated the resident had severe cognitive impairment and was unable to interview. Further record review of the Quarterly MDS Assessment indicated that the resident required setup or clean-up assistance (Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) for eating. Record review of Resident #56's Comprehensive Care Plan, revision on 01/30/2025, reflected the resident required EATING - supervision assistance with meals. Observation on 04/07/2026 at 11:47 AM, revealed CNA-A was assisting Resident #56 for lunch in the dining area. CNA-A was standing next to the resident while she was feeding the resident. During an interview on 04/07/2026 at 11:55 AM, CNA-A stated she should be sitting down when she assisted somebody in the dining area. CNA-A said she was not assigned to help Resident #56 to eat and she was waiting for meal carts to be delivered on the halls, but she saw the resident did not eat her lunch very well, so just assisted the resident. CNA-A said when assisting somebody during mealtimes, she should sit down so she would be face to face with the resident. She said standing next to the resident was not a way of showing respect and dignity, and it was her mistake. During an interview on 04/09/2026 at 4:04 PM, the DON stated facility staff should sit down next to the resident when assisting them during mealtimes. The DON said not sitting beside the resident to assist in eating did not uphold dignity and respect. Record review of the facility's policy, titled Resident Rights, undated, revealed 1. To be treated with consideration, respect, and full recognition of his or her dignity and individuality.

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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** Based on interviews and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental needs that were identified in the comprehensive assessment, and described services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 27 residents (Resident #115) reviewed for care plans. The facility failed to ensure Resident #115's care plan reflected her bladder and bowel incontinence status and included a care plan regarding how to take care of the resident's bladder and bowel incontinence. This failure could place residents at risk for not receiving proper care and services due to inaccurate care plans. The findings included:Record review of Resident #115's face sheet, dated 04/10/2026, revealed a [AGE] year-old female, originally admitted to the facility on [DATE], and re-admitted to the facility on [DATE] with diagnoses of senile degeneration of brain (progressive decline in cognitive function, impacting memory, reasoning, and the ability to perform everyday activities), type 2 diabetes mellitus (a condition where the body has trouble regulating blood sugar levels, leading to persistently high blood glucose levels), and dementia (loss of memory and thinking ability). Record review Resident #115's admission MDS assessment, dated 01/20/2026, revealed the resident's BIMS score was 0 out of 15, which indicated the resident had severe cognitive impairment, and the resident was always incontinent of bladder and bowel. Record review of Resident #115's comprehensive care plan, dated 01/20/2026, revealed there was no care plan related to bladder and bowel incontinence care. Interview on 04/07/2026 at 12:04 p.m. with LVN-H stated Resident #115 had bladder and bowel incontinence and received bladder and bowel incontinence care. Interview on 04/10/2026 at 10:31 a.m. with the MDS nurse LVN-B stated she should have developed Resident #115's comprehensive care plan related to bladder and bowel incontinence care because the resident was always bladder and bowel incontinence. The MDS nurse LVN-B said she overlooked it, and it was her mistake, and no care plan potentially caused improper care to Resident #115. Record review of the facility policy, titled Comprehensive Person-Centered Care Planning, revision date 12/2023, revealed . 4. The facility IDT will develop and implement a comprehensive person-centered, culturally-competent, and trauma-informed care plan for each resident within seven days of completion of the MDS and will include resident's needs identified in the assessment, and any specialized services as a result of PASARR recommendation, and resident's goals and desired outcomes, preferences for future discharge and discharge plan.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to review and revise Resident Care Plans after each assessment for 1 of 27 Residents (Resident #10) whose records were reviewed for care plan revision/timing, in that: The facility failed to ensure Resident #10's care plan was updated after IDT meeting when the resident had a fall and changes to intervention where put in place to prevent fall from one person assist for baths to two persons assist on 01/05/2026. This failure could place residents at risk and contribute to residents not receiving the care and services they needed. The findings included:Record review of Resident #10's face sheet, dated 04/10/2026, revealed an 84-years-old female, originally admitted on [DATE], and readmitted to the facility on [DATE] with diagnosis of traumatic subdural hemorrhage (it is caused by a traumatic head injury, such as a blow to the head of a fall and bleeding inside the skull), 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 #10's Quarterly MDS assessment, dated 01/14/2026, revealed the resident's BIMS score was 6 out of 15 which indicated the resident had severe cognitive impairment, and Section GG (Functional Abilities) indicated the resident was dependent (Helper does ALL of the effort. Resident does none of the effort to complete the activity) to shower/bathe. Record review of Resident #10's comprehensive care plan, revision on 01/30/2025, revealed the care plan for BATHING: the resident requires extensive one person assistance with Showering/Bathing. Review of the care plan, dated 01/05/2026, revealed the resident had an actual fall with injury 1/5/26 and for interventions 1/5/26 - Install scooped air mattress, fall mat and grab bars and Monitor/document /report to doctor for signs and symptoms: Pain, bruises, Change in mental status, New onset: confusion, sleepiness, inability to maintain posture, agitation. Record review of Resident #10's incident report, dated 01/05/2026, revealed the resident fell from the bed to grab something on the nightstand without asking help while CNA-C was providing bed bath to the resident on 01/05/2026. Observation on 04/07/2026 at 11:20 a.m. revealed Resident #10 was on the bed and sleeping on the scooped air mattress, and there were grab bars and fall mat in place. During an interview on 04/08/2026 at 12:25 PM with CNA-C stated on 01/05/2026, after dinner time, she was providing a bed bath to Resident #10. CNA-C stated she rolled the resident to the side, and had the resident grab the bed. She stated the resident was trying to grab something on the nightstand and suddenly fell from the bed. CNA C stated she called the charge nurse immediately, and the charge nurse started assessing the resident. CNA-C said after the fall on 01/05/2026, the facility updated the care plans to prevent further fall such as fall mat, setting grab bar, scoop mattress, and two persons to assist activities of daily living, such as showering/bathing for just in case, instead of one person, and CNAs were to provide two persons assist to the resident for showering/bathing. During an interview on 04/10/2026 at 10:22 AM, the MDS nurse LVN-B said Resident #10 had two persons assist for showering/bathing after IDT meeting on 01/05/2026, but the care plan did not update correctly after IDT meeting. The MDS nurse LVN-B stated she had responsibility to update the care plan and not updating the care plan correctly was her mistake, and it should have been updated from one person to two persons after 01/05/2026, and not updating care plan might cause incorrect care. During an interview on 04/10/2026 at 2:27 PM, the DON said Resident #10 had fall incident on 01/05/2026, and because of the incident, the facility had an IDT meeting on 01/05/2026 and updated the care plans. She said the updated care plans included fall mat, setting grab bar, scoop mattress, and two persons to assist activities of daily living, such as showering/bathing for just in case, instead of one person. Record review of the facility policy, titled Comprehensive Person-Centered Care Planning, revision date 12/2023, revealed . 6. The resident's comprehensive plan of care will be revised and/or revised by the IDT after each assessment, including both comprehensive and quarterly review assessments.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the residents' environment remains as free of accident hazards as possible for 1 (Resident #39) of 2 residents reviewed for transfers in that: The facility failed to engage brakes of the mechanical lift when slowly lowering Resident #39 onto the bed on 04/09/2026. This failure could place residents at risk for falls, injuries, and decline in health. Findings included:Record review of Resident #39's face sheet, dated on 04/10/2026, revealed the resident was a 73-years-old female and admitted to the facility on [DATE] with diagnosis of fracture of lower and right femur (fracture to right thigh bone), muscle wasting and atrophy (loss of skeletal muscle mass), and obesity (complex disease involving having too much body fat). Record review of Resident #39's admission MDS assessment, dated on 02/11/2026, revealed the resident's BIMS score was 15 out of 15 which indicated the resident's cognitive was intact and was dependent (Helper does ALL of the effort. Resident does none of the effort to complete the activity) to chair to bed and toilet transfer in the Section GG (Functional Abilities). Record review of Resident #39's comprehensive care plan, dated on 02/10/2026, revealed TRANSFER (CHAIR/BED TO CHAIR TRANSFER, TOILET TRANSFER): Resident requires extensive 2-person assistance with Hoyer lift [mechanical lift] for transferring. Observation on 04/09/2026 at 11:17 a.m., revealed CNA-D and CNA-E transferring Resident #39 from wheelchair to bed with mechanical lift in the resident's room. CNA-D and CNA-E attached the sling straps to sling bar, lift the resident from the wheelchair, and slowly moved the lift to the bed. When CNA-E was lowering the resident onto the bed, CNA-E did not engage brakes of the lift, so the lift swung a little bit from side to side while CNA-D was gently holding Resident #39. The CNAs completed transferring Resident #39 from the wheelchair to the bed and left the room. Interview on 04/09/2026 at 11:24 a.m. with CNA-E stated she should have engaged brakes of the lift when lowering Resident #39 onto the bed for safety and to prevent possible incidents, and she had been trained on how to properly use the mechanical lift in 2025, and it was her mistake because she was very nervous. Interview on 04/09/2026 at 4:06 p.m. with DON said CNA-E should have engaged brakes of the lift when lowering Resident #39 onto the bed for safety. Record review of the facility policy and procedure, titled Transfers (Mechanical Lift), undated, revealed Base/Legs of [NAME] should be opened completely while lift is in motion. Engage brakes of lift after positioned. Slowly lower resident toward receiving surface.

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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 observation and interview, the facility failed to ensure a resident with an indwelling catheter, received the appropriate care and services for 1 of 3 residents (Resident #43) and the facility failed to ensure a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections for 1 of 4 residents (Resident #108), reviewed for quality of care. 1. The facility failed to ensure resident #43's urinary drainage bag remained below the level of the bladder during catheter care on 4/9/26.2. When CNA-F and CNA-C were providing incontinent care to Resident #108 on 04/09/2026, CNA-F did not clean the resident's suprapubic area (the area of the abdomen located below the umbilical region) and did not separate the resident's labia area. These failures could place residents at risk of cross contamination, urinary tract infections and complications. The findings were: 1. Record review of Resident #43's face sheet dated 4/10/26 revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with readmission on [DATE]. Resident #43's diagnoses included Obstructive and reflux uropathy (structural or functional blockage of urine flow, and the backward flow of urine), and Benign prostatic hyperplasia with lower urinary tract symptoms (enlargement of the prostate that commonly causes lower urinary tract symptoms). Record review of Resident #43's discharge return anticipated MDS assessment dated [DATE] revealed the resident BIMS score was blank, the resident had an indwelling urinary catheter and was frequently incontinent of bowel. Record review of Resident #43's undated care plan revealed a focus initiated on 1/26/26 for an indwelling urinary catheter with interventions for catheter care every shift and to position the urinary drainage bag and tubing below the bladder. Record review of Resident #43's physician orders revealed an order with a start date of 1/30/26 for catheter care every shift. In an observation and interview on 4/9/26 at 3:10 p.m. Resident #43 was provided catheter care by MA I and CNA L. The resident was asked by CNA L if he wanted his brief changed and he stated that he would prefer it and as CNA L and MA I were assisting the resident to turn to his left side, MA I grabbed the urinary drainage bag by the hook at the top and held it in the air approximately 2.5 feet above the level of the resident's bladder and urine in the clear tubing drained back to the resident's bladder. MA I held the bag in the air until surveyor intervened and then placed it back down on the bed. The resident was also pointing and attempting to tell MA I to put the bag back down. CNA L was also observed telling MA I to put the urinary bag down on the bed. The resident denied any issues or concerns and the staff completed his care. In an interview on 4/9/26 at 3:26 p.m. MA I stated she was not supposed to lift the urinary drainage bag into the air or above the bladder and she knew that and had been trained but she was very nervous at the time and was not sure what to do with the urinary bag as she was drawing a blank due to being so nervous. In an interview on 4/9/26 at 4:09 p.m. the DON stated the staff had been trained not to lift the urinary (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kirkwood Manor	2590 Loop 337 N New Braunfels, TX 78130

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	drainage bag above the bladder and it was the standard of care not to raise it above the bladder. The DON stated raising it above the bladder could cause backflow of urine but the system was a closed system. Review of training and competencies revealed MA I was trained on catheter and perineal care on 9/2/25 and her skills competency for catheter care was completed and passed on 12/11/25. Review of the skill competency for catheter care only included what to do for the catheter care and did not include what not to do. Review of the facility policy on nursing staff competency revised 1/2022 did not address raising the urinary drainage bag above the bladder. Record review of Resident #108's face sheet, dated 04/10/2026, revealed the resident was a [AGE] year-old female, originally admitted on [DATE], and readmitted to the facility on [DATE] with diagnoses of type 2 diabetes mellitus (uncontrolled blood sugars), chronic kidney disease (kidneys have damage and less able to filter waste and fluid), and urinary tract infection (infection in any part of the urinary system such as bladder or urethra). Record review of Resident #108's quarterly MDS assessment, dated 01/13/2026, revealed the resident's BIMS score was 15 out of 15 which indicated the resident's cognition was intact, always incontinent of bladder, and frequently incontinence of bowel. Resident #108 required substantial/maximal assistance (helper does more than half the effort) to toilet transfer. Record review of Resident #108's comprehensive care plan, dated 11/24/2024, revealed [Resident #108] Has bowel/ bladder incontinence related to increased need of assistance with toileting due to generalized weakness with toileting. For intervention - INCONTINENT: Check as required for incontinence. Wash, rinse and dry perineum. Change clothing as needed for after incontinence episodes. Observation on 04/09/2026 at 2:56 p.m. revealed when CNA-C and CNA-F were providing perineal care to Resident #108, CNA-F opened the resident's old and dirty brief and cleaned the resident's left and right groin area and cleaned the resident's genital area without separating the labia. Further observation revealed CNA-F turned the resident to her left side without cleaning the suprapubic area, which was the area of the abdomen located below the umbilical region, and CNA-F cleaned the resident's buttock and rectum area, then put a new and clean brief on the resident. Interview on 04/09/2026 at 3:04 p.m. with CNA-F she stated she did not clean Resident #108's suprapubic area and did not separate the resident's labia area when cleaning the resident's genital area because she was nervous and forgot to clean the area and to separate the labia. CNA-F said she should have cleaned the area and separated the labia when providing peri-care to Resident #108 to prevent possible infection. Interview on 04/09/2026 at 4:07 p.m. the DON stated CNA-F should have cleaned Resident #108's suprapubic area and separated the labia area when providing peri-care to Resident #108 to prevent possible infection. Record review of the facility policy and procedure, titled Peri Care – Female, undated, revealed Wash genital area, moving from front to back, using a clean part of the washcloth for each stroke or a clean wipe for each stroke. After cleansing genital area, assist resident on side.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 needed respiratory care were provided such care, consistent with professional standards of practice for 2 (Resident #3 and Resident #137) of 3 residents. 1. The facility failed to ensure Resident #3's oxygen tubing attached to the AVAP machine was bagged when not in use on 04/07/2026 and 04/08/2026. 2. The facility failed to ensure Resident #137's oxygen concentrator was set to 3 liters per minute as ordered by the physician on 04/8/2026. This failure could place residents at risk of illness, and respiratory complications.Findings included:1. Record review of Resident #3's face sheet, dated 04/08/2026, revealed she was admitted to the facility on [DATE], with an original admission date of 06/03/2025, with diagnoses which included: acute and chronic respiratory failure with hypoxia (sudden, severe worsening of baseline lung function in patients with chronic lung disease, resulting in critical oxygen deficiency), chronic obstructive pulmonary disease (a progressive, irreversible lung disease causing restricted airflow), and heart failure, unspecified. Record review of Resident #3's Quarterly MDS assessment, dated 02/05/2026, revealed the resident's BIMS score was 15, which indicated intact cognition. Section O Special Treatments, Procedures, and Programs revealed Section G1 Non-invasive Mechanical Ventilator was coded for Resident #3's AVAP use while a resident.Record review of Resident #3's care plan, initiated date of 06/06/2025, revealed a focus of Has altered respiratory status/Difficulty Breathing r/t Obstructive Sleep Apnea with an intervention of Apply CPAP machine with home settings at bedtime every evening . Record review of Resident #3's physician order summary report, dated, 04/08/2026, revealed a physician order reading Apply AVAP on QHS and off QAM, ensure AVAP is connected to oxygen when applying, at bedtime related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE, UNSPECIFIED and remove per schedule with a start date of 02/03/2026. Observation and interview on 04/07/2026 at 10:46 a.m. revealed Resident #3 lying in bed with the head of bed elevated wearing nasal cannula with oxygen concentrator set at 2 liter per minute and on the floor next to the oxygen concentrator was the oxygen tubing that was detached from the oxygen concentrator that led to Resident #3's AVAP machine. Resident #3 stated her oxygen should have been set to 2 liters per minute and she would wear her AVAP/CPAP machine at night. Resident #3 further stated her AVAP machine was hooked up to her oxygen concentrator at night. Observation on 04/08/2026 at 9:27 a.m. revealed Resident #3 lying in bed with oxygen nasal cannula on with oxygen concentrator set at 2 liters, and the oxygen tubing from her AVAP machine was looped up and stuffed in the handle to her oxygen concentrator not bagged. During an interview and observation on 04/08/2026 at 9:38 a.m. LVN M stated Resident #3's oxygen was supposed to be set at 2 liters per minute. LVN M stated the green oxygen tubing that went to her AVAP machine should have been bagged when it was not in use and further stated he would have to go get a bag for it. LVN M stated bagging the tubing prevented contamination. LVN M stated if the oxygen tubing was to get contaminated it could get in the tubing and possibly cause a respiratory infection. LVN M removed the oxygen tubing that was attached to the AVAP machine and stated it was due to it having been on the floor and he was going to replace it. During an interview on 04/09/2026 at 4:14 p.m. the DON stated the oxygen tubing should have been stored in a bag when not in use. The DON stated by bagging the oxygen when not in use reduced the chance of contamination. The DON further stated if it got contaminated there was a possibly of infections. During an interview on 04/10/2026 at 1:59 p.m. the Administrator stated the oxygen tubing was supposed to be bagged when not in use, to keep it clean and it would keep it from being contaminated. The Administrator stated everyone was responsible but on the day to day it would be the staff on the floor to ensure it was bagged and stored properly. 2. Record review of Resident #137's face sheet, dated 04/08/2026, revealed she was admitted to the facility on [DATE], with an original admission date of 12/17/2022, with diagnoses which included: chronic respiratory failure with hypoxia (sudden, severe worsening of baseline lung (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	function in patients with chronic lung disease, resulting in critical oxygen deficiency), chronic obstructive pulmonary disease (a progressive, irreversible lung disease causing restricted airflow), and hypoxic ischemic encephalopathy (brain injury caused by oxygen deprivation (hypoxia) or reduced blood flow (ischemia)), unspecified.Record review of Resident #137's Quarterly MDS assessment, dated 02/03/2026, revealed the resident's BIMS score was 13, which indicated borderline cognitive impairment. Section O Special Treatments, Procedures, and Programs revealed Section C1 Oxygen Therapy was coded for Resident #137's oxygen use while a resident.Record review of Resident #137's care plan, initiated date of 08/06/2025, revealed a focus of Has COPD (Chronic Obstructive Pulmonary Disease) and Chronic Hypoxia with an intervention of Give oxygen therapy as ordered by the physician. Record review of Resident #137's physician order summary report, dated, 04/08/2026, revealed a physician order reading O2 at 3 L/MIN CONTINUOUS PER nasal cannula every shift with a start date of 07/25/2025. Observation and interview on 04/08/2026 at 9:53 a.m. revealed Resident #137 sitting up in her wheelchair working with a knitting loom wearing her nasal cannula and oxygen concentrator set at 2.5 liters per minute. Resident #137 stated it was supposed to be set at 3 liters per minute and that the staff had been setting the oxygen concentrator between 3 and 4 liters per minute. During an interview and observation on 04/08/2026 at 10:01 a.m. LVN M stated Resident #137's oxygen concentrator was supposed to be set at 3 liters per minute then LVN M checked the concentrator, stated it was set at 2.5 liters per minute and then adjusted it to 3 liters per minute. LVN M stated if Resident #137 was exerting herself and oxygen was not at the proper setting of liters Resident #137 could possibly become hypoxic. LVN M further stated this could cause a lack of oxygen and it could possibly cause a resident to go into respiratory distress. During an interview on 04/09/2026 at 4:16 p.m. the DON stated the facility needed to follow the orders and the orders were typically based on the residents' O2 needs. The DON stated by Resident #137's oxygen concentrator not being set at the proper setting Resident #137 could become short of breath by the oxygen not being set as ordered. During an interview on 04/10/2026 at 2:07 p.m. the Administrator stated oxygen would be considered a medication and the nurse on the floor would be responsible to ensure it was at the proper setting. The Administrator stated that by not having Resident #137's oxygen concentrator at the proper setting it could possibly cause Resident #137's oxygen level to not be high enough and she could possibly desat (A drop in hemoglobin oxygen saturation). Review of the policy on Oxygen provided by the facility revised on 05/2007 did not address the oxygen tubing. Record review of facility's policy titled Oxygen Administration (Mask, Cannula, Catheter),, revised date 05/2007, read, Policy: It is the policy of this facility that oxygen therapy is administered, as ordered by the physician .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation, interview, 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 (400-hall nursing cart) of 6 medication carts reviewed for medication storage and for 1 (Resident #134) of 10 residents reviewed for medication administration. 1. There was one bottle of blood glucose test strips inside the 400-hall nursing cart on [DATE], and the test strips expired on [DATE]. 2. The facility failed to reorder Resident #134's buspirone hydrochloride 7.5 MG Oral Table for depression on time. As a result, the medication was not available when administering the medication to the resident. This failure could place the residents at risk of not receiving therapeutic doses of their medication. Findings included:1. Observation on [DATE] at 3:01 p.m. revealed there was one bottle of blood glucose test strips inside the 400-hall nursing cart, and the test strips expired on [DATE]. Further observation revealed there was a date written with red marker on the bottle of the glucose test strips, and the date was [DATE]. Interview on [DATE] at 3:02 p.m. with LVN-H stated the date ([DATE]) written with red marker on the bottle of glucose test strips was the open date and used the test strip since [DATE]. LVN-H said she did not know the test strips expired on [DATE] because she did not check the expiration date, and it was her mistake. LVN-H stated she should have checked the expiration date of the test strips and should not have used them because they expired on [DATE], and the nurse said residents on 400-hall did not have any negative outcome related to blood glucoses, but nurses should not use expired blood glucose test strips to have accurate blood sugar values. Interview on [DATE] at 3:49 p.m. with DON revealed the facility nurses should have checked the expiration date of the blood glucose test strips and should not have used the strips if the strips were expired to have accurate blood sugar values. 2. Record review of Resident #134's face sheet, dated on [DATE], revealed the resident was a [AGE] year-old male and admitted to the facility on [DATE] with diagnoses of cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), major depressive disorder (persistently low or depressed mood and interest in pleasurable activities), and anxiety disorder (symptoms of intense anxiety or panic that are directly by a physical health problem). Record review of Resident #134's annual MDS assessment, dated [DATE], revealed the resident's BIMS score was 15 out of 15 which indicated the resident's cognitive was intact and in the Section N (Medications) the resident was receiving antidepressant. Record review of Resident #134's comprehensive care plan, dated [DATE], revealed the resident had the care plan of At risk for depression related to history of major depressive disorder. For intervention - Administer medications as ordered. Monitor/document for side effects and effectiveness. Record review of Resident #134's physician order, started on [DATE], revealed the resident had the order of busPIRone hydrochloride Oral Tablet 7.5 MG (Buspirone hydrochloride) Give 1 tablet by mouth two times a dayfor agitation related to MAJOR DEPRESSIVE DISORDER. Record review of Resident 134's Medication Administration Record from [DATE] to [DATE] revealed Resident #134 was receiving his busPIRone hydrochloride 7.5 mg by mouth one tablet for depression every morning and every hour of sleep. Observation on [DATE] at 8:44 a.m. revealed MA-I prepared Resident #134's morning medications and could not find the resident's busPIRone hydrochloride for depression in the cart. MA-I reported to RN-J regarding she could not find Resident #134's busPIRone hydrochloride for depression, and RN-J searched the medication room and the facility emergency kit, but RN-J said she could not find the medication, and the facility emergency kit did not have the medication, so the nurse would contact the resident's primary care physician and pharmacy. Further observation on [DATE] at 9:13 a.m. revealed MA-I notified Resident #134 regarding the medication was not available and said whenever she got the medication, she would give it to the resident, and the resident said he was fine. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 9:00 a.m. with MA-I she said she did not know what reason the medication was not available because she usually did not work at the 600-hall, but the facility nurses or medication aides should have reordered the medication at least 5 days ago before the medication ran out. Interview on [DATE] at 9:10 a.m. with RN-K she said she was the charge nurse of Resident #134, and nurses or medication aides should have reordered the resident's busPIRone hydrochloride for depression at least 5 days ago before the medication ran out, and if the resident did not take the medication, the resident might have increased signs and symptoms related to depression. Interview on [DATE] at 3:48 p.m. with DON said the facility nurses reported about Resident #134's busPIRone hydrochloride for depression was not available, so he called to the facility pharmacy, and the pharmacy delivered the medication right away, and the resident took the medication within time frame because the pharmacy was located very close to the facility. However, nurses or medication aides should have reordered the resident's busPIRone hydrochloride for depression at least 5 days ago before the medication ran out per the facility policy. Record review of the facility policy, titled Physician orders, reviewed on 08/2024, revealed . 9. Drugs and biologicals that are required to be refilled must be reordered from the issuing pharmacy prior to the last dosage being administered to assure that refills are on hand.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure medications and biologicals were stored in locked compartments for 1 of 2 medication rooms (Medication room station-2 for 100 and 500 hall) reviewed for medication storage. The facility failed to ensure the narcotic box inside the refrigerator for medications in the medication room station-2 for 100 and 500 hall was permanently affixed to the refrigerator. This failure could place residents at risk of not having controlled medications as ordered due to diversion of medication. Findings included:Observation on 04/08/2026 at 2:02 p.m. revealed there was a refrigerator inside the medication room station-2 for 100 and 500 hall, and the refrigerator was for medications. Further observation revealed one narcotic box for controlled medications was inside the refrigerator, but the narcotic box was affixed to one of refrigerator shelves, and the shelf was not permanently affixed to the refrigerator, so anybody could remove freely the shelf that the narcotic box was affixed to. Inside the narcotic box, there was one medication (Lorazepam injection pen). Interview on 04/08/2026 at 2:12 p.m. with ADON LVN-G he stated the narcotic box inside the refrigerator in the medication room station-2 for 100 and 500 hall was not permanently affixed, and anybody could remove it, but the facility had camera systems. The ADON said the narcotic box should have been permanently affixed to the refrigerator to prevent possible diversion of medication, and he would call maintenance right away to fix it. Interview on 04/09/2026 at 3:49 p.m. with DON revealed the narcotic box inside the refrigerator in the medication room station-2 for 100 and 500 hall should have been permanently affixed to the refrigerator to prevent possible diversion of medication. Record review of the facility policy, titled Controlled Medications - Storage and Reconciliation, review date on 12/2023, revealed It is the policy of this facility to safeguard access and storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse using separately locked, permanently affixed compartments with the exception that controlled mediations and those medications subject to abuse may be stored with non-controlled mediations as part of a single unit package mediation distribution system.

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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 to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen observed for plate preparation. The facility failed to ensure dietary staff properly air-dried insulated domes for tops of plates prior to meal service observed on 04/09/2026. These failures could place residents who received meals and/or snacks from the kitchen at risk of food born illness. The findings included: Observation on 04/09/2026 at 11:29 a.m. revealed Dietary Aide N placing plates on trays once they were prepared and covering them with insulated domes that had pooling water in them and as the Dietary Aide N would turn them over and place them on the plates of approximately 7 plates water would dribble across the plates. Dietary Aide N would then place the trays on the rack that were sent to 600 hall. Observation and interview on 04/09/2026 at 11:37 a.m. the Dietary Supervisor observed the insulated domes being placed on plates, that had not been dried properly and instructed the Dietary Aide N to remove the wet lids from the serving area so they could be racked and allowed to dry thoroughly. The Dietary Supervisor stated the Dietary Aide O was new and possibly had not allowed them enough time to dry as she was responsible for pulling the clean dishes when they finished washing and putting them away. The Dietary Supervisor further stated they did not have large drying racks to place the trays and lids on but would let them dry in the dish rack they would send through the dishwasher. The Dietary Supervisor stated the lids should be allowed to air dry totally. The Dietary Supervisor further stated this was to prevent residents from getting sick and prevent the dishwater from getting on the food. During an interview on 04/09/2026 at 11:40 a.m. the Dietary Aide N stated that by not drying the lids all the way it could allow for water to drip in the food and this could cause stomach upset for the residents. During an interview on 04/09/2026 at 11:42 a.m. the Dietary Aide O stated by not allowing the lids to dry all the way it could allow for bacteria growth from the moisture. The Dietary Aide O further stated this could possibly cause residents to get sick. During an interview on 04/10/2026 at 2:13 p.m. the Administrator stated before insulated domes were put in use, they should have been fully dried to prevent contamination issues. The Administrator stated the staff in the kitchen were responsible for ensuring they have dried properly. Review of facility's policy, Mechanical Warewashing: Dish Machines, no date, read Machine Warewashing Techniques: Air-dry all items. Towels may contaminate items.

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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 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement their policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption, for 1 (Residents #1) of 27 residents reviewed, in that: Resident #1's personal refrigerator located in her room contained a small plastic container and some food wrapped with kitchen aluminum foil with no date and no label on 04/07/2026. The failure could place the residents at risk for food borne illness. The findings included:Record review of Resident #1's face sheet, dated 04/10/2026, revealed the resident was a [AGE] year-old female originally admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses of pneumonia (infection that affects one or both lungs), dysphagia (difficulty swallowing), and muscle wasting and atrophy (decrease in muscle size and mass, which results in reduced muscle strength and function). Record review of Resident #1's Medicare 5-days MDS assessment, dated 02/19/2026, revealed the resident's BIMS score was 15 out of 15, which indicated the resident's cognitive was intact. Further record review of the MDS assessment revealed the resident required setup or clean-up assistance (Helper sets up or cleans up; resident completes activity.Helper assists only prior to or following the activity) for eating. Record review of Resident #1's comprehensive care plan, dated 01/21/2026, revealed the resident had the care plan of REGULAR diet, REGULAR texture, THIN LIQUIDS consistency and Explain and reinforce to the importance of maintaining the diet ordered. Encourage to comply. Explain consequences of refusal, obesity/malnutrition risk factors. Observation on 04/07/2026 at 10:40 a.m. revealed Resident #1 was on her wheelchair and watching television in her room. There was a personal refrigerator in the room, and inside the refrigerator there was a small plastic container with food and some food wrapped with kitchen aluminum foil, but no date and no label were on the container and wrap. Interview on 04/07/2026 at 10:41 a.m. with Resident #1 said the food inside the small plastic container and wrapped with kitchen aluminum foil was apple pie, and the resident's daughter brought the food, but the resident said she did not know when her daughter brought the food. Interview on 04/07/2026 at 12:06 p.m. with LVN-H stated Resident #1's refrigerator in her room had a small plastic container with food and some food wrapped with kitchen aluminum foil, but they were not dated and labeled. LVN-H said that she did not know what this food was and how long the food was inside the refrigerator because of no label and date, and the nurse said the facility night nurses were supposed to check it every day. Interview on 04/09/2026 at 3:48 p.m. the DON stated facility nurses were responsible for overseeing Resident #1's personal refrigerator and also responsible for monitoring it daily and should have dated and labeled the food that the family member brought. The DON stated the resident might have food illness. Record review of the facility policy, titled Resident Personal Food Storage, review dated on 01/2022, revealed Food or beverage brought in from outside sources for storage in facility pantries, refrigerator units or personal/resident room refrigerator units will be monitored by designated facility staff for food safety.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455732	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kirkwood Manor	2590 Loop 337 N 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 interview and record review, the facility failed to ensure medical records on each resident were complete, readily accessible, and contained the results of any preadmission screening and resident review evaluations and determinations conducted by the State for 2 of 5 residents (Resident #13, and #81), reviewed for Administration. 1. The facility failed to ensure Resident #13's PASARR level 1 screening, and PASARR level 2 evaluation were included in the resident's EHR. 2. The facility failed to ensure Resident #81's PASARR level 2 evaluation, and her specialized service plans were included in the resident's EHR. This failure could place residents at risk of a delay in or not receiving their needed care and specialized services, and decreased continuity of care.The findings were: 1. Record review of Resident #13's face sheet dated 4/8/26 revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE]. Resident #13's diagnoses included major depressive disorder recurrent and moderate (recurring mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life moderate in severity), and PTSD (mental health condition that's caused by being a part of or witnessing an extremely stressful or terrifying event and symptoms may include flashbacks, nightmares, severe anxiety and uncontrollable thoughts about the event). Record review of Resident #13's annual MDS assessment dated [DATE] revealed A1500 Preadmission Screening and Resident Review was coded as the resident did not have a serious mental illness and A1510 Level II Preadmission Screening and Resident Review was left blank. Record review of Resident #13's undated care plan revealed a focus initiated on 12/3/19 and revised on 10/16/24 for potential for psychosocial well-being problem related to diagnoses of depression and PTSD with interventions for psych and social services consults, monitoring, and anticipating needs. Another focus initiated on 10/3/24 for potential for re-traumatization related to the resident's PTSD being triggered by loud noises with interventions that included a revised intervention on 1/30/25 to provide a calm and quiet environment and notify the resident of fire alarm testing prior to alarms going off. Another focus initiated 12/3/19 and revised 10/16/24 for depression with interventions for monitoring and psychiatry consults. Record review of Resident #13's EHR revealed there was no evidence a PASSAR level 1 screening, or a PASSAR level 2 evaluation had been completed in the resident's medical record. Record review of iQIES survey environment indicated Resident #13's MDS triggered for no PASSR level 2 evaluation with a qualifying diagnosis. Record review of Resident #13's EHR revealed the resident's PASSR negative level 2 evaluation dated 10/3/24 was uploaded to the resident's medical record on 4/10/26. 2. Record review of Resident #81's face sheet dated 4/10/26 revealed the resident was a [AGE] year-old female admitted to the facility on [DATE]. Resident #81's diagnoses included Down syndrome (a genetic condition caused by an extra copy of chromosome 21 (Trisomy 21), leading to physical traits like low muscle tone, small stature, and an upward slant to the eyes with mild-to-moderate intellectual disability and developmental delays). Record review of Resident #81's admission MDS assessment dated [DATE] revealed A1500 Preadmission Screening and Resident Review was coded as the resident did not have an intellectual disability or related condition and A1510 Level II Preadmission Screening and Resident Review was left blank. And A1550 Conditions Related to ID/DD Status Down syndrome was checked. The resident had unclear speech and was sometimes understood by others and sometimes understood others. The resident had a BIMS score of 00 indicating the resident was severely cognitively impaired. Record review of Resident #81's undated care plan revealed a focus initiated on 12/15/25 and revised on 1/22/26 for the resident receiving PASRR services, PASRR positive diagnosis: Down syndrome and had the name of the resident's habilitation coordinator listed. The interventions initiated 12/18/25 included IDT meeting to be completed as required, notify local authority of any significant changes, PASRR (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455732	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kirkwood Manor	2590 Loop 337 N New Braunfels, TX 78130

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	evaluation to be completed by local authority, and therapy services as ordered. Record review of iQIES survey environment indicated Resident #81's MDS triggered for no PASSR level 2 evaluation with a qualifying diagnosis. Record review of the facility provided list of PASRR positive residents revealed Resident #81 was on the list and received specialized services. Record review of Resident #81's EHR on 4/9/26 at 11:18 a.m. and 4/10/26 at 10:00 a.m. revealed there was no PASSAR level 2 evaluation, and no IP or HSP completed in the resident's medical record indicating she received specialized services. Record review of Resident #81's EHR revealed Resident #81's PASSAR level 2 evaluation, and her IP dated 1/22/26 and her HSP dated and signed by the LIDDA Habilitation coordinator on 1/22/26 were uploaded to the medical record on 4/10/26. In an interview on 4/10/26 at 2:18 p.m. the DON stated the HSP and IP should have been in Residents medical record and was not sure why it had not been uploaded previously. The DON stated this did not affect the residents and Resident #81 continued to receive specialized services uninterrupted. Facility Policy on medical record content provided by the facility revised 3/2019 did not address PASSR records.