

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676121	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/17/2025
NAME OF PROVIDER OR SUPPLIER Silver Tree Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 930 Roy Richard Dr Schertz, TX 78154	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47564</p> <p>Based on observations, interviews, and record review, the facility failed to ensure residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 1 of 6 residents (Resident #6) reviewed for abuse.</p> <p>The facility failed to ensure residents were free from verbal abuse on 01/17/2024 when CNA L spoke in a negative manner about a resident at a high volume while in a resident hallway outside of a resident room.</p> <p>This failure could place residents at risk for abuse, trauma, and psychosocial harm.</p> <p>The findings included:</p> <p>Record review of Resident #6's face sheet reflected a [AGE] year-old resident with an admitted [DATE] and diagnosis including cerebral infarction due to unspecified occlusion or stenosis of left anterior cerebral artery (a type of stroke that occurs when blood flow to the brain is disrupted), type 2 diabetes mellitus (a chronic disease in which the body has trouble controlling blood sugar and using it for energy), and hemiplegia (paralysis of one side of the body).</p> <p>Record review of Resident #6's Quarterly MDS Assessment, dated 12/09/2024, reflected that Resident #6 had a BIMS score of 9, suggesting moderate cognitive impairment. The Quarterly MDS Assessment also reflected that Resident #6 was dependent on staff and unable to complete himself for activities of daily living to include showering, toileting, and dressing. Further record review reflected that Resident #6 was dependent on staff and unable to complete for himself: rolling left and right, sit to lying, lying to sitting on side of bed, sit to stand, and all transfers (chair, toilet, tub/shower). Resident #6's MDS Assessment further reflected a diagnosis of depression.</p> <p>Record review of Resident #6's Care Plan reflected he had an ADL Self Care Performance Deficit with interventions which included Assist with personal hygiene as required, and that he requires antidepressant medication with interventions which included monitor/document/report to MD prn ongoing s/sx of depression unaltered by antidepressant meds.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation of CNA L on 01/17/2025 at 9:48 AM, the State Surveyor was walking on the 800 hallway and observed CNA L walk toward HA J, stop in front of a resident room, and tell HA J, Mr. [Resident #6] is so lazy, he acts like we are his maids. CNA L was heard by the State Surveyor from 15 feet away. Resident rooms on the 800 hall, within 15 feet of CNA L, were observed to have their doors open.</p> <p>Interview on 01/17/2025 at 10:37 AM, CNA L stated that she was discussing Resident #6 on the hallway with HA J. CNA L stated that she was speaking with HA J about how it seemed as though Resident #6 was not working to help her as much as he used to during showers and that it was very difficult to shower Resident #6. CNA L stated she did not say that the resident was lazy or that he treated them as maids.</p> <p>Interview on 01/17/2025 at 10:53 AM, HA J stated that while she was doing rounds on 800 hall, CNA L had walked up to her and said that Resident #6 did not cooperate, was lazy, thought that the CNA's were his maids, and wouldn't move when CNA L wanted him to. HA J stated that it was known to those who work with Resident #6 that he was weak on one side of his body due to his condition and that he was physically unable to help more than he did. HA J stated she had never heard CNA L say this before and had not talked with CNA L much before in general. HA J stated it was inappropriate for CNA L to speak about a resident that way and that she was going to report the incident to the administrator immediately, but the state surveyor already had. HA J stated that she felt uncomfortable with CNA L calling Resident #6 lazy and went to check on the resident after the conversation ended. HA J stated that it was not right to call a resident lazy in general, as there could be many reasons someone was more resistive to care such as being in pain.</p> <p>Interview on 01/17/2025 at 11:05 AM, the Administrator stated she suspended CNA L and would be completing an investigation and training staff on abuse. The Administrator stated she spoke to Resident #6, and he did not hear the discussion between CNA L and HA J as he resides on the 600 hall and the conversation was on 800 hall .</p> <p>Observation and interview on 01/17/2025 at 11:20 AM, Resident #6 was observed in his bed. Resident #6 stated he did not have any concerns for how people treat him at the facility.</p> <p>Record review of HA J's written statement regarding the incident, dated 01/17/2025 reflected, I [HA J] was walking the halls checking on the residents, as I was doing my rounds a staff by the name [CNA L] stop me in the hallway, and start telling me how she don't like working with one resident, he lazy and he think's we his [maid], she went on saying he want help us move him, and he cry about everything.</p> <p>Record review of the facility policy titled, Abuse/Neglect dated revised 03/29/2018, reflected, verbal abuse: Any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents, or within their hearing distance, regardless of their age, ability to comprehend, or disability . examples of verbal abuse include, but are not limited to: threats of harm; saying things to frighten a resident, such as telling a resident that she will never be able to see her family again . and further reflected the facility will provide the resident, families, and staff an environment free of abuse and neglect.</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47564</p> <p>Based on interviews and record review, the facility failed to ensure residents had the right to be free of misappropriation of resident property and exploitation for 1 of 4 residents (Resident #7) reviewed for misappropriation and exploitation.</p> <p>The facility did not prevent misappropriation when CNA M and/or CNA N stole Resident #7's bank card and began using it at the facility vending machine, as well as various grocery stores, convenience stores, and restaurants around the facility.</p> <p>This failure could place residents at risk of misappropriation of money, possessions, and feelings of loss.</p> <p>The findings included :</p> <p>Record review of the facility provider investigation report written by the facility administrator, dated 07/25/2024, reflected: [Resident #7] is an [AGE] year-old woman who resided at the facility for long term care services. [Resident family member] reached out to facility letting the facility know that [Resident #7]'s credit card was being used at the facility vending machines as well as around town at various grocery stores/restaurants. The resident does not have visitors and the resident is unable to use the card herself. Facility conducted safety rounds with residents and no other instances of misappropriation or abuse were mentioned. Facility contacted the local law enforcement, and the police came to the facility. The facility provided the police with information regarding the incident as well as the [resident family member] information. The [resident's family member] was able to provide the bank statements to the officer. The officer told Administrator that a detective would be receiving the case and be going from there. The facility nor the [resident's family member] have yet to hear from the detective. The facility attempted to reach out to one of the [Grocery Store]'s that was listed on the CC statement, a restaurant, and the neighboring [convenience store] to gather information but was unsuccessful, this information on the perpetrator will have to be gathered by law enforcement. At this time the facility does not have any suspects in mind. Once the detectives give facility information on who the perpetrator is, if it is in fact an employee, the facility fully intends to press criminal charges as well as terminate the employee effective immediately .</p> <p>During an interview on 01/16/2025 at 10:00 AM, the administrator stated that it was determined that either CNA M and/or CNA N had stolen the residents credit card. The administrator stated that CNA M and CNA N were twins, and they were unable to determine if only one of them stole and used the card or if it was both of them. The administrator stated that she was not the administrator at the time of the incident, but that both CNA M and CNA N were terminated on 07/30/2024.</p> <p>An attempt to contact Resident #6's family was made on 01/16/2025 at 4:30 PM. The phone call was not answered or returned.</p> <p>Record review of facility in-service training dated 07/25/2024 after the incident reflected that all staff had been trained on abuse, neglect, and misappropriation after this incident occurred.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 1/16/2025 at 10:43 AM, LVN K stated that she was familiar with misappropriation of resident property, gave an example of what misappropriation of resident property was, and stated that they have it as part of their regular abuse and neglect training approximately every month, if not sooner.</p> <p>Interview on 1/14/2025 at 1:48 PM, the ADON H stated that there was abuse and neglect training at least one time a month, and the training included misappropriation of resident property, and how to report it.</p> <p>Record review of facility policy titled, Abuse/Neglect dated revised 03/29/2018, reflected, The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart .misappropriation of resident property: means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the residents' consent .</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>39049</p> <p>Based on observations, interviews, and record review, the facility failed to ensure all drugs and biologicals were stored in locked compartments for 1 of 2 nursing carts (400-hall nursing cart) reviewed for storage.</p> <p>The facility failed to ensure the 400-hall nursing cart was locked when left unattended.</p> <p>This failure could place residents at risk of misappropriation of medications or harm due to accidental ingestion of unprescribed medications.</p> <p>The findings were:</p> <p>During an observation on 01/17/2025 at 12:15 p.m. revealed the 400-hall nursing cart was found unlocked and unattended on the 400 hallway. This state surveyor was able to open all drawers revealing multiple medication blister packs, scissors, and bottles of medications.</p> <p>Interview on 01/17/2025 at 12:19 p.m. with LVN-A stated the 400-hall nursing cart was unlocked and unattended on the 400 hall. LVN-A stated she did not realize she left the cart unlocked. LVN-A stated it was important the nursing cart was locked at all times due to resident, visitor, and staff safety. LVN-A stated by the nursing cart being unlocked, anyone could get into the cart and take medications or scissors from the cart.</p> <p>Interview on 01/17/2025 at 1:24 p.m. the DON stated the 400-hall nursing cart should not have been unlocked as it would not be safe for residents and visitors. The DON stated if the nursing cart was not locked someone other than the nurse, like a resident with dementia, could open the medication cart, take out the medications and take them. The 400-hall nurse was responsible for overseeing this and monitored if the cart was locked sometimes.</p> <p>Record review of the facility's policy, titled Storage of Medication, revised 03/02/2003, revealed The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049</p> <p>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 1 Residents (Residents #1) of 3 residents reviewed for infection control.</p> <p>The wound care nurse LVN-B entered Resident #1's room, who was on EBP, on 01/15/2025 at 9:00 a.m., and failed to put on a gown when the nurse performed wound treatment for Resident 1.</p> <p>These deficient practices affect residents who require direct care and could place residents at risk for cross contamination and infections.</p> <p>The findings were:</p> <p>Record review of Resident #1's electronic face sheet, dated 01/17/2025, reflected he was [AGE] years old male, originally admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses included: Parkinson disease (movement disorder of the nervous system that worsen over time), dermatitis (swelling and irritation of the skin), type 2 diabetes mellitus (trouble controlling blood sugar), and hypertension (high blood pressure).</p> <p>Record review of Resident #1's quarterly MDS assessment with an ARD of 10/22/2024 reflected he scored a 12/15 on his BIMS assessment which signified he had moderate cognitive impairment, and the resident had a risk of developing pressure ulcers/injuries in the section M (Skin conditions).</p> <p>Record review of Resident #1's comprehensive care plan, dated 04/01/2024, revealed the resident has actual impairment to skin integrity related to adhesive reaction. For intervention, monitor/document location, size, and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, and maceration to medical doctor and the resident is on enhanced barrier precautions. For intervention, gloves and gown should be donned if any of the following activities are to occur, such as linen change, resident hygiene, transfer, dressing, toilet/incontinence care, bed mobility, wound care, bathing, or other high-contact activity.</p> <p>Record review of Resident #1's physician order, dated 01/15/2025, revealed Wound care: Left heel - Clean with normal saline, pat dry, apply povidone/Iodine and leave open to air one time a day.</p> <p>Observation on 01/15/2025 at 9:00 a.m. revealed there was a sign posted on Resident #1's door, and the sign was Enhanced Barrier Precaution - EVERYONE MUST: Clean their hands, including before entering and when leaving the room. Wear gloves and a gown for the following High-Contact Resident Care Activities . Changing briefs and assisting with toileting .Wound Care: Any skin opening requiring a dressing.</p> <p>Observation on 01/15/2025 at 9:01 a.m. revealed the wound care nurse LVN-B sanitized her hands outside Resident #1's room and put on gloves. The wound care nurse LVN-B entered Resident #1's room and cleaned, pat dry, and applied Iodine to Resident #1's left heel without putting on a gown, then the nurse went out of the resident's room, and took off the dirty gloves and sanitized her hands.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 01/15/2025 at 9:10 a.m. with the wound care nurse LVN-B confirmed she did not wear a gown when she cleaned, pat dry, and applied Iodine to Resident #1's left heel. She stated, Resident #1 had Enhanced Barrier Precaution, so the wound care nurse LVN-B should have put on a gown when providing the wound care to prevent possible contamination, and the wound care nurse was trained previously regarding Enhanced Barrier Precaution. The wound care nurse LVN-B stated she was nervous and forgot to wear a gown, and the potential harm was Resident #1 might have infection.</p> <p>Interview on 01/16/2025 at 1:48 p.m. with the DON confirmed the wound care nurse LVN-B should have put on a gown when entering Resident #1's room to provide wound care because the resident had Enhanced Barrier Precaution. The wound care nurse was trained previously regarding Enhanced Barrier Precaution. The wound care nurse might be very nervous and forgot to wear a gown.</p> <p>Record review of the facility policy, titled Enhanced Barrier Precaution, revised 04/01/2024, revealed Enhanced Barrier Precautions - during high-contact resident care activities: dressing, bathing/showering/transferring, changing linens, changing briefs, device care or use, and wound care: any skin opening requiring a dressing. Gloves and gown prior to the high contact care activity.</p>