STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676121	A. Building B. Wing	10/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Tree Nursing and Rehabilitation Center	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)
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. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 2 of 8 residents (Resident #2 and #3) reviewed for care plans: The facility failed to ensure Residents #2's Care Plan reflected he refused wound treatment prior to 10/01/25. The facility failed to ensure Residents #3's Care Plan reflected her behaviors of making allegations/accusations about resident care.The findings included: Record review of Resident #2's admission record, dated 10/10/25, revealed resident was an [AGE] year-old male resident admitted [DATE] with diagnoses to include protein-calorie malnutrition. Record review of Resident #2's admission MDS assessment, dated 09/11/25, revealed Resident #2's had a BIMS score of 06 out of 15, indicating severe cognitive impairment. Record review of Resident #2's care plan, undated, reflected a focus The resident has a potential for pressure ulcer development., initiated 09/10/25, with interventions . [Resident #2] with hx of wound care refusal, initiated 10/07/25. Record review of Resident #2's October 2025 Wound Administration Record reflected WOUND CARE: unstageable PI to right buttock. one time a day for WOUND HEALING for Lib A (liberal in the AM shift, meaning wound treatment could be done any time in the morning) did not have anything documented for 10/01/25 to 10/06/25. Record review of Resident #3's admission record, dated 10/10/25, revealed resident was a [AGE] year-old female resident admitted [DATE] with diagnoses to include dementia (loss of cognitive functioning that interferes with daily life and activities). Record review of Resident #3's annual MDS assessment, dated 09/06/25, revealed Resident #3's had a BIMS score of 08 out of 15, indicating moderate cognitive impairment. Record review of Resident #3's care plan, undated, reflected no mention of resident having behaviors of making false accusations/allegations. Interview on 10/09/2025 at 10 AM, LVN AA revealed Resident #3 had behaviors and can be really dramatic at times. She revealed Resident #3 got mad easily and would get mad at certain CNAs (not let certain staff care for her). She revealed they accommodated for Resident #3's preferences like ensured staff she liked helped her.Interview on 10/09/2025 at 11:59 AM, LVN AD revealed in the last 2 weeks, Resident #2 had a history of refusing wound care and had to get Resident #2's family member to help Resident #2 agree to wound treatment. LVN AD revealed Resident #3 had a history of making accusations against staff Interview on 10/09/25 at 02:50 PM, RN C revealed she did wound treatment for Resident #2 from 09/30/25 to 10/03/25 and 10/06/25. She revealed Resident #2 had a history of refusing wound care. She revealed she tried 2 or 3 times for wound treatment, but he continued to refuse wound treatment. She revealed they had to educate Resident #2 and Resident #2's family member every day about importance of wound treatment. Interview on 10/10/25 at 01:03 PM, SW revealed Resident #3 had a history of making unsubstantiated allegations against staff. (specific examples not given) Interview on 10/10/25 at 01:27 PM, Resident #3's RP revealed Resident #3 could be manipulative when she got mad and did not get her way. She revealed Resident #3 had a history of making up stories about her care in order to make it seem like Resident #3 had to come home instead of staying at the facility. Interview on 10/10/25 at 04:37 PM, the ADM and DON revealed they should have documented Resident #2 refused wound treatments in his care plan because care plans were person centered and reflected what care resident received. They further revealed for Resident #3 they did not document in her care plan that she made accusations and allegations of her care. (The ADM revealed these accusations and allegations were not reportable events.) They revealed Resident #3 had a history of making allegations about staff, and they had been working on helping this resident with these behaviors through psychiatric and psychological services. Interview on 10/13/25 at 03:54 PM, [Mental Health Organization] counselor revealed Resident #3 did not like being in the facility because she wanted to go home. She revealed Resident #3 had a history of making up accusations about care. She revealed if Resident #3 got into a bad mood, anything bothered her. She revealed the facility and she had been working on these behaviors with her. Record review of the facility's policy, titled Comprehensive Care Planning, undated, reflected The comprehensive care plan will describe the following- The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; and the right to refuse treatment

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible and each resident received adequate supervision to prevent accidents for 1 of 6 residents (Resident #1) reviewed for accidents and supervision. The facility failed to provide appropriate supervision for Resident #1 resulting in Resident #1 leaving the facility without the facility's knowledge on 08/28/2025 between 1:20 and 1:40 AM and being found face down on the ground in the facility parking lot. The noncompliance was identified as PNC. The Immediate Jeopardy (IJ) began on 08/28/25 and ended on 08/29/25. The facility had corrected the noncompliance before the investigation began.This deficient practice could place residents at-risk of harm, serious injury, or death. The findings included:Record review of Resident #1's admission Record, dated 10/08/25, reflected Resident #1 was an [AGE] year-old female admitted [DATE] with diagnoses to include dementia (loss of cognitive functioning that interferes with daily life and activities) and repeated falls. Record review of Resident #1's quarterly MDS assessment, dated 06/06/2025, reflected Resident #1 had a BIMS of 7 out of 15 indicating moderately impaired cognition. RR of Resident #1's quarterly Elopement Risk Assessment, dated 08/25/2025, reflected resident had statement and/or threats to leave facility, frequent request to go home, confused expressions related to tasks to complete, and verbalizes anger and frustration re: placement. Resident #1 scored 13, identifying her as an elopement risk. RR of Resident #1's care plan, undated, reflected Resident #1 was At risk for elopement and Actual elopement or elopement attempt Resident was confused and wandered outside the facility unattended, initiated on 08/28/2025. There were no interventions prior to this date. Record Review of the Provider Investigation Report for this incident, dated 08/28/25 and authored by the ADM, reflected the investigation summary On 08/28/2025 at 1:40am, the resident was found to be laying on the ground, outside the dining room door. The staff heard the door alarm and immediately started searching. Once the resident was located the staff, immediately assisted her and notified EMS due to her nose bleeding and having skin tears on her forehead and cheek. [Resident #1] was transferred to the local ED and returned a few hours later with no injuries noted. When [Resident #1] returned, she was placed on one on one monitoring and skin assessment was completed. Upon investigation, it was noted that the CNAs last saw her at 1:20am in the hallway with coffee in her hand while they were completing a round. Elopement protocol was immediately initiated and completed. On 8/29/2025, the resident was transferred to another facility with a secure unit. Observation on 10/08/2025 at 3:07 PM revealed the distance from the dining room exit door to the alleged spot where Resident #1 fell was 0.01 miles. Interview on 10/08/2025 at 2:40 PM, LVN A revealed she heard the alarm for the exit door in the dining room alarming. She revealed she went to the dining room door that was sounding and saw something that looked like possible bicycle wheels outside and went to get assistance. She further revealed when she came back with help, they saw a wheelchair and it appeared a resident had fallen. Interview on 10/09/2025 at 9:45 AM, Med Aide B revealed she was doing her rounds around 1:20 AM and had to escort Resident #1 back to her room. She revealed at 1:40 AM, she was told Resident #1 was on the ground, outside of the facility. She revealed she could not really hear the alarm. She further revealed Resident #1 was not exit-seeking prior to this event. Interview on 10/09/2025 at 10 AM, LVN AA revealed Resident #1 would wander and would be confused/looking for her family member at night but would stay around the nurse's station. She revealed she had never seen Resident #1 exit seek. Interview on 10/09/25 at 03:56 PM, the ADM and the DON revealed Resident #1 scored high on her elopement risk assessment because she was agitated from her family member's recent visit. They revealed if the admission elopement risk was high, they would wait a couple of days until the resident got acclimated so they could understand resident's true behaviors. They let staff know if there was a resident who was at high risk for elopement via care plans and word of mouth.Interview on 10/10/25 at 02:11 PM, Resident #1's doctor revealed this facility took precautions to prevent elopements like letting people in at the entrance, and there were not any residents he was concerned would exit seek. He revealed it was important to stop people from eloping to prevent injuries. He revealed he did not think Resident #1 was an elopement risk because she did not try to exit the facility. The facility's policy, undated, reflected 2. All residents who are at risk for harm because of wandering (elopement) will be assessed by the interdisciplinary care planning team.3. The resident's current chart and assessments will be reviewed to determine what changes have occurred that would trigger elopement episodes.4. The resident's care plan will be modified to indicate the resident is at

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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 interviews and record reviews, the facility failed to ensure resident medical records were kept in accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are complete and accurately documented for 1 of 6 residents (Resident #2) reviewed for clinical records. The facility failed to ensure Resident #2's wound treatment was accurately documented from 10/01/25 to 10/06/25. These failures could place residents at risk of not receiving the care and services needed due to inaccurate or incomplete clinical records. The findings included:Record review of Resident #2's admission record, dated 10/10/25, revealed resident was an [AGE] year-old male resident admitted [DATE] with diagnoses to include protein-calorie malnutrition. Record review of Resident #2's admission MDS assessment, dated 09/11/25, revealed Resident #2's had a BIMS score of 06 out of 15, indicating severe cognitive impairment. Record review of Resident #2's care plan reflected a focus The resident has a potential for pressure ulcer development., initiated 09/10/25, with interventions . [Resident #2] with hx of wound care refusal, initiated 10/07/25. Record review of Resident #2's October 2025 Wound Administration Record reflected WOUND CARE: unstageable PI to right buttock. one time a day for WOUND HEALING for Lib A (liberal in the AM shift meaning wound treatment could be done any time during the morning shift) did not have anything documented for 10/01/25 to 10/06/25. Interview on 10/09/2025 at 11:59 AM, LVN AD revealed in the last 2 weeks, Resident #2 had a history of refusing wound care and had to get Resident #2's family member to help Resident #2 agree to wound treatment. Interview on 10/09/25 at 02:50 PM, RN C revealed she did wound treatment for Resident #2 from 09/30/25 to 10/03/25 and 10/06/25. She revealed Resident #2 had a history of refusing wound care. She revealed she tried 2 or 3 times for wound treatment, but he continued to refuse wound treatment. She revealed they had to educate family member and Resident #2 every day about importance of wound treatment. Interview on 10/10/25 at 04:37 PM, the ADM and DON revealed Resident #2 refusing wound treatment should be documented in his administration record. They revealed this was important, so his records were accurate.Record review of the facility's policy Wound Treatment Management, dated 2021, reflected 7. Treatments will be documented on the Treatment Administration Record.Record review of facility's policy Documentation, undated, reflected 1. The facility will maintain complete and accurate documentation for each resident on all appropriate clinical record sheets.