| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676121 | A. Building<br>B. Wing | 12/01/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Silver Tree Nursing and Rehabilitation Center | 930 Roy Richard Dr<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>(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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to implement a comprehensive person-centered care plan for each resident to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 12 residents (Resident #1) reviewed for care plans. The facility failed to ensure Resident #1 was transferred with the appropriate number of qualified staff required when using a mechanical lift. This failure could place the residents at risk of injury by not following the resident's care plan and clinical standards of practice. Findings included: Record review of Resident #1's electronic health record reflected a [AGE] year-old female, with an admission date of 04/08/202. Resident #1 had diagnoses which included: Generalized anxiety disorder (excessive persistent worry about everyday things), Muscle wasting and atrophy (thinning or loss of muscle tissue), Rheumatoid arthritis (autoimmune disease causing swelling, pain and stiffness of joints), Lack of Coordination, Sequelae Cerebral Infarction (physical, cognitive, & emotional impairments such as one-sided weakness or paralysis, speech problems, memory problems), Hypomagnesemia (low magnesium in the blood causing weakness, seizures, muscle cramps), Vascular Dementia with mood disturbance (decline in cognition due to reduced blood flow to the brain and can include depression, irritability or sudden anger), Schizoaffective Disorder (condition combining schizophrenia such as hallucinations and disorganized thinking, and mood disorder like bipolar or depression), End stage renal disease (kidney failure and can no longer perform their function). Resident #1 had a BIMS of 09, which indicated moderate cognitive impairment. Record review of Resident #1's electronic health record reflected the most recent Care Plan, dated 09/11/25, date initiated 02/02/2021, revealed, transferring: requires staff x2 for assistance use [mechanical lift]. Record review of Resident #1's electronic health record reflected the MDS dated [DATE], Section GG, Chair/bed-to-chair transfer requires 01-Dependent- Helper does all the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity. Record review Resident #1's electronic health record reflected the MDS dated [DATE], Section GG, Chair/bed-to-chair transfer requires 01-Dependent- Helper does all of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity. In an observation on 11/29/25 at 3:12 p.m., CNA A wheeled a mechanical lift out of Resident #1's room and placed it against the wall and walked back into Resident #1's room. CNA A rolled Resident #1 to her side towards CNA A's body and removed the sling from under Resident #1. No other staff member was in the room. Resident #1 did not have any injuries noted. In an interview on 11/29/25 at 3:12 p.m., CNA A stated she transferred Resident #1 from her wheelchair to the bed with the mechanical lift on her own because Resident #1 wanted to lay down. CNA A stated it was her first day at the facility and she was orientating. She stated she had not been trained on mechanical lift transfers by the facility. CNA A stated she had been a CNA for 20 years and she knew there were supposed to be two people to use a mechanical lift to transfer a resident. CNA A stated everyone was busy and the staff she was supposed to be orientating with, CNA B, was down the hall changing other patients because the previous shift did not change their patients. She stated she took it upon herself to transfer Resident #1 with the mechanical lift, and she did not ask anyone for help with the transfer. CNA A stated Resident #1 was not injured. When asked how the residents could be affected, CNA A stated when a facility was short staffed, staff did one-person mechanical lift transfers and nothing bad happened to the residents. In an interview on 11/29/25 at 4:57 p.m., Resident #1 stated staff used a mechanical lift to transfer her. She stated CNA A transferred her by herself with the mechanical lift, but she did not get hurt. Resident #1 stated she did not remember how many people the staff used normally but she has never been hurt during a transfer. In an interview on 11/29/25 at 5:28 p.m., LVN C stated she was CNA A's direct supervisor, and she was in the dining room talking to a resident when CNA A transferred Resident #1. She stated she was not aware CNA A needed assistance with Resident #1, and she had not been asked to help. LVN C stated staff knew where she was and knew the expectation was to use two people to transfer a resident with a mechanical lift. LVN C stated she did not know where CNA B was at the time of the incident. In an interview on 11/29/25 at 6:00 pm, LVN D stated she did not know CNA A was transferring Resident #1 with a mechanical lift by herself and she had not asked her for any assistance. LVN D stated she did not know where CNA B was at the time of the incident. In an interview on 11/29/25 at 6:07 p.m., CNA B stated she was trained on mechanical lift transfers by the facility. She stated she was orientating CNA A |