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	01/28/2026

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure assessments accurately reflected the resident's status of 1 of 4 residents (Resident #1) reviewed for accuracy of assessments. The facility failed to ensure Resident #1's quarterly MDS assessment dated [DATE] accurately coded to reflect Resident #1's diagnoses of GERD (gastric reflex) and hypothyroidism.The facility failed to ensure Resident #1's quarterly MDS assessment dated [DATE] and Resident #2's assessment were accurate and reviewed and signed by a Registered Nurse before submission. This failure could place residents at risk for not receiving needed care and services to maintain the highest level of well-being. The findings included: Record review of Resident #1's face sheet dated 1/28/2026 revealed a [AGE] year-old female admitted on [DATE] with diagnoses which included: cerebral infarction (stroke), gastro-esophageal reflux disease without esophagitis (GERD)(reflux of acid from stomach into esophagus resulting in heartburn), and hypothyroidism (2/08/2025). Record review of Resident #1's care plan dated 3/13/2025 revealed a diagnosis of hyperthyroidism (the opposite of hypothyroidism) (in error). Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed a BIMS score of 10 which indicated a moderate cognitive impairment. The MDS did not list either hypo or hyperthyroidism or GERD as a diagnosis. The assessment is signed by the MDS Coordinator who is a LVN on 12/02/2025 under section Z0500 Signature of RN Assessment Coordinator Verifying Assessment Completion. The assessment was not signed by an RN.Record review of Resident #1's care plan dated 3/13/2025 revealed a diagnosis of hyperthyroidism (the opposite of hypothyroidism).Record review of Resident #1's provider note dated 1/23/2026 revealed a current diagnosis which included unspecified hypothyroidism. Record review of Resident #2's face sheet dated 1/28/2026 revealed a [AGE] year-old female admitted on [DATE] with diagnoses which included: acute kidney failure, essential hypertension (high blood pressure), and rheumatoid arthritis (chronic immune disease which attacks the joints causing pain and stiffness).Record review of Resident #2's quarterly MDS assessment dated [DATE] revealed a BIMS of 13 which indicated she was cognitively intact with total functional dependance on staff form movement. The assessment was signed by the MDS Coordinator who was a Licensed Vocational Nurse on 11/06/2025 under section z0500 marked signature of RN Assessment Coordinator Verifying Assessment Completion. An RN did not sign the assessment.During an interview on 1/28/2026 at 1:38 p.m., the MDS Coordinator stated he was responsible for MDS assessments and care plans. He stated after reviewing her medical record in November when the assessment was completed and currently, Resident #1 was being treated for both GERD by protonix and hypothyroidism with levothyroxine. He stated they were active diagnoses that were not included on the MDS assessment. He stated active diagnoses were normally auto populated into the MDS assessment. He stated he did not see a button to push to add GERD or hypothyroidism like some of the other diagnoses. He stated she should have written in both diagnoses under the category of other since they were both being treated and both should have been on the assessment. The MDS Coordinator stated it was just an oversight and something he would have to be (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	more careful about. the MDS Coordinator confirmed he was a LVN. He stated he was aware the MDS assessments required review and a signature from a RN. He stated he did not know why Resident #1 and Resident #2's MDS assessments were not reviewed or signed by a RN and had his signature. He stated he normally would give the DON a list every week of what needed to be signed. He stated he would take his laptop to the DON's office to review the assessments. The MDS Coordinator stated sometimes he would mark the assessments as completed by signing them to check for errors but may have failed to unmark it as incomplete because he was in a rush. He stated he believed it was an oversight and something he would have to be more careful about.During an interview on 1/28/2026 at 2:08 p.m., the DON stated she was unable to speak to the missing GERD and hypothyroidism diagnosis from Resident #1's quarterly MDS assessment. She stated the assessment was asking for active diagnoses and there was no category for those diagnoses. She stated the MDS Coordinator could have documented the diagnoses under the category other. The DON stated it was important to include all diagnoses for accuracy. The DON stated she reviews and signs MDS assessments for accuracy. She stated she did not know why Resident #1 and Resident #2's MDS assessments had not been signed by an RN. She stated she was not sure what happened. She stated the MDS Coordinator was in her office several times a week. The DON stated an RN had to sign and validate and check for accuracy the MDS assessments. She stated an LVN could not sign them. She stated she could not speak to the missing diagnoses of GERD and Hypothyroidism from Resident #1's assessment. The DON stated it was important for an RN to review the assessments for accuracy.Record review of the facility policy titled Minimum Data Set (MDS) Policy for MDS assessment Date Accuracy dated 8/2025 revealed: The purpose of the MDS policy is to ensure each resident receives an accurate assessment by qualified staff to address the needs of the resident who are familiar with his/her physical, mental, and psychosocial well-being. Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require that: 1. The assessment accurately reflects the resident's status. Record review of the facility policy titled Minimum Data Set (MDS) Policy for MDS assessment Data Accuracy dated 8/2025 revealed: Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require that: 1. The assessment accurately reflects the resident's status 2. a registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals.

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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 observation, 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 1 of 4 residents (Resident #1) reviewed for care plans: The facility failed to ensure Resident #1's comprehensive care plan was accurate and included the correct diagnoses of hypothyroidism (instead of hyperthyroidism) with appropriate interventions. This deficient practice could cause confusion for staff members responsible for providing direct care to the residents and place residents at risk of receiving improper care and services. The findings included:Record review of Resident #1's face sheet dated 1/28/2026 revealed a [AGE] year-old female admitted on [DATE] with diagnoses which included: cerebral infarction (stroke), gastro-esophageal reflux disease without esophagitis (GERD)(reflux of acid from stomach into esophagus resulting in heartburn), and hypothyroidism (2/08/2025). Record review of Resident #1's care plan dated 3/13/2025 revealed a diagnosis of hyperthyroidism (the opposite of hypothyroidism) with interventions which included interventions for adjustment of lighting to prevent eye irritation, safety for altered mental status and altered muscle coordination and encourage periods of rest to reduce energy needs. Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed a BIMS score of 10 which indicated a moderate cognitive impairment with reliance of moderate assistance for ADL's. The MDS did not list either hypo or hyperthyroidism as a diagnosis. Record review of Resident #1's provider note dated 1/23/2026 revealed a current diagnosis which included unspecified hypothyroidism. During an interview on 1/28/2026 at 1:38 p.m., the MDS Coordinator stated he was the nurse responsible for MDS assessments and care plans. He stated any licensed charge nurse; any member of the management team could alter and/or change a resident care plan. He stated care plans were discussed in morning meetings and reviewed with quarterly assessments. He stated Resident #1's Care Plan indicated hyperthyroidism instead of her actual disease process of hypothyroidism. he stated the interventions listed were not all appropriate for hypothyroidism. He stated the care plan for hyperthyroidism was created by LVN A who no longer worked for the facility. He stated it was not something that was caught during the reviews. He stated the last review was 1/14/2026. During an interview on 1/28/2026 at 2:08 p.m., the DON stated on admission important items for the care plan are added by various members of the team which included: the wound care nurse, ADON and DON. She stated the active diagnoses are entered by the MDS nurse after the MDS assessment. She stated she reviews the assessments for accuracy. She stated for Resident #1 she did not review the MDS assessment. She stated accurate care plans were important for the accuracy of care for the resident. Record review of the facility policy titled Comprehensive Care Planning (undated) revealed: The facility will 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. 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.

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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 interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 1 of 4 residents (Resident #2) reviewed for medical records accuracy, in that: The facility failed to ensure Resident #2 physician progress notes were obtained by the medical provider and uploaded into the medical record. This failure could affect residents whose records were maintained by the facility and could place them at risk for an incomplete clinical picture and errors in care and treatment. The findings included: Record review of Resident #2's face sheet dated 1/28/2026 revealed a [AGE] year-old female admitted on [DATE] with diagnoses which included: acute kidney failure, essential hypertension (high blood pressure), and rheumatoid arthritis (chronic immune disease which attacks the joints causing pain and stiffness). Record review of Resident #2's quarterly MDS assessment dated [DATE] revealed a BIMS of 13 which indicated she was cognitively intact with total functional dependance on staff for movement. Record review of Resident #2's electronic medical record on 1/28/2026 revealed there were no physician notes in the medical record. During an interview on 1/28/2026 at 12:48 p.m. the DON stated confirmation that no physician progress notes had been uploaded into Resident #2's medical record. During an interview on 1/28/2026 at 1:11 p.m., the DON was able to provide physician notes for 3/21/2025, 10/15/2025 and 11/17/2025. She stated none of these physician notes were in the electronic medical record. She stated they had not been uploaded because the facility was behind with uploads and doing it as fast as they could. She stated the medical records person was responsible for uploading. During an interview on 1/28/2026 at 1:20 p.m. the Medical Records staff stated he was not on a facility email group with the facility doctors. He stated he had noticed the physicians were behind with providing physician notes and the Administrator was aware. He stated if there was any document that was specifically needed, he could call the physician office, request the document and get it fairly quickly. Medical Records stated he had been doing the job since June of 2025. He stated he was told his expectation was to upload and scan documents. When asked about a time frame he stated he could not upload a document unless someone requested a specific document because he was not in the email group, and he does not upload unless there was a specific request for a specific document, he used the example of this surveyor requesting physician notes for Resident #2 as an example of a request. He stated the physician notes were not coming to him to upload unless he requested them specifically and he was not requesting them unless there was a specific need. During an interview on 1/28/2026 at 2:08 p.m., the DON stated the physician offices were behind in sending their notes to the facility. She stated it was the Administrators responsibility to contact the physician's office on a regular basis to get these records. The DON stated she was not sure what the facility policy indicated for uploading of physician notes into the medical record. She stated it was her expectation that medical records staff upload as quickly as possible once they were received. The DON stated the Medical Records staff would be responsible for contacting a physician office when a document was noted as needed. She stated she didn't know if Medical Records had any sort of schedule for regular contact. She stated she would assume he was auditing records and contacting whom he needed for missing documentation. The DON stated she was not providing medical record oversight. She stated it was a corporate person providing oversight and she was unsure who was doing it. During an interview on 1/28/2026 at 3:07 p.m., the Administrator stated she was aware some of the physicians' offices were behind in sending documentation. She stated it was not her hyperfocus. She stated she did not have a system for requesting physician notes or records. She stated (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they just request what was needed at the time. The Administrator stated the physician visits were compliant it was a failure between the physician office and the facility office to get them uploaded. The Administrator stated she did not know the facility policy off the top of her head. She stated it was important to have physician visits in the medical record for accuracy of documentation. Record review of a policy titled Physician's Progress Notes (PPN) dated 2023 revealed: 2. It is our responsibility to notify the physician when a physician's progress note is due. Routine clinical chart audits will alert you which physician needs to be notified.