STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676472	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sundance Inn Health Center	2034 Sundance Parkway 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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34788 Based on interview, record review, and observation, the facility failed to ensure residents have a right to personal privacy for 1 of 4 resident (Resident #2) reviewed for privacy, in that: CNA C and CNA D did not completely close Resident #2's privacy curtain while providing incontinent care on 4/11/25. This failure could place residents at-risk of loss of dignity due to lack of privacy. The findings included: Record review of Resident #2's face sheet, dated 04/11/2025, revealed an admitted [DATE], with diagnoses which included: Non traumatic acute subdural hemorrhage (bleeding between the layers surrounding the brain), Dysphagia (difficulty swallowing), Malignant neoplasm of prostate (prostate cancer), Type 2 diabetes mellitus (high level of sugar in the blood), Hypertension (high blood pressure), Depression (mood disorder that causes a persistent feeling of sadness and loss of interest). Record review of Resident #2's Cognitive and Swallowing assessment dated [DATE], revealed the resident had a BIMS score of 12, indicating he was moderately impaired. Record review of Resident #2's Admission progress note dated 04/07/2025, revealed the resident required extensive assistance with his activity of daily living and was always incontinent of bowel and bladder. Record review of Resident #2's care plan, dated 04/09/2025, revealed a problem of Pressure Ulcer Prevention, with an intervention of Incontinent care provided every 2 hours and as needed. Observation on 04/11/2025 at 9:42 a.m. revealed CNA C and CNA D did not completely close the privacy curtain while they provided incontinent care for Resident #2, exposing the resident's genital area during care. The privacy curtain was too short to surround the bed. The resident's end of the bed was completely uncovered. An Housekeeper opened the room's door and started entering before she was stopped by this surveyor and CNA C and CNA D. (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
	676472	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sundance Inn Health Center	2034 Sundance Parkway 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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with CNA C and CNA D on 04/11/2025 at 9:46 a.m., CNA C and CNA D confirmed the privacy curtain was not completely closed while they provided care for Resident #2 but it should have been. CNA D added the privacy curtain had been changed because it was long enough to close completely the day before. They confirmed they received resident rights training within the year. During an interview with the Administrator on 04/11/2024 at 1:30 p.m., the Administrator confirmed privacy must be provided during nursing care and Resident #2's privacy curtain should have been closed completely. He confirmed the staff had received training on resident rights within the year. Review of State Long-Term Care Ombudsman Program. Your Rights in a Nursing Facility, dated January 2025, revealed you have the right to: privacy, including during visits, phone calls and while attending to personal needs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676472	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sundance Inn Health Center	2034 Sundance Parkway 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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36232 Based on interview and record review, the facility failed to ensure a resident had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 1 of 8 residents (R#8) reviewed for misappropriation of resident property. The facility failed to ensure that Resident #8 was not subject to financial misappropriation or exploitation from Housekeeper E from the time period 11/10/2024 to 11/11/2024. Housekeeper E accepted a check for $350 from Resident #8. This deficient practice was determined to be Past Non-Compliance from 11/10/2024 to 11/11/2024, due to the facility having implemented actions that corrected the non-compliance prior to the beginning of the survey. This failure had the potential to affect the residents in the facility by placing them at risk for misappropriation of resident property. The findings included: Record review of Resident #8's face sheet dated 11/11/2024 revealed the resident was a [AGE] year-old male admitted on [DATE] and discharged [DATE]. The resident's diagnoses included: Rhabdomyolysis (a serious medical condition where damaged skeletal muscle tissue breaks down, releasing its contents into the bloodstream), alcohol abuse with intoxication, hypertension (high blood pressure), anxiety disorder (excessive worry, fear, and other physical and behavioral symptoms that interfere with daily life) and depression (a persistent sadness that interferes with daily life). A family member was listed as the resident's RP. Record review of Resident #8s admission MDS dated [DATE] revealed a BIMS score of 15, indicating the resident was cognitively intact. The resident was continent of bowel and bladder and able to perform ADLs independently or with partial/moderate assistance. Record review of Resident #8's comprehensive care plan, accessed on 04/08/2025, revealed the resident took psychotropic medications to treat his depression and anxiety. Interventions included monitoring for involuntary behaviors and weight loss and protecting the resident from self-harm or harm to others. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676472	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sundance Inn Health Center	2034 Sundance Parkway 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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 04/07/2025 at 12:28 PM, Resident #8's family member stated she had control of Resident #8's checkbook. She took it to the facility for the resident to sign some checks for his bills and left it there. When she returned to pick it up on 11/10/2024, she noticed one check was gone and confronted Resident #8 about it. At first, the resident did not know where it went, then he said, She needed help for a trip. When asked who needed help, Resident #8 stated, The housekeeper. Resident #8 saw the family member got upset and stopped talking. She did not know the amount of the check. The family member was livid. She approached the receptionist at the front desk and told her she was extremely upset and wanted it handled immediately and was told by the receptionist she would pass it along. The Administrator called her two days later, apologized immensely, and stated he instructed the housekeeper to bring cash back. The Administrator said Housekeeper E did not understand it was not okay to receive money from the resident. Resident #8 had dementia brought on by alcoholism. Two days later the Administrator said he had the cash but did not want to give it to the resident. She came to the facility and picked up an envelope of cash containing $350. During an interview on 04/10/2025 at 10:35 AM, the facility's receptionist stated she received training on abuse and neglect yearly and knew what to do if she became aware of such an incident; she would report the incident to the abuse coordinator, the Administrator. She vaguely remembered the incident but not the day. Resident #8's family member came to her mid-morning or after lunch. She was very upset and stated there was money missing, taken from Resident #8. The receptionist apologized to the family member and texted the Administrator immediately. She tried calling the DON but the DON was busy with a resident. She did not speak with the DON. During an interview on 04/11/2025 at 11:17 AM, the Administrator stated a staff member told him on 11/10/24 a family member called and they were upset someone cashed a check from a resident. He (the Administrator) did not recall who told him about the incident. The case was investigated by the facility's former DON. Housekeeper E returned the money before she went on vacation. She acknowledged she knew what she was doing was wrong but Resident #8 insisted she take the money. Housekeeper E went on vacation for 2 weeks and when she returned to duty, she was terminated. He did not report the incident to the police and he did not have a case number. He did not know why. The Administrator later stated on 04/11/2025 at 1:05 PM he did not notify law enforcement because Resident #8 had a BIMS of 15, he gave the Housekeeper the check voluntarily, and therefore the act did not fit the definition of misappropriation and instead fell under the category of accepting gifts from residents. During an interview on 04/11/2025 at 1:30 PM, the Housekeeping Director stated Housekeeper E talked about her past in [NAME] with Resident #8 and he stated he was going to help her out and take care of her. He was going to give her a check between him (Resident #8) and Housekeeper E, from him to her. Housekeeper E said she could not accept it but took it. She did not tell him (the Housekeeping Director) about it. She was not one of those who had ever done anything like that. He did not know what she was thinking. The DON found out about it and sent her home. She (the DON) told him about it. When he talked to Housekeeper E, she said they sent her home because she took some money that a patient gave her. He said it was going to be between us. The housekeepers knew they were not supposed to take it. She knew the right thing to do. She said she was going to tell me about it. He told her soon as she got that check she should have come to him. She had his phone number, she could have called him, but she did not. Record review of a statement provided by Housekeeper E dated 11/10/2024 revealed she cleaned the room for Resident #8, had a conversation with him, told him she was going on vacation, he asked her how much money she needed and gave her $350. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676472	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sundance Inn Health Center	2034 Sundance Parkway 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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility's Reportable Incident Protocol dated August 2024 read: In reporting accidents/incidents, the following protocol must be observed: External Reportable Incidents: In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: .Misappropriation of Patient Funds: The taking, secretion, misapplication, deprivation, transfer, or attempted transfer to any person not entitled to receive any property, real, or personal, or anything of value belonging to or under the legal control of a Patient, without the effective consent of the Patient or other appropriate legal authority, or the taking of any action contrary to any duty imposed by federal or state law prescribing conduct related to the custody or disposition of property of a Patient . 2. Our Facility will not condone Patient abuse, neglect, mistreatment or misappropriation of patient property and exploitation (collectively Patient Abuse) by anyone, including staff members, other Patients, consultants, volunteers, staff of other agencies serving the Patient, family members, legal guardians, friends, or other individuals. Reporting of crimes: The facility must report to the State Agency and law enforcement in which the facility is located any reasonable suspicion of a crime against any individual who is a patient of or is receiving care from the facility. The facility MUST report immediately, but no later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury. It was determined this failure placed residents in Past Non-Compliance from 11/10/2024 - 11/11/2024. The facility took the following actions to correct the non-compliance: 1. Record review of Housekeeper E's employment record revealed she was suspended from employment pending investigation of the incident on 11/10/2024. She had taken a 14-day planned leave of absence and was terminated upon her return to duty. 2. Record review of facility's Inservice training dated 11/10/2024 revealed 32 employees were trained by the abuse coordinator on not accepting gifts and financial abuse. 3. Facility investigation and reporting of incident to HHSC on 11/11/2024. 4. Emergency QAPI completed. 5. Money retrieved from Housekeeper E and returned to Resident #8's family member. Interviews conducted on 04/10/2025 from 12:27 PM - 3:18 PM and 4/11/2025 from 9:42 AM - 2:10 PM with LVNs A, H and I; CNAs C, D, F, G and J; the Housekeeping Supervisor, Nutrition Supervisor and Social Worker revealed they were familiar with the abuse policy, could define abuse, neglect and misappropriation, knew who the abuse coordinator was and how to report allegations of abuse or neglect. Interviews on 04/11/2025 from 09:45 AM - 10:15 AM with 15 residents from Halls 100, 200, 300, 500 and 600 revealed they felt safe at the facility with no concerns of abuse or neglect, no concerns with staff, and no observations of abuse or neglect from staff or resident to resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676472	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sundance Inn Health Center	2034 Sundance Parkway 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36232 Based on interviews and record review, the facility failed to develop and/or implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act for 1 of 8 residents (Resident #8) reviewed for abuse, neglect, exploitation, or mistreatment and report to one or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility. The facility failed to report to a law enforcement entity of an allegation of exploitation on 11/10/2024, where Housekeeper E received a check in the amount of $350 from Resident #8. This failure had the potential to affect the residents in the facility by placing them at risk for exploitation and/or misappropriation of resident property. The findings included: Record review of Resident #8's face sheet dated 11/11/2024 revealed the resident was a [AGE] year-old male admitted on [DATE] and discharged [DATE]. The resident's diagnoses included: Rhabdomyolysis (a serious medical condition where damaged skeletal muscle tissue breaks down, releasing its contents into the bloodstream), alcohol abuse with intoxication, hypertension (high blood pressure), anxiety disorder (excessive worry, fear, and other physical and behavioral symptoms that interfere with daily life) and depression (a persistent sadness that interferes with daily life). A family member was listed as the resident's RP. Record review of Resident #8s admission MDS dated [DATE] revealed a BIMS score of 15, indicating the resident was cognitively intact. The resident was continent of bowel and bladder and able to perform ADLs independently or with partial/moderate assistance. Record review of Resident #8's comprehensive care plan, accessed on 04/08/2025, revealed the resident took psychotropic medications to treat his depression and anxiety. Interventions included monitoring for involuntary behaviors and weight loss and protecting the resident from self-harm or harm to others. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676472	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sundance Inn Health Center	2034 Sundance Parkway 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 04/07/2025 at 12:28 PM, Resident #8's family member stated she had control of Resident #8's checkbook. She took it to the facility for the resident to sign some checks for his bills and left it there. When she returned to pick it up on 11/10/2024, she noticed one check was gone and confronted Resident #8 about it. At first, the resident did not know where it went, then he said, She needed help for a trip. When asked who needed help, Resident #8 stated, The housekeeper. Resident #8 saw the family member got upset and stopped talking. She did not know the amount of the check, and she was livid. She approached the receptionist at the front desk and told her she was extremely upset and wanted it handled immediately and was told by the receptionist she would pass it along. The Administrator called her two days later, apologized immensely, and stated he instructed the housekeeper to bring cash back. The Administrator said Housekeeper E did not understand it was not okay to receive money from the resident. The family member told the Administrator Resident #8 had dementia brought on by alcoholism, she knew it was not okay, but wanted the matter escalated and inquired as to whether she needed to call the police department or he would do it. The Administrator told her he would take care of it. Two days later the Administrator said he had the cash but did not want to give it to the resident. She came to the facility and picked up an envelope of cash. During an interview on 04/11/2025 at 11:17 AM, the Administrator stated a staff member told him on 11/10/2024 a family member called and they were upset someone cashed a check from a resident. He (the Administrator) did not recall who told him about the incident. The case was investigated by the facility's former DON. Housekeeper E returned the money before she went on vacation. She acknowledged she knew what she was doing was wrong but Resident #8 insisted she take the money. Housekeeper E went on vacation for 2 weeks and when returned to duty, she was terminated. He did not report the incident to the police and he did not have a case number. He did not know why. The Administrator later stated on 04/11/2025 at 1:05 PM he did not notify law enforcement because Resident #8 had a BIMS of 15, he gave the Housekeeper the check voluntarily, and therefore the act did not fit the definition of misappropriation and instead fell under the category of accepting gifts from residents. During an interview on 04/11/2025 at 1:30 PM, the Housekeeping Director stated Housekeeper E talked about her past in [NAME] with Resident #8 and he stated he was going to help her out and take care of her. He was going to give her a check between him (Resident #8) and Housekeeper E, from him to her. Housekeeper E said she could not accept it but took it. She did not tell him (the Housekeeping Director) about it. She was not one of those who had ever done anything like that. He did not know what she was thinking. The DON found out about it and sent her home. She (the DON) told him about it. When he talked to Housekeeper E, she said they sent her home because she took some money that a patient gave her. He said it was going to be between us. The housekeepers knew they were not supposed to take it. She knew the right thing to do. She said she was going to tell me about it. He told her soon as she got that check she should have come to him. She had his phone number, she could have called him, but she did not. Record review of a statement provided by Housekeeper E dated 11/10/2024 revealed she cleaned the room for Resident #8, had a conversation with him, told him she was going on vacation, he asked her how much money she needed and gave her $350. Record review of Provider Investigaion Report dated 11/10/2024 revealed under section were other parties notified?, Physician and Responsible Party. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676472	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sundance Inn Health Center	2034 Sundance Parkway 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility's Reportable Incident Protocol dated August 2024 read: In reporting accidents/incidents, the following protocol must be observed: External Reportable Incidents: In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: .Misappropriation of Patient Funds: The taking, secretion, misapplication, deprivation, transfer, or attempted transfer to any person not entitled to receive any property, real, or personal, or anything of value belonging to or under the legal control of a Patient, without the effective consent of the Patient or other appropriate legal authority, or the taking of any action contrary to any duty imposed by federal or state law prescribing conduct related to the custody or disposition of property of a Patient . 2. Our Facility will not condone Patient abuse, neglect, mistreatment or misappropriation of patient property and exploitation (collectively Patient Abuse) by anyone, including staff members, other Patients, consultants, volunteers, staff of other agencies serving the Patient, family members, legal guardians, friends, or other individuals. Reporting of crimes: The facility must report to the State Agency and law enforcement in which the facility is located any reasonable suspicion of a crime against any individual who is a patient of or is receiving care from the facility. The facility MUST report immediately, but no later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676472	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sundance Inn Health Center	2034 Sundance Parkway 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 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** 34788 Based on observation, interview, and record review, the facility failed to ensure environment remains as free of accident hazards as is possible; for residents for 1 of 8 units (unit 800) observed for environment, in that: 1. The facility failed to ensure potential hazards Clorox (disinfecting wipes) were locked up and kept out of resident rooms. This failure could place residents at risk of a diminished quality of life due to an unsafe environment. The findings included: Review of Resident #1's face sheet dated 04/09/2025, revealed an admitted [DATE] with diagnoses which included: Hydrocephalus (Buildup of fluids in the brain), Dementia (decline in cognitive abilities), Hypertension (high blood pressure), Type 2 diabetes mellitus (high level of sugar in the blood), Anxiety disorder (A group of mental illnesses that cause constant fear and worry). Review of Resident #1's Quarterly MDS assessment dated [DATE], revealed Resident #1 had a BIMS score of 00, indicating he was severely impaired. Review of Resident #1's care plan dated 10/07/2024 revealed the resident had a self-care deficit and required assistance with ADLs. Observation on 04/10/2025 at 10:30 a.m. revealed a container of Clorox (disinfecting wipes) on top of the bedside table in Resident's 1's room. The container had a hazard statement causes eye irritation. During an interview on 04/10/2025 at 10:35 a.m. with LVN A, the LVN verbally confirmed the Clorox wipes container should not have been left in the room. RA B added Resident #1's wife had brought the container of wipes. During an interview on 04/10/2025 at 1:44 p.m. with the Administrator, he verbally confirmed the disinfecting wipes should not have been kept in a resident's room. He added Resident #1's family member had brought the container of wipes and she had been educated in the past about not bringing certain items to the facility. Review of the State Long-Term Care Ombudsman Program. You rights in a Nursing Facility flyer, dated January 2025, revealed You have the right to live in safe, decent and clean conditions.