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	06/09/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure all drugs and biologicals were stored in locked compartments for 1 of 1 nursing treatment carts out of 3 nursing carts reviewed for storage. The facility failed when on 06/09/2025 the nursing treatment cart was left unlocked and unattended by the Treatment Nurse when she entered the room to wash her hands and when wound care was provided to Resident #3. This failure could place residents at risk of misappropriation of medications or harm due to accidental ingestion of unprescribed mediations. The findings included: Record review of Resident #3's admission Record (Facesheet), dated 06/09/2025, revealed he was admitted to the facility on [DATE] with diagnosis which included heart failure, high blood pressure, and open wound of right toes. Record review of Resident #3's Physician Order Summary Report, revealed an order for Povidone-Iodine Solution 10% apply to 2nd toe topically every day shift with a start date of 05/23/2025. Record review of Resident #3's admission MDS, an assessment dated [DATE], revealed his BIMS score of 15 which indicated his cognitive skills for daily decision making were intact, and he was admitted with an open lesion on his foot. Record review of Resident #3's care plans for wounds with a start date of 04/21/2025 revealed interventions which included administer treatments as ordered. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 06/09/2025 from 8:50 AM to 8:59 AM revealed when the Treatment Nurse entered Resident #3's room to wash her hands in the bathroom, she left the nursing treatment cart in the hallway unattended, out of her line of sight, and unlocked with the lock sticking out with the red portion of the lock handle visible indication it was unlocked. Further observation revealed the Treatment Nurse removed betadine from the treatment cart and applied the betadine to Resident #3's toes as part of the wound care treatment.The Treatment nurse came out of the bathroom, closed the door to Resident #3's room without locking the nursing treatment cart that had the lock sticking out in the unlocked position while she provided wound care to Resident #3. After wound care was provided, the Treatment Nurse opened the door to Resident #3's room and pulled open a drawer on the unlocked nursing treatment cart to remove an item, then the Treatment Nurse locked the cart. In an interview on 06/09/2025 at 9:00 AM, the Treatment Nurse stated she thought she had locked the treatment cart when she was in Resident #3's room because she usually would lock it when she goes into a resident's room. Observation on 06/09/2025 at 9:26 AM revealed the Treatment Nurse removed triad cream from the treatment cart. In an interview on 06/09/2025 at 10:56 AM, the DON stated the nursing treatment cart should be locked when unattended so that medications would not be removed from the cart, and the harm could be that someone or a resident could remove a medication from the cart they were not supposed to have access to. Record review of the Storage of Medications policy, revised April 2007, revealed The facility shall store all drugs and biologicals in a safe, secure and orderly manner .7. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others.