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	08/03/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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

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	08/03/2025

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 0600 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 residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 1 of 4 residents (Resident #1) reviewed for abuse. The facility failed to ensure Resident #1 had the right to be free from abuse when CNA A allegedly physically and verbally assaulted her on 07/28/2025. An IJ (Immediate Jeopardy) was identified on 08/02/2025. The IJ began on 08/02/2025 and was removed on 08/03/2025. The facility took action to remove the IJ before the abbreviated survey began; however, all staff had not been trained on staff-to-resident abuse prevention. The IJ template was provided to the facility on [DATE] at 04:53 p.m. and signed by the ED. While the IJ was removed on 08/03/2025, the facility remained out of compliance at a scope of isolated and severity level of no actual harm with potential for more than minimal harm due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk for emotional and physical abuse. The findings included: Record review of Resident #1's admission Record, dated 07/30/2025, reflected Resident #1 was admitted on [DATE] and discharged on 07/29/2025. Resident #1 was noted to be [AGE] years old. Record review of Resident #1's EMR Medical Diagnosis tab, undated and accessed 07/30/2025, reflected Resident #1 was diagnosed with rhabdomyolysis (a condition that causes skeletal muscle to break down rapidly which can result in muscle pain and kidney injury), dorsalgia (back pain), and morbid (severe) obesity (overweight or excess body fat). Record review of Resident #1's EMR MDS tab, undated and accessed 07/30/2025, reflected Resident #1's Entry MDS was the only MDS complete. Record review of Resident #1's .Brief Interview For Mental Status (BIMS) Evaluation, dated effective 07/28/2025, reflected a BIMS score of 15.0, indicating she was cognitively intact. During an interview on 07/30/2025 at 09:08 a.m., Resident #1's family member stated Resident #1 called him on 07/28/2025 around 04:00 p.m. regarding a CNA (CNA A) making threatening statements and throwing a wheelchair at her (Resident #1). He stated he was not present to witness the incident, but Resident #1's roommate, Resident #2 and Resident #2's family were present in the room. He stated he stayed in Resident #1 and Resident #2's room overnight (07/28/2025 to 07/29/2025) following the incident and until both residents were discharged to another facility, due to feeling unsafe. He stated ADON G did not seem to care and only offered to change the CNA assigned to Resident #1 and Resident #2. He stated the facility staff did not immediately the police following the report of CNA A making threatening statements or throwing the wheelchair at Resident #1 until after he told ADON G he reported the incident to the police. During an observation and interview with Resident #1, at NF C, on 07/30/2025 at 02:00 p.m., revealed Resident #1 discharged from NF B and admitted to a different nursing facility, NF C on 07/29/2025. Resident #1 stated an incident occurred on 07/28/2025 at 02:51 p.m. Resident #1 observed to verify the time of the incident by reviewing her text messages to a family member. Resident #1 stated the incident occurred after she had turned on her call light due to needing assistance to go to the restroom. She stated CNA A came into her room, took the wheelchair that was in the room and removed it from the room. She stated the facility staff seemed to be trying to locate a missing wheelchair for another resident and that was why CNA A took the wheelchair out of the room. She stated she told CNA A that she needed to go to the restroom and CNA A replied by pushing a walker at her. Resident #1 stated the only reason the walker didn't hit her was because she lifted her leg out of the way. Resident #1 was observed to indicate her leg with no visible injury. Resident #1 stated after CNA A returned and assisted her to the restroom on the day of incident, 07/28/2025, she overheard CNA A say under her breath, I'm getting ready to shoot people and later stated I'm fixing to start busting people. Resident #1 stated she would have normally taken CNA A's statements as expressions of annoyance or frustration but because CNA A had been visibly getting more and more heated prior to those statements, she took the statements as threats and didn't know what people CNA A was referring to, the other staff or the residents. Resident #1 stated after the incident her family could not leave due to her and her roommate's concerns for safety. Resident #1 stated she and her roommate transferred to a different nursing facility due to concerns for quality of care and safety. Record review of Resident #2's admission Record, dated 07/30/2025, reflected Resident #2 was admitted on [DATE] and discharged on 07/29/2025. Resident #2 was noted to be [AGE] years old. Record review of Resident #2's EMR Medical Diagnosis tab, undated and accessed 07/30/2025, reflected Resident #2 was diagnosed with cerebral infarction (a disruption in the brain's blood flow), fracture (break) of right patella (kneecap), and type 2 diabetes mellitus

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	08/03/2025

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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (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	08/03/2025

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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Base of observations, record reviews and interviews the facility failed to develop and implement written policies and procedures that: Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property for 1 of 4 residents (Resident #1) reviewed for abuse. The facility failed to ensure Resident #1 had the right to be free from abuse when CNA A allegedly physically and verbally assaulted her on 07/28/2025. An IJ (Immediate Jeopardy) was identified on 08/02/2025. The IJ began on 08/02/2025 and was removed on 08/03/2025. The facility took action to remove the IJ before the abbreviated survey began; however, all staff had not been trained on staff-to-resident abuse prevention. The IJ template was provided to the facility on [DATE] at 04:53 p.m. and signed by the ED. While the IJ was removed on 08/03/2025, the facility remained out of compliance at a scope of isolated and severity level of no actual harm with potential for more than minimal harm due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk for emotional and physical abuse.The findings included: Record review of Resident #1's admission Record, dated 07/30/2025, reflected Resident #1 was admitted on [DATE] and discharged on 07/29/2025. Resident #1 was noted to be [AGE] years old. Record review of Resident #1's EMR Medical Diagnosis tab, undated and accessed 07/30/2025, reflected Resident #1 was diagnosed with rhabdomyolysis (a condition that causes skeletal muscle to break down rapidly which can result in muscle pain and kidney injury), dorsalgia (back pain), and morbid (severe) obesity (overweight or excess body fat). Record review of Resident #1's EMR MDS tab, undated and accessed 07/30/2025, reflected Resident #1's Entry MDS was the only MDS complete. Record review of Resident #1's .Brief Interview For Mental Status (BIMS) Evaluation, dated effective 07/28/2025, reflected a BIMS score of 15.0, indicating she was cognitively intact. During an interview on 07/30/2025 at 09:08 a.m., Resident #1's family member stated Resident #1 called him on 07/28/2025 around 04:00 p.m. regarding a CNA (CNA A) making threatening statements and throwing a wheelchair at her (Resident #1). He stated he was not present to witness the incident, but Resident #1's roommate, Resident #2 and Resident #2's family were present in the room. He stated he stayed in Resident #1 and Resident #2's room overnight (07/28/2025 to 07/29/2025) following the incident and until both residents were discharged to another facility, due to feeling unsafe. He stated ADON G did not seem to care and only offered to change the CNA assigned to Resident #1 and Resident #2. He stated the facility staff did not immediately the police following the report of CNA A making threatening statements or throwing the wheelchair at Resident #1 until after he told ADON G he reported the incident to the police. During an observation and interview with Resident #1, at NF C, on 07/30/2025 at 02:00 p.m., revealed Resident #1 discharged from NF B and admitted to a different nursing facility, NF C on 07/29/2025. Resident #1 stated an incident occurred on 07/28/2025 at 02:51 p.m. Resident #1 observed to verify the time of the incident by reviewing her text messages to a family member. Resident #1 stated the incident occurred after she had turned on her call light due to needing assistance to go to the restroom. She stated CNA A came into her room, took the wheelchair that was in the room and removed it from the room. She stated the facility staff seemed to be trying to locate a missing wheelchair for another resident and that was why CNA A took the wheelchair out of the room. She stated she told CNA A that she needed to go to the restroom and CNA A replied by pushing a walker at her. Resident #1 stated the only reason the walker didn't hit her was because she lifted her leg out of the way. Resident #1 was observed to indicate her leg with no visible injury. Resident #1 stated after CNA A returned and assisted her to the restroom on the day of incident, 07/28/2025, she overheard CNA A say under her breath, I'm getting ready to shoot people and later stated I'm fixing to start busting people. Resident #1 stated she would have normally taken CNA A's statements as expressions of annoyance or frustration but because CNA A had been visibly getting more and more heated prior to those statements, she took the statements as threats and didn't know what people CNA A was referring to, the other staff or the residents. Resident #1 stated after the incident her family could not leave due to her and her roommate's concerns for safety. Resident #1 stated she and her roommate transferred to a different nursing facility due to concerns for quality of care and safety. Record review of Resident #2's admission Record, dated 07/30/2025, reflected Resident #2 was admitted on [DATE] and discharged on 07/29/2025. Resident #2 was noted to be [AGE] years old. Record review of Resident #2's EMR Medical Diagnosis tab, undated and accessed 07/30/2025, reflected Resident #2 was diagnosed with cerebral infarction (a disruption in the brain's blood flow), fracture (break) of right patella (kneecap), and type 2 diabetes mellitus

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	08/03/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (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	08/03/2025

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 0677 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 ensure a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 of 4 residents (Resident #1) reviewed for ADL care. The facility did not provide showers or baths to Resident #1 as scheduled and requested on 07/26/2025. This failure can affect residents by decreasing their quality of life. The findings included: Record review of Resident #1's admission Record, dated 07/30/2025, reflected Resident #1 was admitted on [DATE] and discharged on 07/29/2025. Resident #1 was noted to be [AGE] years old. Record review of Resident #1's EMR Medical Diagnosis tab, undated and accessed 07/30/2025, reflected Resident #1 was diagnosed with rhabdomyolysis (a condition that causes skeletal muscle to break down rapidly which can result in muscle pain and kidney injury), dorsalgia (back pain), and morbid (severe) obesity (overweight or excess body fat). Record review of Resident #1's EMR MDS tab, undated and accessed 07/30/2025, reflected Resident #1's Entry MDS was the only MDS complete. Record review of Resident #1's .Brief Interview For Mental Status (BIMS) Evaluation, dated effective 07/28/2025, reflected a BIMS score of 15.0, indicating she was cognitively intact. Record review of Resident #1's . Functional Abilities, dated effective 07/26/2025, reflected Resident #1 needed some help with self-care and indoor mobility (ambulation). Resident #1's Shower/bathe self ability and Tub/Showr [sic] Transfer ability was noted as Not assessed/no information. Resident #1 was noted to need partial/moderate assistance with upper and lower body dressing and personal hygiene; and supervision or touching assistance with sit to stand mobility. Record review of Resident #1's Task: Bathing, undated and accessed 08/01/2025 with look back period of 14 days, reflected Resident #1 with only 1 documented bath or shower, 07/28/2025 at 10:45 (a.m. or p.m. not noted). Record review of facility Skin Site Identification Form provided upon request for shower sheets, dated 07/26/2025 reflected 26 residents received a shower on Saturday, 07/26/2025. Resident #1 form not found in forms dated 07/26/2025. Record review of facility Skin Site Identification Form, dated 07/28/2025 reflected Resident #1 received a shower on 07/28/2025 at 07:30 p.m. During an interview with Resident #1, at NF C, on 07/30/2025 at 02:50 p.m., revealed Resident #1 discharged from NF B and admitted to a different nursing facility, NF C on 07/29/2025. Resident #1 stated she was not provided a shower in the hospital prior to her admission to NF B on 07/25/2025 and had asked multiple CNAs after her admission for a shower. She stated the CNAs would respond by stating it was a different staff member's responsibility. She stated she did not receive a shower until Monday, 07/28/2025, 3 days after her admission. During an interview on 07/31/2025 at 03:06 p.m., ADON G stated she was notified by Resident #1's roommate and Resident #1's roommate family member on Monday, 07/28/2025 that Resident #1 had not received a shower since her admission. ADON G stated Resident #1 was supposed to be showered on Saturday (07/26/2025). She stated she had not completed her daily audit list, which included a review of the shower sheets from the daily list. ADON G stated A and B beds were showered on opposite days and the facility had a shower book with a shower list. She stated the shower list included a list of each shower due for each shift. ADON G stated Resident #1 would probably not have been on the shower list on 07/26/2025 since she was admitted on a Friday, but the expectation was for the CNAs to still check their rooms and provide showers for their residents. ADON G stated the charge nurse would have been accountable for ensuring all their residents received their expected shower. The ADON G stated the charge nurse for weekends worked a double, so the missed shower should have been caught on Saturday, 07/26/2025. During an interview on 08/01/2025 at 03:11 p.m., the Th Dir stated she met with Resident #1 on Friday, 07/25/2025 and Resident #1 was assessed on Saturday, 07/26/2025 for transfers. The Th Dir stated Resident #1 was found to require moderate assistance with bathing, was able to transfer by using a walker, and was not able to walk with the walker during the 07/26/2025 assessment. During an interview on 08/01/2025 at 04:03 p.m., CNA A stated residents were provided showers on Monday, Wednesday, and Fridays or Tuesdays, Thursdays, and Saturdays, depending on if the resident was in A bed or B bed. She stated the time of day of the shower, during the 06:00 a.m. to 02:00 p.m. shift or the 02:00 p.m. to 10:00 p.m. shift, would depend on the resident's room number. CNA A stated if a resident was a new admission, the therapy department would have to evaluate the resident's activity of daily living needs for mobility prior to her providing the resident with a shower. CNA A stated Resident #1 asked about a shower on the night of her admission, Friday 07/25/2025, but she stated she told Resident #1 that therapy would have to first assess

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	08/03/2025

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. (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	08/03/2025

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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that the resident's environment remained as free of accident hazards as was possible for 1 of 4 residents (Resident #2) whose environment was reviewed for safety hazards. Nursing staff failed to properly discard and remove a syringe used for insulin (a hormone essential for individuals with insulin insufficiency, such as diabetics, to convert food into energy and maintain blood sugar levels) administration from Resident #2's room. This deficient practice could affect residents exposed to syringes and could contribute to avoidable accidents.The findings included: Record review of Resident #2's admission Record, dated 07/30/2025, reflected Resident #2 was admitted on [DATE] and discharged on 07/29/2025. Resident #2 was noted to be [AGE] years old. Record review of Resident #2's EMR Medical Diagnosis tab, undated and accessed 07/30/2025, reflected Resident #2 was diagnosed with cerebral infarction (a disruption in the brain's blood flow), fracture (break) of right patella (kneecap), and type 2 diabetes mellitus (DM2; a condition that develops with the way the body regulates and uses sugar as fuel). Record review of Resident #2's EMR MDS tab, undated and accessed 07/30/2025, reflected Resident #2's Entry MDS was the only MDS complete. Record review of Resident #2's .Brief Interview For Mental Status (BIMS) Evaluation, dated effective 07/23/2025, reflected a BIMS score of 15.0, indicating she was cognitively intact. Record review of Resident #2's Order Recap Report, dated 07/30/2025 with order date: 07/01/2025-07/31/2025, reflected an active order Humulin R Infection Solution 100 UNIT/ML (Insulin Regular (Human)) Inject 8 unit subcutaneously [under the skin] two times a day for DM2. The order was ordered on 07/22/2025 and started on 07/23/2025. Record review of Resident #2's Medication Administration Record, dated 07/01/2025- 07/30/2025 and printed 07/30/2025, reflected the order Humulin R Injection Solution 100 UNIT/ML (Insulin Regular (Human)) Inject 8 unit subcutaneously [under the skin] two times a day for DM2 was administered by LPN E at 0800 (08:00 a.m.) and 2000 (08:00 p.m.) on 07/26/2025 and 07/27/2025. During an interview with Resident #2, at NF C, on 07/30/2025 at 04:40 p.m., revealed Resident #2 discharged from NF B and admitted to a different nursing facility, NF C on 07/29/2025. Resident #2 stated she did not have any problems with her medications while a resident at NF B. During an interview on 07/31/2025 at 11:01 a.m., Resident #2's family member stated Resident #2 did not have any medication administration issues at NF B, but she had found a used syringe for injecting Resident #2's insulin on Resident #2's bedside table. She stated she found a syringe one day while visiting Resident #2 and when she asked Resident #2 and her roommate, they replied that it was not the first time the incident had happened. She stated she picked up the syringe and walked it to the nurses' station and said, isn't this supposed to be in the nurses' station?. The nurse said yes and that she was sorry. She stated she told the charge nurse that she better not see this happen again. She stated she didn't know if the syringe was the one used to inject Resident #2's insulin or if it was someone else's. She stated she discovered the syringe in the afternoon and if it was Resident #2's, the syringe would have been sitting on Resident #2's side table since the morning due to the timing of Resident #2's insulin administrations. During an interview on 08/01/2025 at 05:53 p.m., LPN E stated she worked double shifts on the weekends, Saturday and Sunday from 06:00 a.m. to 10:00 p.m. She stated she worked the prior weekend, 07/26/2025 and 07/27/2025 and Resident #2 was one of her assigned residents. LPN E stated Resident #2's family member approached her on Saturday morning, 07/26/2025 about finding a used syringe in Resident #2's room. LPN E stated she apologized for the incident and reviewed Resident #2's orders to verify Resident #2 was a diabetic patient. LPN E stated Resident #2's family member stated, it better not happen again. LPN E stated she might have left it in the room. She stated she recalled going into Resident #2's room to check her blood sugar, but did not recall Resident #2 requiring insulin that morning. LPN E stated the incident only happened that one time and she did not report it since she just corrected the situation and made sure it would not happen again. LPN E stated she believed it happened because she was trying to figure out what her residents with diabetes needed prior to breakfast and got distracted while taking blood pressures and other vitals. LPN E stated the syringe was locked so a person could not access the needle when she received it from Resident #2's family member. During an interview on 08/01/2025 at 05:22 p.m., the DON stated there were sharp containers in resident rooms and on the medication carts. The DON stated staff needed to dispose of used sharps or syringes in the biohazard containers and if they found one, they were to dispose of it and make sure they notified their supervisor so administrative staff could take additional measures, such as training or education