

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676472	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2026
NAME OF PROVIDER OR SUPPLIER Sundance Inn Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain medical records that were complete and accurately documented in accordance with accepted professional standards and practices for 1 of 1 resident (Residents #1) reviewed for medical records. The facility failed to ensure Resident #1's medication consent form was completed on the most recent consent for antipsychotic or neuroleptic medication treatment for Seroquel (an atypical antipsychotic used to treat schizophrenia, bipolar disorder, and major depressive disorder) and available in the resident's medical record. This deficient practice could place residents at risk of delayed or improper care due to inaccurate medical records. The findings include: 1. Record review of Resident #1's admission record revealed a female admitted on [DATE] with diagnoses that included metabolic encephalopathy, acute respiratory failure with hypoxia, bipolar disorder, and insomnia. Record review of Resident #1's discharge MDS, dated [DATE], revealed the resident's BIMS score was 13 (fully intact cognition). Record review of Resident #1's care plan, initiated 3/8/26, revealed the resident used psychotropic medications with interventions to administer psychotropic medications as ordered by the physician, monitor for side effects, and effectiveness every shift. Record review of Resident #1's order summary, dated 4/17/26, revealed an order for Seroquel 100 mg tablet, give 1 by mouth two times a day related to bipolar disorder, with a start dated of 3/8/26, and no end date. Record review of a document titled Psychoactive Medication Consent, dated 3/8/26, revealed Resident #1 consented to receive Seroquel 100 mg tablet by mouth two times a day. The document was digitally signed by LVN A and contained Resident #1's initials written at the bottom of the document. During an interview on 4/17/26 at 2:00 p.m. LVN A did not respond to attempts to interview. During an interview on 4/17/25 at 2:46 p.m. the SW stated nursing staff handled medication consents for the residents. During an interview on 4/17/26 at 3:10 p.m. the DON stated the charge nurses usually would complete medication consent for residents on admission. The DON stated she was unfamiliar with a 3713 form for consent of psychotropic medications. She stated the facility would not normally accept residents who were taking antipsychotic medications and were not aware of the required 3713 consent forms that were needed for resident #1's Seroquel. During an observation, interview, and record review on 4/17/26 at 4:45 p.m. the DON provided a different copy of Resident #1's Medication consent, dated 3/8/26. The form was version from September 2021-E and titled Consent for Antipsychotic or Neuroleptic Medication Treatment. The form revealed the resident was admitted with bipolar disorder. The form did not list the diagnostic criteria and assessment findings exhibited by Resident #1. The form stated Seroquel 100 mg twice a day per admission orders- home regime for the dosage and frequency. The form listed side effects of the medications. The form listed the need for the proposed treatment because the patient admitted to the facility with home regime treatment from the hospital, no changes made, managed by PCP, and treatment in place to treat bipolar disorder. The form had the provider's name typed out, the last name of the provider was crossed out, and a different last name was written in. Section II of the document contained Resident #1's initials and a date of 3/8/26. There was no printed name of Resident #1 in section II. The bottom of the form stated, the original copy of this form (continued on next page)</p>

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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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>must be included the resident's clinical record, as required by. Record review of facility policy titled Maintenance of Electronic Clinical Records, implemented 10/1/2025, revealed .a complete and accurate electronic clinical record will be maintained on each resident and kept accessible and systematically organized.electronic clinical records will contain at least, but are not limited to. pre-admission screening assessments and results with required signatures as required by state and federal regulations.each staff responsible for an attestation (electronic signature) has an individualized identifier.the date and time is recorded from the computer's internal clock at the time of entry.</p>		