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	06/27/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45957 Based on observation, interview and record review, the facility failed to ensure each resident was treated with respect and dignity and care in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life for 1 of 5 residents (Residents #86) reviewed for dignity. The facility failed to ensure the urinary collection bag for Resident #86's catheter was covered with a privacy bag. This failure could place residents at risk for a loss of dignity, decreased self-worth and decreased self-esteem. Findings include: Record review of Resident #86's face sheet, dated 06/27/2024, revealed a [AGE] year-old male admitted to the facility on [DATE] had diagnoses which included hypertension (blood is pumping with more force than normal through your arteries), gastroesophageal reflux disease (condition in which the stomach contents move up into the esophagus), acute kidney failure (when your kidneys suddenly become unable to filter waste products from your blood), muscle weakness (lack of muscle strength), & cognitive communication deficit (difficulty paying attention to a conversation, staying on topic, remembering information, responding accurately, or following instructions). Record review of Resident #86's admission MDS Assessment, dated 05/28/2024, reflected a BIMS score of 15, which indicated the resident is cognitively intact. Resident #86 admission MDS assessment also revealed Resident #86 had an indwelling catheter and was always incontinent of bowel. Record review of Resident #86's care plan, dated 06/26/2024, reflected Resident #86 was care planned for risks for infection r/t indwelling catheter and enhanced barrier precautions implemented r/t urinary catheter. During an interview and observation on 06/25/2024 at 11:26am, Resident #86 was observed in his room with his urinary collection bag almost full with no privacy bag covering it. Resident #86 stated he did not know his catheter bag was not covered. Resident #86 stated he was not sure how long it had not been covered. Resident #86 stated that he would like for his catheter bag be covered at all times. (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	06/27/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/27/2024 at 11:35am, LVN A stated that a resident's catheter drainage bag should always be covered. LVN A stated that it was everyone's responsibility to ensure that all residents drainage bag were covered. LVN A stated that anyone can put a resident's catheter bag in a privacy bag. LVN A stated if a resident's catheter bag was not covered then that would be an infection control and a dignity issue. In an interview on 06/27/2024 at 1:55pm, the DON stated that a residents catheter drainage bag should always be covered. The DON stated it was the nurse's responsibility to ensure that the resident's catheter drainage bag was covered. The DON stated that if a resident's catheter drainage bag was not covered it would be a dignity issues. In an interview on 06/27/2024 at 2:10pm, the ADM stated that a residents catheter drainage bag should always be covered. The ADM stated he believed it would be the nurse's responsibility for ensuring the resident's catheter bag was covered. The ADM stated that it was his expectation for residents with catheter drainage bags to always be covered. Record review of the facility's policy titled, Resident Rights, dated December 2016, reflected Employees shall treat all residents with kindness, respect and dignity. Policy Interpretation and Implementation 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. A dignified existence; b. Be treated with respect, kindness, and dignity;

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	06/27/2024

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47926 Based on observation, interview, and record review, the facility failed to ensure residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs for 1 of 6 residents (Resident #18) who were reviewed for accommodation of needs. The facility failed to ensure Residents #18's call lights were placed within their reach. This failure could place dependent residents at risk of injuries and unmet needs. Findings included: Review of Resident #18's undated face sheet reflected the resident was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses of congestive heart failure (a condition that develops when your heart doesn't pump enough blood your body needs), urinary tract infection, generalized anxiety, unspecified falls, and legal blindness. Record review of Resident #18's care plan dated 06/07/24 reflected Resident #18 had a risk for falling. The approach on the risk for falling care plan was to remind resident to call for assistance before moving from bed to chair and from chair to bed. Approaches also included to place call bell/light within easy reach. Review of Resident #18's admission MDS Assessment, dated 06/12/24, reflected he had a BIMS score of 8 indicating he was moderately cognitively impaired. Section GG (Functional Abilities and Goals) of the same MDS indicated Resident #18 was partial moderate assistance with ADL care such as toileting, dressing, and personal hygiene. In an interview and observation on 06/25/24 at 10:24 AM, Resident #18 was sitting up in his wheelchair on the left side of his bed. His call light was observed laying on right side of bed. Resident #18 said he needs his ostomy emptied prior to therapy. When Resident #18 was asked to reach his call light he stated he was legally blind and he attempts to grab his call light but has limited range of motion in his right shoulder and was unable to reach across the bed. Resident #18 stated he would just sit for long periods of time prior to someone coming in to help him and gets frustrated by the wait. He stated occasionally he will call out to shadows in the hall for help. In an interview on 6/27/24 at11:06am with CNA B she stated the call light had to be attached to or very close to the resident. Staff would generally attach the call light to Resident #18's shirt by his chest, so he knew exactly where it was. CNA B stated it was everyone's responsibility to make sure call lights were in residents reach. She stated negative effects for the resident related to not having a call light within their reach were falls, accidents, not able to receive help, and unable to have their needs met. CNA B stated the DON generally educates staff use on call lights frequently. (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	06/27/2024

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 6/27/24 at 11:23am with RN C she stated call the light was generally attached to Resident #18's shirt so he can reach it with his left hand. She stated that everyone was responsible for making sure the call lights were in residents reach. RN C stated the staff were educated monthly and as needed by in-services given by the DON to ensure call lights were within all residents reach. She stated negative effects for a resident for not having their call light within reach could include a risk for falling. In an interview on 06/27/24 at 1:51pm with DON she stated her expectations were that call lights to be answered fast as possible and need to be in reach of all residents. She stated she was responsible for educating the staff and the staff were educated on call lights being within reach all the time. The DON stated if a resident was without the call light, they would be at risk for not getting the care they need. She stated everyone and anyone can answer call lights and make sure it's within the residents reach. A record review of facility policy titled Answering the Call Light dated 10/2010 reflected Procedure #5 When the resident is in bed or confined to a chair be sure the call light is within easy reach of the 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	06/27/2024

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 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** 47926 Based on observation, interview and record review, the facility failed to implement a comprehensive care plan to meet the resident's highest practicable physical, mental, and psychosocial well-being of 1 (Resident #30) of 6 residents reviewed for care plans. The facility failed to implement a comprehensive person-centered care plan for Resident #30's active wounds to right heel, left foot second toe, and a contracted right hand. This failure could place residents of risk for not receiving appropriate care and treatment, lack of skin/wound interventions, a delay in treatment, a decline in health, and hospitalization . Findings included: Record review of undated face sheet reflected Resident #30 was an [AGE] year-old male admitted to the facility on [DATE]. Resident #30 had the following diagnoses of hemiplegia following cerebral infarct right dominate side (paralysis following a stroke), dysphagia (difficulty swallowing), type 2 diabetes (elevated blood Pressure), contracture of muscle, Peripheral Vascular Disease (lack of blood flow to the extremities), and Hypertension (elevated blood pressure). Record review of Resident #30's Braden Scale (an assessment to predict skin breakdown) dated 01/20/24 reflected a score of 14 indicating Resident #30 was a moderate risk for skin breakdown. Record review of Resident #30's Annual MDS dated [DATE] reflected he had modified independence in his cognitive skill for daily decision making indicating he had difficulty in new situations only. The MDS also reflected Resident #30 had functional limitations to one side of the body in his upper and lower extremity. Resident #30 was wheelchair bound and required partial moderate assistance for personal hygiene. Record review of Resident #30's Physician Orders dated 06/26/24 reflected a wound treatment to monitor between right hand 2nd and 3rd digits for redness and irritation due to contracture fingers overlapping and may place gauze padding in between fingers for comfort start date 11/28/23. The physicians' orders also reflected wound treatment to the right heel to cleans with soap and water apply plurogel (a wound treatment), abdominal pad Coban (a wrap) light compression on Monday Wednesday and Friday for rash skin eruption other nonspecific skin eruption dated 6/15/24 and a wound treatment to apply betadine to left foot 2nd digit daily dated 6/15/24. Record review of the care plan dated 06/26/24 for Resident #30 reflected a care plan with the focus of at risk for pressure development /impaired skin integrity. Related to self-care deficit, generalized weakness, decreased mobility, hemiplegia, diabetes type 2, and history of protein calorie malnutrition. The goal was for Resident #30 to not develop any pressure or skin breakdown over the next 90 days. Interventions include to monitor skin for breakdown and report to MD and RP. Resident #30 also had a care plan that reflected a current skin issue for a bruise to left side of the neck. There was no care plan reflecting current treatment for skin issues to right foot, left foot, and contracture to right hand. (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	06/27/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #30 wound assessment dated [DATE] reflected Resident #30 had a wound to the left foot 2nd toe with an onset date of 6/14/24. Intervention listed on skin assessment included handrolls, lift sheet, low air loss mattress, offload bony prominences, wedges, and other positioning devices. The comments on the wound assessment reflected the wound was a venous ulcer to the left foot 2nd toe with 100% scab, no drainage, no odor, and surrounding tissue was purple. Record review of Resident #30 wound assessment dated [DATE] reflected Resident #30 had a wound to his right heel with an onset date of 06/14/24. Intervention listed on skin assessment included handrolls, lift sheet, low air loss mattress, offload bony prominences, wedges, and other positioning devices. The comments on the wound assessment reflected the wound was a venous ulcer to the right heel. The peri wound was macerated (moist) the physician was notified of the maceration and new orders were given for a treatment change. In an interview and observation with Resident #30 on 06/25/24 at 11:06 AM, Resident #30 was observed with thick fingernails to right hand. The right hand was contracted with a rolled-up washcloth in hand. Resident #30 nodded head yes that staff change his washcloth and wound dressings to right and left foot as ordered. He pointed to other parts of his body with dressing intact to wounds. Resident #30 was on a low air loss mattress and wearing heel protectors. In an interview on 06/27/2024 at 11:42 AM with the DON, she stated it was her expectation that all types of wounds should be care planned. She stated she was not aware of any residents' wounds that was not care planned. She stated nursing staff, including herself, her ADON's, and the MDS nurses were responsible for completing and updating residents care plans. She stated they all talked in the morning meetings and if there was a new concern that came up, that would have indicated that they needed to update the care plans. She stated she would specifically tell the MDS nurse that was responsible for that resident to update the care plan if there was a new concern. She stated if a wound developed after a care plan had already been completed, the care plan should be updated to reflect the wound. She stated nursing administration was in-serviced and trained on how to correctly complete and update care plans. She stated if a care plan was not completed correctly, it could cause failure of care. In an interview on 06/27/2024 at 1:34 PM the MDS Coordinator stated she had worked in the facility for about 3 years. She stated she was responsible for and had been trained on completing and updating the residents care plans. She stated she was responsible for completing the care plans based on the CAAS (Care Area Assessment Summary) which came off the MDS assessments. She stated they have a clinical meeting after the stand-up meeting every morning and discuss each patient and what was going on with them, and if anything, new comes up that needs to be care planned, the DON will ask her or another nursing manager to care plan new issues. She stated she was not aware of any residents' wounds that were not care planned. She stated if a wound developed after a care plan had already been completed, the care plan should have been updated to reflect the wound. She stated if a care plan was not completed correctly, she does not have an answer for that because if they had orders and the resident was still being treated, she could not see how it would have affected the resident. A record review of facility policy titled Care Plans, Comprehensive Person Centered Dated 03/2022 reflected A comprehensive, person-centered care plan that includes measurable objective and timetables to meet the residents physical, psychosocial, and functional needs is developed and implemented for each 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	06/27/2024

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47926 Based on interviews and record review the facility failed to ensure residents were free of significant medication errors for 1 (Resident #42) of 6 residents reviewed for medication errors in that: The facility transcribed a medication (hydralazine a medication used to treat high blood pressure) be given oral for a resident who was to receive her medications per her gastrostomy tube. The failure could cause residents who receive medications by gastrostomy tube at risk for aspiration and related complications. The findings included: Review of Resident #42's undated face sheet reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of Hemiplegia following cerebral infarct affecting the right dominate side (paralysis of the right side), essential hypertension (high blood pressure) , dysphagia (difficulty swallowing), and gastrostomy status (meaning the resident has a stomach tube in abdomen in which she received nutrition and medications). Review of Resident #42's quarterly MDS Assessment, dated 04/05/24, reflected she was rarely/never understood, but sometimes understands others. Her cognitive skills for daily decision making were moderately impaired indicating she had poor decision-making skills and required staff cues and supervision. The MDS reflected Resident #42 was dependent for activities of daily living such as dressing and grooming. Section K of the same MDS reflected Resident #42 received nutrients through a feeding tube. Record review of a care plan dated 06/26/24 reflected Resident #42 had a G-Tube (gastrostomy tube) and was receiving tube feeding with a goal to receive adequate nutrition without side effects associated with bolus tube feedings (aspiration, Diarrhea, and dehydration) over the next 90 days. Interventions on the care plan included to crush medications as ordered may mix and flush each medication with 5-10 ml of water. Record review of Resident #42's Physician Orders dated 06/26/24 reflected a NPO (nothing by mouth) status dated 4/23/2020. Resident #42 had an order to Crush medications before administering through Gastrostomy tube dated 4/23/2020. The same Physicians' orders also reflected the following medications were ordered to be given oral (by mouth) Ondansetron (a medication used for nausea and vomiting), Lactulose (a medication used to treat constipation), Hydralazine (a medication used to treat high blood pressure). In an observation and interview of medication administration on 6/26/24 at 12:06pm, RN C administered Hydralazine 100mg 1 tablet crushed via Resident #42s gastrostomy tube. The order reflected on the screen of the computer on the medication cart read to give 1 tab of Hydralazine 100mg by mouth. (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	06/27/2024

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN C stated medications for Resident #42 were given by gastrostomy tube only. RN C stated when the medication card doesn't match the order for the medication the order should have been clarified with the physician . The risk for the resident in this case would have been the medication would be administered by the wrong route possible causing aspiration. RN C stated he was the ADON and was responsible for checking the new orders for accuracy daily. In an interview on 06/27/24 at1:51pm with the DON she stated she would expect the nurse to double check the order first thing when administering medications. She stated the risk for residents not receiving their medication by the right route could be not getting the medication they need to manage their disease process. She stated nurses were educated on medication administration. She stated there was skills check off in the training packet for nursing, but she was not sure how often the nurse completed the skills check off. She stated she was responsible for educating the nurses. A record review of facility policy titled Administering Medications through an Enteral Tube dated 10/2018 reflected: Preparation #1 Verify there is a physician medication order for this procedure. Steps and Procedure #3 Check the label and confirm the medication name, route, and dose with Medication Administration Record. Confirm that the medication dosage form is compatible with eternal administration.