

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 08/28/2025
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)		
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to immediately inform or consult the physician and the resident's representative when there was a need to alter treatment for one (Resident #8) of three residents reviewed for physician notifications.1. The facility failed to ensure MA X and nursing staff alerted the physician that Resident #8 missed 7 doses of ear drop medication on 08/22/25 at 9:00 AM, 12:00 PM, 5:00 PM, 9:00 PM and 08/23/25 at 9:00 AM, 12:00 PM, 5:00 PM.2. The facility failed to ensure LVN G notified the physician that Resident #8 had missed 2 doses of ear drop medication on 08/28/25 at 9:00 AM and 12:00 PM.This failure placed residents at risk of a delay in treatment, and a worsening of their condition.Findings included:Record review of Resident #8's Quarterly MDS assessment, dated 06/30/25, revealed Resident #8 was a [AGE] year-old female admitted on [DATE] and readmitted on [DATE]. Resident #8 had moderate cognition impairment with a BIMS score of 8. Resident #8 required supervision or touching assistance by staff for personal hygiene and partial assistance for shower/bathing. Resident #8 had adequate hearing reflecting no difficulty in normal conversation, social interaction or listening to the television. Active diagnoses included Renal Insufficiency (when both kidneys no longer work on their own), Non-Alzheimer's Dementia (memory loss), Hypertension (high blood pressure), Depression (mood disorder that causes persistent feeling of sadness and loss of interest), anxiety disorder (excessive worry or fear).Review of Resident #8's care plan, undated, revealed Resident #8 had a self-care performance deficit and required assistance with ADLs. Goal: Resident #8 will maintain current level of function. Intervention: Hygiene/Grooming required set-up to supervision/touching assistance. Bathing required supervision/touching to partial/moderate assistance. Record review of Resident #8's physician orders revealed:1. May have podiatry, dental, audiology, and ophthalmology consult as needed. No directions specified for order. Active 5/14/2025 2. Cortisporin-TC Otic Suspension 3.3-3-10-0.5 MG/ML (Neomycin-Colistin-HC-Thonzonium) Instill 4 drop in left ear four times a day for Left Ear Pain for 7 Days. Active 8/22/2025 09:00 Record review of Resident #8's progress notes written by LVN H revealed: 8/27/2025 08:24Orders - Administration NoteNote Text: Cortisporin-TC Otic Suspension 3.3-3-10-0.5 MG/MLInstill 4 drop in left ear four times a day for Left Ear Pain for 7 Days8/23/2025 13:51Orders - Administration Note Written by Medication AideNote Text: Cortisporin-TC Otic Suspension 3.3-3-10-0.5 MG/MLInstill 4 drop in left ear four times a day for Left Ear Pain for 7 DaysEar drops pending delivery from central supply.8/23/2025 13:50Orders - Administration Note Written by Medication AideNote Text: Cortisporin-TC Otic Suspension 3.3-3-10-0.5 MG/MLInstill 4 drop in left ear four times a day for Left Ear Pain for 7 Days8/22/2025 20:41Orders - Administration Note written by RN KNote Text: Cortisporin-TC Otic Suspension 3.3-3-10-0.5 MG/MLInstill 4 drop in left ear four times a day for Left Ear Pain for 7 Days8/22/2025 16:07 Orders - Administration Note written by RN KNote Text: Cortisporin-TC Otic Suspension 3.3-3-10-0.5 MG/MLInstill 4 drop in left ear four times a day for Left Ear Pain for 7 Days8/21/2025 21:58 Nursing- General Note written by LVN LNote Text: Received return call from [name of doctor] regarding left ear pain with some hearing loss. New orders received to include (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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Cortisporin Otic Suspension 4 drops to the left ear four times daily for 7 days.8/21/2025 18:51Nursing- General Note written by LVN LNote Text: Resident reported left ear pain with difficulty hearing. Contacted [name of doctor] through Perfect Serve, awaiting physician response.Record review of Resident #8's medication administration record revealed a physician's order Cortisporin-TC Otic Suspension 3.3-3-10-0.5 MG/ML (Neomycin-Colistin-HC-Thonzonium) Instill 4 drop in left ear four times a day for Left Ear Pain for 7 Days. Start date 08/22/2025 0900 (9:00 AM, 12:00 PM, 5:00 PM, 9:00 PM)On 08/22/25 Resident #8 received treatment at 9:00 AM, 12:00 PMOn 08/22/25 Resident #8 did not receive treatment at 5:00 PM, 9:00 PMOn 08/23/25 Resident #8 did not receive treatment at 9:00 PM, 12:00 PMOn 08/23/25 Resident #8 received treatment at 5:00 PM, 9:00 PMOn 08/24/25, 08/25/25, 08/26/25, 08/27/25 Resident #8 received treatment at 9:00 AM, 12:00 PM, 5:00 PM, 9:00 PMOn 08/28/25 the medication administration record indicated Resident #8 received treatment at 9:00 AM, 12:00 PMInterview and observation on 08/26/25 at 11:08 AM revealed Resident #8 in bed with something white sticking out her left ear, according to Resident #8 she had an earache for about a week. Resident #8 stated staff were applying drops 4 times a day, however Resident #8 felt that the treatment was not working. Resident #8 stated she had not finished the treatment so far and would report to the staff if she did not see an improvement after the treatment. Interview on 08/28/25 2:30 PM with MA X revealed Resident #8 had not been receiving ear drops due to central supply not delivering them yet. MA X stated she was not sure of what had been going on, but they were checking off on the MAR that it had been administered due to it popping up on the Medication administration; (staff did not clearly express why she would indicate as completed instead of on hold however, Resident #8 had not received drops. All ear drops had been placed on HOLD. MA X stated she reported to the ADON (on unknown date) the medication had not delivered . Attempted interview on 08/28/25 at 2:48 PM with LVN H was unsuccessful.Attempted interview on 08/28/25 at 2:52 PM with LVN I was unsuccessful. Attempted interview on 08/28/25 at 2:56 PM with ADON A was unsuccessful.Interview and observation on 08/28/25 at 3:10 PM with LVN G and the DON revealed LVN G confirmed she did not administer Resident #8 with ear drop medication and that she checked it as administered by mistake. LVN G stated she was not able to find the medication and needed to return to the medication administration record and make the correction. LVN G went to the medication cart and was able to locate the medication, while looking for the medication the DON stated Resident #8 had been administered the ear drop medication as ordered by the physician. LVN G had expressed to the DON that she could not find the ear drop medication earlier but had indicated she administered it on the medication administration record. The DON advised that the physician be notified. LVN G further explained the medication administration record indicated 4 additional missed doses due to the medication being placed on hold due to not being delivered. The DON reiterated to LVN G to contact the physician to report all missed doses. According to the DON nursing staff was responsible for administering Resident #8's medication treatment for her earache according to the physician orders. The DON stated she was not able to explain why there were missed doses because the medication entered the facility on 08/22/25. Interview on 08/28/25 at 4:00 PM with LVN G stated she contacted the physician to notify him of the missed doses and was told to provide Resident with a dose at 3:30 PM and provided a new order to extend the dates of treatment to end on 08/30/25 at 5:00 PM. According to LVN G she was responsible for communicating with the physician on any missed doses to ensure Resident #8 completed treatment as ordered. LVN G stated not doing so placed Resident #8 at risk for continued ear infections. Record review of Resident #8's revised physician order revealed: Cortisporin-TC Otic Suspension 3.3-3-10-0.5 MG/ML (Neomycin-Colistin-HC-Thonzonium) Instill 4 drop in left ear four times a day for Left Ear Pain for 7 Days. Active 8/23/2025 5:00 PM End 08/30/25Interview on 08/28/25 at 4:25 PM with the DON revealed she expected nurses to follow physician orders, and if there was a time when orders could not be followed or there was a delay with administering treatment it was the responsibility of nurses to call the physician and rectify the order and document results. The DON stated she was not aware Resident #8 had missed treatments, and (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated she was not able to identify the reason for the missed doses but believed the medication had been in the building therefore there was no reason or documentation for those missed doses. The DON stated with today's missed treatment the LVN G should have fixed the medication administration record to reflect the dose was not given. The DON stated all staff should document accurately, not doing so placed residents at risk of delayed infections and allowing symptoms to become worse. Interview on 08/28/25 at 4:40 PM with the Physician revealed he expected the nursing staff to call him with any missed doses of medication treatment. The Physician stated he was not sure if Resident #8 in fact had an ear infection however the medication was provided as a prevention, he further stated Resident #8 would be ok with just a three-day dose however he extended the treatment to end on 08/30/25 at 5:00 PM. The Physician stated he did not see any risk to resident at this time. Review of the facility's Physician Orders policy revised February 2010 reflected: Responsibility of the Licensed Nurse staff for orders to be carried out as stated by the physician.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident had a discharge summary that included, but not limited to a recapitulation of the resident's stay, that included but was not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology and consultant results and a final summary of the resident's status to include items, at the time of the discharge that was available to release to authorized persons and agencies, with the consent of the resident or resident's representative for 1 of 3 residents (Resident #92) reviewed for discharge summary. The facility failed to complete a discharge summary for Resident #92. This failure could place residents at risk of not having complete records after permanent discharge from the facility. Findings included: Record review of Resident #92's Discharge MDS Assessment, dated 06/28/25, reflected Resident #92 was a [AGE] year-old male, who was admitted to the facility on [DATE]. Resident #92 had diagnoses which included Chronic obstructive pulmonary disease with acute exacerbation (ongoing lung condition caused by damage to the lungs with sudden worsening in airway function and respiratory symptoms), acute respiratory failure with hypoxia (occurs when there is not enough oxygen in the blood), Diabetes Mellitus (group of diseases that affect how the body uses blood sugar), anxiety disorder (a type of mental health condition), and unspecified atrial fibrillation (a type of irregular heartbeat where the upper chambers of the heart beat irregularly and rapidly, but the specific cause or underlying condition is unknown) insomnia (sleep disorder), unspecified Record review of Resident #92's physician order, dated 06/26/25, reflected Discharge Home with home health on 06/29/25 with current medications, PT, OT, ST, Nurse to Eval and Treat as Indicated, DME-None. Record Review of Resident #92's Nursing Progress Note by LVN E on 06/28/25 at 22:16 reflected Resident #92 was sent to the Emergency Room. Record review of Resident #92's care plan, revised date 06/18/25, reflected: Focus-The resident wished to (Specify return/be discharged to (Specify home, another facility)) Goal-The resident will verbalize/communicate an understanding of the discharge plan and describe the desired outcome by the review date. Interventions-Encourage the resident to discuss feelings and concerns with impending discharge. Monitor for and address episodes of anxiety, fear, distress. Evaluate the resident's motivation to return to the community. Make arrangements with the required community resources to support independence post-discharge. Record review of Resident #92's clinical record reflected no discharge summary. Interview on 08/27/25 at 3:57 PM with LVN D revealed that a discharge summary should be completed by the social worker. LVN D stated that the nurse would follow up with the hospital to determine if a resident would be returning from the hospital. LVN D said if the resident would not be returning to the facility, the nurse would notify the ADON and document it in the clinical record. LVN D then stated the social worker was responsible for the discharge summary. LVN D said that with no discharge summary the resident would continue returning to the ER for treatment and would have no follow up services at home. Interview on 08/27/25 at 4:10 PM with ADON B revealed every discharged resident should have a discharge summary. ADON B said that Resident #92 did not have a discharge summary. ADON B stated that if there was no discharge summary, there would be no means for the resident to have follow-up services such as medications and durable medical equipment. ADON B said that primary nurse's responsibility was to ensure that the resident had a discharge note. ADON B then revealed that the discharge summary was completed by social services, and the nurse completed and locked it. Interview on 08/27/25 at 4:29 PM with the Social Worker revealed that Resident #92 did not have a discharge summary. The Social Worker stated that Resident #92 exited the facility, and the responsible party refused to sign paperwork that she was taking Resident #92 out of the building. The Social Worker said that she did not know how to complete a discharge summary when a resident left the facility and refused to sign any paperwork. The Social Worker revealed that the DON should direct the charge nurse to open the discharge (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	summary and direct how it should be followed. The Social Worker stated she was unclear about the policy and procedure after that or who was responsible for the discharge summary. The Social Worker would not answer how not having a discharge summary would affect the resident. Interview on 08/27/25 at 4:49 PM with the DON revealed that Resident #92 did not have a discharge summary. The DON stated that normally medical records should open the discharge summary. The DON said that each discipline then would enter their information. The DON revealed that the normal procedure did not occur because the resident left the facility without signing any documentation on a Saturday and the nursing department expected Resident #92 to return to the facility. The DON stated that the discharge summary was important because it provided residents with medications, equipment, etcetera. The DON said that it was her responsibility to ensure discharge summaries are completed. Interview on 08/27/25 at 5:44 PM with the Administrator revealed he expected the nursing department to complete the discharge summary for residents. The Administrator stated the discharge summary should be started immediately after discharge. The Administrator said that the discharge summary was important so that the resident could continue care services after exiting the facility. The Administrator revealed that he was not familiar with the specific procedure of the discharge summary. Record review of the facility's Discharge Summary and Plan, dated 11/2016, reflected the following: .The Discharge summary will include a recapitulation of the Patient's/Resident's stay at his facility and a final summary of the Patient's/Resident/s status at the time of the discharge in accordance with the established regulations governing release of resident information and as permitted by the resident.		

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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** Based on interviews and record reviews the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 (Resident #12) of 8 residents reviewed for care plans. The facility failed to include Resident #12's PTSD (Post Traumatic Stress Disorder) in his care plan. This failure could place the residents at risk of not receiving services to meet their needs. Findings included: Record review of Resident #12's admission MDS, dated [DATE], reflected the resident was admitted to the facility on [DATE] with diagnoses which included stroke, Diabetes, and (PTSD). Resident #12 had a BIMS score of 14, indicating he was cognitively intact. Record review of Resident #12's care plan, dated 8/8/25 reflected he had no intervention for his PTSD. In an interview on 8/27/25 at 10:42 AM the DON stated the MDS nurse was responsible for ensuring the care plans were comprehensive and up-to-date. In an interview on 8/27/25 at 10:47 AM the MDS Nurse stated she was primarily responsible for care plans being completed, but the DON and ADONs could also add to the care plans as needed. She stated after she completes the MDS assessment, she then transfers that info to the care plan. She stated the risk of not having a comprehensive care plan could be the resident not receiving the services they need. She said she should have added Resident #12's PTSD to his care plan. In an interview on 8/28/25 at 9:35 AM the Social Worker stated she would be the one responsible for notifying psychiatric services of a consult for Resident #12. She stated she had ordered the consult on 8/22/25 but did not recall who had notified her of the need. She did not know why the consult had not been ordered when the resident's MDS had been completed on 8/14/25. She stated the consult was pending insurance approval. In an interview on 8/28/25 at 9:50 AM ADON- B stated she had not been aware of Resident #12's PTSD diagnosis. She stated the resident had been visited by the local fire department's Mobile Integrated Health resources staff while in the facility. She stated they had followed the resident when he lived independently and had followed up with him in the facility after he was admitted . In an interview on 8/28/25 at 9:55 AM the Nurse Practitioner stated she had been unaware Resident #12 had a PTSD diagnosis. She stated she had been aware of his anxiety and had prescribed medications for that. She stated his anxiety was related to his dialysis. She stated she had not ordered a psych consult. She stated there were no risks to his PTSD not being addressed since he was being treated with anxiety medications and was not exhibiting any symptoms. In an interview on 8/28/25 at 10:34 AM the Paramedic with the local fire department stated she works with community members who overuse the 911 system, connecting them with services in the community with the goal of keeping them out of the 911 system. She stated she had worked with Resident #12 for about a year arranging for dialysis and doctor's appointment transportation. She stated she continued to check on Resident #12 after he was admitted to the facility just to see how he was doing. She stated she did not provide any psych services for Resident #12. Record review of the facility's policy Care Plans-Comprehensive, dated September 2010. An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs is developed for each resident. 1. Our facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative develops and maintains a comprehensive care plan for each resident. 9. The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans.		

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident received foot care that was consistent with professional standards of practice and treatment to prevent complications from conditions such as diabetes and assisting residents in making necessary appointments with qualified healthcare providers such as podiatrists and arranging transportation for 1 (Resident #7) of 10 residents reviewed for foot care. The facility failed to provide Resident #7 assistance with foot care leaving his toenails to be about an inch long on both feet. This failure could place the residents at risk for decreased feelings of self-worth, skin breakdown, and infection. Findings included: Record review of Resident #7's Quarterly MDS assessment, dated 06/30/25, revealed Resident #7 was a [AGE] year-old male admitted on [DATE]. Resident #7 had cognition intact with a BIMS score of 11. Resident #7 was dependent on staff for shower/baths. Active diagnoses included Diabetes Mellitus (high blood sugar), Non-Alzheimer's Dementia (memory loss), Hypertension (high blood pressure), Depression (mood disorder that causes persistent feeling of sadness and loss of interest). Review of Resident #7's care plan, undated, revealed Resident #7 had a diagnosis of chronic venous insufficiency and is at an increased risk for pain, skin breakdown, heart attack, stroke, and blood clots. Goal: Resident #7 will remain free of complications related to chronic venous insufficiency. Interventions included: elevate legs when sleeping. If resident had thick nails, corns, calluses, refer to podiatrist. Resident #7 had a diagnosis of Diabetes Mellitus II and was at risk for frequent infections, skin breakdown, decline/changes in vision, renal failure, and acute changes in cognition due to abnormal glucose levels. Goal: The resident will have no complications related to diabetes. Interventions: Refer to podiatrist to monitor/document foot care needs and to cut long nails as needed. Record review of podiatry request for service dated 06/23/25 for Resident #7 revealed a verbal consent with the Social Worker. Record review of Resident #7's podiatry request for services/consultation dated 06/24/25 revealed to have the podiatrist examine the resident for the following reasons: Thickened, dystrophic, and/or painful nails with increased risk of infection. Observation on 08/26/25 at 12:05 PM of Resident #7 revealed the resident was in bed covered by a sheet, Resident #7's toenails were uncovered. His toenails were at least an inch long. Resident #7 stated he had been in the facility over a year and had not been seen by the podiatrist at any time during his stay. Resident #7 stated he had spoken with the Social Worker about having his toenails trimmed, and he was supposedly placed on the list to be seen, however when podiatry was last in the building, they did not visit him. Resident #7 stated podiatry was last in the building a couple of weeks ago. Resident #7 stated he felt he was not seen by podiatry due to him being overweight. He stated this made him feel uncomfortable and sad, and he did not know what to do about getting his nails cut. Resident #7 expressed that he had not talked to anyone about how he felt when he was not seen by the podiatrist on 08/19/25. Interview on 08/27/25 at 9:59 AM with LVN F revealed she worked with Resident #7 for some time now. LVN F stated she was aware of the condition of his toenails and described them as really long with possible fungal symptoms so she requested a referral for podiatry. LVN F stated she notified ADON, DON, and the Social Worker during morning stand up meeting about two weeks ago. LVN F stated the Social Worker provided the referral and LVN F stated she presented them to the ADON for physician signatures. LVN F stated she last saw podiatry in the building about two weeks ago, however, was not aware that his toenails were still long. According to LVN F, Resident #7 was a diabetic, so it was her responsibility to provide nail care. LVN F stated she had never tried to trim his toenails; persons diagnosed with diabetes were referred to the Social Worker to be seen by podiatry. Interview on 08/27/25 at 10:30 AM with the Social Worker revealed she spoke with Resident #7 on Saturday 08/23/25, and saw his toenails, and described them as long and needed to be trimmed. The Social Worker stated Resident #7 was placed on the list for the first time to be seen by podiatry on 08/19/25. The Social Worker stated Resident #7 was not seen and stated (continued on next page)		

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	perhaps he would be seen on the next podiatry visit to the facility in mid-October 2025. According to the Social Worker she contacted the podiatry service provider to inquire why Resident #7 was missed and she found out the provider will only see 30 residents per visit. The Social Worker stated nurses were responsible for trimming resident nails and toenails, not ensuring residents received proper nail care placed them at risk of infections. Interview on 08/28/25 at 10:30 AM with ADON A stated resident's with a diagnosis of diabetes were referred to the podiatrist to have their toenails cut and trimmed. The DON stated the podiatrist came to the facility every so often but if a resident had a need for immediate care, we would inform the Social Worker to call out to be seen immediately. The DON stated he had not seen Resident #7's toenails and it had not been reported to him that they needed to be cut and trimmed. The DON stated the nurses should report to him so that he could complete an assessment and notify the Social Worker. Observation and interview on 08/28/2025 at 11:14 AM with ADON A and Resident #7 of Resident #7's feet revealed ADON A stating he was seeing Resident #7's feet for the first time in a long while. Resident #7 shared he felt like he was missed by the podiatrist because he was fat, and that it made him feel uncomfortable. The ADON, stopped to express to Resident #7 that his weight was not a factor, and apologized to Resident #7 for being missed by the podiatry provider. ADON A stated Resident #7 toenails appeared to have not been cut or trimmed in a long time by looking at the length and appeared to have jagged edges. ADON A stated the appearance of his feet and toes was not ok and he needed to speak with the Social Worker to have someone come out to cut resident toenails. According to ADON A not having routine toenail care placed Resident #7 at risk for infection, bacteria, unwanted skin conditions and could create a dignity issue. The ADON stated he would work with the Social Worker to get Resident #7 an expedited appointment to have his nails cut and trimmed. Review of the facility's Diabetes Mellitus Patient - Nursing Care of Adult policy revised February 2024 reflected: Responsibility of the Licensed Nurse and Certified Nurse Assistant to provide foot care by gently bathe feet as necessary to keep clean, keep feet dry, especially between toes, encourage use of non-constricting, well-fitting shoes, slippers and hose, keep feet warm without using external sources of heat, with physicians orders only, licensed nurse may trim toenails straight across and with caution, consult podiatrist regarding care of corns, calluses, thick and indurated toenails.		

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NAME OF PROVIDER OR SUPPLIER Sundance Inn Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2034 Sundance Parkway New Braunfels, TX 78130	
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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the menu was followed for one of one meal (lunch on 08/27/25) reviewed for food and nutrition services. The facility failed to ensure the menu was followed for the lunch meal on 08/27/25 by providing the pureed trays with lemon pudding for dessert and the regular trays with a cherry cream cheese swirl brownie for dessert. This failure could place residents at risk of weight loss, altered nutritional status and diminished quality of life. Findings included: Record review of the facility's menu, dated 08/27/25, reflected for Wednesday (08/27/25) the following: Lunch-Open Face [NAME] Sandwich, Breaded Corn Nuggets, Marinated Vegetable Salad, Cherry Cream Cheese Swirl Brownie. Observation on 08/27/25 at 10:35 AM revealed that the [NAME] pureed rye bread, the [NAME] sandwich ingredients (pastrami, sour kraut, cheese, and thousand island dressing), creamed corn, and the vegetables. No cherry cream cheese brownie was pureed or served to residents who should have received pureed meals. Interview on 08/27/25 at 2:15 PM with the [NAME] revealed that puree meals should be the same as the regular meals. The [NAME] stated she was unaware of the desserts served because she only cooks the main courses. The [NAME] said that no one brought her a cherry cream cheese swirl brownie to puree. The [NAME] revealed both the regular diets and puree diets should be the same so that everyone gets the same flavors and nutrition. The [NAME] also stated that it was also important that staff received the same meals so that no one feels left out or different. The [NAME] said that different meals would create confusion both for the residents, because they would not understand why they could not eat the same as everyone else, as well as in the kitchen staff when preparing meals. The [NAME] revealed that it was important for residents who received puree meals to have the same variety as residents who received regular meals because it would increase their meal intakes. The [NAME] stated that if she knew something was not being served according to the menu, she would report it to the dietary manager. The [NAME] said that she was in-serviced recently on following the facility menu but did not recall the date. Interview on 08/27/25 at 2:22 PM with the Dietician revealed that all residents should receive the same items on the menu so that all residents receive a variety of flavor and tastes. The Dietician stated it was important for residents to receive the correct proteins and calories per the menu items for nutrition purposes. The Dietician also revealed if residents received different meals or menu items such as the lemon pudding instead of the cherry cream cheese brownie, then they could get upset because they would not understand why their food is different. The Dietician stated that it was the Dietary Manager's responsibility to ensure that the menus were followed and notify her if any substitutions were necessary. Interview on 08/27/25 at 2:39 PM with the Dietary Manager revealed that the pureed dessert was not the same as the regular dessert. The Dietary Manager stated that the facility policy was that all residents should have the same meals. The Dietary Manager acknowledged that the pureed dessert was lemon pudding, and the regular tray had a cherry cream cheese brownie as the dessert. The Dietary Manager stated she did not notice that the desserts were not the same on the puree tray and the regular tray that day. The Dietary Manager said it was her responsibility to ensure that the meals served were the same as on the menu. The Dietary Manager revealed it was important for puree meals to have the same items as the regular meals so that residents received the necessary calories and nutrients for their bodies. The Dietary Manager stated all substitutions should have been posted and approved by the dietician. The Dietary Manager said she in-serviced the dietary staff in June 2025 on following dietary menus. Record review of the facility's Puree Diet policy, revised, 03/2013, reflected: Policy: It is the policy of the facility to serve a puree diet that is nutritionally adequate and textually appropriate to the Patients. Procedures: 1. The Chef/Cooks must follow the Puree Diet as written on the Menu Guide Report (therapeutic diet spreadsheets). 2. The Regular Diet is followed as closely as possible to provide adequate nutrition.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 1 (Resident #8) of 3 residents reviewed for accuracy of medical records. The facility failed to ensure Resident #8's missed doses of ear drops was documented accurately and completely on 08/22/25 and 08/23/25. This failure could place the residents at risk for incomplete and inaccurate clinical records which could lead to miscommunication or a delay in services. Findings included: Record review of Resident #8's Quarterly MDS assessment, dated 06/30/25, revealed Resident #8 was a [AGE] year-old female admitted on [DATE] and readmitted on [DATE]. Resident #8 had moderate cognition impairment with a BIMS score of 8. Resident #8 required supervision or touching assistance by staff for personal hygiene and partial assistance for shower/bathing. Resident #8 had adequate hearing reflecting no difficulty in normal conversation, social interaction or listening to the television. Active diagnosis included Renal Insufficiency (when both kidneys no longer work on their own), Non-Alzheimer's Dementia (memory loss), Hypertension (high blood pressure), Depression (mood disorder that causes persistent feeling of sadness and loss of interest), anxiety disorder (excessive worry or fear). Review of Resident #8's care plan, undated, revealed Resident #8 had a self-care performance deficit and required assistance with ADLs. Goal: Resident #8 will maintain current level of function. Intervention: Hygiene/Grooming required set-up to supervision/touching assistance. Bathing required supervision/touching to partial/moderate assistance. Record review of Resident #8's physician orders revealed: 1. May have podiatry, dental, audiology, and ophthalmology consult as needed. No directions specified for order. Active 5/14/2025 2. Cortisporin-TC Otic Suspension 3.3-3-10-0.5 MG/ML (Neomycin-Colistin-HC-Thonzonium - used to treat outer ear infections caused by bacteria) Instill 4 drop in left ear four times a day for Left Ear Pain for 7 Days. Active 8/22/2025 09:00 Record review of Resident #8's progress notes written by LVN H revealed: 8/27/2025 08:24 Orders - Administration Note Note Text: Cortisporin-TC Otic Suspension 3.3-3-10-0.5 MG/ML Instill 4 drop in left ear four times a day for Left Ear Pain for 7 Days 8/23/2025 13:51 Orders - Administration Note Written by Medication Aide Note Text: Cortisporin-TC Otic Suspension 3.3-3-10-0.5 MG/ML Instill 4 drop in left ear four times a day for Left Ear Pain for 7 Days Ear drops pending delivery from central supply. 8/23/2025 13:50 Orders - Administration Note Written by Medication Aide Note Text: Cortisporin-TC Otic Suspension 3.3-3-10-0.5 MG/ML Instill 4 drop in left ear four times a day for Left Ear Pain for 7 Days Ear drop on order pending delivery from central supply. 8/22/2025 20:41 Orders - Administration Note written by RN K Note Text: Cortisporin-TC Otic Suspension 3.3-3-10-0.5 MG/ML Instill 4 drop in left ear four times a day for Left Ear Pain for 7 Days. 8/22/2025 16:07 Orders - Administration Note written by RN K Note Text: Cortisporin-TC Otic Suspension 3.3-3-10-0.5 MG/ML Instill 4 drop in left ear four times a day for Left Ear Pain for 7 Days. 8/21/2025 21:58 Nursing- General Note written by LVN L Note Text: Received return call from Dr. [NAME] regarding left ear pain with some hearing loss. New orders received to include Cortisporin Otic Suspension 4 drops to the left ear four times daily for 7 days. 8/21/2025 18:51 Nursing- General Note written by LVN L Note Text: Resident reported left ear pain with difficulty hearing. Contacted Dr. [NAME] through Perfect Serve, awaiting physician response. Record review of Resident #8's medication administration record revealed a physician's order Cortisporin-TC Otic Suspension 3.3-3-10-0.5 MG/ML (Neomycin-Colistin-HC-Thonzonium) Instill 4 drop in left ear four times a day for Left Ear Pain for 7 Days. Start date 08/22/2025 0900 (9:00 AM, 12:00 PM, 5:00 PM, 9:00 PM) On 08/22/25 Resident #8 received treatment at 9:00 AM, 12:00 PM On 08/22/25 Resident #8 did not receive treatment at 5:00 PM, 9:00 PM On 08/23/25 Resident #8 did not receive treatment at 9:00 PM, 12:00 PM On 08/23/25 Resident #8 received treatment at 5:00 PM, 9:00 PM On 08/24/25, 08/25/25, (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	08/26/25, 08/27/25 Resident #8 received treatment at 9:00 AM, 12:00 PM, 5:00 PM, 9:00 PM On 08/28/25 the medication administration record indicated Resident #8 received treatment at 9:00 AM, 12:00 PM Interview and observation on 08/26/25 at 11:08 AM revealed Resident #8 in bed with something white sticking out her left ear, according to Resident #8 she had an earache for about a week. Resident #8 stated staff were applying drops 4 times a day, however Resident #8 felt that the treatment was not working. Resident #8 stated she had not finished the treatment so far and would report to the staff if she did not see an improvement after the treatment. Interview on 08/28/25 2:30 PM with MA X revealed Resident #8 had not been receiving ear drops due to central supply not delivering them yet. MA X stated she was not sure of what had been going on, but they were checking off on the MAR that it had been administered due to it popping up on the Medication administration; (staff did not clearly express why she would indicate as completed instead of on hold however, Resident #8 had not received drops. All ear drops had been placed on HOLD. MA X stated she reported to the ADON (on unknown date) the medication had not delivered. Attempted interview on 08/28/25 at 2:48 PM with LVN H was unsuccessful. Attempted interview on 08/28/25 at 2:52 PM with LVN I was unsuccessful. Attempted interview on 08/28/25 at 2:56 PM with LVN J was unsuccessful. Interview on 08/28/25 at 3:10 PM with LVN G and the DON revealed LVN G confirmed she did not administer Resident #8 with ear drop medication and that she checked it as administered by mistake. LVN G stated she was not able to find the medication and needed to return to the medication administration record to make the correction. LVN G went to the medication cart and was able to locate the medication, while looking for the medication the DON stated Resident #8 had been administered the ear drop medication as ordered by the physician. LVN G had expressed to the DON that she could not find the ear drop medication earlier but had indicated she administered it on the medication administration record. The DON advised that the physician be notified. LVN G further explained the medication administration record indicated 4 additional missed doses due to the medication being placed on hold. The DON reiterated to LVN G to contact the physician to report all missed doses. According to the DON nursing staff was responsible for administering Resident #8's medication treatment for her earache according to the physician orders. The DON stated she was not able to explain why there were missed doses because the medication entered the facility on 08/22/25. Interview on 08/28/25 at 4:00 PM with LVN G revealed she contacted the Physician to notify him of the missed doses at 9:00 AM and 12:00 PM on 08/28/25 and missed doses on 08/22/25 and 08/23/25. LVN G stated she was told to provide Resident with a dose at 3:30 PM on 08/28/25 and she was provided a new order to extend the dates of treatment until 08/30/25 at 5:00 PM. According to LVN G she and the administering nurses and medication aide was responsible for accurately documenting any missed doses. LVN G stated the ear infection medication for Resident #8 was received by LVN J on 08/23/25 during the 2:00 PM - 10:00 PM shift. LVN G stated the order should have been entered to start administration on 08/24/25 instead of 08/22/25 so that she could complete the full order. LVN G stated not doing so placed Resident #8 at risk for continued ear infections. Record review of Resident #8's revised physician order revealed: Cortisporin-TC Otic Suspension 3.3-3-10-0.5 MG/ML (Neomycin-Colistin-HC-Thonzonium) Instill 4 drop in left ear four times a day for Left Ear Pain for 7 Days. Active 8/23/2025 5:00 PM End 08/30/25 Interview on 08/28/25 at 4:25 PM with the DON revealed she expected nurses to follow physician orders, and if there was a time when orders could not be followed or there was a delay with administering treatment it was the responsibility of nurses to call the physician, rectify the order and accurately document results. The DON stated with today's missed treatment the LVN G should have fixed the medication administration record to reflect the dose was not given. The DON stated all staff should document accurately, not doing so placed residents at risk of delayed infections and allowing symptoms to become worst. Review of the facility's Documentation of Medication Administration on eMAR/eTAR policy revised February 2010 reflected: Responsibility of the Licensed Nurse, Certified Nurse Assistant and Certified Medication Aide to provide proper documentation of medication (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administration and treatments in the medical record. Medications must be administered within the required time, within one hour the time in the eMAR/eTAR. Only the RN, LVN, or MA that removes the medication from the package may administer and document the medications, When removing a medication from the package, the RN, LVN or MA will electronically sign the eMAR/eTAR then administer the medication or the RN, LVN or MA will remove the medication from the package, administer the medication then initial the eMAR/eTAR. If the patient refuses or the mediation is not given due to other situations note in the eMAR/eTAR.		