STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455618	A. Building B. Wing	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Home	631 Lakeview Blvd 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. (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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to immediately consult the resident's Physician and notify, consistent with his or her authority, the resident representative(s) when there is a significant change in the resident's physical, mental, or psychosocial status or an accident involving the resident which results in injury and has the potential for requiring physician intervention for 1 of 4 residents (Resident #1) reviewed for notification of changes. The facility failed to notify Resident #1's Physician and notify the resident's Responsible Party of a worsened wound to sacrum. This failure could place residents at risk of delays in decision making, and poor quality of care and life. Findings Include:Record review of Resident #1's face sheet revealed an [AGE] year old male admitted for respite on 12/01/2025. At the time of admission resident had active diagnosis of sequelae of cerebral infarction (commonly known as a stroke), cerebrovascular disease (condition that affects blood flow to the brain), and hemiplegia, unspecified affecting right dominant side (condition characterized by paralysis on one side of the body). Resident #1 was receiving hospice care at the time of admission. Record review of Resident #1's admission skin assessment, dated 12/01/2025, revealed in section AS_2 nonblanchable (area of skin remains red and does not turn white when pressed) redness to the coccyx (commonly known as the tailbone) was identified. Record review of Resident #1's progress note dated 12/08/2025 revealed LVN A documented Skin Issues : Skin Issue: #001: Skin issue has been evaluated. Location: Coccyx. Additional location information: . Issue type: Other skin issue. Other skin issue description: nonblanchable redness Progress: Deteriorating: wound characteristics deteriorated. Wound was present on admission. It is unknown how long the wound has been present. Length (cm): 2.5 Width (cm): 2.5 Depth (cm): 0 Undermining: No. Tunneling: No. Skin Issues Note: cna notified me that reddened area had opened up. triad applied. Skin issue education: Moisture barrier. Interview with CNA B on 12/11/2025 at 2:08 PM revealed Resident #1 was at the facility for respite. CNA B stated Resident #1 had a small red spot on his butt that looked to be a healing sore when he was admitted . CNA B stated the sore was not open or bleeding. Interview with CNA C on 12/11/2025 at 2:32 PM revealed she had worked with Resident #1 a few days and Resident #1 had a light red spot on his coccyx. CNA C stated while she provided care to Resident #1 on 12/08/2025 at the end of her overnight shift she noticed the skin on Resident #1's sore was redder and appeared to be open. CNA C stated she reported the sore to LVN A who cleaned and applied a cream to the sore. CNA C stated LVN A said he would document the sore and make the notifications. Attempted phone interview with LVN A on 12/11/2025 at 3:09 PM. Surveyor left a message for LVN A requesting a call back. No return call was received. Interview with LVN D on 12/11/2025 at 3:45 PM revealed LVN A had informed her Resident #1 had a new/worsened sore on his coccyx as of late in the overnight shift on 12/08/2025. LVN D stated she agreed to make the notifications to Resident #1's responsible party and physician. LVN D stated she did not make the notifications. LVN D stated it is the responsibility of the charge nurse to make the notifications to ensure residents get appropriate care/treatment. Interview with DON on 12/11/2025 at 3:55 PM revealed LVN A made note that Resident #1 had a worsened wound to the coccyx on 12/08/2025. DON stated the charge nurse was responsible for making notifications to responsible parties and physicians. DON stated it was important to make notifications to ensure the residents were getting the appropriate treatment. Interview with Resident #1's Responsible Party (RP) on 12/12/2025 at 9:00 AM revealed resident was at the facility for 9 day for a respite stay. RP stated Resident #1 did not have any skin integrity issues prior to his stay. RP stated she provided care to Resident #1 upon his return home and found the sore on his coccyx. RP stated she was not notified that the resident had a sore or how to care for the sore. Attempted phone interview with LVN A on 12/12/2025 at 9:25 AM. Surveyor left a message for LVN A requesting a call back. No return call was received. Interview with Nurse Practitioner on 12/12/2025 at 11:08 AM revealed that the facility was to notify the resident's doctor when finding a new or worsened wound. Nurse Practitioner stated the doctor and/or nurse practitioner were not notified of Resident #1's wound. Record review of facility policy named Nursing-Wound Care, dated 04/17/19 revealed c. Licensed nurses will conduct a full body skin assessment on all residents upon admission/re-admission, weekly, and upon any newly identified skin issues. Licensed nurse will notify the attending physician/provider and wound care coordinator,. obtain orders, notify POA or Responsible party of wound/treatment, and then document all communication, orders and findings in the medical record. Attempted phone interview with LVN A on 12/12/2025 at 9:25 AM. Surveyor left a message for LVN A