STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455796	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Town and Country Nursing and Rehabilitation Center	625 N Main St Boerne, TX 78006

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 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 all alleged violations involving abuse/neglect/exploitation or mistreatment including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 24 hours if the events that caused the allegation did not involve abuse and did not involve serious bodily injury, to the administrator of the facility and other officials, including the State Survey Agency, in accordance with State Law through established procedures for 1 of 7 residents (Resident #1) reviewed for abuse and neglect.The facility failed to ensure Resident #1 had the proper medication given to the resident at the time of discharge.This deficient practice could place residents at risk of not being given proper medication on discharge resulting in an impaired health status.The findings included:1-Record review of Resident #1's face sheet dated 12/3/25 revealed an [AGE] year old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included type 2 diabetes (a condition in which the body does not use insulin properly), general anxiety disorder (a condition of excessive worry about every day things), and essential hypertension (a condition of high blood pressure).Record review of Resident #1's admission MDS dated [DATE] revealed a BIMS of 15 (a score of intact cognition).Record review of Resident #1's care plan initiated on 8/5/25 revealed the resident had a self care performance deficit.Record review of Resident #1's nursing progress notes revealed the resident was discharged home on 8/19/25.2-Record review of Resident #2's face sheet dated 12/3/25 revealed the [AGE] year old male who was originally admitted on [DATE]. Resident 32 had diagnosis which included alzheimers disease (a condition on progressive brain disorder), cerebral infarction (a condition in which there is a blockage in the brain), and peripheral vascular disease (a problem with circulation of blood in the veins)Record review of Resident #2's quarterly MDS dated [DATE] revealed a BIMS of 0 (a score of severe cognitive impairment)Record review of Resident #2's care plan initiated 9/8/23 revealed the resident had a self-care performance deficit.Record review of Resident # 2's nursing progress notes revealed the resident's care was continued in the facility.During an interview on 12/2//25 at 200pm with the VA Social worker stated Resident #1 had not taken any of Resident #2's medications that were found at the home residence of Resident #1 as they had been sent home with him in error at the time of his discharge from the facilityDuring an interview on 12/2/25 at 220pm with the VA Nurse Practitioner stated Resident #1 had not taken any of Resident #2's medications that were found at the home residence of Resident #1 as they had been sent home with him in error at the time of his discharge.During an interview on 12/3/25 with the Administrator, Director of Nurses (DON) and Assistant Director of Nurses (ADON) the ADON stated she completed the discharge of Resident #1 on 8/19/25 from the facility and mistakenly placed four of Resident #2's medication in with Resident #1's discharge medications. Resident #2's medications that were given to Resident #1 at the time of his discharge from the facility included the following medications: (Trazadone 50mg, Tenisartine 80mg, Pepcid 20 mg, and Celexa 10 mg). The DON stated she had received a call from VA Nursing on 8/22/25 informing her Resident #1 was seen in his home by the VA Nurse and the four medications were sent home in error with Resident #1 had been destroyed by the VA Nurse. The DON stated the VA Nurse advised her that Resident #1 had not taken any of Resident #2's medications sent in error during his discharge. The DON stated that Resident #2's medications had been re-ordered and there were no missed medication administrations of the four medications (Trazadone 50mg,Tenisartine 80mg, Pepcid 20mg, and Celexa 10 mg) and that Resident #2 remained as a resident at the facility .The DON stated on 8/22/25 she and the ADON went to the home residence of Resident #1 and confirmed with Resident #1 he had not taken any of Resident #2's medications that were sent home with him in error at the time of his discharge. The Administrator stated the following in-services were completed by staff in follow-up to the discharge incident of Resident #1.a. Protocol for-Discharge Medications Given to Residents-All nursing staffb. Medication Administration Procedures Post Test-All nursing staffc. Abuse/Neglect Policy-All facility staffd. Hippa- Privacy Policy-All facility staffDuring an interview on 12/3/25 with the Administrator and ADON they stated that the risk to the residents of being given the wrong medications on discharge could impact the resident's health status. The Administrator stated the medication error incident was not reported to Tx HHS at the time of the incident as they were advised by the facility's regional staff that report of the medication discharge error to Tx HHS was not necessaryRecord review of in-services # a-d competed at the facility on 8/25/25 revealed that the selected staff received the in-services as noted by the Administrator and DON.Record review of the