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	12/17/2025

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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, 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, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for one of nine resident (Resident #2), in the facility reviewed for reportable events, in that: The facility failed to report an allegation of neglect when RN A did not follow physician's orders for administration of morphine for Resident #2. This failure placed residents at risks of preventing the appropriate authorities from taking necessary action to investigate the incident, not having systemic concerns identified, and preventing future errors from occurring. The findings included: A Record Review of Resident #2's admission Record dates 12/14/2025 documented a [AGE] year-old male resident with a current admission date of 06/20/2025 and an original admission date of 07/11/2024, with diagnoses including malignant neoplasm of lower lobe, right bronchus, or lung (lung cancer) and chronic obstructive pulmonary disease (a long-term, progressive lung disease that makes breathing difficult due to damaged airways). A Record Review of Resident #2's Order Summary Report dated 12/17/2025 reflected an order dated 11/19/2025 for the following: Morphine Sulfate (Concentrate) Solution 20 MG/ML Give 10 mg by mouth every 1 hours as needed for Pain/SOB Palliative Care Patient [Palliative care-specialized medical support focused on relieving symptoms, pain, and stress for people with serious illnesses]. A Record Review of Resident #2's Medication Administration Record dated 12/01/2025-12/31/2025 revealed the following medication signed as administered by RN Aon 12/09/2025 at 4:41 PM: Morphine Sulfate (Concentrate) Solution 20 MG/ML Give 10 mg by mouth every 1 hours as needed for Pain/SOB Palliative Care Patient. A Record Review of Resident #2's Morphine Sulphate Individual Resident's Controlled Substance Record (narcotic count sheet), dated 11/20/2025 revealed a 30 ml bottle of Morphine Sulphate 100mg/5ml was received by the facility. Continued review reflected on 12/09/2025 at 4:41 PM RN A signed out 10 mg of Morphine Sulfate as administered to Resident #2. Further review revealed the morphine started out with 30 ml, with 28 ml (or cc) of the medication left on hand after RN A administered the medication on 12/09/2025. During an interview and observation on 12/14/2025 at 5:25 PM, with the DON, observed Resident #2's Morphine Sulfate liquid bottle, the DON stated it has 28 ml, observed the measurements on the bottle and the liquid was at the 28 ml mark. The DON pointed out that the label on the bottle of Morphine Sulfate for Resident #2 instructed to give 0.5 ml q hour prn on the box label and the medication bottle. The DON stated she asked RN A how much morphine she administered to Resident #2 on 12/09/2025 and RN A said she gave the resident 2 ml of morphine. During an interview with RN A, on 12/15/2025 at 10:26 AM, when asked how much morphine she administered to Resident #2 on 12/09/2025, RN A stated I gave him . I looked at the dose, it seemed a bit high to me, the ordered dose was 10 mg, and I believe I gave him 10 mg . When asked how many milliliters she drew up, RN A stated she drew up the entire syringe, which was 1 ml. RN A stated it came to her attention that the dose should have been 0.5 ml. During an interview and observation with the Administrator on 12/16/2025 at 2:40 PM, when asked if the facility's response to Resident #2's medication error dated 12/09/2025 included reporting the incident to the State Survey Agency, the Administrator stated, We reviewed the medication error with our corporate team, and decided the incident did not meet the reportable criteria from the nursing facility provider letter 2024-14. The Administrator then stated Resident #2's morphine medication error on 12/09/2025 was not reported to the State Survey Agency as of 12/16/2025. When asked who was responsible for reporting, reportable events to the State Survey Agency, she stated, the Administrator. During an interview with the DON on 12/16/2025 at 4:28 PM, regarding the administration of Resident #2's Morphine Sulphate liquid medication, the DON was asked when did RN A give the medication, the DON stated on the 10/9/25 around 4:00 PM-4:30 PM. When the DON was asked how much medication was administered to Resident #2, the DON said, 2 ml which equaled 40mg. When asked how many milligrams were ordered the DON said, 10mg. When asked if the facility reported the incident to the State Survey agency, the DON stated that she and the Administrator consulted with their corporate team and