

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455796	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2025
NAME OF PROVIDER OR SUPPLIER Town and Country Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50531</p> <p>Based on record review, interviews and observation, the facility failed to ensure residents (Resident #63) was able to communicate in preferred Language to caregivers for 1 of 4 residents reviewed for resident rights.</p> <p>Resident #63 who was English speaking only had difficulty communicating with primarily Spanish-speaking caregivers using communication tools.</p> <p>This failure could place residents at risk for not being informed about care and treatment that may affect resident's well-being and being able to participate in daily plan of care and delay in treatment.</p> <p>Findings included:</p> <p>Record review of Resident #63's face sheet revealed a [AGE] year-old female admitted on [DATE] and readmitted on [DATE]. Diagnoses included Alzheimer's Disease (progressive Brain disorder that slowly destroys memory and thinking skills), Bipolar Disorder (mental health disease of high and low mood swings), Diabetes Type II (bodies difficulty to regular sugar), Hypertension (high blood pressure), Atrial Fibrillation (irregular heart rhythm), lymphedema (tissue swelling caused by fluid buildup), encephalopathy (brain disease or damage).</p> <p>Record review of Quarterly MDS assessment dated [DATE] revealed BIMS (Basic Interview of Mental Status) Score of 11 indicating moderate cognitive impairment and required supervision with self-feeding, toilet hygiene, dressing, bed mobility, bathing and gait.</p> <p>During an interview with Resident #63 on 5/20/25 at 10:30 a.m., Resident #63 stated she had difficulty communicating with staff who are non-English speaking.</p> <p>An observation of CNA H on 5/20/25 at 12:25 p.m., revealed that she did not read or speak English but that she had an application on her phone to facilitate communication with non-Spanish speaking residents. CNA H was asked to demonstrate the use of the translation application with Resident #8 but she was unable to manipulate the translation application and effectively communicate with Resident #8.</p> <p>(continued on next page)</p>

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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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An observation of CNA I on 5/20/25 at 12:45 p.m., revealed she did not speak English but she had an application on her phone to communicate with non-Spanish speaking residents. CNA I was asked to demonstrate the translation application with Resident #8 and was unable to effectively communicate questions to Resident #8.</p> <p>A review of Resident Council meeting minutes dated 1/15/2025, revealed residents in attendance identified a language barrier and residents having a hard time communicating.</p> <p>During an interview with the DON on 5/20/25 at 1:00 p.m., the DON stated that all staff were advised to utilize translation application when communicating with residents who do not speak their native language. DON stated that staff are advised to notify Charge Nurse of communication difficulties with residents who do not speak their native language. DON stated that staff's inability to communicate with residents could affect their care and well-being and potentially cause harm if needs are not met timely.</p> <p>Review of the facility policy titled, The Facility Manual, revised 7/14/2020, reflected Resident Rights, Rights of Elderly Individuals, Rights of the Elderly (j) A person providing services shall fully inform an elderly individual, in language that the individual can understand, of the individual's total medical condition and shall notify the individual whenever there is a significant change in the person's medical condition.</p>		

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<p>F 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow resident to participate in the development and implementation of his or her person-centered plan of care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50531</p> <p>Based on record review and resident interview, the facility failed to ensure resident of the right to participate in the development and implementation of his/her person-centered plan of care for 1 of 5 (Resident #61) residents reviewed for resident rights.</p> <p>The facility failed to invite and include the input of Resident #61 as members of the interdisciplinary team in Care Conference meetings.</p> <p>This failure could place residents at risk of not receiving the interventions, treatments, and care necessary for the resident to reach their highest practicable physical, mental, and psychosocial well-being by not involving the resident in Care Plan Conference meetings.</p> <p>The findings included:</p> <p>Record review of Resident #61's face sheet date 5/22/25 revealed a [AGE] year-old male admitted on [DATE] and readmitted on [DATE]. Diagnoses included peripheral Neuropathy (a condition that damages the nerves), hypertension (high blood pressure), dysphagia (swallowing difficulty), osteomyelitis (infection of bone marrow), Benign Prostatic Hyperplasia (enlarged prostate causing urination difficulty in men).</p> <p>Record review of BIMS (Basic Interview for Mental Status) dated 3/12/25 revealed Score of 15 indicating intact cognition.</p> <p>During an interview on 5/20/25 at 10:30 a.m., Resident #61 stated he had not been invited to a Care Plan meeting in a long time. Resident #61 stated he has gone to one Meeting sometime last year.</p> <p>During an interview on 5/21/25 at 3:15 p.m., the MDS Nurse stated that she kept a copy of care plan letters that were sent to the Responsible Party. MDS Nurse verified that the resident's son did receive an invitation to the Care Plan meeting held on 1/8/25 and 4/9/25. The MDS Nurse stated that the son did not attend the review meeting or voice concerns. The MDS Nurse stated that Interdisciplinary Team Members should have invited Resident #61 to the meeting as he was cognitively able to participate in individual plan of care.</p> <p>During an interview on 5/22/25 at 11:30 p.m., the DON stated that she expected Care Plan Meeting to include the resident if he/she were cognitively able to participate in plan of care regardless of whether or not the family member was informed of the meeting.</p> <p>During an interview on 5/22/25 at 11:50 a.m., ADMIN stated her expectation was for IDT (Interdisciplinary Team) members involve residents who were alert and able to participate in the care plan review meetings.</p> <p>Record review of Care Plan Signature sheets revealed that the last time Resident #61 attended a Care Plan meeting was August 2024.</p> <p>(continued on next page)</p>		

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<p>F 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy titled, Facility Manual, Revised 7/14/2020, Resident Rights, Admissions Policy revealed, .the resident and his or her Representative are encouraged to participate in the resident's assessment and in the development and implementation of the resident's care plan .The facility will inform the resident, legal representative, responsible party, or other appropriate person in advance of the time and place of this conference.</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51512</p> <p>Based on observation, interview, and record review, the facility failed to ensure the use of the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints for 1 of 1 (Resident #81) residents reviewed for restraints.</p> <p>The facility failed to provide assessment, care planning, and ongoing re-evaluation of the use of a seatbelt restraint for Resident #81.</p> <p>Findings included:</p> <p>Record review of Resident #81's face sheet dated 5/20/2025 revealed a [AGE] year old female, initially admitted to the facility on [DATE]. Relevant diagnoses included Lennox-Gastaut Syndrome (a severe disorder characterized by multiple seizure types and cognitive and behavioral problems); dependence on wheelchair; aphasia (difficulties with speech); and gastrostomy status (a surgical opening in the abdomen to allow for the intake of food and medication directly into the stomach).</p> <p>Review of Resident #81's quarterly MDS assessment dated [DATE] revealed the BIMS score was not assessed due to the resident's communication deficits. Resident #81 was assessed as not using a trunk restraint.</p> <p>Record review of Resident #81's comprehensive care plan revealed the following related to the seatbelt restraint:</p> <p>a. Problem: [Resident #81] is at risk for falls r/t seizures, poor safety awareness, confusion (date initiated: 12/01/2024). Interventions: Make sure resident has hear seat belt on when she sits up in her wheelchair; she has a medical need for it (date initiated 12/02/2024).</p> <p>b. Problem: [Resident #81] has a seizure disorder and wears a soft helmet and has a wheelchair seat belt for safety (date initiated 12/11/2024). Interventions: Ensure [Resident #81]'s seat belt is in place when she is in her wheelchair for her safety related to falls. Respect her right to refuse to wear (date initiated 04/02/2025). Restraint assessment related to wheelchair belt per facility policy date initiated 04/02/2025.</p> <p>The comprehensive care plan did not include interventions to prevent and address any risks related to the use of the restraint, how to meet the needs of the resident during periods of restraint, monitoring/supervision to be provided during the use of the restraint, or parameters for release of the restraint.</p> <p>A review of active physician's orders did not reveal an order to apply the seatbelt restraint or parameters for monitoring or removal.</p> <p>Record review of Resident #81's MAR and TAR for May 2025 revealed scheduled tasks as follows:</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>a. Resident to wear seatbelt when out of bed; it benefits outweigh any risks [sic]/every shift (start date 3/27/2025 10:00 PM, discontinue date 5/16/2025 9:37 AM)</p> <p>b. Resident to wear seatbelt in wheelchair when out of bed; benefits outweigh risks/every shift (start date 5/21/2025 10:00 PM)</p> <p>No additional monitoring or directives for the seatbelt were contained within the MAR or TAR.</p> <p>Review of all assessments documented in the EMR from Resident #81's admission on 11/29/2024 through the survey date did not reveal an assessment specifically related to restraint use. The skilled nursing assessment documented on 5/21/2025 by the ADON was reviewed to determine if this assessment included restraints, but it was not revealed to be an topic covered by this assessment.</p> <p>A scanned document dated 12/2/2024 titled physical restraint/DME/monitoring device consent revealed a checkbox for physical restraint and a check mark indicating permission for the facility to use restraints as needed in accordance with the resident's comprehensive care plan and physician's order. The area underneath type of restraint to be used (list only one) was not filled in with the type of restraint. This document was signed by the resident's mother and the ADON.</p> <p>An additional scanned document titled Pre-restraint Assessment/Screening, dated 11/29/2024, listed a diagnosis of Lennox-Gastaut Syndrome and type of restraint currently used as seatbelt. The time parameters when used was entered as when placed in w/c. The reason for restraint was documented as seizure disorder and a check mark was documented next to balance problem. In the next section, the document asked, what measures were implemented prior to restraint use? The author documented resident admitted with seatbelt. The recommended plan of action was documented as continue to use seatbelt for seizure disorders to keep resident from falling. This document was signed on 12/2/2024 by the physician and four others identified as the interdisciplinary care team.</p> <p>Resident #81 was observed in her wheelchair wearing the seatbelt restraint on 5/20/2025 at 12:03 PM self propelling through the communal dining areas. She was again observed 5/22/2025 at 9:00 AM in the communal sitting area of the east hall near in her wheelchair with the seatbelt restraint in place, and 5/22/2025 at 1:07 PM in the dining area eating lunch in her wheelchair with the seatbelt restraint in place.</p> <p>During an interview on 5/21/25 at 9:50 a.m., LVN A stated Resident #81 used the seatbelt restraint every time she in the wheelchair. LVN A stated there is a task within the TAR for staff to document the resident is wearing the restraint and that there should be a physician's order for application of the restraint.</p> <p>PT reported in an interview on 5/21/2025 at 11:17 that she did not think Resident #81 could unlatch the seatbelt restraint independently. She stated that the resident's mother was adamant about the use of the seatbelt restraint due to previous falls prior to admission. She reported no concerns about entrapment when Resident #81 has seizures while restrained in the wheelchair and no injuries to the resident related to restraint use since admission.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview conducted on 5/22/2025 at 12:30 PM, the DON explained Resident #81 had been using the wheelchair since admission to the facility due to falls with injury prior to admission, and the restraint use was continued upon admission at the request of the resident's mother. She stated there had been no less restrictive alternatives attempted prior to the use of restraint at the facility. She reported there was no formal documentation process for the supervision and monitoring of the restraint while it is in place, but the staff supervise and monitor the restraint use throughout the day and also by the rounding performed by the DON. She said the seatbelt restraint was only removed at the end of the day, when the resident was going to bed, and she previously made one attempt to perform a test of the resident's ability to independently release the restraint, but the resident refused to participate. The DON stated the need for the seatbelt restraint was periodically re-evaluated but that alternatives were not considered because Resident #81's mother requested continued use. The DON confirmed a physician's order and care planning for the restraint should be present in the EMR.</p> <p>Record review of the facility policy titled Restraints (date implemented 8/15/2022) revealed the following:</p> <ul style="list-style-type: none"> a. Behavioral interventions should be used and exhausted prior to application of a physical restraint. b. Before a resident is restrained, the facility will determine . <ul style="list-style-type: none"> a. How the use of restraints would treat the medical symptom b. The length of time the restraint is anticipated to be used to treatt the medical symptom, who may apply the restraint, and the time and frequency that the restraint will be released. c. The type of direct monitoring and supervision that will be provided during use of the restraint. d. How the resident will request staff assistance and how his/her needs will be met while the restraint is in place c. The resident's record needs to include documentation that less restrictive alternatives were attempted to treat the medical symptom but were ineffective, ongoing re-evaluation of the need for the restraint, and the effectiveness of the restraint in treating the medical symptoms. The care plan should be updated accordingly to include the development and implementation of interventions, to address any risks related to the use of the restraint. d. The . resident's representative may request the use of a physical restraint, however the facility is responsible for evaluating the appropriateness of the request. 		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51512</p> <p>Based on observation, interview, and record review, the facility failed to ensure the resident assessments accurately reflected the resident's status for 1 of 8 residents (Resident #81) who were reviewed for resident assessments.</p> <p>The facility failed to document the use of a restraint device in Resident #81's quarterly MDS dated [DATE].</p> <p>This failure could place residents at risk of improper or incorrect care and services necessary for their physical, mental, and psychosocial well-being.</p> <p>Findings included:</p> <p>Record review of Resident #81's face sheet dated 5/20/2025 revealed a [AGE] year old female, initially admitted to the facility on [DATE]. Relevant diagnoses included Lennox-Gastaut Syndrome (a severe disorder characterized by multiple seizure types and cognitive and behavioral problems); dependence on wheelchair; aphasia (difficulties with speech); and gastrostomy status (a surgical opening in the abdomen to allow for the intake of food and medication directly into the stomach). Review of Resident #81's quarterly MDS dated [DATE] revealed a BIMS score was not assessed due to the resident's communication deficits. Question P0100 item E. of the MDS (trunk restraint used in chair or out of bed) was assessed as 0. not used. No active physician order was located within the EMR for application of the seatbelt. Resident #81's comprehensive care plan included an intervention dated 12/02/2024 as follows:</p> <p>Make sure resident has her seat belt on when she sits up in her wheelchair; she has a medical need for it.</p> <p>A scanned document dated 12/2/2024 titled physical restraint/DME/monitoring device consent revealed a checkbox for physical restraint and a check mark indicating permission for the facility to use restraints as needed in accordance with the resident's comprehensive care plan and physician's order. This document was signed by the resident's mother and the ADON.</p> <p>An additional scanned document dated 11/29/2024 titled pre-restraint assessment/screening indicated resident admitted with seatbelt and that the seatbelt would be used for the time parameters when placed in w/c. This document includes a physician's signature and 4 illegible signatures of the interdisciplinary care team.</p> <p>Resident #81 was observed in her wheelchair wearing the seatbelt on 5/20/2025 at 12:03 PM, 5/22/2025 at 9:00 AM, and 5/22/2025 at 1:07 PM.</p> <p>LVN A reported in an interview 5/20/2025 at 9:50 AM that Resident #81 uses the seatbelt device every time that she is in her wheelchair.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with the MDS Nurse on 5/21/2025 at 3:29, she explained data used to complete the restraint section Resident #81's quarterly MDS was obtained from the MAR. As the MAR did not include an order for staff to apply the seatbelt/restraint, the assessment regarding restraint use was documented as no. She also reported awareness that Resident #81 has used the seatbelt since admission.</p> <p>A document titled Restraint and Involuntary Seclusion located within a facility manual titled Facility Manual revealed use of restraints and their release must be documented in the clinical record.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51512</p> <p>Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's needs for 1 of 8 (#81) residents reviewed for comprehensive resident centered care.</p> <ol style="list-style-type: none"> The facility failed to provide care planning for the use of a wheelchair seatbelt restraint for Resident #81. The facility failed to revise the comprehensive care plan for Resident #81 after hospitalization s resulting from the dislodgement of the resident's g-tube. <p>This failure could lead to residents not receiving the care necessary to meet their highest practicable well-being.</p> <p>Findings included:</p> <p>Record review of Resident #81's face sheet dated 5/20/2025 revealed a [AGE] year old female, initially admitted to the facility on [DATE]. Relevant diagnoses included Lennox-Gastaut Syndrome (a severe disorder characterized by multiple seizure types and cognitive and behavioral problems); dependence on wheelchair; aphasia (difficulties with speech); and gastrostomy status (a surgical opening in the abdomen to allow for the intake of food and medication directly into the stomach). Review of Resident #81's quarterly MDS dated [DATE] revealed a BIMS score was not assessed due to the resident's communication deficits. Question P0100 item E. of the MDS (trunk restraint used in chair or out of bed) was assessed as 0. not used.</p> <ol style="list-style-type: none"> Record review of Resident #81's comprehensive care plan revealed the following related to the seatbelt restraint: <ol style="list-style-type: none"> Problem: [Resident #81] is at risk for falls r/t seizures, poor safety awareness, confusion (date initiated: 12/01/2024). Interventions: Make sure resident has hear seat belt on when she sits up in her wheelchair; she has a medical need for it (date initiated 12/02/2024). Problem: [Resident #81] has a seizure disorder and wears a soft helmet and has a wheelchair seat belt for safety (date initiated 12/11/2024). Interventions: Ensure [Resident #81]'s seat belt is in place when she is in her wheelchair for her safety related to falls. Respect her right to refuse to wear (date initiated 04/02/2025). Restraint assessment related to wheelchair belt per facility policy date initiated 04/02/2025. <p>The comprehensive care plan did not include interventions to prevent and address any risks related to the use of the restraint, how to meet the needs of the resident during periods of restraint, monitoring/supervision to be provided during the use of the restraint, or parameters for release of the restraint.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of active physician's orders did not reveal an order to apply the seatbelt restraint or parameters for monitoring or removal.</p> <p>A scanned document dated 12/2/2024 titled physical restraint/DME/monitoring device consent revealed a checkbox for physical restraint and a check mark indicating permission for the facility to use restraints as needed in accordance with the resident's comprehensive care plan and physician's order. The area underneath type of restraint to be used (list only one) was not filled in with the type of restraint. This document was signed by the resident's mother and the ADON.</p> <p>Resident #81 was observed in her wheelchair wearing the seatbelt restraint on 5/20/2025 at 12:03 PM self propelling through the communal dining areas. She was again observed 5/22/2025 at 9:00 AM in the communal sitting area of the east hall near in her wheelchair with the seatbelt restraint in place, and 5/22/2025 at 1:07 PM in the dining area eating lunch in her wheelchair with the seatbelt restraint in place.</p> <p>In an interview on 5/21/24 at 9:50 a.m., LVN A stated Resident #81 used the seatbelt restraint every time she was in the wheelchair. LVN A stated there is a task within the TAR for staff to document the resident was wearing the restraint and that there should be a physician's order for application of the restraint. She stated the application of the seatbelt restraint is just known by the facility staff. She was not aware of any additional documentation or assessment requirements for the seatbelt restraint.</p> <p>CM Nurse was identified by the facility as responsible for care plans, and she was interviewed on 5/22/2025 at 10:50 AM. She stated the seatbelt restraint is addressed in the problem area of seizure disorder. She stated there was no care planning for the seatbelt as a restraint.</p> <p>In an interview conducted on 5/22/2025 at 12:30 PM, the DON explained Resident #81 had been using the wheelchair since admission to the facility due to falls with injury prior to admission, and the restraint use was continued upon admission at the request of the resident's mother. She stated there had been no less restrictive alternatives attempted prior to the use of restraint at the facility. She reported there was no formal documentation process for the supervision and monitoring of the restraint while it is in place, but the staff supervised and monitored the restraint use throughout the day and also by the rounding performed by the DON. She said the seatbelt restraint was only removed at the end of the day, when the resident was going to bed, and she previously made one attempt to perform a test of the resident's ability to independently release the restraint but the resident refused to participate. The DON stated the need for the seatbelt restraint was periodically re-evaluated but that alternatives were not considered because Resident #81's mother requested continued use. The DON confirmed a physician's order and care planning for the restraint should be present in the EMR.</p> <p>2. Review of Resident #81's quarterly MDS dated [DATE] revealed a BIMS score was not assessed due to the resident's communication deficits.</p> <p>Record review of the resident's comprehensive care plan, date printed 5/20/2025, did not reveal care planning to prevent dislodgement of the g-tube. Further record review of the assigned tasks within the electronic medical record did not reveal a task to check placement / presence of the abdominal binder.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #81's progress notes indicated the resident required hospitalization on [DATE] and 5/15/25 for g-tube replacement. Progress notes did not indicate how the tube became dislodged.</p> <p>Resident #81 was observed on 5/22/2025 at 1:07 PM with the abdominal binder in place.</p> <p>LVN A stated in an interview conducted on 5/21/2025 at 9:50 AM that Resident #81 would occasionally pull on the g-tube, but she had not witnessed Resident #81 intentionally dislodge the device. She stated Resident #81 was wearing an abdominal binder at this time, to prevent dislodgement of the device, and nursing staff would check for placement out of routine. She reported there was no task within the electronic medical record to check for placement.</p> <p>In an interview on 5/22/2025 at 10:50 AM, CP Nurse identified as being primarily responsible for maintaining the care plans for residents. CP Nurse reported her process for updating care plans included running a daily audit report and attendance to daily morning meetings. She stated she had not yet made any updates to Resident #81's care plan regarding potential dislodgement. She also stated she wanted to do more research on the issue to ensure the correct interventions were in place.</p> <p>In an interview with the DON on 5/22/2025 at 12:30 PM, she reported Resident #81 was now wearing an abdominal binder to prevent the g-tube from being dislodged. She stated the staff should be checking fore placement of the abdominal binder, and the task should be present in the electronic medical record to ensure it is completed routinely.</p> <p>Record review of the facility policy titled Restraints (date implemented 8/15/2022) revealed the following:</p> <p>The resident's record needs to include documentation that less restrictive alternatives were attempted to treat the medical symptom but were ineffective, ongoing re-evaluation of the need for the restraint, and the effectiveness of the restraint in treating the medical symptoms. The care plan should be updated accordingly to include the development and implementation of interventions, to address any risks related to the use of the restraint.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26869</p> <p>Based on interviews, and record reviews, , the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 of 4 (#19) residents reviewed for quality of care in that:</p> <p>Resident #19's pacemaker maker, model, and additional information was not documented in his chart.</p> <p>This could affect residents with pacemakers and could result in residents not receiving needed care to maintain optimum health and placing them at risk for injury and/or deterioration in their condition.</p> <p>The Findings were:</p> <p>Record review of Resident # 19's Admission Record dated 5/21/2025 revealed he was admitted on [DATE], age was 83 no diagnosis description was documented for a cardiac pacemaker .</p> <p>Record review of Resident # 19's MDS assessment dated [DATE] revealed the presence of cardiac pacemaker, and he had a BIMS score of 8/15 (moderate cognitive impairment).</p> <p>Resident # 19's care plan dated 5/15/2025 revealed he had a pacemaker related to Atrial fibrillation. The interventions for Resident #19's pacemaker included will remain free from s/sx of pacemaker malfunction or failure through the review date, Monitor VITAL SIGNS as ordered. Notify MD of significant abnormalities. Notify MD of significant abnormalities. Monitor/document/report PRN any s/sx of altered cardiac output or pacemaker malfunction: dizziness, syncope, difficulty breathing (Dyspnea), pulse rate lower than programmed rate, lower than baseline B/P, Pacemaker checks as ordered, resident's Pacemaker information: (no make and model was added).</p> <p>Record review of Resident # 19's consolidated orders for May 2025 nothing related to his pacemaker's make and model.</p> <p>Observation on 5/21/2025 at 4:13 PM with Resident # 19 revealed with his hand pointed to his left chest area, indicating his cardiac pacemaker.</p> <p>During an interview on 5/21/2025 at 4:14 PM with Resident #19, he stated he had a cardiac pacemaker and pointed to his left chest area.</p> <p>During an interview on 5/1/2025 at 4:14 PM, LVN B confirmed that Resident #19 had a pacemaker.</p> <p>During an interview on 5/21/2025 04:59 PM, the DON confirmed Resident #19 had a pacemaker and had the make and model in an email. The DON stated she had not placed the information in Resident #19's record.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/22/2025 at 10:13 AM with the corporate Admin, (SHE) stated there was no pacemaker policy.</p> <p>During an interview on 05/22/25 11:42 AM with the CP, she stated she put in the care plan for the pacemaker on 4/10/25 for Resident #19. The CP stated she added the make and model of the cardiac pacemaker on 5/21/2025.</p> <p>During an interview on 5/22/2025 at 12:57 PM with the DON, she confirmed there was no order for Resident #19's pacemaker. The DON's expectation was that resident devices, such as a pacemaker, would have a physician's order. The DON stated the risk would be not have monitoring and adverse effects, such as heart failure.</p>		

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51512</p> <p>Based on observation, interview, and record review, the facility failed to ensure that residents receive proper treatment and assistive devices to maintain vision abilities for 1 (Resident #12) of 1 residents reviewed for quality of care.</p> <p>The facility failed to provide necessary arrangements to repair broken eyeglasses for Resident #12.</p> <p>This failure could lead to injury and/or decreased quality of life.</p> <p>Findings included:</p> <p>Record review of Resident #12's face sheet dated 5/20/2025 revealed an [AGE] year old male, admitted to the facility on [DATE]. Relevant diagnoses included unsteadiness on feet and muscle wasting and atrophy.</p> <p>Review of Resident #12's quarterly MDS assessment submitted 4/1/2025, reflected a BIMS score of 09, indicating moderately impaired cognition. Resident #12 was assessed as having vision impairment, and the resident required corrective lenses.</p> <p>Record of review of a progress note dated 5/2/2025, written by LSW, revealed the following:</p> <p>One of [Resident #12]'s ear pieces on his glasses is missing. Referred to [optometrist].</p> <p>Record review of a scanned document titled Request for Services/Consultation dated 5/12/2025 revealed a written request for an optometry appointment due to broken eyeglasses and decreased visual acuity.</p> <p>In an interview on 5/20/2025 at 10:10 AM, Resident #12 stated his glasses were broken approximately a month prior. He said he had reported the issue to the facility and was not aware of an appointment to get the glasses fixed. The resident reported difficulty watching television and seeing other objects in the distance but stated he was able to ambulate/use wheelchair and had not fallen or injured himself due to not having glasses.</p> <p>During observation on 5/20/2025 at 10:10 a.m., Resident #12's glasses were observed and noted to be missing both ear pieces required to affix the glasses to the resident's face.</p> <p>In an interview on 5/21/2025 at 10:00 AM. with the LSW, the LSW confirmed awareness of the broken eyeglasses. She did not know the glasses were missing both ear pieces and felt that the glasses were in usable condition when missing only one side piece. She confirmed a referral had been done for an optometry appointment but stated an appointment time had not been set. She estimated the typical timeline from referral to appointment time to be a couple of months and said she could make alternative arrangements for a different optometry provider due to the glasses missing both ear pieces.</p> <p>(continued on next page)</p>		

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a subsequent interview with LSW on 5/22/2025 at 11:00 AM, the LSW reported she had not yet confirmed an optometry appointment. the LSW said she was going to arrange for transportation to take Resident #12 to a different location that would allow for evaluation without an appointment.		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50531</p> <p>Based on observation, resident and staff interviews, and record reviews, the facility failed to ensure that residents' environment remained as free of accident hazards as possible for 1 of 4 residents (Resident #14) reviewed for quality of care.</p> <p>The facility failed to ensure Resident #14 had cushioned hip covers (hipsters) in place at all times.</p> <p>This failure could place residents at an increased risk for injury related to falls.</p> <p>The findings include:</p> <p>Record review of Resident #14's face sheet dated 5/22/25 revealed an [AGE] year-old female admitted [DATE] and readmitted [DATE]. Diagnoses included Alzheimer's dementia (memory loss that affects learning and memory), COPD (Chronic Obstructive Pulmonary Disease, a progressive respiratory condition), Right femur (thigh bone) fracture, Right hip pain, dysphagia, abdominal aortic aneurysm, Bipolar Disorder (mood disorder ranging from depressive lows to manic highs), emphysema (a condition that causes breathlessness), Hypertension, Cardiomegaly, Polyosteoarthritis (arthritis in five or more joints simultaneously).</p> <p>Record review of Resident #14's Quarterly MDS assessment dated [DATE] revealed resident presented with upper and lower extremity range of motion deficits, required moderate assistance in self-feeding, upper body dressing and transfers, and maximum assistance in toileting, bathing, lower body dressing and bed mobility.</p> <p>Record review of Resident #14's BIMS (Basic Interview for Mental Status) assessment dated [DATE] revealed she had a score of 3 indicating severe cognitive impairment.</p> <p>Record review of Resident #14's Comprehensive Care Plan, printed 5/22/25 revealed the resident was at risk for injury related to falls due to osteoporosis (a condition where the bones become thin and weak, increasing the risk of fractures, especially in the spine, hip, and wrist) and one intervention was to wear padded hip protectors to prevent hip fractures.</p> <p>Record review of physician's order dated 12/27/2024 revealed order to Ensure resident is wearing hipsters (cushioned hip protectors) at all times every shift for fall precautions.</p> <p>In observations on 5/20/25 at 10:06 a.m., 5/21/25 at 12:36 p.m., and 5/22/25 at 10:00 a.m., hipsters were not utilized.</p> <p>In an interview on 5/21/25 at 12:40 p.m. with CNA H, CNA H revealed that Resident #14 was supposed to wear hip protectors for safety.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 5/21/25 at 1:49 p.m. with PT G, he revealed that the resident was evaluated on re-admission and padded hip protectors were identified as preventative measures. He stated nursing staff was responsible for placing hip protectors.</p> <p>In an interview with the DON on 5/22/25 at 1:00 p.m., the DON stated that the Charge Nurse was responsible for ensuring hip protectors were utilized and that she (the DON) is ultimately responsible for ensuring ordered devices were utilized. The DON stated she expected the nursing staff to follow the physician's orders. The DON stated that not utilizing hip protectors placed Resident #14 at greater risk for injury related to falls due to debilitating diagnoses.</p> <p>Record review of the facility's policy Fall Prevention, dated [DATE], reflected, It is the policy of this facility to provide an environment that remains as free of accident hazards as possible and provide each resident with appropriate assessment and interventions to minimize complications if a fall occurs.</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51512</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure a medication error rate below 5% for 28 medication administration opportunities with 3 errors resulting in a 10% medication error rate, for 2 of 4 (Residents #1 and #37) reviewed for medication administration.</p> <ol style="list-style-type: none"> The facility failed to ensure Resident #1 received medications Amiodarone (used to regulate rapid and/or irregular heart rhythms) and Apixaban (used to prevent blood clots) as ordered by the physician. The facility failed to ensure Resident #37 received medication Xifaxan (used to treat the brain function decline that can occur secondary to liver damage) as ordered by the physician. <p>These failures could result in residents not receiving the intended therapeutic benefits of medications.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet dated 5/22/2025 revealed an [AGE] year-old female, admitted to the facility on [DATE]. The resident had relevant diagnoses of atrial fibrillation (a condition that causes rapid, irregular heartbeats and can cause blood clots) and cerebral infarction (a blood clot in the brain causing brain damage).</p> <p>Record review of Resident #1's quarterly MDS assessment, submitted 4/23/2025, revealed a BIMS score of 12, indicating moderately impaired cognition.</p> <p>Review of Resident #1's active physician's orders reflected the following:</p> <ol style="list-style-type: none"> Amiodarone Hcl oral tablet 200mg; give 1 tablet by mouth one time a day for arrythmias (order date 4/22/2025) Apixaban oral tablet 2.5mg; give 1 tablet by mouth two times a day for a-fib (order date 4/22/2025) <p>During an observation of medication administration on 5/22/2025 at 9:03 AM for Resident #1, LVN E was observed withholding Apixaban. LVN E confirmed that the medication was not found in the medication cart and was out of stock in the back-up supply within the e-kit.</p> <p>LVN E was interviewed simultaneously to the observation and stated the facility process was to order medications prior to having zero tablets available for administration. Since the medication had not been ordered, she stated she would order it immediately, notify the DON or ADON and the provider, and the resident should receive the next scheduled dose but would not receive that morning dose of Apixaban. Also, during the same observation of Resident #1's medication administration, LVN E was observed withholding Amiodarone after taking Resident #1's blood pressure and receiving a value of 110/79. In an interview performed simultaneously, LVN E stated the resident's blood pressure was below the ordered parameters for the medication, and the medication would not be given.</p> <p>(continued on next page)</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a record review occurring after the observation, it was revealed the physician did not include blood pressure parameters for Amiodarone, as the medication was ordered for treatment of the resident's heart rhythm.</p> <p>Record review of Resident #37's face sheet dated 5/22/2025 revealed a [AGE] year-old female admitted to the facility on [DATE] with a relevant diagnosis of unspecified cirrhosis of liver (progressive damage to the liver inhibiting proper function that leads to decline in brain function).</p> <p>Review of Resident #37's quarterly MDS assessment submitted on 2/28/2025 revealed a BIMS score of 14, indicating intact cognition.</p> <p>Review of Resident #37's active physician orders reflected an order for Xifaxan tablet 550mg; give 1 tablet by mouth two times a day for cirrhosis.</p> <p>During an observation of medication administration for Resident #37 on 5/22/2025 at 9:26 AM, LVN E was unable to locate the Xifaxan for administration. In a simultaneous interview, LVN E stated the medication should have been ordered prior to having zero tablets available for administration. She also reported that medication was not included in the facility's stock on back-up medications for emergencies, so she would re-order and notify the DON or ADON as well as the provider.</p> <p>In an interview with the DON on 5/22/2025 at 9:10 AM, the DON stated the facility used a local pharmacy in order to receive out of stock medications needed for administration. She said the medications would be received the same day. The DON also confirmed the medications should have been ordered prior so the residents did not miss an ordered dose.</p> <p>Review of the facility policy titled Medication Administration (implemented 10/24/2022) revealed on page 1, item 1. keep medication cart . stocked with adequate supplies. Item 8. stated obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters (emphasis added for clarity).</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>26869</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure Food safety requirements to prepare, distribute and serve food in accordance with professional standards for food service safety for 1 of 5 (Cook D) kitchen staff working that day, in that:</p> <p>Cook D's beard/mustache restraint was off and exposed his thin mustache, while taking food temperatures on the steam table.</p> <p>This failure could place residents at risk for food borne illness.</p> <p>The Findings were:</p> <p>Observation on 5/21/2025 at 11:47 PM with [NAME] D, during food temperature observations on the steam table, [NAME] D was wearing a beard guard that had fallen and exposed his thin mustache.</p> <p>During an interview on 5/21/2025 at 11:50 PM with [NAME] D, he stated he had the beard restraint on, and it had fallen and was not covering his thin mustache.</p> <p>During an interview on 5/21/2025 at 11:52 PM, the Dietician stated [NAME] C should have had the hair restraint over his mustache as well.</p> <p>During an interview on 5/22/2025 10:42 AM, the Dietary Manager stated staff should wear hair restraints to cover hair while in the kitchen. The Dietary Manager stated exposed hair from staff, while in the kitchen, could fall on food, contaminate the food that could influence residents by causing food illness.</p> <p>During an interview on 5/22/2025 at 12:40 PM the Admin stated the staff told her the beard/mustache restraint had fallen while taking food temperature over the steam table. The Admin stated the Dietary Manager in-serviced the kitchen staff, including [NAME] C. The Admin stated the risk would be that hair can get into food or items around the kitchen.</p> <p>Record review of the Food Code, U.S. Public Health Service, U.S. FDA , 2017, U.S. Department of H&HS, 2-402.11, revealed, (A) Except as provided in (B) of this section, Food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single service and single-use articles.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51512</p> <p>Based on observation, interview, and record review, the facility failed to handle and transport linens so as to prevent the spread of infection and to maintain an infection prevention and control program to provide a safe and sanitary environment to help prevent the development and transmission of communicable diseases and infections for 3 of 7 residents (Residents #15, 75 and 139) reviewed for infection control.</p> <ol style="list-style-type: none"> The facility failed to ensure staff put soiled linen of Residents #15 and #75 into a container or bag prior to transporting. The facility failed to ensure staff utilized PPE when providing high-contact care for Resident #139, whom was identified as requiring EBP. <p>These failures could lead to the spread of infection and illness.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Record review of Resident #15's face sheet dated 5/21/2025 revealed a [AGE] year-old male admitted to the facility on [DATE] with relevant diagnoses that included need for assistance with personal care and gastrostomy (surgical opening in the abdomen allowing for intake of food/medications directly into the stomach). Review of the resident's quarterly MDS submitted on 2/19/2025 indicated the MDS was not assessed due to communication deficits. <p>On 5/22/2025 at 6:41 AM, CNA C was observed carrying a blue blanket and a clear bag containing other linen down the hallway with bare hands. The blanket was not contained inside of a bag. CNA C entered the room where the facility stored soiled linen and returned to the hallway without the items.</p> <p>CNA C was immediately interviewed following the observation, at 6:42 AM. CNA C stated the facility policy is to put linen into a bag prior to transporting, but she did not due to the size of the blanket. She reported there are bags large enough to accommodate bigger items but she did not have one immediately available so she carried it unbagged. CNA C reported ongoing training regarding infection prevention and control, and she stated carrying soiled linen in the hallway could cause the spread of infection.</p> <p>Record review of Resident #75's face sheet dated 5/22/2025 revealed a [AGE] year-old female admitted to the facility on [DATE] with a relevant diagnosis of spina bifida (a congenital defect of the spinal cord). Review of the resident's quarterly MDS submitted 2/19/2025 reflected a BIMS score of 15, indicating intact cognition.</p> <p>On 5/21/2025, the LSC team observed CNA F removing soiled linen from Resident #75's room. CNA F threw the linen from the room into the hallway, then picked up the unbagged linen with bare hands and took it to the soiled storage area. CNA F was not observed performing hand hygiene after this task. CNA F left the facility before the health survey team could perform an interview.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455796	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2025
NAME OF PROVIDER OR SUPPLIER Town and Country Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 625 N Main St Boerne, TX 78006	

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 5/22/2025 with the DON/Assistant Infection Preventionist, she reported that staff are expected to put soiled linen into plastic bags prior to transporting. She also reported that larger sized plastic bags are available for use by staff and that staff are expected to perform hand hygiene after handling soiled linen. She indicated the risk to residents of not properly handling soiled linen was infection and cross contamination.</p> <p>Record review of the facility policy Infection Prevention and Control Program implemented 5/13/2025 revealed soiled linen shall be collected at the bedside and placed in a bag. When the task is complete, the bag shall be closed securely and placed in the soiled utility room/laundry barrel.</p> <p>2. Record review of Resident # 139's Admission record dated 5/22/2025 was documented he was admitted on [DATE] with diagnoses of dementia (a term for a group of brain disorders that cause a decline in thinking, memory, and reasoning abilities, significantly impacting daily life), epilepsy (a neurological disorder that causes recurrent, unprovoked seizures.), cognitive communication deficit and gastrostomy status (typically refers to its functionality and the presence or absence of any complications).</p> <p>Record review of Resident # 139's consolidated orders for May 2025 was documented he had an order for every shift Jevity 1.5 at 60 ml/hr 22 hours via g-tube stationary pump, Check for residual every shift. If residual is greater than 100cc - hold feeding for one hour and recheck. if residual continues to be greater than 100cc - call MD, Enteral Feed Order every 4 hours Flush tube with 150 ml of water and Enteral Feed Order every 4 hours Flush tube with 150 ml of water.</p> <p>Record review of Resident # 139's MARs for May 2025 he was administered Check for residual every shift. If residual is greater than 100cc - hold feeding for one hour and recheck. if residual continues to be greater than 100cc - call MD, Enteral Feed Order every 4 hours Flush tube with 150 ml of water and Enteral Feed Order every 4 hours Flush tube with 150 ml of water.</p> <p>Record review for Resident #139's initial nursing assessment dated on 5/8/2025 was documented he had a G-tube on abdominal area.</p> <p>Record review of Resident # 139's care plan dated 6/2/2025 on was documented he had potential for malnutrition related to per tube feeds.</p> <p>Observation on 5/21/2025 at 3:51 PM of LVN J upon observing an administration of medication via g-tube the LVN J walked into Resident #139's room, CNA K was in the room with no PPE and had just gotten done with providing care to resident. Observation of Resident #139's door was posted a sign about TBP and what PPE to wear.</p> <p>During an interview on 5/21/2025 at 3:52 PM, LVN J stated she did not realize CNA K did not wear PPE while bathing Resident # 139. LVN J stated CNA K should have been wearing PPE, gown, gloves, mask while providing care to Resident #139, because he was on TBP for G-tube and catheter.</p> <p>During an interview on 5/21/2025 at 4:06 PM with CNA K, was in Resident # 139's room proving a bed bath. CNA K stated he was in a hurry and forgot to put on his PPE, gown, gloves and mask.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/22/25 12:48 PM with DON stated risk for staff not wearing PPE and expectation was for staff to wear PPE (gown, gloves, mask) while providing care to resident on TBP. DON stated there are postings in front of resident doors, a PPE cart and staff had been trained on infection control and when to wear PPE. DON stated the risk would be cross contamination.</p> <p>The facility provided the survey team with information printed from the Center Disease Control website when asked for a policy regarding transmission-based precautions. This page, titled Transmission-Based Precautions revealed a recommendation of wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment.</p>