STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675371	A. Building B. Wing	03/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverview Nursing & Rehabilitation	1102 River Rd 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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48366 Based on interviews, observation, and record reviews, the facility failed to protect residents' rights to be free from verbal abuse, physical abuse, and involuntary seclusion for 7 (Resident #1, 2, 3, 4, 5, 6, and 7) of 12 residents reviewed for abuse and neglect, in that: 1. Residents #2, 5, and 6 were pinched, pulled, and told bad words by CNA A on 01/11/24. 2. CNA A was arguing with Resident #4 in a disrespectful manner on 01/11/24. 3. CNA A was physically aggressive with Resident #7 on 01/11/24 4. Residents #1 and #3 revealed CNA A verbally abused them, undated. The noncompliance was identified as past noncompliance IJ (Immediate Jeopardy). The noncompliance began on 01/11/24 and ended on 01/12/24. The facility had corrected the noncompliance before the investigation began. The facility implemented interventions to prevent further abuse and neglect risks to include educating staff about abuse, neglect, exploitation, performing resident safe surveys to ensure safety of residents, and terminating the alleged perpetrator. This failure could affect all residents at the facility by placing them at risk for physical, mental, and emotional decline, psychosocial harm, and can lead to residents being at risk for harm and injury. The findings included: 1. Record review of Resident #2's face sheet revealed Resident #2 was a female initially admitted to the facility on [DATE] and readmitted [DATE]. Resident #2 had diagnoses to include major depressive disorder, anxiety disorder, altered mental status, dementia (loss of cognitive functioning that interferes with daily life and activities), and unspecified pain. Record review of Resident #2's BIMS report, completed 10/18/23, revealed resident had a BIMS of 03 out of 15, which signified severe cognitive impairment. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record Review of Resident #2's Nursing progress note, dated 01/11/24 at 05:09 PM, revealed a head-to-toe assessment with a slight discoloration identified on resident's left forearm identified. The MD and RP were notified. Record review of Resident #5's face sheet revealed Resident #5 was a female initially admitted to the facility on [DATE]. Resident #5 had diagnoses to include depression, cognitive communication deficit, anxiety disorder, restlessness and agitation, and mild cognitive impairment. Record review of Resident #5's BIMS report, completed 01/08/24, revealed resident had a BIMS of 03 out of 15, which signified severe cognitive impairment. Record Review of Resident #5's Nursing progress note, dated 01/11/24 at 05:05 PM, revealed a head-to-toe assessment with no skin concerns identified. The MD and RP were notified. Record review of Resident #6's face sheet revealed Resident #6 was a female initially admitted to the facility on [DATE]. Resident #6 had diagnoses to include major depressive disorder, cognitive communication deficit, anxiety disorder, and Alzheimer's disease (brain disorder that causes problems with memory, thinking, and behavior). Record review of Resident #6's BIMS report, completed 12/26/23, revealed resident had a BIMS of 02 out of 15, which signified severe cognitive impairment. Record Review of Resident #6's Nursing progress note, dated 01/11/24 at 05:07 PM, revealed a head-to-toe assessment with no skin concerns identified. The MD and RP were notified. Record Review of Accident/Incident Investigation Witness Statement on 01/11/24, written by NA E in regard to Residents #2, 5, and 6, reflected I report [CNA A] since today she was quite rude and abusive person with the residents, pinching them, pulling them to sit in their place, fighting with them and telling them bad words just because they were not letting her change their briefs. She doesn't let them walk in the hallway and wants to keep them sitting. Since 3:30 pm she took them to the dining room while they were trying to watch a movie. I told her it was too early for food and she got angry. I immediately reported it to my nurse. Attempted interview on 03/06/24 at 10:35-10:40 AM with Resident #2 and #6 with no success due to improper responses. Resident #5 was not in the facility for an interview. 2. Record review of Resident #4's face sheet revealed Resident #4 was a female initially admitted to the facility on [DATE]. Resident #4 had diagnoses to include dementia (loss of cognitive functioning that interferes with daily life and activities), unspecified hip pain, altered mental status, and hearing loss. Record review of Resident #4's BIMS report, completed 12/28/23, revealed resident had a BIMS of 07 out of 15, which signified severe impairment. Record Review of Resident #4's Nursing progress note, dated 01/11/24 at 05:06 PM, revealed a head-to-toe assessment with no skin concerns identified. The MD and RP were notified. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record Review of Accident/Incident Investigation Witness Statement on 01/11/24, written by MA H, reflected I was helping a resident to seat down in the tv room when [CNA A] was arguing in a [disrespectful] manner to the [Resident #4]. I told the CNA to not treat the resident that way. I immediately reported to my nurse. Attempted interview on 03/06/24 at 10:35-10:40 AM with Resident #4 with no success due to improper responses. 3. Record review of Resident #7's face sheet revealed Resident #7 was a female initially admitted to the facility on [DATE]. Resident #4 had diagnoses to include recurrent depressive disorders and unspecified pain. Record review of Resident #7's BIMS report, completed 10/18/23, revealed resident had a BIMS of 02 out of 15, which signified severe impairment. Record Review of Resident #7's Nursing progress note, dated 01/11/24 at 05:07 PM, revealed a head-to-toe assessment with no skin concerns identified. The MD and RP were notified. Record Review of Accident/Incident Investigation Witness Statement on 01/11/24, written by the Activities Director, reflected At 4:30 pm on 1/11 I witnessed [CNA A] aggressively shove a baby doll into [Resident #7] arms and forcefully sit her down. I then reported to ADON. Resident #7 was not in the facility for an interview. 4. Record review of Resident #1's face sheet revealed that Resident #1 was a male initially admitted to the facility on [DATE] and readmitted [DATE]. Resident #1 had diagnoses to include major depressive disorder, anxiety disorder, and unspecified pain. Record review of Resident #1's BIMS report, completed 01/30/24, revealed resident had a BIMS of 12 out of 15, which signified moderate cognitive impairment. Record review of Resident #3's face sheet revealed that Resident #3 was a male initially admitted to the facility on [DATE] and readmitted [DATE]. Resident #3 had diagnoses to include depression and anxiety disorder. Record review of Resident #3's BIMS report, completed 02/27/24, revealed resident had a BIMS of 13 out of 15, which signified intact cognition. During an interview on 03/06/24 at 10:42 AM, LVN B revealed CNA A was not physically or verbally abusive towards residents. LVN B mentioned residents would complain about not being able to understand CNA A and CNA A needed to speak more clearly when providing care with residents for them to not be confused and accepting of care. After 01/11/24 incidents of abuse from CNA A, LVN B revealed he reported to ADON prior behaviors he witnessed from other residents to CNA A due to their frustration with the miscommunication and care they would receive from CNA A. He further revealed this may have caused CNA A's inappropriate responses to the residents, which were unacceptable. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 03/06/24 at 10:57 AM, Resident #1 revealed CNA A was not good and she yelled at him multiple times. Resident #1 revealed he told a nurse (he could not recall their name) and the administrator about CNA A, but they did not do anything about it. He further revealed CNA A yelled at other residents too. During an interview on 03/06/24 at 11:25 AM, MA C revealed CNA A would overwhelm residents due to language barrier and not slowing down to speak with residents. MA C educated CNA A on the job about not overwhelming residents before it would escalate into a problem. MA C further revealed CNA A probably should not have worked in the women's secured unit based on her interactions with CNA A. MA C further revealed she could have written this complaint, had it addressed, and would do this in the future. During an interview on 03/06/24 at 03:22 PM, the ADON revealed 3 residents (2 out of the 3 residents were still at the facility) did not want CNA A to care for them. The ADON further revealed she did not ask why these residents did not want CNA A to be caring for them. The ADON was not able to provide any documentation that showed Residents #1 and #3 had complaints/grievances about CNA A. During an interview on 03/07/24 at 09:22 AM, CNA G revealed Resident #1 reported he did not want CNA A to care for him. CNA G did not ask why Resident #1 felt this way about CNA A, but shared this information with the ADON. CNA G further revealed she could have helped Resident #1 fill out a grievance form to address his complaint. During an interview on 03/08/24 at 10:22 AM, Resident #3 revealed CNA A yelled at him and he did not want CNA A to be in his area. He could not express how he felt during the interview, but he told a CNA, the ADON, and the Administrator D about CNA A but Administrator D didn't do anything about it. During an interview on 03/06/24 at 09:40 AM, the ADON revealed NA E came to Administrator D about abuse on 01/11/24. After this, the ADON interviewed staff about CNA A and 2 other staff (the Activities Director and MA H) confessed more incidents involving CNA A exhibiting abusive behaviors. The ADON revealed CNA A was immediately suspended pending investigations. During an interview on 03/06/24 at 10:13 AM, CNA F revealed CNA A had little patience with residents and should probably not have worked with the individuals in the women's secure unit. CNA F recalled since November 2023 CNA A would be more aggressive with residents in the women's secure unit and should have been more patient. CNA F revealed she had to tell CNA A to calm down with the residents. CNA F reported to her nurse about CNA A's behavior. CNA F further revealed residents would complain to CNA F about CNA A not being nice to them. CNA F further revealed she did not observe any abuse. CNA F could not remember any resident names, nurse names, or specific dates. CNA F revealed she had been trained after this incident on Abuse, Neglect, and Exploitation and was aware to contact the Administrator. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 03/06/24 at 10:42 AM, LVN B revealed CNA A was not physically or verbally abusive towards residents. LVN B mentioned residents would complain about not being able to understand CNA A and CNA A needed to speak more clearly when providing care with residents for them to not be confused and accepting of care. After 01/11/24 incidents of abuse from CNA A, LVN B revealed he reported to ADON prior behaviors he witnessed from other residents to CNA A due to their frustration with the miscommunication and care they would receive from CNA A. He further revealed this may have caused CNA A's inappropriate responses to the residents, which were unacceptable. LVN B revealed he had been trained and was aware of letting ADON, DON, and the Administrator know of suspected abuse, neglect, and exploitation. During an interview on 03/06/24 at 04:17 PM, MA H revealed she was passing out medications when she observed CNA A was impatient and had inappropriate tone/behavior [MA H did not reveal any arguing]. MA H further revealed she had not seen CNA A act like this towards residents before, but she had expressed stress with residents in the past. MA H revealed NA E came to her after NA E saw CNA A pinching residents when CNA A thought NA E was not looking. MA H further revealed NA E expressed she did not know what to do. After this conversation, MA H revealed she went with NA E to report to the nurse and the ADON. MA H was unable to identify the nurse that was working. MA H revealed she had been trained after incident and was aware of reporting abuse, neglect, and exploitation to the Administrator. During a combined interview on 03/07/24 at 09:49 AM with the Administrator and the ADON, the ADON revealed last week staff were trained on abuse, neglect, and exploitation. The Administrator showed documentation of safe surveys being done for every resident. Agency staff or anyone who comes into work for the facility is trained on abuse, neglect, and exploitation and reporting prior to working their shift. The Administrator and the ADON revealed agency staff and new staff members are trained on Abuse, Neglect, Exploitation and Reporting Incidents before they worked with residents. During an interview on 03/07/24 at 01:06 PM the Administrator and the ADON ensured staff are assessing residents to make sure they are safe in the facility. The Administrator revealed he will also check in with staff regularly to ensure they are aware of the facility's abuse, neglect, and exploitation policy. The following were interviews showing staff as educated on the Abuse, Neglect, and Exploitation policy: During an interview on 03/06/24 at 03:08 PM, the Director of Rehab, PT O, and OT P identified what abuse, neglect, and exploitation was and to report to the Administrator if they had any concerns. During an interview on 03/06/24 at 03:10 PM, the DM revealed he trained his staff on Abuse, Neglect, and exploitation and the Administrator is the Abuse Coordinator. During an interview on 03/07/24 at 02:50 PM LVN M shared examples of abuse and how to report abuse, neglect, and exploitation. He further revealed nurses are mandated reporters and he would report it to the state as well During an interview on 03/07/24 at 02:59 PM, LVN L identified examples of abuse, neglect, and exploitation and knew to report to the ADON, the DON, and the Administrator. She further revealed she will report to the state if she did not feel heard. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 03/07/24 at 03:01 PM, NA N revealed she was trained on abuse, neglect, and exploitation and knew the Administrator was the Abuse Coordinator. During an interview on 03/08/24 at 12:12 PM, HSK I, HSK J, and HSK K were able to identify what abuse, neglect, and exploitation were and knew to report straight to the administrator if they had any suspicion of residents being mistreated. During an interview on 03/07/24 at 04:01 PM, Human Resources revealed CNA A was suspended 1/11/24 and did not physically come into the facility. CNA A's time sheet revealed she clocked in on 01/16/24, 01/17/24, and 01/18/24. She further revealed the facility cannot terminate an employee until their Paid Time Off was paid out. Unable to connect with NA E via telephone on 03/22/24 at 12:17 PM and 04:25 PM. Observations from 03/05/24 through 03/08/24 revealed no incidents of abuse, neglect, exploitations. Observations revealed interactions between staff and residents yielded appropriate care with no deficiencies noted. Record Review of the facilities investigation report revealed NA E and MA H reported incidents involving CNA A to ADON at 04:15 PM. CNA A was immediately suspended. The facility reported to [state agency] at 07:28 PM. Record Review of 16 Resident Safe Surveys for the residents in the women's secure unit on 01/11/24 revealed compliance with the abuse, neglect, exploitation facility policy because residents reported feeling safe in the facility. Record Review of Residents #2. 4, 5, 6, and 7 revealed trauma-informed assessments were done 01/17/24 and staff requested evaluation for mental health by psychiatry. Record Review of the in-service attendance sheet, dated 01/12/24, presented by the ADON, revealed a topic of ABUSE/NEGLECT that included reviewing facility policies Abuse Prevention Program and Preventing Resident Abuse. Record review revealed 100% of the regular staff was trained, including Agency Staff that was available. Record Review of CNA A's human resources packet revealed CNA A was hired 04/14/23 and suspended 01/11/24. Record review of CNA A's Timesheet showed hours for 01/16/24, 01/17/24, and 01/18/24, to pay out her PTO(paid time off) although not physically worked. During a combined interview on 03/08/24 at 12:28 PM with the ADON and the Administrator, the ADON revealed staff got trained on grievances/complaints upon hire and yearly. The Administrator revealed he will combine training on grievances along with abuse, neglect, exploitation training. The Administrator further revealed he will train the staff to document all relevant concerns so he can solve any grievances or complaints that residents may have. The Administrator further revealed he believed addressing grievances/complaints prevented issues like abuse, documented any concerns, and monitored any possible trends. Record Review of the facility's Abuse Prevention Program policy, revised January 2011, revealed: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Policy Statement: Our residents have the right to be free from abuse, neglect, misappropriation of resident property, corporal punishment, and involuntary seclusion . 1. Our facility is committed to protecting our residents from abuse by anyone including, but not necessarily limited to: facility staff . 3. Comprehensive policies and procedures have been developed to aid our facility in preventing abuse, neglect, or mistreatment of our residents. Our abuse prevention program provides policies and procedures that govern, as a minimum: c. Identification of occurrences and patterns of potential mistreatment/abuse; f. Timely and thorough investigations of all reports and allegations of abuse . Record Review of the facility's Preventing Resident Abuse policy, revised November 2010, revealed: 1. The facility's goal is to achieve and maintain an abuse-free environment. 2. Our abuse prevention/intervention program includes, but is not necessarily limited to, the following: a. Training all staff and practitioners how to resolve conflicts appropriately. q. Encouraging all personnel, residents, family members, visitors, etc., to report any signs or suspected incidents of abuse to facility management immediately. The noncompliance was identified as past noncompliance IJ (Immediate Jeopardy). The noncompliance began on 01/11/24 and ended on 01/12/24. The facility had corrected the noncompliance before the investigation began. The facility implemented interventions to prevent further abuse and neglect risks to include educating staff about abuse, neglect, exploitation, performing resident safe surveys to ensure safety of residents, and terminating the alleged perpetrator.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48366 Based on interviews and record reviews the facility failed to ensure 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 for 2 of 10 residents (Resident #1 and #3) reviewed for allegations of abuse, neglect, exploitation, and mistreatment, in that: The facility failed to report to the State Survey Agency on behalf of Residents #1 and #3 when the residents reported not wanting care from CNA A, which was further revealed to be due to verbally abusive behavior by CNA A. This failure could place residents who reside in the facility at risk for abuse, neglect, exploitation. The findings included: Record review of Resident #1's face sheet revealed that Resident #1 was a male initially admitted to the facility on [DATE] and readmitted [DATE]. Resident #1 had diagnoses to include major depressive disorder, anxiety disorder, and unspecified pain. Record review of Resident #1's BIMS report, completed 01/30/24, revealed resident had a BIMS of 12 out of 15, which signified moderate cognitive impairment. Record review of Resident #3's face sheet revealed that Resident #3 was a male initially admitted to the facility on [DATE] and readmitted [DATE]. Resident #3 had diagnoses to include depression and anxiety disorder. Record review of Resident #3's BIMS report, completed 02/27/24, revealed resident had a BIMS of 13 out of 15, which signified intact cognition. During an interview on 03/06/24 at 10:42 AM, LVN B revealed CNA A was not physically or verbally abusive towards residents. LVN B mentioned residents would complain about not being able to understand CNA A and CNA A needed to speak more clearly when providing care with residents for them to not be confused and accepting of care. After 01/11/24 incidents of abuse from CNA A, LVN B revealed he reported to ADON prior behaviors he witnessed from other residents to CNA A due to their frustration with the miscommunication and care they would receive from CNA A. He further revealed this may have caused CNA A's inappropriate responses to the residents, which were unacceptable. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/06/24 at 10:57 AM, Resident #1 revealed CNA A was not good and she yelled at him multiple times. Resident #1 revealed he told a nurse (he could not recall their name) and the administrator about CNA A, but they did not do anything about it. He further revealed CNA A yelled at other residents too. During an interview on 03/06/24 at 11:25 AM, MA C revealed CNA A would overwhelm residents due to language barrier and not slowing down to speak with residents. MA C educated CNA A on the job about not overwhelming residents before it would escalate into a problem. MA C further revealed CNA A probably should not have worked in the women's secured unit based on her interactions with CNA A. MA C further revealed she could have written this complaint, had it addressed, and would do this in the future. During an interview on 03/06/24 at 03:22 PM, the ADON revealed 3 residents (2 out of the 3 residents were still at the facility) did not want CNA A to care for them. The ADON further revealed she did not ask why these residents did not want CNA A to be caring for them. The ADON was not able to provide any documentation that showed Residents #1 and #3 had complaints/grievances about CNA A. During an interview on 03/07/24 at 09:22 AM, CNA G revealed Resident #1 reported he did not want CNA A to care for him. CNA G did not ask why Resident #1 felt this way about CNA A, but shared this information with the ADON. CNA G further revealed she could have helped Resident #1 fill out a grievance form to address his complaint. During an interview on 03/08/24 at 10:22 AM, Resident #3 revealed CNA A yelled at him and he did not want CNA A to be in his area. He could not express how he felt during the interview, but he told a CNA, the ADON, and the Administrator D about CNA A but Administrator D didn't do anything about it. During a combined interview on 03/08/24 at 12:28 PM with the ADON and the Administrator, the ADON revealed staff got trained on grievances/complaints upon hire and yearly. The Administrator revealed he will combine training on grievances along with abuse, neglect, exploitation training. The Administrator further revealed he will train the staff to document all relevant concerns so he can solve any grievances or complaints that residents may have. The Administrator further revealed he believed addressing grievances/complaints prevented issues like abuse, documented any concerns, and monitored any possible trends. Record review of the facility's grievances/complaints in the last 6 months (October 2023-March 2024) showed no grievances or complaints pertaining to CNA A. There were no grievances or complaints in December 2023 and January 2024. Record Review of the facility's Preventing Resident Abuse policy, revised November 2010, revealed: 1. The facility's goal is to achieve and maintain an abuse-free environment. 2. Our abuse prevention/intervention program includes, but is not necessarily limited to, the following: q. Encouraging all personnel, residents, family members, visitors, etc., to report any signs or suspected incidents of abuse to facility management immediately.