

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675371	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/19/2024
NAME OF PROVIDER OR SUPPLIER Riverview Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</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** 27520</p> <p>Based on observation, interview and record review revealed the facility failed to ensure the resident environment remained as free of accident hazards as is possible for 1 of 12 Residents (Resident #1) whose records were reviewed for smoking.</p> <p>1. The facility staff failed to ensure Residents did not have access to smoking paraphernalia. Resident #1 obtained a lighter, set a piece of paper on fire in his room while his oxygen concentrator was on.</p> <p>An Immediate Jeopardy (IJ) was identified on 08/17/2024. The IJ template was provided to the facility on [DATE] at 04:59 P.M While the IJ was removed on 08/19/2024, the facility remained out of compliance at a scope of Isolated and a severity level of no actual harm with the potential for more than minimal harm because all staff had not been trained on smoking policies.</p> <p>2. The facility staff failed to have a smoking sign identifying the designated smoking area and failed to have metal ashtrays resulting in residents disposing of the cigarette butts on the ground.</p> <p>These deficient practices could affect any resident who smoked and other residents in the near vicinity by exposing them to a fire which could have resulted in injury and or death.</p> <p>The findings were:</p> <p>Review of Resident #1's face sheet, dated 8/17/24, revealed he was admitted to the facility on [DATE] with diagnoses including Chronic obstructive pulmonary disease with (acute) exacerbation (Primary), Pneumonia, unspecified organism (Admission), Heart failure, unspecified, Hypertensive heart disease with heart failure, and Unspecified right bundle-branch block. Further review revealed Resident #1 was discharged from the facility on 8/13/24,</p> <p>Review of Resident #1's smoking assessment completed on 6/12/24 revealed he smoked cigarettes and was assessed as being a safe smoker.</p> <p>Review of Resident #1's quarterly MDS assessment, dated 6/27/24, revealed his BIMS was 13 indicating he had minimal cognitive impairment, he did not have behavior or mood indicators, used a walker for ambulation and he was receiving an antidepressant and hypnotic medications. Further review revealed he was not receiving oxygen during this assessment period.</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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #1's Care Plan, updated on 8/8/24, revealed he had potential for complications related to: Pneumonia. An approach was to Administer oxygen as ordered. Observe oxygen precautions.; Resident had episodes of anxiety and was at riskor fluctuations in moods. An approach was to monitor and record any abnormal behaviors and or moods.</p> <p>Review of Resident #1's consolidated physician orders revealed he had an order for oxygen, 2-5 Liters per minute for shortness of breath/SATs below 90% as needed.</p> <p>Review of SBAR report for Resident #1, dated 8/1/24, revealed there was concern for mental status changes related to Resident #1 stating he doesn't feel right. The summary read, Resident had been complaining of not feeling well. He reported that he had some SOB concentrator hooked up at 2l per min and resident reported feeling much better. After a few minutes resident was seen running to front office where he fell . DON/ADON and regional nurse at his side. At later time this Ln called 911. Resident was then admitted to hospital for further eval.</p> <p>Review of Resident #1's hospital discharge report, dated 8/8/24, revealed Resident #1 was discharged with an order for Nicotine patch 7 mg/24 hr. 1 patch for smoking cessation.</p> <p>Review of Resident #1's admission nursing assessment dated , 8/8/24, completed by LVN A revealed Resident #1 was readmitted to the facility. The document included he returned as a non-smoker, used a walker for ambulation and would receive oxygen. Further review revealed there was no indication LVN A asked Resident #1 if he had smoking materials in his possession.</p> <p>Review of incident/accident report, dated, 8/13/2024, revealed at 6:15 PM Resident #1 told LVN A he started a fire in his room with his oxygen. He told LVN A that he was hearing voices that told him to burn down the building and he could not control himself.</p> <p>Interview on 8/16/24 at 10:20 AM with the ADON, who assessed Resident #1 after the incident on 8/13/24, stated she did not know where Resident #1 obtained a lighter. Resident #1 did not tell her, and she did not ask him. The ADON stated upon Resident #1's return from the hospital on 8/8/24, he had orders for a nicotine patch to help him quit smoking.</p> <p>Interview on 8/16/24 at 10:45 AM with the ADM and ADON revealed prior to the incident with Resident #1, nursing staff would review the smoking policy with residents during the admission process but would not have them sign the policy. The ADM stated they did not have a process in place to ensure smoking residents returning from the hospital did not have smoking materials on their possession. Nursing staff would not ask the residents if they had smoking items.</p> <p>Interview on 8/16/24 at 11:15 AM with the ADON revealed she had a conversation with Resident #1's family member about the incident but did not think to ask if she knew how Resident #1 obtained a lighter. She did not ask the Resident #1 either.</p> <p>Interview on 8/16/24 at 12:42 PM with the DON revealed the ADM called her and told her about the incident involving Resident #1. She stated she was in shock because Resident #1 did not have a history of mental illness. She stated she was grateful nothing major happened because Resident #1's oxygen was on.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview on 8/16/24 at 2:06 PM with Resident #2 revealed residents were not able to have cigarettes or lighters but his roommate would have a cigarette in his possession during smoke breaks. He also stated staff would not stay with them for the entire smoke break like they were supposed to stay. Resident #2 presented as being alert and oriented to person, place and time.</p> <p>Review of Resident #2's smoking assessment dated , 8/14/24, revealed his General Awareness and Orientation- Including Ability to Understand the Facility Safe Smoking Policy was rated as no problem. Further review revealed Resident #2 was a safe smoker.</p> <p>Telephone interview on 8/16/24 at 2:20 PM with LVN A revealed Resident #1 walked up to the nurse's station and told her he did not know what he was doing and started a fire in his room. She stated she was walking down the hall towards Resident #1's room as a CNA was walking up the hall yelling out fire. She stated when she arrived, to Resident #1's room, there was a burnt piece of paper on the floor in front of the nightstand. It was smoldering and the front of the nightstand was black in color but not burned through the wood. She stated she and the CNA stomped the embers out without the use of an extinguisher. LVN A stated she turned Resident #1's oxygen tank off at this time. LVN A stated the CNA did not pull the alarm. She stated they immediately put the fire out, but protocol required he pull the alarm when there was a fire. LVN A stated Resident #1 did not have a history of behaviors and had never done anything similar. She stated Resident #1's behavior was new onset and totally out of character. LVN A stated Resident #1 was discharged from the facility on the same date on an emergency detainment.</p> <p>Telephone interview on 8/16/24 at 4:33 PM with LVN A revealed she readmitted Resident #1 on 8/8/24 and did not ask him about having smoking paraphernalia because he returned as a non-smoker with orders for a nicotine patch even though he had been a daily smoker up to the date of discharge to the hospital, 8/1/24. LVN A stated she did not usually receive residents after being out on pass and had not been instructed to ask residents upon their return if they had smoking paraphernalia.</p> <p>Interview on 8/16/24 at 5 PM with the ADM and ADON revealed they reiterated they did not know where or when Resident #1 obtained a lighter. They stated he had not been out on pass, was hospitalized from 8/1/24 to 8/8/24 and then he started the fire on 8/13/24. The ADM and ADON were asked about safeguards in place to prevent families/residents from bringing paraphernalia into the facility. The ADON stated staff reviewed the smoking policy with residents and family members upon the resident's admission and as needed and they had never had a problem. The ADM stated staff was not asking the residents or family members upon re-entering the facility if the resident had smoking paraphernalia on them. The ADON stated family members were also allowed to visit, sit outside and smoke with residents at any time during their visit. She stated again they had not had a problem. The ADM and ADON stated they did not have a process in place to ensure residents did not have smoking paraphernalia during readmissions and upon returns from being out on pass. The ADM stated Staff could not [NAME] the residents upon their return to the facility, but stated staff was not required to ask residents if they had paraphernalia in their possession either.</p> <p>Interview on 8/17/24 at 11:19 AM with agency RN B revealed the charge nurse would provide her with the resident's status during shift change. However, stated she was new to the facility and not familiar with smokers. RN B stated after outings families would sign residents back into the facility in the sign on their Out on Pass Log and would return medications to the charge nurse. She stated she was not instructed to ask the families and residents if they had smoking paraphernalia on them.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Observation and interview on 8/16/24 at 3:20 PM revealed a glass ashtray on top of a small table under the eve right outside the door and a second glass ashtray on top of a picnic table under the covered patio. Further observation revealed a cigarette butt on the ground between a chair and the cigarette butt trash can under the eve. Interview with the ADM revealed he stated there was a cigarette butt on the ground and should be disposed in the cigarette butt trash can for safety precautions. He stated he understood if the cigarette butt was not completely turned off it could start a fire.</p> <p>Interview on 8/16/24 at 3:38 PM with the SW revealed she would take residents out for a smoke break on M, W, F at 11 AM. The SW stated she was not sure about what type of ashtrays the residents used. She stated there were metal trash cans available for the residents' use.</p> <p>Review of facility Smoking Policy, dated October 2022, read This facility shall establish and maintain safe resident smoking practices. 1. Prior to, and upon admission, residents shall be informed of the facility smoking policy, including designated smoking areas, and the extent to which the facility can accommodate their smoking or non-smoking preferences. 2. Smoking is not allowed inside the facility under any circumstances. Smoking is only permitted in designated resident smoking areas, which are located outside of the building. 7. The resident will be evaluated on admission to determine if he or she is a smoker or non-smoker. 13. Lighters, including matches are prohibited to be kept in patients' rooms.</p> <p>Review of facility policy, [Code Red], dated July 2024 read:</p> <p>POLICY: To ensure the safety of the residents, this policy provides instructions for staff to know and follow in the event of a fire.</p> <p>RESPONSIBLE PERSONS: Every employee is responsible to understand and to follow these procedures.</p> <p>PROCEDURE: Upon finding a fire staff must:</p> <ol style="list-style-type: none"> 1) Yell CODE RED and the location of the fire, remove any residents from immediate danger. 2) Remove any residents in immediate danger. 3) Pull the alarm. 4) Use the overhead paging system and announce, 'CODE RED, and give a brief description of the location of the fire. 5) Contain the fire by closing doors, and/or windows. 6) Extinguish Fire if possible. 7) Close all doors in the area, checking bathrooms. 8) Close remaining windows and doors on the floor. 9) Do Not cross the fire area. <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>10) Visitors will not be permitted to enter floors. They will be permitted to remain in the lobby until the fire emergency is cleared.</p> <p>Remember RACE >>> R = Rescue/Remove resident from fire location and yell out CODE RED.</p> <p>A = Alarm: pull the fire alarm and tell someone to overhead page CODE RED.</p> <p>C = Contain: close all doors in the area.</p> <p>E = Extinguish: while removing residents from the area.</p> <p>This was determined to be an Immediate Jeopardy (IJ) on 08/17/2024 at 4:59 PM and the Administrator was notified. The Administrator was provided with the IJ template on 08/17/2024 at 4:59 PM.</p> <p>The following Plan of Removal was accepted on 08/18/2024 at 12:20 PM and it included:</p> <p>8/13/2024 Residents #1 was assessed by ADON and resident was not a smoker and had a nicotine patch in place, police were notified and in building at this time. Resident was Emergency discharged to [hospital]. MD notified and aware of ED. There were no new orders obtained. Affected resident responsible party was notified by ADON of the alleged incident and plan of correction.</p> <p>8/13/2024 ADON in serviced staff on smoking policy and reporting fire.</p> <p>On 8/13/2024 the Social worker, ADON, and Administrator interviewed all residents in the facility to determine if any other residents experienced any psychosocial harm from the alleged incident. There was no concern identified. The interviews were completed before midnight on 8/16/2024.</p> <p>On 8/14/2024 Administrator reported alleged incident to THHS and initiated an investigation immediately.</p> <p>8/14/2024 Administrator/designee re-educated residents on smoking policy and letters were emailed/mailed to resident responsible parties who smoke.</p> <p>8/14/2024 Residents who smoke were re-evaluated on 08/14/2024 using the facility smoking assessment.</p> <p>Ad-Hoc QAPI meeting was held on 8/17/2024 at 5:30 PM, with the Medical Director, NHA (Nursing Home Administrator), RDO (Regional Director of Operations) and DON to review the alleged incident, policy and procedure, and the plan for removal of immediacy.</p> <p>On 8/17/2024 in-servicing to all staff on smoking policy and procedure, admission checklist for paraphernalia checks reviewed, and questions when coming back from Out on Pass. Staff will receive Quiz post in-service to ensure understanding of process.</p> <p>8/17/2024 Safe Surveys conducted. No issues at this time. Any issues will be brought to QAPI.</p> <p>8/17/2024 Activity Director and Assistant in serviced on signing residents out and back in when out on activities as well as asking about paraphernalia.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of a daily checks log revealed from 8/13/24 to 8/15/24 12 smoking residents were asked about smoking paraphernalia.</p> <p>14. Interview on 8/18/24 at 3:51 PM with the ADM, DON, ADON and Regional Consultant revealed the DON/designee would monitor compliance of the smoking policy by completing an audit of (5) residents per week for four (4) weeks. They stated this was initiated on 8/17/2024. In addition, any identified concerns would be addressed immediately and if trends and patterns were identified, the facility would conduct an Ad-Hoc QAPI meeting to discuss if additional interventions were needed to ensure compliance.</p> <p>15. Interview at 3:51 PM with ADM, DON, ADON and Consultant revealed nursing staff would continue asking residents daily about paraphernalia. The DON would interview 5 residents a week about any issues and paraphernalia. The ADON stated all staff was quizzed via text sent out; she sent a screen shot of the quiz and staff responded with their answers. Staff would conduct daily checks with residents on C and D halls. Residents on the A and B halls consisted of residents in the memory care units. The ADM and ADON stated none of the residents smoked until most recently Resident #3, in the men's unit decided he wanted to smoke. The ADM stated Resident #3 would join the rest of the residents at regularly scheduled smoking breaks every odd hour beginning at 7 AM with the last smoke break scheduled at 9 PM. Staff would escort him to the courtyard on the days he chose to smoke. The ADM stated he sent out an email, letter re-iterating the smoking P&P with edits including staff asking for paraphernalia after outings with the Residents. Staff followed up with a call to RPs for all smokers. He stated family/residents would have to sign out and back in before residents were allowed back into their room. Nursing staff would complete the admission checklist: nursing staff would ensure they asked the question about smoking and if the resident had smoking materials. Nursing staff would also ask residents if they had smoking materials upon readmissions. The ADM stated 100% of staff was in-serviced on the smoking and fire policies and quizzed including dietary and housekeeping.</p> <p>16. Interview at 4:03 PM with the AD revealed she and her assistant would ensure residents signed out and back in after taking residents on outings. She stated they would ask Residents what they were taking with them and would ask about smoking paraphernalia upon their return. She stated she and her assistant would also be responsible for ensuring the residents/families signed the resident back in upon their return. She stated they would be quizzing everyone who left the facility about smoking paraphernalia and about the smoking policy. They would let the ADM know right away if residents noted with paraphernalia. The AD stated she called families and made sure they received a letter/email about the smoking policy and edits. She stated she would follow up with families who she left a VM. The AD stated she would also ask resident/families about smoking paraphernalia after returning from smoking breaks during visits.</p> <p>17. Interview at 4:17 PM with the SW revealed she would be make sure cigarette butts were destroyed (completely put out) and dumped in the metal trash cans after smoke breaks. She would also ensure ash trays were emptied. The SW stated, in addition, she would, be asking relatives/families about paraphernalia.</p> <p>18. Interview at 4:20 PM with the AIT revealed there was a new sign/in out sheet; staff was to ask residents upon return for paraphernalia. Staff was to continue supervision during smoke breaks. Nurses would inquire about smoking paraphernalia upon readmission. Weekend supervisor would make rounds, in-servicing staff, talking to residents making sure everyone was compliant with the smoking policy.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675371	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/19/2024
NAME OF PROVIDER OR SUPPLIER Riverview Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>19. Interview at 4:24 PM with the DM revealed she was in-serviced about staff asking residents for smoking materials upon return from being out on pass. They also reviewed the fire policy.</p> <p>20. Interview at 4:26 PM with the MS revealed he was in-serviced on checking resident rooms every day and would ask about smoking materials upon return from residents being out on pass. He stated residents who chose not to comply with the smoking policy would get a 30-day notice for discharge. He stated all staff was in-serviced about following the smoking rules during breaks: being more vigilant about ensuring residents did not obtain paraphernalia. The MS stated they would be ordering more ash trays. They would keep the courtyard cleaner by making sure there were not cigarette butts on the ground, emptied ash trays and trash cans daily.</p> <p>21. Interview at 4:34 PM with RN B revealed nursing staff would be asking residents for smoking materials anytime they left the facility or upon their return.</p> <p>22. Interview at 4:37 PM with MA E revealed nursing staff would be asking residents for smoking materials anytime they left the facility and/or upon their return.</p> <p>23. Interview at 4:41 PM with RN D revealed staff was to ensure residents signed/out and back into the facility; nursing staff was to ensure they asked the questions about smoking materials upon admission. Staff was to reinforce the smoking rules ensuring residents adhered to it to ensure their safety.</p> <p>24. Interview at 4:47 PM with CNA F revealed she understood the smoking policy and amendments made. She stated nursing staff would be asking residents about smoking materials anytime they left and returned to the facility.</p> <p>25. Interview at 4:48 PM with CNA G revealed staff was in-serviced about the fire and smoking P&P including changes related to asking residents about smoking materials including new admissions; making sure residents signed out when going out on pass; the sign in and out sheet was updated, and they reviewed resident supervision while smoking in the courtyard.</p> <p>26. Interview at 4:52 PM with CNA H revealed they reviewed the smoking and fire P&P and the changes made including asking residents about smoking materials anytime they left and returned to the facility.</p> <p>27. Interview at 5:03 PM with CNA I revealed they reviewed the smoking and fire P&P and the changes made including asking residents about smoking materials anytime they left and returned to the facility.</p> <p>28. Interview at 5:10 PM [NAME] J revealed they reviewed the smoking and fire P&P and the changes made including asking residents about smoking materials anytime they left and returned to the facility.</p> <p>29. Interview at 5:14 PM with Dishwasher K revealed they reviewed the smoking and fire P&P and the changes made including asking residents about smoking materials anytime they left and returned to the facility.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>30. Interview at 5:25 PM with LVN L revealed she they reviewed the smoking and fire P&P and the changes made including asking residents about smoking materials anytime they left and returned to the facility.</p> <p>31. Interview at 5:30 PM with RA M revealed they reviewed the smoking and fire P&P and the changes made including asking residents about smoking materials anytime they left and returned to the facility.</p> <p>32. Interview at 5:32 PM with MA N revealed they reviewed the smoking and fire P&P and the changes made including asking residents about smoking materials anytime they left and returned to the facility.</p> <p>33. Interview at 5:48 PM with LVN O revealed they reviewed the smoking and fire P&P and the changes made including asking residents about smoking materials anytime they left and returned to the facility.</p> <p>34. Interviews with smoking Residents from 6:00 PM to 6:30 PM included Resident #2 to Resident #13. All Residents verbalized an understanding of the smoking policy and stated they should not have cigarettes or smoking items on them. Furthermore, they could not keep smoking items in their room. Residents #2 to Resident #13 stated staff kept their cigarettes and lighter under lock and key and stated staff was stricter.</p> <p>35. Attempted calls were made on 8/19/24 from 4:15 PM to 5:36 PM to family members for Resident #4, Resident #7, Resident #2 and Resident #5. A voicemail was left.</p> <p>36. Telephone interviews on 8/19/24 from 4:15 PM to 5:36 PM with family members for Resident #6, Resident #11, Resident #9, Resident 8, and Resident #13 revealed they had not received a call from</p>		