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	05/08/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and interview, the facility failed to provide a safe, clean, comfortable, and homelike environment with maintenance services necessary to maintain a sanitary, orderly, and comfortable interior for 1 of 4 units (Unit B), reviewed for physical environment. The facility failed to ensure the door jamb, strike plate, and latch hole of the women's secure unit B shower room was not covered with black duct tape which prevented the door from latching and locking and the push buttons 5, 6, 7, and 9 on the electronic door lock were not missing. The facility failed to ensure the shower floor drain had a drain cover over it. This failure could place residents at risk of being exposed to others while being provided with care and showers, an unsanitary environment, accidents, and could result in embarrassment and being uncomfortable. The findings were: Review of the facility women's secure unit B resident roster on 5/5/25 at 9:45am revealed there were 17 female residents residing on the unit. In an observation on 5/5/26 at 10:35 a.m. the unit B shower room door was pulled to but not fully closed and latched and there was an area of solid black that could be seen between the wall and the door where it would latch. There was an electronic lock with numbered push buttons sticking out and numbered buttons missing were 5, 6, 7, and 9. After knocking and ensuring it was not occupied the door was pushed opened. The door jamb, strike plate, and latch hole were covered with black duct tape approximately 12 inches in length and it was pulling away from the door jamb in an area approximately 6 inches long and in that area was what appeared to be sheetrock or part of the frame that had gotten stuck to the duct tape. There was another piece of duct tape going crossways across this area from the outside of the door frame to the inside of the door frame and wrapping around to the inside wall. Inside the shower room there were two linen carts, a toilet, sink and shower area behind a partial tiled wall. There were no razors or chemicals observed. In the shower area the drain hole in the floor was observed to be open and not covered with what looked to be hair and debris in the drain and a shower chair was inside. The shower chair and floor were damp but not wet and the room smelled of fresh soap. In an observation and interview on 5/5/26 at 10:53 a.m. in the secure women's unit B shower room, MA C stated she was unsure of how long the shower room door jamb had black duct tape on it, or how long the buttons on the lock had been missing and she was unsure of how long the drain cover had been missing on the shower room drain. MA C stated there had been no accidents or issues that she was aware of with residents walking in on other residents or of residents or staff stepping in the drain hole. MA C stated they did not keep shampoo, body washes, razors, or anything the resident could injure themselves with, out in the open in the shower room. The shower room was observed to be exactly as observed at 10:35 a.m In an interview on 5/5/26 at 11:02 a.m. LVN E stated the shower room door and lock had not been like that for long but unable to state how long it had been like that. LVN E stated there had been no issues with the residents wandering into the room while another resident was being showered and provided care as the door was pulled shut and the residents did not try to open closed doors and just walk past them. LVN E stated residents pulled the buttons off of the electronic lock and she was unsure if it had been reported to maintenance. In an interview on 5/5/26 at 11:05 a.m. the DON stated she was unaware of the shower room door in the women's secure unit B having tape on it or the buttons on the lock missing. An (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	unknown staff member in the DON's office stated it was being fixed by maintenance already. In an observation and interview on 5/8/26 at 11:30 a.m. in the secure women's unit B shower room, the black duct tape was removed, the electronic lock had been replaced with a new working lock. CNA G demonstrated the lock worked and let the surveyor into the shower room. Observation revealed there was still no drain cover over the shower floor drain and all four of the shower chair wheels would fit into the first upper ring of the drain but only tilted the shower chair slightly and was not enough to tilt the chair significantly. The shower chair was wet as was the shower floor and CNA G stated they had been showering residents and had not had any issues or concerns with the floor drain cover missing. CNA G stated she was unsure of how long the drain cover had been missing or if it had been reported to maintenance but that there had been no issues with the shower chair wheels going into the top of the drain or any staff stepping or tripping on the drain while showering residents. CNA G grabbed the shower chair and pushed it back and forth to demonstrate the drain hole was not near the shower chair wheels and stated there had been no issues or concerns with the drain cover missing. Debris that was dark in color remained in the uncovered drain of the shower floor. In an interview on 5/8/26 at 11:50 a.m. the Maintenance Director stated he was not aware the women's secured unit B shower room floor drain cover was missing and he would fix it right now. The Maintenance Director stated there was an online computer reporting system for all staff to report maintenance issues, anything reported went directly to his notifications, and nothing had been entered in the system for the shower room floor drain cover. In a joint interview on 5/8/26 at 1:35 p.m. with the Administrator and DON, the Administrator stated the door to the women's secure unit B shower room should not have had duct tape on it, the lock should work and have no missing buttons, and the drain cover should be in place. The Administrator stated there could possibly be a dignity issue with the door not being able to be locked and a possible accident with the drain cover missing but there had been no negative occurrences and all of the issues with the door, lock, and drain had already been resolved and the Administrator had a picture of the drain cover in place. Review of the facility policy on maintenance service revised December 2009 indicated Maintenance service shall be provided to all areas of the building, grounds, and equipment. 1. The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. 2. Functions of maintenance personnel include but are not limited to: a. maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines. b. maintaining the building in good repair and free from hazards.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an effective pest control program so that the facility is free of pests for 1 of 8 resident rooms (Resident #43) reviewed for physical environment.The facility failed to ensure there were no roaches in Resident #43's room and other areas of the facility.This failure could place residents at risk of unsanitary conditions, feelings of fear, irritation, embarrassment, depression, and an overall decline in quality of life.The findings were:Record review of Resident #43's face sheet dated 5/6/26 revealed the resident was an [AGE] year-old male resident admitted to the facility on [DATE]. Resident #43's diagnoses included encephalopathy unspecified (general, non-specific brain disease or damage where the exact cause is not yet determined), major depressive disorder recurrent and moderate (recurring mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life moderate in severity), and PTSD (mental health condition that's caused by being a part of or witnessing an extremely stressful or terrifying event and symptoms may include flashbacks, nightmares, severe anxiety and uncontrollable thoughts about the event).Record review of Resident #43's quarterly MDS assessment dated [DATE] revealed the resident had clear speech, understands and was understood by others. The resident had a BIMS score of 9 out of 15 indicating the resident had moderate cognitive impairment. The resident had rejected care daily and used a walker. The resident was frequently incontinent of urine and bowel.Record review of Resident #43's undated care plan revealed a focus initiated on 11/28/25 with revision on 2/4/26 for a potential behavior problem related to his diagnoses the resident refused care and assistance to include allowing sheets to be placed on mattress, bathing or to receive personal hygiene refusing nursing care, medications, labs, and preferring to eat in his room in the dark at times. This focus had multiple interventions to include psych services, family involvement, and encouragement. Another focus initiated on 9/24/25 with revision on 5/5/26 for verbal aggression towards staff and refusing showers and medications at times. Multiple interventions included on 4/26/26 an off-cycle care conference with family, Administrator, Activities Director, DON, Social worker, and the Ombudsman to address resident's refusal of showers, clean clothing, and medications. Family member will start coming in at least once a week to get the resident to shower, family will get a hamper for his room so they can keep track of his clothing and will encourage him to take his medications. A nurse will sign off on the shower so day staff will know it has been done. The team agreedto follow up in about three weeks.Record review of an anonymous visitor complaint received by HHSC (Health and Human Services Commission) revealed roaches were seen crawling on the visitor's belongings while in the facility.In an observation on 5/5/26 at 11:10 a.m. Resident #43 was not in his room, a sign on the door indicated there was video surveillance in his room. The resident's bed was stripped and was against the hallway wall, a recliner was across the room, the blinds were open, the room had an odor of cleaner and slight urine and looked to be recently mopped and was sticky. A large approximately 2-inch X 3/4 inch roach was observed on the same wall as the bed near the ceiling facing head down towards the bed. An unknown staff member was notified of the roach and stated he would report it and stated Resident #43 was most likely in the courtyard.In an observation and interview on 5/6/26 at 10:35 a.m. Resident #43 was sitting on the side of his bed, no linens on mattress and his walker next to him. The resident was looking out the window. The resident was dressed in a t-shirt, jogging style pants, and croc style shoes. The resident stated he was irritated and raised his voice slightly while stating no one here at the facility knows what they are doing and that he should not be here and wants the facility to show him one physician's note or piece of paper stating that he belongs here. While interviewing the resident, I was standing at the end of his bed at the door with the door closed and a large roach approximately 1 inch X 1/2 inch ran into my shoe and then went under the resident's bed. The resident asked me what kind of bug it was, and I stated it was a roach and the resident (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated, oh yeah, there are thousands of them around here. The resident further stated the roaches get on all his belongings and the roach came out from under the resident's bed and was crossing in front of the resident's feet and he pointed down and stated, there's another one. The resident was calm and was no longer raising his voice. The roach then went across the room and under the resident's recliner. The resident stated someone came and sprayed today but it never helps. The resident stated he was used to the roaches and had served in Vietnam and those bugs were worse. The resident started talking about the bugs in Vietnam and I did not ask any more questions due to his PTSD. The resident was calm and heading outside to smoke.In a resident group meeting on 5/6/26 at 9:19 a.m. two other facility residents reported seeing small roaches in the facility on 5/5/26 at different times and the facility needed to address roach issues. The residents did state the facility does have pest control come.Review of the facility pest control invoices revealed Pest control visits were completed on 11/11/25, 12/5/25, 1/6/26, 2/6/26, 2/13/26, 3/6/26, 3/12/26, 3/20/26, 3/27/26, 4/3/26, 4/10/26, 4/24/26, 5/1/26, and an emergency visit on 5/6/26. At each visit American and or German cockroaches were targeted pests and on each visit different areas throughout the facility were targeted. Pest control time spent treating the facility on each visit varied from 1 hour to 3 hours. On the 5/6/26 visit per the pest control invoice the time in was recorded as 9:51 a.m. and time out was 10:53 a.m. and the only room treated was Resident #43's room and bathroom as that was where the roach was observed on 5/5/26 by surveyor and no other rooms or halls were treated at that time. In a joint interview on 5/8/26 at 1:35 p.m. with the Administrator and DON. The Administrator stated they notify pest control anytime there were reported issues with pests and have pest control come out. The DON stated part of the issue with roaches in Resident #43's room was the resident had a documented history of crumbs on himself and the floor and general uncleanliness but that was addressed in his care plan meeting and was much improved from previously. The Administrator and DON stated the roach problem was much better not only in Resident #43's room but facility wide and pest control continues to address the issues. Review of the facility pest control policy revised May 2008 indicated Our facility shall maintain an effective pest control program. 1. This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents. 6. Maintenance services assist, when appropriate and necessary, in providing pest control services.