STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675678	A. Building B. Wing	04/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care Choice of Boerne	200 E Ryan St Boerne, TX 78006

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26481 Based on observations, interviews, and record reviews the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. for 1 (Resident #1) of 4 residents reviewed in that: Resident #1's care plan was incomplete and did not accurately describe his care need to have his coffee served in a mug with a tight lid to prevent coffee spills. This failure could place residents at risk of not receiving care as ordered and needed. The findings were: Record review of Resident #1's Admission Record [Face Sheet], dated 3/31/24 revealed he was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included heart failure, high blood pressure, swallowing difficulty, and Alzheimer's disease (type of dementia that affects memory, thinking and behavior). Record review of Resident #1's physician's orders revealed an order for a Mechanical Soft No Added Salt diet with thin liquids with a start date of 11/08/23 and was discontinued on 11/30/23. Record review of Resident #1's physician's orders revealed an order for a Pureed diet with thin liquids with a start date of 02/23/24. Record review of Resident #1's MDS, a Quarterly assessment dated [DATE], revealed his BIMS score was 8 out of 15, indication his cognitive skills for daily decision making were moderately impaired; and he was independent with eating. Record review of Resident #1's MDS, a Quarterly assessment dated ,d+[DATE]//24, revealed his BIMS score was 2 out of 15, indication his cognitive skills for daily decision making were severely impaired; and he required partial/moderate assistance with eating. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Nurse's notes dated 11/06/23 by LVN A revealed Resident #1 was in the dining room with a cup of coffee that he was trying to put a lid on when the cup turned over spilling coffee into his lap. Staff assisted resident, used terry cloth protectors to soak up coffee in resident's lap. Resident was checked following incident with redness noted to his thighs. Record review of Resident #1's resolved/discontinued care plans revealed the focus area related to the coffee spill was resolved on 01/23/24 and cancelled interventions included Staff to assist resident with handling his coffee cup .resident had a coffee mug that had a lid he could not handle, which he refused help to pour the coffee in. He now has a cup which the top is hard to take off and put back on. Staff will need to assist him with handling his cup and pouring coffee for him .and make sure coffee cup lid is on tightly. Record review of Resident #1's active care plan in his electronic clinical record revealed there was no mention of staff to assist the resident with handling his coffee cup, to have a cup with a lid that is hard to take off and put back on, and to ensure the lid was on the cup tightly. Observation and interview on 03/31/24 at 12:14 PM in the dining room revealed LVN B was handed a mug of coffee from a dietary employee to which she added sugar, cream, and a couple of ice cubes to the coffee, placed a lid tightly on the mug. As LVN B handed the coffee to Resident #1, she stated the coffee was the right temperature and not too hot for him to drink. Observation on 03/31/24 at 12:17 PM revealed Resident #1 was able to slowly, safely bring the mug of coffee with the lid on it to him mouth to drink. Observation on 04/01/24 at 07:42 AM revealed LVN D gave Resident #1 his breakfast meal tray with a mug of coffee that had a lid on it to the resident after she added sugar, cream, and a few ice cubes to the coffee. In an interview on 03/31/24 at 3:41 PM, CNA C stated Resident #1 has a special coffee mug with a lid that his coffee was served to him in that was implemented after he spilled coffee on himself. In an interview on 04/01/24 at 4:06 PM, CNA G stated Resident #1 loved his coffee, had a special mug with a lid on it that he can not get off that was kept in the kitchen. In a telephone interview on 04/01/24 at 9:50 AM, LVN A stated she was in the dining room feeding another resident the day Resident #1 spilled coffee on himself and did not see it happen. LVN A stated she did not remember the type of cup his coffee was in that day but stated at that time he was able to feed himself and handled his beverages a lot better than compared to now. LVN A stated back in November 2023, Resident #1 could propel himself in his wheelchair while holding a cup of coffee. LVN A stated now Resident #1's coffee was served to him in a special cup with a lid on it only when he was in the dining room where he could be monitored while he drinks the coffee. In an interview on 04/01/24 at 07:49 AM, the FSS stated Resident #1 had a special cup that was provided by his family that had a lid that could easily be removed when he had spilled the coffee on himself. The FSS stated the facility no longer has that cup and Resident #1's family brought the mug his coffee was served in yesterday for the resident to drink from. The FSS stated if a resident comes to the kitchen door to ask for coffee, the dietary staff know to not give the coffee to the resident, to only give it to the nurse to hand to the resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/31/24 at 2:57 PM, Cook F stated the dietary staff will place coffee on a residents' tray in accordance with the resident's tray card, coffee was not kept out in the dining room between meal service or during meal service, and if a resident comes to the kitchen door to ask for coffee, she does not give it to the resident unless a nurse was present. In an interview on 04/01/24 at 12:28 PM, the MDS Nurse E stated after Resident #1 had spilled coffee on himself, the DON created a temporary care plan with interventions to prevent further spills and that care plan had been resolved. The MDS Nurse reviewed Resident #1's current care plan and stated she did not see anything in his care plan about the special mug with a lid to serve Resident #1 his coffee. In an interview on 04/01/24 at 2:37 PM, the DON stated in November 2023, Resident #1 had a cup of coffee that was served to him in a mug his family had bought for him. The DON stated Resident #1 was trying to put the lid on or take it off and spilled the coffee on himself in the dining room. The DON stated after the incident, they disposed of that mug, his family brought in another mug with a tighter-screw-top lid and the dietary staff makes sure the coffee has cooled down before any coffee was given to the nursing staff to be given to the residents. The DON stated she created the special care plan for Resident #1 after he spilled coffee on himself, but it might have been resolved when he went to the hospital and not reactivated when he was readmitted . The DON stated usually the MDS Nurse would reactivate the care plans when residents were readmitted and if the DON sees something missing from the care plans, she would reactivate it herself. In an interview on 04/01/24 at 4:18 PM, the Administrator stated care plan meetings would be held with the resident's family, then the care plan would be reviewed during the meetings to ensure the interventions listed were appropriate for the resident or if they needed to be removed. Record review of the facility's policy Care Plans, Comprehensive Person-Centered, revised December 2016, revealed A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 1. The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 2. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment .8. The comprehensive, person-centered care plan will: b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .