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	11/01/2024

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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** 41651 Based on interview and record review, the facility failed to ensure the resident's right to be free from abuse for 1 of 11 residents (Resident #2) reviewed for abuse, in that: The facility failed to protect Resident #2 from Resident #3 during a resident-to-resident altercation on 09/21/2024. The non-compliance was identified as past non-compliance (PNC). The PNC IJ began on 09/21/2024 and ended on 09/24/2024. The facility had corrected the non-compliance before the state's investigation began on 10/29/2024 at 9:30 a.m. This deficient practice could place residents at risk of physical injury and/or psychosocial harm. The findings were: Record review of Resident #2's face sheet, dated 11/01/2024, revealed the resident was admitted to the facility on [DATE] with diagnoses including: hemiplegia, muscle weakness, low vision in his right eye, and blindness in his left eye. Record review of Resident #2's quarterly MDS, dated [DATE], revealed a BIMS score of 4 which indicated severe cognitive impairment. Record review of Resident #2's care plan, initiated 11/01/2021, revealed [Resident #2] is highly visually impaired .may bump into things from not seeing them. [Resident #2] is at moderate risk for falls [related to] Confusion, Gait/balance problems, Paralysis. Record review of Resident #3's face sheet, dated 11/01/2024, revealed the resident was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses including: unspecified dementia, generalized anxiety disorder, and impulse disorder. Record review of Resident #3's quarterly MDS, dated [DATE], revealed a BIMS score of 8 which indicated moderate 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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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #3's care plan, initiated 04/20/2024, revealed, [Resident #3] has sexual and aggressive behaviors and enters residents' rooms without permission, takes food from other residents in dining room and other resident's refrigerators . he cannot control his impulses . Resident hit another resident. Police came to facility to assess altercation . after resident attempted to punch another resident, he was separated and redirected. Further review of Resident #3's care plan, revised 09/24/2024, revealed an intervention to redirect resident from other resident rooms as a result of the incident on 09/21/2024. Further review revealed a Care Plan meeting occurred on 10/03/2024 which resulted in an increase in medication of trazadone (medication used to treat anxiety disorders). Record review of Resident #3's clinical record, as of 11/01/2024, revealed, a behavior notes, dated 03/14/2024, Flinging snot and phlegm at other residents and the floor in the dining room in the middle of dinner. Parking his wheelchair in the middle of the hall, blocking other residents and continuing to [NAME] phlegm; 03/15/2024, Resident grabbed food out of another resident's hand then attempted to run into another resident with his wheelchair, 06/30/2024, Yelling slurs and shut the fuck up at his roommate whenever he makes a noise. Stealing food items off other residents' tables during mealtimes and flinging phlegm on the floor in the dining room; 07/29/2024, This resident came up to this female resident; both in [wheelchair]. [Resident #3] reached out for her right breast with his [NAME]. This female resident blocked [Resident #3] hand and he laughed. The Occupational Therapist, who witnessed this incident; explained to [Resident #3] that it was inappropriate for him to do that. This nurse redirected him. Resident expressed understanding. Will continue to monitor; 09/28/2024, Attempting to punch another resident for accidentally bumping into him with his wheelchair. Nurse intervened and redirected both residents. Resident very passive aggressive, constantly putting his wheelchair in the middle of the hall, blocking access; 10/03/2024, Yelling at another resident to Shut Up very loudly in front lobby area. Then as he was heading back to his room, he is gesturing angrily at staff and stopped and yelled at another resident to Shut up; 10/17/2024 Behavior: Verbal abuse, cursing, hostility. Incident: Resident outside amongst smokers and asked 2 residents for cigarettes. Both residents denied this residents cigarette. This resident then told other 2 residents to FUCK YOU. Further review of Resident #3's clinical record, as of 11/01/2024, revealed no additional incidents of verbal or physical aggression toward peers or staff since 10/17/2024 (2 weeks after the intervention to increase his Trazadone). Record review of Resident #3's clinical record, as of 11/01/2024, revealed his plan of care had been updated to include additional monitoring and supervision. Further review revealed that after the new intervention of enhanced supervision and redirection of the resident was introduced, on 9/24/24, the number of Resident #3's incidents of aggression decreased. Record review of Resident #3's electronic health record revealed after 9/24/24, his incidents of physical aggression decreased. Incidents consisted of verbal aggression (yelling expletives) only. Record review of the facility incident report, dated 09/21/2024, revealed, An altercation occurred between two residents on 9/21/24 at approximately 7pm. [Resident #3] perpetrator struck [Resident #2]. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Both residents are wheelchair bound, but [Resident #2] resulted on the floor . - The only witness of the event revealed that Resident #2 stood from his wheelchair to hit Resident #3 but Resident #3 pushed Resident #2 away resulting in Resident #2 falling. - The local police department were called in response to the 09/21/2024 incident but Resident #2 did not want to press charges against Resident #3. - The facility had conducted Resident Satisfaction Surveys with none reporting they felt unsafe at the facility. - Record review of the facility in-service, Resident-to Resident, dated 09/24/2024, revealed staff received additional training regarding recognizing and defusing conflicts between residents including methods such as redirecting aggressive residents to calm activities. Record review of Resident #2's clinical record, dated 09/21/2024, revealed a nurse assessment was performed immediately following the incident with no injuries noted. Further review of Resident #2's clinical record revealed he was assessed by a nurse each subsequent day for one week with no injuries noted. During the state's investigation, from 10/29/2024 to 11/01/2024, staff were observed interacting with Resident #3 in a pleasant manner, assisting him to maneuver within the facility, and maintaining close supervision of the resident. Further observations revealed the resident self-propelled slowly and frequently required staff assistance. Observations of Resident #3 on 11/01/2024 between 10:00 a.m. and 4:30 p.m. revealed while sitting in his wheelchair, Resident #3 moved slowly utilizing both feet and one hand/arm to propel himself. His feet would slip when he applied pressure against the floor resulting in several attempts at moving before being successful and going only a very short distance. Staff were observed assisting Resident #3 by pushing his wheelchair. Resident #3 did not exhibit any signs of physical or verbal aggression. During an interview with Resident #3 on 11/01/2024 at 4:32 p.m., Resident #3 stated he was friends with Resident #2 and declined to further converse. During an attempted interview with Resident #2 on 11/01/2024 at 4:36 p.m., Resident #2 was unable to be interviewed. During an interview with Resident #4 on 11/01/2024 at 4:42 p.m., Resident #4 stated she was afraid of Resident #3. She stated Resident #3 hit her during his first admission to facility in 2011, but that he had not done so since his readmission in 2024 and added that Resident #3 often used threatening speech and aggressive mannerisms. Resident #4 further stated that she had not witnessed Resident #3 attempt to strike anyone recently. Resident # 4 further stated she did not inform anyone of her fear. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interviews with nine additional residents on 11/01/2024 between 10:00 a.m. and 4:30 p.m. revealed none who answered affirmatively when asked if Resident #3 had displayed verbal or physical aggression toward them, and none who answered affirmatively when asked if they were afraid of Resident #3. Further interviews with residents revealed Resident #3's incidents of aggression decreased in number and become less physical in nature following the interventions. During an interview with the DOR on 11/01/2024 at 2:56 p.m., the DOR stated that Resident #3 had experienced a decline in physical functioning and lacked the ability to hit or kick peers or staff. The DOR also stated he had been alerted to assist with monitoring and supervising Resident #3 due to the resident's past aggression. Interviews with three CNAs and two LVNs on 11/01/2024 between 10:00 a.m. and 4:30 p.m. revealed they all had been alerted to assist with monitoring and supervising Resident #3 due to the resident's past aggression. Further interviews with staff revealed they had been directed to closely monitor Resident #3, and the resident's incidents of aggression had decreased in number and become less physical in nature following the interventions. Record review of in-service records revealed staff had been provided with training regarding defusing resident-to-resident altercations. Record review of Resident #3's clinical record revealed that in addition to enhanced supervision and monitoring by the staff, the resident was offered psychological services, visited by the facility Social Worker, and his physician ordered medication changes to assist the resident to cope. Further review revealed the incidents of aggression had decreased in number and become less physical in nature following the interventions. During an interview with the Administrator on 11/01/2024 at 5:05 p.m., the Administrator stated that Resident #3 would be involuntarily discharged from the facility due to his aggressive behaviors. Record review of the facility policy, Resident to Resident Altercations, revised September 2022, revealed, All altercations, including those that may represent resident-to-resident abuse, are investigated and reported .

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42402 Based on observations, interviews and record reviews the facility failed to ensure 1 (Resident #1) of 7 residents reviewed for mechanical device used by staff received adequate supervision and assistance with devices to prevent accidents. On [DATE] Agency nurse aide A transferred Resident#1 with a mechanical lift by herself. The mechanical lift tipped over causing Resident #1 to obtain a head laceration and a left femur fracture requiring surgery. The non-compliance was identified as past non-compliance (PNC). The PNC IJ began on [DATE] and ended on [DATE]. The facility had corrected the non-compliance before the state's investigation began on [DATE] at 9:30 AM. Failure of facility to provide adequate supervision and assistance with devices could lead to injury or death to residents. Findings included: Record review of Resident #1's face sheet electronically dated [DATE] revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of dementia (the loss of cognitive functioning, thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities.), contractures to right and left knee(a permanent shortening and tightening of muscle fibers that reduces flexibility and makes movement difficult.), bipolar disorder(A serious mental illness characterized by extreme mood swings. They can include extreme excitement episodes or extreme depressive feelings), and anxiety disorder (intense fear and inability to control moments.) Record review of Resident #1's state optional MDS assessment section C, dated [DATE], reflected Resident #1 had a BIMS score of 01, indicative of cognitively unaware. Section G revealed Resident #1 required extensive assistance with 2 persons for transfers. Record review of Resident #1's care plan dated [DATE], reflected Resident #1 required assistance with ADLs potential for self-care deficit. On [DATE] a revision was made for Resident #1 to be transferred using a Hoyer (mechanical lift) and assistance of two staff members if he is fighting staff. Record reveiw of Resident #1's nursing progress notes dated [DATE] timed at 5:38 pm , {resident on floor, hoyer on top of him. CNA beside him. Has laceration to forehead, complaints of left knee pain during assesment. Laceration to forehead cleansed. He is moving the upper extremeties as usual . No other apparent injuy. Responding to questions as usual , assisted to bed with assistance of 3 staff members. Notified sisiter, and doctor. sent to er.by ems.} Record review of Resident #1's EMR physician progress notes dated [DATE] revealed Resident #1 had a left hip fracture and underrwent cephalomedullary nailing on [DATE] returning to facility on [DATE]. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Agency CNA A's written statement dated [DATE] at 4:45 pm, read I was getting ready to transfer {resident #1} to his chair. I looked around for help, but all the aides were getting up their residents and I was behind, so I went ahead and transferred {res #1} by myself. When I started transferring him, he got agitated and held onto the Hoyer bars and was shaking it. Then before I knew it the Hoyer fell , and resident went to floor. I screamed for help. And pressed his forehead to stop the bleeding then the nurse walked in. Telephone interview attempt with Agency CNA A x3 on [DATE] and [DATE] were unsuccessful. During a telephone interview on [DATE] at 11:36 am the previous DON stated the manufacture recommendations of mechanical lift used during transfer said could be one person usage. She further stated, I don't know if having 2 persons would have made a difference because he (Resident #1) became agitated while in the air. During an interview with current DON on [DATE] at 11:45 am stated 2 staff members were to be used for transfers of residents with a mechanical lift. She further stated this is for the safety of the residents and staff. During a telephone interviw on [DATE] at 12:05 pm Resident #1's Nurse practitioner stated he did not believe that his death on [DATE] was related to his fall on [DATE]. He further stated Resident #1 had multiple commorbidiites that could have contributed to his death. The facility took the following measures on [DATE] after the event and prior to surveyor entrance: Record review of facility in services post incident beginning on [DATE] with competencies and demonstration of mechanical lift transfers were done with 28 of 29 staff members and 4 of 4 agency staff having completed. The facility did not allow Agency CNA A to return to the facility. The facility put a system into place for agency staff to review forms prior to their shift to identify the care needs of each resident. Observations by surveyor on [DATE] at 11:30 am and [DATE] at 2:00 pm and 2:30 pm of 3 mechanical lift transfers of residents(Resident #10, #11, #12) revealed was done with 2 staff members during transfers. During investigation period of [DATE]-[DATE] surveyor interviews with 19 of 29 current nursing staff members on all shifts were done and all said they were to use 2 staff members when doing mechanical lift transfers and can verbalize how to transfer residents. Record review of facility in services post incident with competencies and demonstration of mechanical lift transfers were done with 28 of 29 nursing staff members and 4 of 4 agency staff having completed. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of facility's policy titled: Lifting Machine, using a Mechanical dated 2001, Staff will perform mechanical lifts/transfers according to the manufacturer's instructions for use of the device. Manufacturer's operation for mechanical lift states Although [manufacture] recommends two assistants be used for all lifting preparation, transferring from, and transferring to procedures, our equipment will permit proper operation by one assistant. The use of one assistant is based on the evaluation of the health care professional for each individual case.