

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675678	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/19/2025
NAME OF PROVIDER OR SUPPLIER  Care Choice of Boerne		STREET ADDRESS, CITY, STATE, ZIP CODE  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 0550  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.  (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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interviews, and record reviews, the facility failed to ensure each resident was treated with respect, dignity, and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for one of seven residents (Resident #1) reviewed for resident rights. The facility failed to ensure. Resident #1 was provided with effective communication strategies to help her convey her daily needs and the nursing staff were not provided with communication strategies to assist Resident #1 to improve effective communication abilities for her day-to-day activities. These failures could place residents at risk of diminished dignity and affect their quality of life. The findings included: Record review of Resident #1's admission Record, dated 10/14/2025, revealed a [AGE] year-old female admitted on [DATE]. Record review of Resident #1's Medical Diagnoses, dated 10/14/2025, revealed diagnoses including unspecified dementia (range of symptoms affecting memory, thinking, and social abilities), Alzheimer's disease (most common type of dementia), nondisplaced fracture of head of left radius, initial encounter for closed fracture (means that the fracture has not caused the bone fragments to shift out of alignment and has not punctured the skin), depression (mental state of low mood and aversion to activity), and muscle weakness. Record review of Resident #1's Significant Change MDS Assessment, dated 09/04/2025, reflected Resident #1 had a BIMS of 00, indicating severe cognitive impairment. She was noted as having moderate difficulty with hearing when using hearing aids and the speaker had to increase volume and speak distinctly. She was noted for using hearing aids for completing the assessment. She usually made herself understood and had some difficulty communicating some words or finishing thoughts but is able if prompted or given time to respond. She was noted to sometimes understand others and responds adequately to simple, direct communication only. She had no evidence of an acute change in mental status from her baseline. She had no inattention behaviors present; however, she had disorganized thinking behaviors present. Record review of Resident #1's care plan, dated 04/02/2025, revealed Resident #1- Had impaired cognitive function related to diagnosis of Dementia/Alzheimer's with the intervention to include ask yes/no questions to determine needs with intervention to include communicating basic needs daily through the review date, initiated, date initiated 09/16/2025.- Had moderate decreased hearing loss in both ears and used hearing aids, date initiated 07/28/2025. - Had a history of choosing not to wear her hearing aids, taking them out, and losing them with the intervention to include assisting resident with putting the hearing aids in each day, facing resident when speaking and speaking in clear simple sentences, and ensuring hearing aids are kept in a safe place, date initiated 07/28/2025. - Her care plan did not include a noted intervention for communication strategies for hearing loss after hearing aids were lost by the resident on 08/24/2025. Record review of Resident #1's EMR on 10/14/2025 and 10/15/2025 did not reveal care plan revision documentation of an update to the loss of hearing aids on 08/24/2025. Record review of Resident #1's EMR on 10/14/2025 and 10/15/2025 did not reveal care plan revision documentation of an update of communication strategies for hearing loss. During an observation and interview on 10/14/2025 at 10:30 AM, [JM1] [SM2] Resident #1 was observed in her manual wheelchair sitting near a nursing staff member assigned to hallway 100. The nursing staff member was observed getting at eye level with Resident #1 and speaking loudly and clearly in English and in Spanish to ask her a question about going to her room or going outside. Resident responded to the nursing staff that she wanted to stay put in her chair. Resident #1 appeared groomed well, appropriately dressed ambulating with her manual wheelchair unassisted and without injury. Resident #1 agreed to move the interview to her room for privacy. She revealed in Spanish that her left side hurt, and she pointed to her left elbow. She stated she required total care. She stated she injured herself about two weeks back but doesn't recall where she was in the facility during this injury. She stated she recalls hitting herself on her left elbow, she is given medication for pain, she had x-rays done, and she was taken to the hospital. She stated she doesn't recall what happened, only that she remembers she was standing. She stated the doctor prescribed her medication for pain, she was given an injection for pain, she was offered physical therapy, but she declined. She stated she is administered Tylenol for pain when she asks for it, and it does help to relieve pain. She stated she uses a wheelchair to help her get around. She doesn't go outside often as she has sinus issues and doesn't want to become ill. She stated she cannot recall details of what occurred to hurt herself but knows she didn't fall, and she has no concerns with staff and feels safe.[JM3] [SM4] The resident did have minor issues during the interview such as not being able to answer questions, she couldn't recall</p>		

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F 0641  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Ensure each resident receives an accurate assessment.  (continued on next page)

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interviews and record reviews, the facility failed to ensure that each resident's MDS assessment accurately reflects the resident's status for one of seven residents (Resident #1) reviewed for accuracy of assessments. The facility failed to ensure the 09/04/2025 MDS assessment accurately reflected Resident #1's cognitive status and the resident's use of hearing aids, which had been lost as of 08/24/2025 This failure could place residents at risk for inaccurate care planning and care delivery. The findings included: Record review of Resident #1's admission Record, dated 10/14/2025, revealed a [AGE] year-old female admitted on [DATE]. Record review of Resident #1's Medical Diagnoses, dated 10/14/2025, revealed diagnoses including unspecified dementia (range of symptoms affecting memory, thinking, and social abilities), Alzheimer's disease (most common type of dementia), nondisplaced fracture of head of left radius, initial encounter for closed fracture (means that the fracture has not caused the bone fragments to shift out of alignment and has not punctured the skin), depression (mental state of low mood and aversion to activity), and muscle weakness. Record review of Resident #1's Significant Change MDS Assessment, dated 09/04/2025, reflected Resident #1 had a BIMS of 00 indicating severe cognitive impairment, which was a significant change upon admission of 08 indicating moderate cognitive impairment. She was noted as having moderate difficulty with hearing when using hearing aids and the speaker had to increase volume and speak distinctly. She was noted for using hearing aids for completing the assessment. She usually made herself understood and had some difficulty communicating some words or finishing thoughts but is able if prompted or given time to respond. She was noted to sometimes understand others and responds adequately to simple, direct communication only. She had no evidence of an acute change in mental status from her baseline. She had no inattention behaviors present; however, she had disorganized thinking behaviors present. Her Significant Change MDS Assessment didn't accurately reflect that Resident #1 did not wear hearing aids as they were lost as of 08/24/2025. Record review of Resident #1's care plan, dated 04/02/2025, revealed Resident #1- Had impaired cognitive function related to diagnosis of Dementia/Alzheimer's with the intervention to include ask yes/no questions to determine needs with intervention to include communicating basic needs daily through the review date, initiated, date initiated 09/16/2025.- Had moderate decreased hearing loss in both ears and used hearing aids, date initiated 07/28/2025.- Had a history of choosing not to wear her hearing aids, taking them out, and losing them with the intervention to include assisting resident with putting the hearing aids in each day, facing resident when speaking and speaking in clear simple sentences, and ensuring hearing aids are kept in a safe place, date initiated 07/28/2025.- Her care plan did not include a noted intervention for communication strategies for hearing loss after hearing aids were lost by the resident on 08/24/2025. Record review of Resident #1's EMR on 10/14/2025 and 10/15/2025 did not reveal care plan revision documentation of an update to the loss of hearing aids on 08/24/2025. Record review of Resident #1's EMR on 10/14/2025 and 10/15/2025 did not reveal care plan revision documentation of an update of communication strategies for hearing loss. Record review of Resident #1's progress notes, dated 10/15/2025 for progress notes created from 08/14/2025 to 08/24/2025 reflected: Resident #1 had a history of having hearing aids go missing and found by staff with final note of hearing aids remained missing on 08/24/2025. No further notes regarding the loss or recovery of hearing aids were documented for Resident #1. - Orders - Administration Note dated 08/24/2025 at 9:32 AM by nursing department, BILATERAL HEARING AIDES. On in AM and Off at HS. Keep HA secured with Nurse. one time a day for Hearing deficit and remove per schedule h/a missing at this time family aware.- Orders - Administration Note dated 08/14/2025 at 9:27 AM BILATERAL HEARING AIDES. On in AM and Off at HS. Keep HA secured with Nurse. one time a day for Hearing deficit and remove per schedule Unable to find right hearing aid this morning. Record review of Resident #1's Quarterly MDS Assessment, dated 08/24/2025 reflected sizable differences from the Significant Change MDS Assessment, dated 09/04/2025. Differences included cognitive patterns; she was noted to have evidence of an acute change in mental status from her baseline and behaviors of inattention were present and fluctuated. Her Quarterly MDS Assessment did not include section on preferences for customary routine and activities. Her Quarterly MDS Assessment did not accurately reflect cognitive pattern changes nor was evidence present in Resident #1's EMR of an acute change in mental status from her baseline and behaviors. Record review of Resident #1's Brief Interview for Mental Status (3.0 BIMS) Forms, dated 03/18/2025 to 09/03/2025 reflected:- 09/03/2025 reflected N/A for overall score indicating severe</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>(continued on next page)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interviews and record reviews, the facility failed to ensure that the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment for one of seven residents (Resident #1) reviewed for care plans. The facility failed to update or add interventions to Resident #1's care plan regarding the loss of her hearing aids that impacted her communication abilities. This failure could place residents at risk of not receiving the necessary services or having the appropriate interventions to meet their current needs. The findings included: Record review of Resident #1's admission Record, dated 10/14/2025, revealed a [AGE] year-old female admitted on [DATE]. Record review of Resident #1's Medical Diagnoses, dated 10/14/2025, revealed diagnoses including unspecified dementia (range of symptoms affecting memory, thinking, and social abilities), Alzheimer's disease (most common type of dementia), nondisplaced fracture of head of left radius, initial encounter for closed fracture (means that the fracture has not caused the bone fragments to shift out of alignment and has not punctured the skin), depression (mental state of low mood and aversion to activity), and muscle weakness. Record review of Resident #1's Significant Change MDS Assessment, dated 09/04/2025, reflected Resident #1 had a BIMS of 00, indicating severe cognitive impairment, which was a significant change upon admission of 08 indicating moderate cognitive impairment. She was noted as having moderate difficulty with hearing when using hearing aids and the speaker had to increase volume and speak distinctly. She was noted for using hearing aids for completing the assessment. 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Her Quarterly MDS Assessment did not include section on preferences for customary routine and activities. Her Quarterly MDS Assessment did not accurately reflect cognitive pattern changes nor was evidence present in Resident #1's EMR of an acute change in mental status from her baseline and behaviors. Record review of Resident #1's Brief Interview for Mental Status (3.0 BIMS) Forms, dated 03/18/2025 to 09/03/2025 reflected:- 09/03/2025, reflected N /A for overall score indicating severe impairment, signed by the MDS- 08/22/2025, reflected N /A for overall score indicating severe impairment, signed by the SW- 05/28/2025, reflected 9 for overall score indicating moderate cognitive impairment, signed by the SW- 03/18/2025, reflected 8 for overall score indicating moderate cognitive impairment, signed by the SW. Her Brief Interview for Mental Status (3.0 BIMS) on 08/22/2025 and 09/03/2025 were not accurately performed as Resident #1 was missing one or both hearing aids during these interviews. Record review of Resident #1's care plan, dated 04/02/2025, revealed Resident #1- Had impaired cognitive function related to diagnosis of Dementia/Alzheimer's with the intervention to include ask yes/no questions to determine needs with intervention to include communicating basic needs daily through the review date, initiated, date initiated 09/16/2025.- Had moderate decreased hearing loss in both ears and used hearing aids, date initiated 07/28/2025. - Had a history of choosing not to wear her hearing aids, taking them out, and losing them with the intervention to include assisting resident with putting the hearing aids in each day, facing resident when speaking and speaking in clear simple sentences, and ensuring hearing aids are kept in a safe place, date initiated 07/28/2025.- Her care plan did not include a noted intervention for communication strategies for hearing loss after hearing aids were lost by the resident on 08/24/2025. 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