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	11/22/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 41937 Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible and each resident received adequate supervision to prevent accidents for 2 of 3 residents (Residents #20 and #25) reviewed for accidents/hazards, in that: 1. Resident #20 was provided a fall intervention on 05/23/2024 to include an anti-rollback device affixed to his wheelchair. Intermittent observations from 11/19/2024 thru 11/22/2024 revealed Resident #20 was observed ambulating in his wheelchair without a functioning ant-rollback device. 2. Resident #25 was provided a fall intervention on 09/22/2023 to include an anti-rollback device affixed to her wheelchair. Intermittent observations from 11/19/2024 thru 11/22/2024 revealed Resident #25 was observed ambulating in her wheelchair without a functioning ant-rollback device. This deficient practice could place residents at risk for harm. The findings included: 1. Resident #20 A record review of Resident #20's admission and discharge record dated 11/21/2024 revealed an admitted [DATE] with diagnoses which included dementia and COPD (an ongoing lung condition caused by damage to the lungs. The damage results in swelling and irritation, also called inflammation, inside the airways that limit airflow into and out of the lungs) and dementia (group of symptoms affecting memory, thinking and social abilities. In people who have dementia, the symptoms interfere with their daily lives). A record review of Resident #20's quarterly MDS assessment dated [DATE] revealed Resident #20 was a [AGE] year-old male admitted for long term care under hospice services. Resident #20 was assessed with a BIMS score of 03 out of a possible 15 which indicated severe cognition impairment. Resident #20 was assessed as needing substantial / maximal assistance helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort with the following activities of daily life: (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Sit to stand: the ability to come to a standing position from a sitting in a chair, wheelchair, or on the side of the bed. Chair bed to chair transfer: the ability to transfer to and from a bed to a chair or wheelchair. Toilet transfer: the ability to get on and off a toilet or commode. A record review of Resident #20's fall risk assessment dated [DATE] revealed Resident #20 was a Moderate Risk For Falling. A record review of Resident #20's Multidisciplinary Care Conference dated 10/30/2024 revealed Resident #20 was under hospice services, used a wheelchair. A record review of Resident #20's care plan dated 11/21/2024 revealed Resident #20 was provided an anti-rollback device affixed to his wheelchair in response to falls without injuries on 05/23/2024 . During an observation on 11/19/2024 at 12:22 PM Resident #20 was observed seated in his wheelchair at the lunch table. The wheelchair presented with an antiroll back device. Further observation revealed only 1 safety prong protecting the right wheelchair wheel was in place; the left wheel safety prong was missing. Continued intermittent observations from 11/19/2024 thru 11/22/2024 revealed Resident #20 continued ambulating in his wheelchair without a functioning ant-rollback device. During an observation on 11/21/24 at 02:52 PM revealed Resident #20 was in his room seated in his wheelchair; the wheelchair presented without a functioning anti-rollback device specifically no safety prong protecting the left wheel from rolling backwards. During a joint interview on 11/21/24 at 03:03 PM CNA C and LVN E stated Resident #20 had only 1 spoke covering Resident #20's right wheel on his wheelchair. CNA C and LVN E stated they had no knowledge of how long the spoke was missing and had not noticed how long it had been missing, CNA C stated she was an agency CNA and had worked 2-3 times a week for the past 3 months. LVN E stated she had been employed since July 2024 and had been assigned all residents at 1 point or another but usually was assigned 100-hall where Resident #20 resided. LVN E stated she had not recognized the anti-roll back device was missing a spoke on the left side and stated the risk to Resident #20 was a potential fall. CNA C and LVN E stated the safety device was not functioning without both spokes to brake the wheels when Resident #20 arose from the wheelchair. CNA C stated the wheelchair could roll away to the left if Resident #20 attempted to rise out of the chair. During an interview on 11/21/24 03:12 PM OT F stated Resident #20 was missing the left side portion of the anti-rollback safety device affixed to Resident #20's wheelchair. OT F stated the device would not function as designed and posed a risk for not preventing the wheelchair to rollback when Resident #20 may attempt to rise out of the wheelchair. 2. Resident #25 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident #25's admission record dated 11/22/2024 revealed an admitted [DATE] whit diagnoses which included Parkinson's disease (a movement disorder of the nervous system that worsens over time; the disorder also may cause stiffness, slowing of movement and trouble with balance that raises the risk of falls) and dyskinesia (A blanket term to describe uncontrollable and involuntary movements. It's when your body moves in ways you cannot control. It can affect just one part of the body, like the head or an arm, or your entire body.) A record review of Resident #25's quarterly MDS assessment dated [DATE] revealed Resident #25 was a [AGE] year-old female admitted for long term care and assessed with a BIMS score of 15 out of a possible 15 which indicated no cognitive impairment. Resident #25 was assessed with adequate hearing and vision and could understand others and make herself understood. Resident was assessed with the need to use a wheelchair. Resident #25 was assessed with the need for assistance with Chair / bed-to-chair transfer as Supervision or touching assistance - helper provides verbal ques and / or touching / steadying and /or contact guard assistance as Resident completes the activity. Assistance may be provided throughout the activity or intermittently. A record review of Resident #25's fall risk assessment dated [DATE] revealed Resident #25 was a High Risk for Falling. A record review of Resident #25's care plan dated 11/22/2024 revealed, (Resident #25) has high risk for falls related to history of falls, antidepressant medication use and gait balance problems . interventions / tasks . 09/22/2023 resident has had two falls with no injuries in three days, Resident (#25) to use anti rolling device to wheelchair During an observation on 11/19/2024 at 12:40 PM Resident #25 was observed seated in her wheelchair at the lunch table. The wheelchair presented with an anti-roll back device. Further observation revealed only 1 safety prong protecting the left wheelchair wheel was in place; the right wheel safety prong was missing. Continued intermittent observations from 11/19/2024 thru 11/22/2024 revealed Resident #25 continued ambulating in her wheelchair without a functioning ant-rollback device. During an observation on 11/20/24 at 11:15 AM revealed Resident #25 attending the Resident council meeting. Resident #25 was seated in her wheelchair. The wheelchair presented without a safety prong over the left wheel of the wheelchair. During an observation and interview on 11/21/2024 at 03:15 PM revealed Resident #25 in her room laying in her bed. Further observation revealed her wheelchair by her bedside. The wheelchair presented with an anti-rollback device affixed to her wheelchair with the right wheel unprotected with a safety prong. The wheelchair only had a safety prong on the right wheel. Resident #25 communicated the wheelchair did not have a functioning anti-rollback device as evidenced by the lack of a right wheel safety prong. Resident #25 stated the device had been missing for some time and could not recall exactly how long. Resident did respond in the negative when questioned if the safety device was missing longer than weeks and indicated the device was missing longer than months. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a joint interview on 11/21/24 at 03:20 PM OT F and RN D stated Resident #25 was at risk for falling and used a wheelchair with anti-rollback device on her wheelchair. OT F and RN D stated Resident #25's wheelchair had a faulty anti-rollback device with the right wheel safety missing. RN D stated the device could malfunction and would not stop the wheelchair from rolling back and could contribute to a fall. RN D stated Resident #25 was diagnosed with Parkinson's disease and had history of falling. RN D stated she had not noticed the device was faulty and could not state how long the device had been faulty. During a joint interview on 11/21/24 at 04:41 PM the Administrator and the DON stated 3 residents out of the entire census of 47 were provided anti-rollback safety devices for their wheelchair's. The Administrator and the DON stated only residents #20 and #25 had presented with an ineffective anti-rollback device affixed to their wheelchairs. During a joint interview on 11/22/24 05:32 PM the Administrator and the DON stated residents who needed safety devices for fall preventions such as anti-rollback devices for wheelchairs and had faulty safety devices were at risk for falls. The Administrator and the DON stated safety mechanisms needed to be in place and working in order to protect the Resident and the direct care staff should be monitoring the safety devices and reporting if there are problems with safety equipment . The Administrator stated he would get with clinical staff, and address training vs execution issues regarding monitoring of safety equipment and hold staff accountable. A record review of the facility's Accidents and Incidents - Investigating and reporting policy dated July 2017, revealed, policy statement: all accidents or incidents involving residents, employees, visitors, vendors, etcetera, occurring on our premises shall be investigated and reported to the Administrator. Policy interpretation and implementation: the nurse supervisor / charge nurse and or the department director or supervisor shall promptly initiate and document investigation of the accident or incident. this facility is in compliance with current rules and regulations governing accidents and for incidents involving a medical device

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937 Based on observation, interviews, and record reviews the facility failed to ensure its medication error rates were not 5% or greater. The facility had a medication error rate of 8.0% (percent), based on 2 errors out of 25 opportunities which involved 1 of 6 residents (Resident #29) reviewed for medication administration and medication errors. 1. LVN E administered Resident #29's medications: metformin (medication for managing high blood sugar in type 2 diabetes) 1000mg and metoprolol tartrate (an immediate-release tablet that must be taken several times per day) 25mg, scheduled at 08:00 AM, at 09:30 AM thirty minutes late. These deficient practices could place residents at risk for not receiving therapeutic effects of their medications and possible adverse reactions. The findings included: 1. A record review of Resident #29's admission record revealed an admitted [DATE] with diagnoses which included diabetes mellitus (a disorder of carbohydrate metabolism characterized by impaired ability of the body to produce or respond to insulin and thereby maintain proper levels of sugar (glucose) in the blood) and heart failure. A record review of Resident #29's quarterly MDS assessment dated [DATE] revealed Resident #29 was a [AGE] year-old female admitted for long term care and was assessed with a BIMS score of 15 out of a possible 15 which indicated no cognitive impairment. A record review of Resident #29's physicians orders dated 11/22/2024 revealed Resident #29 was prescribed to receive metformin (a drug prescribed to assist with blood sugar levels) 1000mg daily, twice a day, at 08:00 AM and at 05:00 PM for diabetes mellitus. Further review revealed Resident #29 was prescribed to receive metoprolol (a drug prescribed to assist with a normal rhythmic heart beat) 25mg daily twice a day at 08:00 AM and at 05:00 PM for heart failure. A record review of Resident #29's care plan dated 11/22/2024 revealed, (Resident #29) has the potential for complications related to diabetes type 2 mellitus with hyperglycemia (high levels of blood sugar) (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 11/21/2024 at 09:20 AM revealed LVN E prepared medications for Resident #29 to include metformin 1000mg and metoprolol 25mg. LVN E administered the medications at 09:30 AM. LVN E stated she was in the reds for medication administration. LVN E described the electronic medication administration record as being highlighted in red to indicate late medication administration. Observation of Resident #29's medication administration record revealed the record to be highlighted red. LVN E stated she was assigned medication administration duty for 1/3 of the facility's residents and described her assignment as the Middle Hall. LVN E stated she was late and was complicated by her breakfast safety monitoring assignment this morning (11/21/2024) LVN E stated she began her shift at 06:00 Am this morning and had concluded her Breakfast dining room safety assignment around 08:45 AM and then began her medication administration assignment. LVN E stated if residents prescribed medication time is past 1 hour the electronic medication record would become highlighted in red to indicate a late medication administration. LVN E stated she had more than 3 residents highlighted in red. LVN E stated she had not communicated the potential for late medication administration with her supervisors the ADON and or the DON. LVN E stated residents who received their medications late were at risk for not receiving the therapeutic effects of their medications. During a joint interview on 11/22/24 05:32 PM the Administrator and the DON stated a medication error includes any failure to meet the 5 rights of medication administration to include: 1. The right Resident. 2. The right drug. 3. The right dosage. 4. The right route of administration. 5. And the right time of administration. The DON stated the right time was considered administration to occur within 1 hour of the prescribed time. If a drug prescribed at 08:00 AM was administered at 09:30 AM the administration was late by 30 minutes and the Resident was at risk for not receiving the intended therapeutic effects of the prescribed medication. The administrator stated he was in agreement with the DON, and stated it was a training vs execution issue, and a skill or will issue and would follow up with medication administration monitoring and would provide accountability measures. A record review of the facility's Administering Medications policy dated April 2019, revealed, Policy statement: medications are administered in a safe and timely manner, and as prescribed. Policy interpretation and implementation: staffing schedules are arranged to ensure that medications are administered without unnecessary interruptions. Medications are administered in accordance with prescriber orders, including any required time frame. Medication administration times are determined by resident need and benefit, not staff convenience. the heart ministered within one hour of their prescribed time,

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937 Based on observations, interviews, and record reviews, the facility failed to ensure residents were free from significant medication errors for 2 of 10 residents (Residents #43 and #47) reviewed for significant medication errors. 1. On 11/21/2024 at 09:45 AM, LVN E administered to Resident #43 memantine (used to treat moderate to severe confusion (dementia) related to Alzheimer's disease) 10mg to Resident #43 late by 45 minutes. 2. On 11/21/2024 at 09:54 AM, LVN E administered to Resident #47: A. Valsartan (used to treat high blood pressure and heart failure. It is also used to improve the chance of living longer after a heart attack.) 160mg late by 54 minutes. B. Levetiracetam (a drug used to suppress seizures) 500mg late by 54 minutes. C. Divalproex 250mg (a drug used to prevent seizures, mood disorders, and migraine headaches) late by 54 minutes . These deficient practices placed residents at risk for not receiving the therapeutic effects of their prescribed medications. The findings include: 1. Resident #43 A record review of Resident #43's admission record dated 11/22/2024 revealed an admitted [DATE] with diagnoses which included Alzheimer's disease (A type of brain disorder that causes problems with memory, thinking and behavior. This is a gradually progressive condition.) A record review of Resident #43's quarterly MDS assessment dated [DATE] revealed Resident #43 was an [AGE] year-old male admitted for long term care and assessed with a BIMS score of 01 out of a possible 15 which indicated severe cognitive impairment. A record review of Resident #43's physicians orders dated 11/22/2024 revealed Resident #43 was prescribed to receive daily twice a day memantine 10mg at 08:00 and again at 05:00 PM. A record review of the facilities Medication Admin Audit Report dated 11/21/2024 revealed Resident #43 was administered memantine 10mg at 09:45 AM by LVN E. 2. Resident #47 A record review of Resident #47's admission record revealed an admitted [DATE] with diagnoses which included atherosclerotic heart disease and seizures. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident #47's quarterly MDS assessment dated [DATE] revealed Resident #47 was a [AGE] year-old female admitted for long term care and assessed with a BIMS score of 00 out of a possible 15 which indicated severe cognition impairment. further review revealed Resident #47 could sometimes make herself understood and could sometimes understand others. A record review of Resident #47's care plan dated 11/22/2024 revealed, (Resident #47) has impaired cognitive function related to dementia. administer medication as ordered . (Resident #47) has the potential for altered cardiac output hypertension (high blood pressure) . administer medications as ordered. A record review of Resident #47's physician's orders dated 11/22/2024 revealed the physician ordered Resident #47 to receive daily twice a day at 08:00 AM and at 05:00 PM Valsartan 160mg and levetiracetam 500mg. further review revealed Resident #47 was prescribed to receive three times a day, at 08:00 AM, 02:00 PM, and 08:00 PM, divalproex 250mgs. A record review of the facilities Medication Admin Audit Report dated 11/21/2024 revealed LVN E administered to Resident #47: Valsartan 160mg on 11/21/2024 at 09:54 AM and was scheduled for 08:00 AM. Levetiracetam 500mg on 11/21/2024 at 09:54 AM and was scheduled for 08:00 AM. Divalproex 250mg on 11/21/2024 at 09:54 AM and was scheduled for 08:00 AM. During an observation and interview on 11/21/2024 at 09:20 AM revealed LVN E prepared medications for Residents. LVN E stated she was in the reds for medication administration. LVN E described the electronic medication administration record as being highlighted in red to indicate late medication administration. Observation of Residents MAR revealed the record to be highlighted red. LVN E stated she was assigned medication administration duty for 1/3 of the facility's residents and described her assignment as the Middle Hall. LVN E stated she was late and was complicated by her breakfast safety monitoring assignment this morning (11/21/2024) LVN E stated she began her shift at 06:00 Am this morning and had concluded her Breakfast dining room safety assignment around 08:45 AM and then began her medication administration assignment. LVN E stated if residents prescribed medication time is past 1 hour the electronic medication record would become highlighted in red to indicate a late medication administration. LVN E stated she had more than 3 residents highlighted in red. LVN E stated she had not communicated the potential for late medication administration with her supervisors the ADON and or the DON. LVN E stated residents who received their medications late were at risk for not receiving the therapeutic effects of their medications. During a joint interview on 11/22/24 05:32 PM the Administrator and the DON stated a medication error includes any failure to meet the 5 rights of medication administration to include: 1. The right Resident. 2. The right drug. 3. The right dosage. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. The right route of administration. 5. And the right time of administration. The DON stated the right time was considered administration to occur within 1 hour of the prescribed time. If a drug prescribed at 08:00 AM was administered at 09:30 AM the administration was late by 30 minutes and the Resident was at risk for not receiving the intended therapeutic effects of the prescribed medication. The administrator stated he agreed with the DON, and stated it was a training vs execution issue, and a skill or will issue and would follow up with medication administration monitoring and would provide accountability measures . A record review of the facility's Adverse Consequences and Medication Errors policy dated February 2023, revealed, Policy heading: the interdisciplinary team monitors medication usage in order to prevent any detect medication related problems such as adverse drug reactions and side effects. Policy interpretation and implementation: . medication errors: a medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physicians orders, manufacturer specifications, or accepted professional standards and principles of the professional providing services, examples of medication errors include: . wrong time

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44906 Based on observation, interview, and record review the facility failed to maintain medical records on each resident that were complete, accurately documented, readily accessible, and systematically organized, for 3 of 8 residents reviewed (Residents #7, #38, and #16) for complete and accurate medical records 1. The facility failed to ensure Resident #7's signed out of hospital do not resuscitation order form was properly uploaded in her medical record and did not contain another residents' (Resident #38's) signed OOH DNR order form; 2. The facility failed to ensure Resident #38's signed OOH DNR order form was properly uploaded in her medical record; 3. The facility failed to ensure Resident #16's signed OOH DNR order form was properly uploaded in her medical record. The findings included: 1. Record review of the Admission Record, dated 11/19/2024, reflected Resident #7 was an [AGE] year-old female, originally admitted [DATE]. Record review of the quarterly MDS assessment dated [DATE], reflected Resident #7 did not have a BIMS conducted due rarely or never being understood, with short and long-term memory problems and had severely impaired cognitive skills for daily decision making. Traumatic brain dysfunction related to unspecified dementia was Resident #7's primary medical condition category for admission. Other active diagnoses included non-Alzheimer's dementia. Resident #7 was coded as not having a prognosis resulting in a life expectancy of less than 6 months. Record review of the Order Summary Report, dated 11/22/2024, reflected Resident #7 had physician orders for a code status of DNR, with an order date of 05/06/2020. Record review of the Care Plan reflected Resident #7 had a focus area of advance directory: Do Not Resuscitate, with an initiated date of 05/12/2020, and revised on 08/14/2024. Record review of the EMR for Resident #7, reviewed on 11/20/2024 at 4:14 PM, revealed a signed OOH DNR order form dated 06/14/2021 but was for Resident #38. There was no signed OOH DNR for Resident #7 in her EMR. Record review of Resident #7's EMR tab entitled Miscellaneous, reflected a signed OOH DNR order form uploaded on 11/20/2024 [after this state agency surveyor alerted facility management of no signed OOH DNR order form for Resident #7 in the EMR, but included the signed OOH DNR order form for Resident #38]. The signed OOH DNR order form for Resident #7 was dated 05/01/2020. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation on 11/19/2024 at 11:09 AM, Resident #7 was supine with pillows under her left side with her eyes closed and steady, unlabored respirations. 2. Record review of the Admission Record, dated 11/22/2024, reflected Resident #38 was a [AGE] year-old female, originally admitted [DATE]. Record review of the quarterly MDS assessment dated [DATE], reflected Resident #38 had a BIMS summary score of 12, indicative of moderate cognitive impairment. Traumatic brain dysfunction related to unspecified dementia was Resident #38's primary medical condition category for admission. Other active diagnoses included non-Alzheimer's dementia and depression. Resident #38 was coded as not having a prognosis resulting in a life expectancy of less than 6 months. Record review of the Order Summary Report, dated 11/22/2024, reflected Resident #38 had physician orders for a code status of DNR, with an order date of 07/08/2021. Record review of the Care Plan reflected Resident #38 had a focus area of advance directory: Do Not Resuscitate, with an initiated date of 07/12/2021. Record review of the EMR tab entitled Miscellaneous, reviewed on 11/19/2024, for Resident #38 revealed there was not a signed OOH DNR order form uploaded. Record review of Resident #38's EMR tab entitled Miscellaneous, reflected a signed OOH DNR order form uploaded on 11/20/2024 [after this state agency surveyor alerted facility management that the signed OOH DNR order form in Resident #7's EMR was a signed OOH DNR order form for Resident #38]. The newly uploaded signed OOH DNR order form for Resident #38 was signed 6/14/2021. 3. Record review of the Admission Record, dated 11/22/2024, reflected Resident #16 was a [AGE] year-old female, originally admitted [DATE]. Record review of the annual MDS assessment dated [DATE], reflected Resident #16 had a BIMS summary score of 13, indicative of intact cognition. Other neurological conditions related to schizophrenia was Resident #16's primary medical condition category for admission. Other active diagnoses included cerebrovascular accident, transient ischemic attack or stroke and bipolar disorder. Resident #16 was coded as not having a prognosis resulting in a life expectancy of less than 6 months. Record review of the Order Summary Report, dated 11/22/2024, reflected Resident #16 had physician orders for a code status of DNR, with an order date of 11/08/2019. Record review of the Care Plan reflected Resident #16 had a focus area of advance directory: Do Not Resuscitate, with an initiated date of 11/13/2019. Record review of the EMR tab entitled Miscellaneous reviewed on 11/19/2024 for Resident #16 revealed there was not a signed OOH DNR order form uploaded. Record review of the Resident #16's EMR tab entitled Miscellaneous, reflected a signed OOH DNR order form uploaded on 11/20/2024 [after this state agency surveyor alerted facility management of no signed OOH DNR consent for Resident #16 in the EMR] for Resident #16. The newly uploaded OOH DNR for Resident #16 was signed 11/5/2019 by her legal guardian. (continued on next page)

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	11/22/2024

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation on 11/19/2024 at 10:49 AM, Resident #16 was sitting upright in a WC, dressed appropriately for the weather, including footwear, hair clean and neatly combed. In an interview on 11/21/2024 at 8:10 AM, the DON stated she began as the DON in July 2024 and had recognized the facility had some paper records, for example OOH DNRs, and had developed and implemented a system to scan all paper records into the electronic medical record for each resident. The DON stated the Nurse Case Manager was assigned this duty; the DON stated she (the DON) was responsible for oversight of the system. The DON stated she received a report on 11/20/2024 that Resident #16, Resident #7, and Resident #38 had errors regarding OOH DNR documents. The DON stated she reviewed all residents for accurate records regarding OOH DNR documents and recognized Resident #16, Resident #7, and Resident #38 did not have their OOH DNR scanned into the electronic medical record. The DON stated Resident #38 OOH DNR was erroneously scanned into Resident #7's record. The DON stated she had not previously reviewed Resident #16, Resident #7, and Resident #38 electronic medical record for accuracy regarding the uploading of scanned paper records. The DON stated the failure could affect residents by not having accurate records. In an interview on 11/21/2024 at 2:21 PM, the SW stated it was of upmost importance to have complete and accurate records for advanced directives so that direct care staff know how to honor the residents' end of life wishes. The SW stated that a delay in care, or wrong care provided could happen if accurate advanced directives are not available. The SW stated that either the business office manager [NAME] or she (the SW) would upload signed OOH DNR order forms into the EMR once completed. The SW stated after the signed OOH DNR order form was uploaded in to the EMR, either the DON or the MDS nurse would immediately update the Care Plan and active order sets. The SW stated that she was unaware of any issues with advanced directives. The SW stated she was unsure of who was responsible to ensure EMR documents are uploaded correctly. The SW stated that as a matter of practice, she kept a binder with a copy of the signed OOH DNR order form as a backup copy. The SW stated this binder would not be readily accessible to direct care staff and would not be considered part of the medical records. The SW stated she had not been tasked to verify that the EMR matched the binder she kept in her office. In a group interview on 11/22/2024 at 5:32 PM, with the ADM and the DON, the DON stated that there was the potential to provide incorrect care for the resident due to the wrong OOH DNR being in the EMR, or no OOH DNR being in the EMR. The ADM stated that the issue was an ongoing process improvement plan and he (the ADM) and the DON were responsible for monitoring accuracy of the EMR. The ADM stated he would be holding the appropriate staff accountable and initiate progressive counseling as necessary. Requested facility policy on accurate medical records from the ADM on 11/21/2024 at 5:16 PM; did not receive prior to exit. Record review of Do Not Resuscitate Order policy, revised April 2017, reflected, under the heading Policy Interpretation and Implementation, step 1.) DNR orders must be signed .maintained in the resident's medical record. 2. A signed DNR order form must be completed and signed .placed in the resident's medical record. (continued on next page)

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	11/22/2024

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Lippincott procedures, Long-Term Care Documentation, revised 5/19/2024, accessed 11/27/2024, https://procedures.lww.com/lnp/view.do?pId=4420213&hits=records,record&a=true&ad=false&q=record, reflected under the heading Introduction, long-term care facilities must maintain complete, accurate, readily accessible and systematically organized medical records for each resident.

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	675678	A. Building B. Wing	11/22/2024

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Care Choice of Boerne	200 E Ryan St Boerne, TX 78006

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937 44906 Based on observation, interview, and record review the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and prevent the development and transmission of communicable diseases and infection for 1 of 10 residents (Resident #31) reviewed for infection control. The facility failed to ensure hand hygiene was initiated between glove changes during blood glucose monitoring and administration of insulin to Resident #31 on 11/21/2024. This deficient practice could affect all residents by contributing to the bacteria load and/or cross contamination during provision of care. The findings included: Record review of Admission Record, dated 11/22/2024, reflected Resident #31was a [AGE] year-old female, originally admitted [DATE]. Record review of the quarterly MDS assessment dated [DATE], reflected Resident #31 did not have a BIMS assessment conducted due to Resident #31 rarely or never understood. Non-traumatic brain dysfunction related to unspecified dementia was Resident #31's primary medical condition category for admission. Other active diagnoses included Diabetes Mellitus. 7 insulin injections were received during the last 7 days of the MDS look back period. Record review of the Order Summary Report, dated 11/22/2024, reflected Resident #31 had physician orders for Sliding Scale Lispro Insulin [required blood glucose monitoring antecedently] before meals and at bedtime with a start date of 6/25/2024. Record review of the Care Plan reflected Resident #31 had a focus area of potential for complications related to diabetes; with the following associated interventions: perform Accuchecks [blood glucose monitoring] as ordered and prn with an initiated date of 10/21/2020 and revision on 10/30/2024. Record review of the MAR, printed on 11/22/2024, reflected Resident #31 had a blood glucose reading of 270 on 11/21/2024 prior to the noon meal: necessitating administration of 6 units of Lispro insulin by LVN A. (continued on next page)

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	675678	A. Building B. Wing	11/22/2024

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Care Choice of Boerne	200 E Ryan St Boerne, TX 78006

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 11/21/2024 at 11:40 AM, LVN A, prepared the equipment necessary to obtain the blood glucose reading for Resident #31, that included a glucometer, test strip, lancet, alcohol wipes and a 2 by 2-inch gauze pad. LVN A sanitized the glucometer according to manufactures recommendations, by wiping the outside of the glucometer with a disposable sanitizing cloth while wearing disposable gloves. LVN A did not perform hand hygiene after discarding those gloves. LVN A then, entered Resident #31's room to obtain the blood glucose reading for Resident #31. LVN A, washed her hands at the sink in Resident #31's room. LVN A donned gloves prior to lancing the tip of Resident #31 index finger for a drop of blood required for the glucometer. Upon the obtaining the reading, LVN A then determined that Resident #31 would require insulin as per the physicians' orders for sliding scale administration. LVN A, discarded her gloves, and exited the room without performing hand hygiene. LVN A then initiated preparing the sliding scale insulin, whereupon she donned gloves without performing hand hygiene. LVN A, discarded those gloves, and entered Resident #31's room. LVN A, donned gloves without performing hand hygiene and proceeded to administer the sliding scale insulin to Resident #31. LVN A, discarded her gloves, but did not perform hand hygiene and then exited Resident #31's room. In an interview on 11/21/2024 at 11:48 AM, LVN A stated she was very nervous being observed and would forget where she was in the process of obtaining the blood glucose reading and administering insulin. LVN A, stated she thought she had performed hand hygiene at each appropriate step as she had been trained, but stated she was very nervous being observed. In a group interview on 11/22/2024 at 5:32 PM, with the ADM and the DON, the DON stated the appropriate time to perform hand hygiene was prior to doing care with a resident, before you touch a resident. The DON stated that if you use gloves, you need to perform hand hygiene prior to donning gloves, and between glove changes. The DON stated this requirement is trained upon new hire on-boarding process, at annual competency training, and in In-Service trainings as needed. The DON stated that it is not a good practice to skip appropriate hand hygiene in a health care setting. The DON stated that could transmit illness among residents, staff and their homes or families. Review of Handwashing/Hand Hygiene policy, revised October 2023, reflected under the heading Indications for Hand Hygiene, step 1. Hand hygiene is indicated: a) immediately before touching a resident; g.) immediately after glove removal. Under the heading Applying and Removing gloves, step 1. Perform hand hygiene before applying non-sterile gloves; Step 5. [after doffing gloves] Perform hand hygiene. Review of CDC Hands web page, dated 02/27/2024, entitled Clinical Safety: Hand Hygiene for Healthcare Workers, accessed from https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html, accessed on 10/07/2024, reflected, under the subheading Know when to clean your hands, immediately after glove removal.