

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 02/14/2026
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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency) in accordance with State law through established procedure. In response to allegations of abuse, neglect, exploitation, or mistreatment, including injuries of unknown source for 3 of 5 residents (Resident #2, Resident #33, and Resident #39) whose records were reviewed for abuse and neglect. 1. The facility DON failed to identify a self-inflicted injury as an alleged violation of neglect for Resident #2 on 9/16/2025 resulting in the resident having to be transported to the hospital by emergency medical services for a psych evaluation. 2. The DON failed to report an alleged violation of neglect for Resident #2 on 9/16/2025 to the Administrator of the facility and the Administrator failed to report the violation of neglect not later than 24 hours to other officials (including to the State Survey Agency) in accordance with State law through established procedure. 3. The facility failed to report an incident on 8/31/2025 in which Resident #39 intentionally struck Resident #33 with her walker. 4. The facility failed to report an injury of unknown origin to Resident #39 on 7/25/2025 that resulted in a subdural (the area surrounding the brain inside of the skull) hemorrhage. This deficient practice could place residents at risk of harm by not having their self-inflicted injuries investigated. The findings included: Review of Resident #2's admission record dated 2/11/2026 reflected a [AGE] year-old female admitted to the facility on [DATE] and re-admitted on [DATE]. Her diagnoses included: dementia (describes a group of symptoms affecting memory, thinking and social abilities), mild cognitive impairment (condition characterized by noticeable memory or thinking problems), major depressive disorder (serious mental health condition characterized by persistent feelings of sadness, loss of interest in activities, and various emotional and physical problems), generalized anxiety disorder (mental health condition characterized by excessive, uncontrollable worry about everyday issues, affecting daily functioning and quality of life), bipolar disorder (mental health condition characterized by significant mood swings, including manic and depressive episodes), and insomnia (characterized by difficulty falling asleep, staying asleep, or waking up too early and not being able to return to sleep). Review of an incident report titled #3054 Self Inflicted Injury dated 9/16/2025 reflected the following: Incident Description: Nursing Description: [DON] Informed by talk therapist that [Resident #2] had disclosed to here that she wanted to harm herself and yesterday she drank a bottle of eye drops. Resident Description: Upon interview and assessment, [Resident #2] verified that she drank a half (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bottle of over the counter eye drops because she is struggling with her bipolarism right now. Was the incident witnessed: No Immediate Action Taken: [DON] immediately went to see [Resident #2] and she is alert and oriented to her situation and verified that she drank a half bottle of over the counter eye drops because she is struggling with her bipolarism right now. [DON] informed [Resident #2] that [DON] would be sending her to ER [emergency room] for evaluation and she is agreeable. [DON] asked about symptoms and [Resident #2] states she was a little queasy after taking the drops yesterday and did throw up a little. She states that she is still nauseated now but attributes it to her current mental state. Charge Nurse informed of events reported and instructed to contact Provider for ER eval and inform of self harm attempt. Per talk therapist, PMHNP was contacted with self harm information and [Resident #2] agrees to ER evaluation. Review of Resident #2's EMR hospital encounter note dated 9/16/2025 reflected the following: Risk-Psychiatric Illness Detailed Suicide Risk Overall level suicide risk: high risk Risk Stratification & Suicide & Adult Risk factors reviewed Calculated Suicide Risk: No Risk. Review of Resident #2's care plan dated 9/22/2025 and revised 12/22/2025 reflected the following: [Resident #2] has depression r/t MAJOR DEPRESSIVE DISORDER, RECURRENT MODERATE. [Resident #2] will exhibit indicators of depression, anxiety or sad mood less than daily by review date. Review of Resident #2's quarterly MDS dated [DATE] reflected a BIMS score of 15, indicating little to no cognitive impairment. It reflected Resident #2 completed functional abilities of self-care and mobility independently and without assistance. Resident #2's active diagnoses for psychiatric/mood disorder Section I included: anxiety disorder, depression, bipolar disorder and she was taking antipsychotic, antianxiety, and antidepressant high-risk medications. Review of Resident #2's electronic medical record reflected that the facility comprehensively assessed the resident's physical, mental, and psychosocial needs. Further review of Resident #2's electronic medical record reflected mental health services and medication management were being provided to assist Resident #2 with function and mood. Review of Resident #2's electronic medical record from 2/10/2026 to 2/12/2026 reflected there was no indication the self-inflicted injury incident on 9/16/2025 was reported to the ADM within 24 hours of the event; nor was it reported to the State Survey Agency not later than 24 hours following the event. In an interview on 2/11/2026 at 6:30 PM, the ADM said the facility follows state protocols with reporting incidents of abuse and neglect. He said there are different incidents that require reporting to the state. The ADM said if there is an unwitnessed fall and resident can explain what occurred he would not report. He said witnessed falls would not be reported. The ADM added that unwitnessed falls with injury requiring hospital transport if resident can say what happened he would not report it. He said suicide attempts or self-injury incidents he would report. The ADM said if abuse and neglect are not reported it could be harmful to a resident and their overall health and care at the facility. He said he does not recall the self-harm incident involving Resident #2 and said he was not aware of the incident from 9/16/2025. The ADM called DON to join the interview. In an interview on 2/11/2026 at 6:35 PM, the DON said she was aware of Resident #2's self-harm (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10:29 PM by LVN D: [Radiology] at facility to perform hip x-ray from previous fall. Upon entering resident's room, resident found standing in bathroom washing hands. Resident wearing pajamas and sandals. Resident verbalized that she had fallen. Resident raised bangs and showed this nurse a large contusion to left eyebrow. Resident assisted to bed. Vitals and neuros assessed. On call [provider] notified. New order received to send resident out to ER for eval. DON notified of incident. POA [family member] notified. Record review of the facility incident report dated 2/10/2025 reflected Resident #39 had an incident of physical aggression initiated on 8/31/2025, and Resident #33 had an incident of physical aggression received on 8/31/2025. Record review of the facility incident report titled #3027 Physical Aggression Initiated dated 8/31/2025 at 8:40 AM, reflected the following: I was walking past nurse's station and observed [Resident #39] ram her rolling walker in to [sic] the legs of another resident who was sitting in her w/c in the hallway. [Resident #39] is saying in Spanish that this man is a son of a [expletive]. Resident #39's family member was interviewed on 2/09/2026 at 11:58 AM. She said Resident #39 had numerous falls over the last year that resulted in bone fractures and bleeding in her brain. She said Resident #39 becomes very agitated whenever her family is not present, and she is frequently asked by the staff to come to the facility to monitor Resident #39 for safety. She said Resident #39 is confused and not able to tell her the circumstances of the falls after they happen. Attempted interview on 2/09/2026 at 2:12 PM, Resident #33 was unable to participate due to cognitive decline. In an interview on 2/12/2026 at 10:29 AM, the DON said she did not report the physical aggression incident between Resident #33 and #39 on 8/31/2025 to HHSC because the behavior was common for Resident #39. She said Resident #33 was not injured, and Resident #39 had a known history of physical and verbal aggression. In an interview with the ADM on 2/12/2026 at 10:56 AM, he said the physical aggression incident between Resident #33 and #39 on 8/31/2025 was not reported to HHSC because it did not result in harm. He said he felt that for an incident to be reportable to HHSC, a resident must have intent to harm another resident that is not due to confusion or other cognitive decline. He said he felt that his decision to not report the incident was aligned with the regulatory standards. In a subsequent interview with the DON on 2/13/2026 at 12:32 PM, she said Resident #39 had a witnessed fall on 7/25/2025 at 4:30 PM that was attributed to ambulating without her walker. She said that later that evening, around 10:00 PM, Resident #39 told the nurse that she had fallen again but could not say when or where, and she had a new bruise on her forehead. Resident #39 was sent to the hospital at that time and diagnosed with a pelvic fracture and a subdural hemorrhage. She said that the unwitnessed fall reported by Resident #39 on 7/25/2025 was not reported to HHSC because the resident stated that she fell, and due to the resident's history of frequent falls, she felt the resident's account of the injury was sufficient to explain the head injury. She said the pelvic fracture was likely caused by the falls earlier in the day on 7/25/2025. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #39's admission Record dated 2/10/2025 reflected a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included unspecified dementia and traumatic subdural hemorrhage without loss of consciousness. Record review of Resident #39's quarterly MDS submitted 10/30/2025 reflected a BIMS score of 03, which indicated severely impaired cognition. Section E0200 (behavioral symptoms) reflected Resident #39 exhibited physical symptoms towards others 4 to 6 days of the lookback period. Section J1800 indicated Resident #39 had experienced 0 falls since previous assessment. Record review of Resident #39's Care Plan Report undated/printed 2/10/2026, revealed the following: 8/31/25- physical aggression initiated, redirected, anticipate needs, encourage resident to talk in a calm manner, listen, follow protocols/policy of facility (date initiated 10/23/2025) 7/25/25- fall w injury, sent to Hosp w hospital admission [DATE]- 7/29/25) . (date initiated 8/11/2025) 7/25/25- x 2 falls, anticipate needs, encourage to call for help, staff to offer assistance as needed (date initiated 10/23/2025). Record review of Resident #39's progress notes reflected the following entry dated 7/25/2025 at 10:29 PM by LVN D: [Radiology] at facility to perform hip x-ray from previous fall. Upon entering resident's room, resident found standing in bathroom washing hands. Resident wearing pajamas and sandals. Resident verbalized that she had fallen. Resident raised bangs and showed this nurse a large contusion to left eyebrow. Resident assisted to bed. Vitals and neuros assessed. On call [provider] notified. New order received to send resident out to ER for eval. DON notified of incident. POA [family member] notified. Record review of the facility incident report dated 2/10/2025 reflected Resident #39 had an incident of physical aggression initiated on 8/31/2025, and Resident #33 had an incident of physical aggression received on 8/31/2025. Record review of the facility incident report titled #3027 Physical Aggression Initiated dated 8/31/2025 at 8:40 AM, reflected the following: I was walking past nurse's station and observed [Resident #39] ram her rolling walker in to [sic] the legs of another resident who was sitting in her w/c in the hallway. [Resident #39] is saying in Spanish that this man is a son of a [expletive]. Resident #39's family member was interviewed on 2/09/2026 at 11:58 AM. She said Resident #39 had numerous falls over the last year that resulted in bone fractures and bleeding in her brain. She said Resident #39 becomes very agitated whenever her family is not present, and she is frequently asked by the staff to come to the facility to monitor Resident #39 for safety. She said Resident #39 is confused and not able to tell her the circumstances of the falls after they happen. Attempted interview on 2/09/2026 at 2:12 PM, Resident #33 was unable to participate in due to cognitive decline. (continued on next page)		

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interview and record review the facility failed to employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required for 1 of 1 kitchen reviewed. The facility failed to employ a qualified dietician or other clinically qualified nutrition professional on a full-time basis or designate a qualified director of nutritional services. A qualified director of nutritional services was last employed February 2025. The facility failed to employ a qualified dietician who designates a person to serve as a full-time director of food and nutrition services for the facility. The person designated to serve as a director of food and nutrition services did not have the qualifications to serve as the director of food and nutrition. These failures could place residents at risk of not having their nutritional needs met. Findings included: In an interview on 2/11/2026 at 11:45 AM, the FSS said she does not have the qualifications to serve as the director of food and nutrition services for the facility. The FSS said she had been working on becoming a certified dietary manager for about a year now. She said she accepted the full-time FSS position over a year back when the former FSS retired after 40 years. She said she was offered the position along with the training to become certified. She said she does have her food safe certification. In an interview on 2/11/2026 at 2:05 PM, the ADM said the facility had been without a qualified director of nutritional services for almost a year. He said he did not know the dietician could not designate the FSS as she does not have qualifications needed and that she is near the end of her training and would be obtaining her director of nutritional services certification within a few weeks. He said he did not see an impact to resident care as he had a dietician on a consultant basis providing resident assessments and guidance to the FSS. Record review of the facility document titled, CONSULT ANT DIETITIAN REPORT dated 11/17/2025, reflected the following: Summary of Consultation Activities: counseled patients on diets. reviewed patients' charts. observed meal preparation/menu followed. discussed general dietetic department admin. resident - problem - recommendation. 1. Completed assessments and MNAs on new admissions. FSS reported she is not completing MNAs due to time constraints. Record review of the facility document titled, CONSULT ANT DIETITIAN REPORT dated 12/23/2025, reflected the following: resident - problem - recommendation. 2. Observed lunch meal service in the dining room. Inadequate portions of pureed foods provided to residents on pureed diets. Limited discussion with cook due to language barrier. Other Dietary staff attempted to translate. Visually showed cook diet spreadsheets and numbers indicated on scoops to serve adequate portions. Recommend: FSS to provide training to cooks on diet spreadsheets and proper portions. 3. Reviewed monthly weights and identified significant weight losses/gains. Completed consults as needed. 4. Received current wound report. No new pressure injuries. 5. Completed assessments and MNAs on new admissions, readmission and annuals due. 6. FSS has submitted no lessons of CDM course for RD review this month. Record review of the facility document titled, CONSULT ANT DIETITIAN REPORT dated 1/26/2026, reflected the following: resident - problem - recommendation. 1. Completed assessments remotely today due to ice storm and icy road conditions. Assessed new admissions, new resident on TF [total fat], significant weight losses/gains, pressure injuries and annuals. Record review of facility document titled, Dietitian dated October 2017 reflected the following: Policy Statement A qualified, competent, and skilled Dietitian will help oversee the food and nutrition services in the facility. Policy Interpretation and Implementation 1. A qualified Dietitian or other clinically qualified nutrition professional will help oversee food and nutrition services provided to the residents. 2. A Food and Nutrition Services Manager will oversee the production, storage, and delivery of food. The Dietitian will work closely with the Food and Nutrition Services Manager and clinical staff. 3. The Dietitian or nutrition professional may be a full time or part time consultant or an (continued on next page)		

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	employee, depending on the current requirements of the facility. These requirements are based on: a. assessments and care plans of resident nutritional needs; and b. the overall facility assessment of the number, acuity and diagnoses of the resident population. 4. The Dietitian will have the qualifications, competency and skills to carry out the functions of the food and nutrition services. 7. If a dietitian is not employed full time (35 or more hours per week) a director of food service management will be designated. This individual will: a. be a certified dietary manager; or b. be a certified food service manager; or c. be nationally certified in food service management and safety; or d. have an associate's (or higher) degree in food service management or hospitality (must be from an accredited institution and include courses in food service or restaurant management); e. Meet any state requirements for food service or dietary managers; and f. Receive frequently scheduled consultations from a qualified dietitian or qualified nutrition professional.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to, in response to allegations of abuse, neglect, exploitation, or mistreatment, have evidence that all alleged violations are thoroughly investigated and report the results of all investigations to the state survey agency within five working days of the incident for 1 of 2 residents (Resident #2) reviewed for abuse and neglect. The facility failed to investigate when Resident #2 had a self-inflicted injury on 9/16/2025. This deficient practice placed all residents at risk of harm from neglect due to not having a thorough investigation conducted. The findings included: Review of Resident #2's admission record dated 2/11/2026 reflected a [AGE] year-old female admitted to the facility on [DATE] and re-admitted on [DATE]. Her diagnoses included: dementia (describes a group of symptoms affecting memory, thinking and social abilities), mild cognitive impairment (condition characterized by noticeable memory or thinking problems), major depressive disorder (serious mental health condition characterized by persistent feelings of sadness, loss of interest in activities, and various emotional and physical problems), generalized anxiety disorder (mental health condition characterized by excessive, uncontrollable worry about everyday issues, affecting daily functioning and quality of life), bipolar disorder (mental health condition characterized by significant mood swings, including manic and depressive episodes), and insomnia (characterized by difficulty falling asleep, staying asleep, or waking up too early and not being able to return to sleep). Review of an incident report titled #3054 Self Inflicted Injury dated 9/16/2025 reflected the following: Incident Description: Nursing Description: [DON] Informed by talk therapist that [Resident #2] had disclosed to here that she wanted to harm herself and yesterday she drank a bottle of eye drops. Resident Description: Upon interview and assessment, [Resident #2] verified that she drank a half bottle of over the counter eye drops because she is struggling with her bipolarism right now. Was the incident witnessed: No Immediate Action Taken: [DON] immediately went to see [Resident #2] and she is alert and oriented to her situation and verified that she drank a half bottle of over the counter eye drops because she is struggling with her bipolarism right now. [DON] informed [Resident #2] that [DON] would be sending her to ER [emergency room] for evaluation and she is agreeable. [DON] asked about symptoms and [Resident #2] states she was a little queasy after taking the drops yesterday and did throw up a little. She states that she is still nauseated now but attributes it to her current mental state. Charge Nurse informed of events reported and instructed to contact Provider for ER eval and inform of self harm attempt. Per talk therapist, PMHNP was contacted with self harm information and [Resident #2] agrees to ER evaluation. Review of Resident #2's EMR hospital encounter note dated 9/16/2025 reflected the following: Risk-Psychiatric Illness Detailed Suicide Risk Overall level suicide risk: high risk Risk Stratification - Suicide - Adult Risk factors reviewed Calculated Suicide Risk: No Risk. Review of Resident #2's care plan dated 9/22/2025 and revised 12/22/2025 reflected the following: [Resident #2] has depression r/t MAJOR DEPRESSIVE DISORDER, RECURRENT MODERATE. [Resident #2] will exhibit indicators of depression, anxiety or sad mood less than daily by review date. Review of Resident #2's quarterly MDS dated [DATE] reflected a BIMS score of 15, indicating little to no cognitive impairment. It reflected Resident #2 completed functional abilities of self-care and mobility independently and without assistance. Resident #2's active diagnoses for psychiatric/mood disorder Section I included: anxiety disorder, depression, bipolar disorder and she was taking antipsychotic, antianxiety, and antidepressant high-risk medications. There was no indication of self-harm documented. Review of Resident #2's electronic medical record from 2/10/2026 to 2/12/2026 reflected that the facility comprehensively assessed the resident's physical, mental, and psychosocial needs. Further review of Resident #2's electronic medical record reflected mental health services and medication management were being provided to assist Resident #2 with function and mood. Review of Resident #2's electronic medical record from 2/10/2026 to 2/12/2026 reflected there was no indication the self-inflicted injury (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Care Choice of Boerne		STREET ADDRESS, CITY, STATE, ZIP CODE 200 E Ryan St Boerne, TX 78006	
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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incident on 9/16/2025 was reported to the ADM within 24 hours of the event; nor was it reported to the State Survey Agency not later than 24 hours following the event and no indication the facility initiated an investigation of alleged violation of abuse or neglect. In an interview on 2/11/2026 at 6:30 PM, the ADM said the facility follows state protocols with investigating incidents of abuse and neglect. He said suicide attempts or self-injury incidents he would report and would undergo an investigation. ADM said if abuse and neglect are not reported it could be harmful to a resident and their overall health and care at the facility. He said he does not recall the self-harm incident on 9/16/2025 involving Resident #2 and he did not investigate. ADM called DON to join the interview. In an interview on 2/11/2026 at 6:35 PM, the DON said she was aware of Resident #2's self-harm incident on 9/16/2025 as she was notified immediately and she started interventions immediately. She said Resident #2 had orders for eye drops that were kept in her room. She said the resident had been allowed over the counter eye drops to be kept in her room by her bedside. She said the resident was transported by emergency services to the hospital to undergo a psych evaluation. She said the resident was cleared the same day and discharged back to the facility. She said the over-the-counter eye drops order was discontinued the same day and removed from Resident #2's room. DON said Resident #2 was placed on one-on-one supervision for three days following her return from the hospital. She said Resident #2 sees therapist weekly and she is stable. DON said she is being monitored by psych services and SW, so she didn't believe the incident needed to be reported to the state and did not require an investigation. She said she did not recall if this incident was reported to the ADM after it occurred. In an interview on 2/12/2026 at 12:11 PM, the SW said she has been working with Resident #2 for numerous years and said she knew this self-inflicted injury on 9/16/2025 was more of a cry for help rather than a self-harm attempt. SW said the self-harm incident was an acute incident and not part of Resident #2's baseline and not her day-to-day behavior. She said Resident #2 does have a history of psychiatric hospitalizations in the past, but she is working with her psychiatrist and therapist, and she had been stable for some time now. In an interview on 2/12/2026 at 12:58 PM, the MDS Coordinator said she was familiar with Resident #2's self-injury incident on 9/16/2025 and recalls the resident was sent to the hospital for an evaluation and psych services and she followed up with resident. She said that Resident #2 was deemed safe by psychiatrist and hospital, so she didn't meet criteria for significant change in status assessment. Record review of facility document titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating dated September 2022 reflected the following: Policy Statement All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Policy Interpretation and Implementation Reporting Allegations to the Administrator and Authorities 1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. 2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility; b. The local/state ombudsman; c. The resident's representative; d. Adult protective services (where state law provides jurisdiction in long-term care); e. Law enforcement officials; f. The resident's attending physician; and g. The facility medical director. 3. Immediately is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury; or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. 6. Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions (if any) are needed for the protection of residents. Investigating Allegations I. All allegations are thoroughly investigated. The administrator initiates investigations. 7. The individual conducting (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the investigation as a minimum: a. reviews the documentation and evidence; b. reviews the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident; c. observes the alleged victim, including his or her interactions with staff and other residents; d. interviews the person(s) reporting the incident; e. interviews any witnesses to the incident; f. interviews the resident (as medically appropriate) or the resident's representative; g. interviews the resident's attending physician as needed to determine the resident's condition; h. interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; i. documents the investigation completely and thoroughly. 9. The investigator notifies the ombudsman that an abuse investigation is being conducted. The ombudsman is invited to participate in the review process. 10. The investigator consults daily with the administrator concerning the progress/findings of the investigation. 11. Upon conclusion of the investigation, the investigator records the findings of the investigation on approved documentation forms and provides the completed documentation to the administrator. Follow-Up Report I. Within five (5) business days of the incident, the administrator will provide a follow-up investigation report. 2. The follow-up investigation report will provide sufficient information to describe the results of the investigation, and indicate any corrective actions taken if the allegation was verified. 3. The follow-up investigation report will provide as much information as possible at the time of submission of the report.		

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete a Significant Change MDS assessment within 14 days after the facility determined, or should have determined, there had been a significant change in a resident's physical or mental condition for 1 of 8 residents (Resident #2) reviewed for assessments. The facility failed to complete a Significant Change MDS for Resident #2 after a self-injury incident on 9/16/2025. This failure could place residents who had a significant change in condition at risk of not receiving needed services. The findings included: Review of Resident #2's admission record dated 2/11/2026 reflected a [AGE] year-old female admitted to the facility on [DATE] and re-admitted on [DATE]. Her diagnoses included: dementia (describes a group of symptoms affecting memory, thinking and social abilities), mild cognitive impairment (condition characterized by noticeable memory or thinking problems), major depressive disorder (serious mental health condition characterized by persistent feelings of sadness, loss of interest in activities, and various emotional and physical problems), generalized anxiety disorder (mental health condition characterized by excessive, uncontrollable worry about everyday issues, affecting daily functioning and quality of life), bipolar disorder (mental health condition characterized by significant mood swings, including manic and depressive episodes), and insomnia (characterized by difficulty falling asleep, staying asleep, or waking up too early and not being able to return to sleep.) Review of Resident #2's quarterly MDS dated [DATE] reflected a BIMS score of 15, indicating little to no cognitive impairment. It reflected Resident #2 completed functional abilities of self-care and mobility independently and without assistance. Resident #2's active diagnoses for psychiatric/mood disorder Section I included: anxiety disorder, depression, bipolar disorder and she was taking antipsychotic, antianxiety, and antidepressant high-risk medications. Review of Resident #2's care plan dated 9/22/2025 and revised 12/22/2025 reflected the following: [Resident #2] has depression r/t MAJOR DEPRESSIVE DISORDER, RECURRENT MODERATE. [Resident #2] will exhibit indicators of depression, anxiety or sad mood less than daily by review date. Review of Resident #2's EMR Psychiatric Subsequent Assessment, dated 9/10/2025 reflected the following: Chief Complaint: Doing OK Medical Necessity for visit: Patient seen today for chronic psychiatric conditions not requiring prescription management. Review of Systems Psychiatric: no current episodes Mental Status Examination: Suicidal Ideation: None Assessment/Plan: [Resident #2] Endorses she's doing OK no current symptoms of depression or mood changes Review of an incident report titled #3054 Self Inflicted Injury dated 9/16/2025 reflected the following: Incident Description: Nursing Description: [DON] Informed by talk therapist that [Resident #2] had disclosed to here that she wanted to harm herself and yesterday she drank a bottle of eye drops. Resident Description: Upon interview and assessment, [Resident #2] verified that she drank a half bottle of over the counter eye drops because she is struggling with her bipolarism right now. Was the incident witnessed: No Immediate Action Taken: [DON] immediately went to see [Resident #2] and she is alert and oriented to her situation and verified that she drank a half bottle of over the counter eye drops because she is struggling with her bipolarism right now. [DON] informed [Resident #2] that [DON] would be sending her to ER [emergency room] for evaluation and she is agreeable. [DON] asked about symptoms and [Resident #2] states she was a little queasy after taking the drops yesterday and did throw up a little. She states that she is still nauseated now but attributes it to her current mental state. Charge Nurse informed of events reported and instructed to contact Provider for ER eval and inform of self harm attempt. Per talk therapist, PMHNP was contacted with self harm information and [Resident #2] agrees to ER evaluation. Review of Resident #2's EMR hospital encounter note dated 9/16/2025 reflected the following: Risk-Psychiatric Illness Detailed Suicide Risk Overall level suicide risk: high risk Risk Stratification - Suicide - Adult Risk factors reviewed Calculated Suicide Risk: No Risk Review of Resident #2's EMR Psychiatric Subsequent Assessment, dated 9/22/2025, reflected (continued on next page)		

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the following: Top Target Symptoms: Description: Current Rating: Anxiety 6 - Severe Depression 6 - Severe Guilt Feelings 6 - Severe Intervention: Assessed current mood and anxiety symptoms to ascertain current emotional functioning. Addressed trauma triggers and continued verbal No Self Harm contract. Patient's Response to Intervention: [Resident #2] denies any [suicide ideations]and agrees to No Self Harm contract.Plan For Next Session: Continue to address recent [suicide ideation] and trauma.Review of Resident #2's EMR Psychiatric Clinical Treatment Plan Review (Plan of Care) dated 9/09/2025 reflected the following: Psychiatric History: [Resident #2] endorsed long history of mental illness including several months of inpatient psychiatric care 20 years ago and subsequent outpatient therapy and medication maintenance. The Brief Psychiatric Rating Scale: Description: Current Rating: Anxiety 3 - Mild Depression 3 - Mild Guilt Feelings 3 - Mild.Review of Resident #2's electronic medical record reflected that no significant change in status assessment or interdisciplinary review was completed following a self-inflicting injury/self-harm incident, a major deviation from Resident #2's established baseline health on 9/16/2025.Review of Resident #2's electronic medical record reflected that the facility comprehensively assessed the resident's physical, mental, and psychosocial needs. Further review of Resident #2's electronic medical record reflected mental health services and medication management were being provided to assist Resident #2 with function and mood.In an interview on 2/11/2026 at 6:30 PM, the DON said she does not recall why the MDS assessment, and the care plan was not updated for Resident #2 and understands that accuracy of MDS assessments is needed for any resident to ensure interventions are in place and to give them the best possible care.In an interview on 2/12/2026 at 12:11 PM, the SW said she had been working with Resident #2 for numerous years and said she knew this incident was more of a cry for help rather than a self-harm attempt. SW said the self-harm incident was an acute incident and not part of her baseline, not her day-to-day behavior. She said Resident #2 does have a history of psychiatric hospitalizations in the past, but working with her psychiatrist and therapist she had been stable for some time.In an interview on 2/12/2026 at 12:58 PM, the MDS Coordinator said admission MDS assessments and significant change in status assessments are required to be accurate and submitted on time. She said by not completing MDS assessments or significant change in status assessments could negatively impact care plans and the care provided to a resident. She said that she is required to review 24-hour nursing notes and attend the nursing management daily meetings for resident changes or incidents from the prior shift. She said if an incident occurs that may be a significant change she would reach out to the [NAME] nursing coordinator for assistance and change of condition assessment guidance. She said she was familiar with Resident #2's self-injury incident on 9/16/2025 and recalls the resident was sent to the hospital for an evaluation and psych services followed up with resident. She said that Resident #2 was deemed safe by psychiatrist and hospital, so she didn't meet criteria for significant change in status. The MDS Coordinator said the self-injury incident was a one-off occurrence and she did not believe this triggers for a significant change in status assessment. She said Resident #2 would have returned to baseline with staff help. She said the incident should have been updated in Resident #2's care plan and believes there was a communication issue. She said she will work on having the care plan updated immediately.In an interview on 2/12/2026 at 5:28 PM, the DON said the self-injury incident with Resident #2 was a significant change to her baseline and was an acute psychiatric episode. She said she is not an expert on MDS assessments, but there are certain criteria that are required to lead to a significant change assessment. She said an RAI assessment should have been completed following Resident #2's self-injury incident on 9/16/25. She also added that Resident #2 should have been care planned for psychiatric episode.Record review of facility document titled, Change in a Resident's Condition or Status dated May 2017 reflected the following: Policy Interpretation and Implementation 2. A significant change of condition is a major decline or improvement in the resident's status that: a. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not self-limiting); b. Impacts more than one area of the resident's health status; c. Requires (continued on next page)		

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interdisciplinary review and/or revision to the care plan; and d. Ultimately is based on the judgment of the clinical staff and the guidelines outlined in the Resident Assessment Instrument. 8. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. 9. If a significant change in the resident's physical or mental condition occurs, a comprehensive assessment of the resident's condition will be conducted as required by current OBRA regulations governing resident assessments and as outlined in the MDS RAI Instruction Manual. Record review of facility document titled, MDS Completion and Submission Timeframes dated October 2023 reflected the following: Policy Statement Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes. 1. The assessment coordinator or designee is responsible for ensuring resident assessments are submitted to CMS' Internet Quality Improvement Evaluation System (iQIES) in accordance with current federal and state guidelines. 2. Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual. Record review of facility document titled, Care Plans, Comprehensive Person-Centered dated March 2022 reflected the following: Policy Statement 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. Policy Interpretation and Implementation 2. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission. 3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: (1) services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; (2) any specialized services to be provided as a result of PASARR recommendations. 12. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition.		

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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** 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 1 of 2 residents (Resident #2) reviewed for care plans. The facility failed to update or add interventions to Resident #2's care plan regarding a self-inflicted incident that occurred on 9/16/2025. These failures could place residents at risk of not receiving the necessary services or having the appropriate interventions to meet their current needs. The findings included: Review of Resident #2's admission record dated 2/11/2026 reflected a [AGE] year-old female admitted to the facility on [DATE] and re-admitted on [DATE]. Her diagnoses included: dementia (describes a group of symptoms affecting memory, thinking and social abilities), mild cognitive impairment (condition characterized by noticeable memory or thinking problems), major depressive disorder (serious mental health condition characterized by persistent feelings of sadness, loss of interest in activities, and various emotional and physical problems), generalized anxiety disorder (mental health condition characterized by excessive, uncontrollable worry about everyday issues, affecting daily functioning and quality of life), bipolar disorder (mental health condition characterized by significant mood swings, including manic and depressive episodes), and insomnia (characterized by difficulty falling asleep, staying asleep, or waking up too early and not being able to return to sleep.) Review of Resident #2's EMR Psychiatric Subsequent Assessment, dated 9/10/2025 reflected the following: Chief Complaint: Doing OK Medical Necessity for visit: Patient seen today for chronic psychiatric conditions not requiring prescription management. Review of Systems Psychiatric: no current episodes Mental Status Examination: Suicidal Ideation: None Assessment/Plan: [Resident #2] Endorses she's doing OK no current symptoms of depression or mood changes Review of an incident report titled #3054 Self Inflicted Injury dated 9/16/2025 reflected the following: Incident Description: Nursing Description: [DON] Informed by talk therapist that [Resident #2] had disclosed to here that she wanted to harm herself and yesterday she drank a bottle of eye drops. Resident Description: Upon interview and assessment, [Resident #2] verified that she drank a half bottle of over the counter eye drops because she is struggling with her bipolarism right now. Was the incident witnessed: No Immediate Action Taken: [DON] immediately went to see [Resident #2] and she is alert and oriented to her situation and verified that she drank a half bottle of over the counter eye drops because she is struggling with her bipolarism right now. [DON] informed [Resident #2] that [DON] would be sending her to ER [emergency room] for evaluation and she is agreeable. [DON] asked about symptoms and [Resident #2] states she was a little queasy after taking the drops yesterday and did throw up a little. She states that she is still nauseated now but attributes it to her current mental state. Charge Nurse informed of events reported and instructed to contact Provider for ER eval and inform of self harm attempt. Per talk therapist, PMHNP was contacted with self harm information and [Resident #2] agrees to ER evaluation. Review of Resident #2's EMR hospital encounter note dated 9/16/2025 reflected the following: Risk-Psychiatric Illness Detailed Suicide Risk Overall level suicide risk: high risk Risk Stratification - Suicide - Adult Risk factors reviewed Calculated Suicide Risk: No Risk Review of Resident #2's EMR Psychiatric Subsequent Assessment, dated 9/22/2025, reflected the following: Top Target Symptoms: Description: Current Rating: Anxiety 6 - Severe Depression 6 - Severe Guilt Feelings 6 - Severe Intervention: Assessed current mood and anxiety symptoms to ascertain current emotional functioning. Addressed trauma triggers and continued verbal No Self Harm contract. Patient's Response to Intervention: [Resident #2] denies any [suicide ideations] and agrees to No Self Harm contract. Plan For Next Session: Continue to address recent [suicide ideation] and trauma. Review of Resident #2's care plan dated 9/22/2025 and revised 12/22/2025 reflected the following: [Resident #2] has depression r/t MAJOR DEPRESSIVE DISORDER, RECURRENT (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MODERATE. [Resident #2] will exhibit indicators of depression, anxiety or sad mood less than daily by review date. There was no care planning related to suicide risk, self-inflicted injury or suicide ideations. Review of Resident #2's EMR Psychiatric Clinical Treatment Plan Review (Plan of Care) dated 9/09/2025 reflected the following: Psychiatric History: [Resident #2] endorsed long history of mental illness including several months of inpatient psychiatric care 20 years ago and subsequent outpatient therapy and medication maintenance. The Brief Psychiatric Rating Scale: Description: Current Rating: Anxiety 3 - Mild Depression 3 - Mild Guilt Feelings 3 - Mild Review of Resident #2's quarterly MDS dated [DATE] reflected a BIMS score of 15, indicating little to no cognitive impairment. It reflected Resident #2 completed functional abilities of self-care and mobility independently and without assistance. Resident #2's active diagnoses for psychiatric/mood disorder Section I included: anxiety disorder, depression, bipolar disorder and she was taking antipsychotic, antianxiety, and antidepressant high-risk medications. Review of Resident #2's electronic medical record from 2/10/2026 to 2/12/2026 reflected that no significant change in status assessment or interdisciplinary review was completed following a self-inflicting injury/self-harm incident, a major deviation from Resident #2's established baseline health on 9/16/2025. Review of Resident #2's electronic medical record from 2/10/2026 to 2/12/2026 reflected that the facility provided Resident #2 with interventions of mental health services and medication management to assist Resident #2 with function and mood. In an interview on 2/11/2026 at 6:30 PM, the DON said she understands accuracy and updates to care plans are necessary to ensure interventions are in place and to give residents the best possible care. She said she does not recall why the care plan was not updated for Resident #2 following her 9/16/2025 self-inflicted injury incident. In an interview on 2/12/2026 at 12:11 PM, the SW said the self-harm incident for Resident #2 on 9/16/2025 was an acute incident and not part of her baseline, not her day-to-day behavior. She said Resident #2 did have a history of psychiatric hospitalizations in the past, but she is working with her psychiatrist and therapist and has been stable for some time. In an interview on 2/12/2026 at 12:58 PM, the MDS Coordinator said significant changes in status assessments and care plans are required to be accurate and submitted on time. She said by not completing assessments or significant change in status could negatively impact care plans and the care provided to a resident. She said that she is required to review 24-hour nursing notes and attend the nursing management daily meetings for resident changes or incidents from the prior shift. She said if an incident occurs that may be a significant change she would reach out to the regional nursing coordinator for assistance and change of condition assessment guidance. She said she was familiar with Resident #2's self-injury incident on 9/16/2025 and recalls the resident was sent to the hospital for an evaluation and psych services followed up with resident. She said that Resident #2 was deemed safe by psychiatrist and hospital, so she didn't meet criteria for significant change in status. MDS Coordinator said the self-injury incident was a one-off occurrence and she did not believe this triggers for a significant change in status assessment. She said Resident #2 would have returned to baseline with staff help. She said the incident should have been updated in Resident #2's care plan and believes there was a communication issue. She said she will work on having the care plan updated immediately. In an interview on 2/11/2026 at 6:30 PM, the ADM said suicide attempts or self-injury incidents are to be investigated. He said he does not recall being informed of this incident and referred me to the DON for more details. In an interview on 2/11/2026 at 6:35 PM, the DON said she was aware of Resident #2's self-harm incident on 9/16/2025 as she was notified immediately and she started interventions immediately. She said the resident was transported by emergency services to the hospital to undergo a psych evaluation. She said the resident was cleared the same day and discharged back to the facility. She said the over-the-counter eye drops order was discontinued the same day and removed from Resident #2's room. The DON said Resident #2 was placed on one-on-one supervision for three days following her return from the hospital. She said Resident #2 sees therapist weekly and she is stable. The DON said that this self-inflicted injury incident should have been care planned for Resident #2 and I would need to speak to the MDS (continued on next page)		

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 02/14/2026
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.			
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinator for further details. In an interview on 2/12/2026 at 12:11 PM, the SW said she has been working with Resident #2 for numerous years and said she knew this self-inflicted injury on 9/16/2025 was more of a cry for help rather than a self-harm attempt. The SW said the self-harm incident was an acute incident and not part of Resident #2's baseline and not her day-to-day behavior. She said Resident #2 has had other incidents in the past that were acute, many that were brought on from a urinary tract infection. She said Resident #2 does have a history of psychiatric hospitalizations in the past, but she is working with her psychiatrist and therapist, and she had been stable for some time now. In an interview on 2/12/2026 at 5:28 PM, the DON said the self-injury incident with Resident #2 was a significant change to her baseline and was an acute psychiatric episode. She said Resident #2 should have been care planned for psychiatric episode and she doesn't understand why this was not completed and I would need to follow up with the MDS Coordinator for more information. Record review of facility document titled, Care Plans, Comprehensive Person-Centered dated March 2022 reflected the following: Policy Statement 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. Policy Interpretation and Implementation 2. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission. 3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: (1) services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; (2) any specialized services to be provided as a result of PASARR recommendations. 12. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition. Record review of facility document titled, Change in a Resident's Condition or Status dated May 2017 reflected the following: Policy Interpretation and Implementation 2. A significant change of condition is a major decline or improvement in the resident's status that: a. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not self-limiting); b. Impacts more than one area of the resident's health status; c. Requires interdisciplinary review and/or revision to the care plan; and d. Ultimately is based on the judgment of the clinical staff and the guidelines outlined in the Resident Assessment Instrument. 8. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. 9. If a significant change in the resident's physical or mental condition occurs, a comprehensive assessment of the resident's condition will be conducted as required by current OBRA regulations governing resident assessments and as outlined in the MDS RAI Instruction Manual.		

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NAME OF PROVIDER OR SUPPLIER Care Choice of Boerne		STREET ADDRESS, CITY, STATE, ZIP CODE 200 E Ryan St Boerne, TX 78006	
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals were stored the facility must store under proper temperature controls for 1 of 1 medication cart (100 hall cart) reviewed for medication storage. The facility failed to ensure Humalog insulin for Resident #8 was discarded after 28 days of opening. This failure could lead to reduced therapeutic effect of medication. Findings included: In an observation and interview on 2/10/2026 at 8:15 AM with the DON, the medication cart for the 200-hall was observed to contain a Humalog insulin vial for Resident #8 with an opened-on date of 12/29/2025. The DON was unsure what the facility's policy was for insulin storage once opened. In an interview on 2/10/2026 at 8:55 AM, LVN C said the facility policy was to keep insulin for 28 days after opening, and the vial should have been discarded on 1/26/2026. She said the label was folded in a position that obstructed her view, and she did not notice. She said Resident #8 had received medication from the vial. Record review of the facility policy titled Medication Labeling and Storage dated 2001, revealed the following: 5. Multi-dose vials that have been opened or accessed (e.g., needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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NAME OF PROVIDER OR SUPPLIER Care Choice of Boerne		STREET ADDRESS, CITY, STATE, ZIP CODE 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** 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 to help prevent the development and transmission of communicable diseases and infections for 1 of 6 (Resident #4) residents reviewed for infection control. The facility failed to ensure staff utilized proper PPE while providing incontinence care to Resident #4 on 2/11/2026 at 9:36 AM. This failure could lead to the spread of infection and illness. Findings included: Record review of Resident #4's admission Record dated 2/12/2026 revealed an [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included pressure ulcer of sacral region [tailbone area on the lower back], stage 3. Record review of Resident #4's quarterly MDS submitted 10/31/2025 revealed a BIMS score of 0 and that the resident is rarely understood. Record review of Resident #4's Order Summary dated 2/12/2026 revealed the following physician's order: Place resident on Enhanced barrier precautions for the following direct care services: Dressing or bathing Transferring Changing linens Assisting with toileting Accessing indwelling medical devices Providing wound care Other high-contact resident care activities, start 1/28/2025 Record review of Resident #4's Care Plan Report, undated/printed 2/12/2026, revealed the following:[Resident #4] is on enhanced barrier precautions r/t wound. Initiation 12/9/2025 In an observation on 2/11/2026 at 9:36 AM, Resident #4's room had a sign posted on the doorway to her room indicating she required EBP precautions. A cart containing PPE supplies were observed in the hallway near Resident #4's doorway. CNA A and CNA B were observed performing incontinence care without donning PPE. In an interview with CNA A and B on 2/11/2026 at 9:45 AM, both staff members said they should have put on gowns prior to entering the room. Both staff members said they were nervous about the observation and forgot, and both had received training from the facility about infection control and isolation precautions. Both staff members said the risk to residents of not donning PPE appropriately was the spread of infection. In an interview with the DON on 2/11/2026 at 10:00 AM, she said her expectation and the facility policy was that staff members would utilize proper PPE when providing care for residents. She said the risk of staff not utilizing PPE properly was the spread of infection.		