STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676228	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kendall House Wellness & Rehabilitation	1050 Grand Blvd. 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48366 Based on observation, interview, and record review the facility failed to ensure the resident had a right to a safe, clean, comfortable, and homelike environment for 1 of 8 residents (Resident #82) reviewed for resident rights . The facility failed to ensure Resident #82 had a functioning bathroom door. This failure could place residents at risk for injuries and falls. Findings include: Record review of Resident #82's Admission Record, dated 10/8/2024, reflected a female who was initially admitted on [DATE] and readmitted on [DATE]. Resident #82 had diagnoses which included history of falls, age-related physical debility, heart failure, osteoarthritis (a degenerative joint disease that can affect the many tissues of the joint), and cardiac pacemaker. Record review of Resident #82's Admission MDS, dated [DATE], reflected it was blank and not filled out by staff. Record review of Resident #82's, undated, Care Plan reflected she was a risk of falls. During an interview and observation on 10/08/24 at 02:08 PM, Resident #82 revealed her bathroom door was too heavy to close . She revealed they let nursing staff know about the bathroom door yesterday and could not recall the name of the staff member. Observation revealed the bathroom door was fully opened and it took a lot of effort to close the door. During an interview on 10/10/2024 at 4:20 PM, Resident #82's family member stated she had been having issues with the sliding bathroom door for several days. She stated at one point, the door was dragging on the floor. She further stated she was concerned for her loved one residing in that room, she might not be able to open the door, or the door could fall on her. Resident #82's family member stated maintenance made some repairs to the door on 10/09/2024, but the door was still hard to slide opened. The Maintenance Director stated the sliding door was hard to open, and it was getting stuck. The Maintenance Director stated was having issues with that door and he would repair the door so it would be easily opened and close. He agreed the door seemed loose on its track and the door could easily fall off the track and injure Resident #82. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/11/24 at 09:12 AM, Safety Officer E revealed the door was of concern because it could come of the hinges and fall on a resident, causing injury . He further revealed he observed on 10/10/24 at 4:15 PM revealed Resident #82 had sliding bathroom doors that were hard to slide open once fully closed. He further demonstrated the door rollers were hard to slide across the track. During an interview on 10/11/24 at 09:25 AM, the Administrator revealed he visited Resident #82's room and the restroom door needed to be fixed and he was getting with the Maintenance Director to fix this door.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48366 Based on interview and record review the facility failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that met professional standards of quality of care for 4 of 16 residents (Residents #15, 27, 80,10) reviewed for baseline care plans. 1. The facility failed to ensure Resident #15's baseline care plan reflected interventions for falls. 2. The facility failed to ensure Resident #27's baseline care plan reflected interventions or problems for falls until 10/08/24 when the resident scored a high risk for falls on 09/18/24, when Resident #27 was admitted . 3. The facility failed to ensure Resident #80's baseline care plan did not address falls. 4. The facility failed to ensure Resident #10's baseline care plan reflected interventions or problems for falls . These deficient practices could place residents at risk of missed or inadequate care. The findings include: 1. Record review of Resident #15's Admission Record, dated 10/11/24, reflected a female initially admitted to the facility on [DATE], Resident #15 had diagnoses which included Parkinson's disease (movement disorder of the nervous system that worsens over time), cognitive communication deficit, lack of coordination, and abnormalities of gait and mobility. Record review of Resident #15's Admission MDS assessment, dated 10/05/24, reflected a BIMS score of 15 out of 15, which indicated intact cognition. Record review of Resident #15's, undated, care plan, reflected no interventions for problem The resident is at risk for falls r/t weakness, recent hospitalization . Record review of Resident #15's Fall Risk Evaluation, dated 09/29/24, reflected Resident #15 was a high risk for falls . 2. Record review of Resident #27's Admission Record, dated 10/08/24, reflected a female initially admitted to the facility on [DATE] with diagnoses which included Diabetes I I (is a disease in which your blood glucose, or blood sugar, levels are too high), cognitive communication deficit and need for assistance with personal care. Record review of Resident #27's Admission MDS assessment, dated 09/25/24, reflected a BIMS score of 14 out of 15, which indicated intact cognition. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #27's, undated, care plan did not reflect a focus or interventions related to falls until 10/08/24 (entrance for survey was 10/08/24). Record review of Resident #27's Fall Risk Assessment, dated 09/18/24, reflected Resident #27 was a high risk for falls . 3. Record review of Resident #80's Admission Record, dated 11/08/24, reflected a female initially admitted to the facility on [DATE]. Resident #80 had diagnoses which included cardiac pacemaker, cognitive communication deficit and need for assistance with personal care. Record review of Resident #80's, undated, care plan did not reflect a focus or interventions related to falls. Record review of Resident #80's Fall Risk Assessment, dated 09/30/24, reflected Resident #80 was a high risk for falls . 4. Record review of Resident #10's Admission Record reflected he was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident #10 had diagnoses which included altered mental status, Diabetes II (is a disease in which your blood glucose, or blood sugar, levels are too high), cognitive communication deficit, acquired absence of left toe, muscle weakness, abnormalities of gait/mobility and chronic pain. Record review of Resident #10's admission MDS assessment, dated 8/12/2024, reflected he had a BIMs of 12 out of 15, which indicated his cognition (thought processes) was moderately impaired. Resident #10 required some help with self-care, was independent for indoor mobility (ambulation), he used a walker for mobility, he required substantial /max assistance with showering/bathing, upper body dressing, lower body dressing, rolling left to right, sit to lying, sit to stand, chair to chair transfer and toilet transfer. Resident #10 was always incontinent of Urinary/Bladder continence, he was ordered pain medications, he did receive oxygen therapy and had no falls indicated . Record review of Resident #10's Consolidated Order Summary report for October 2024 reflected a physician order for skilled physical therapy services 5 times per week for 30 days with a start date of 10/07/2024; walk-to-dine with staff assistance using a walker as tolerated, with a start date of 10/04/2024; post-op[eration] shoe to left foot when ambulating, with a start date of 9/19/2024; weight bearing as tolerated to left foot with a start date of 9/11/24. Record review of Resident #10's Fall Risk Assessment, dated 9/2/2024, reflected he was a high risk for falls. Record review of Resident #10's Care Plan did not include a focus area or interventions related to fall risk. The latest revision date in the document was 10/09/2024 . During an interview on 10/09/24 at 02:32 PM, CNA C revealed she was not aware of what she had access to via POC (a system the CNA used to provide care to residents) but would ask the nurse for more information for interventions needed for falls. She further revealed there was a board inside the residents' rooms that would reflect things like fall interventions sometimes. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/09/24 at 02:53 PM, LVN B revealed the facility followed standard fall interventions like keeping the call light in reach and checking on residents frequently. She revealed if she had any questions on fall interventions for a specific resident, she would ask the DON, ADON or NP. During an interview on 10/11/24 at 02:39 PM, RN A revealed a resident's fall interventions should be in the care plan. She revealed the DON oversaw putting interventions for the care plans so the CNAs could see this in their POC, in order to care for the residents appropriately. During an interview on 10/11/24 at 04:14 PM, the Administrator revealed anything that needed to be in a resident's plan of care needed to be in the care plan. During an interview on 10/11/24 at 04:42 PM, the DON revealed she was in charge of updating care plans appropriately with fall interventions. The DON stated the importance of having interventions on the care plan after a fall in the facility was to prevent further falls, and so staff knew what interventions were necessary to care for the resident. The DON stated universal fall precautions were initiated for all new admissions. Specific fall interventions were typically placed on the care plan only after a fall occurred in the facility. The DON stated the admission fall assessment would indicate a resident was high fall risk at home, the risk factors may not be present once they got into the facility. The DON stated having the fall interventions in the care plan for short term rehab type residents could be beneficial to prevent future falls or significant injuries. Record review of the facility's policy Care Plans-Baseline, revised August 2017, reflected A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission. Record review of the facility's policy Falls and Fall Risk, Managing, revised May 2009, reflected Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Review of Lippincott procedures entitled, Fall Prevention, revised 2/19/2024, accessed from, https://procedures.lww.com/lnp/view.do?pId=4420964&hits=fall,falling,falls&a=true&ad=false&q=falls, accessed on 10/24/2024, reflected under the heading, Implementation, instructions, Ensure that the resident's care plan addresses the fall risk. Under the subheading, Special Considerations, instructions included, Fall prevention plans should be individualized and comprehensive for each resident.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48366 Based on interview and record review the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for one of eight residents (Residents #20) reviewed for medications and pharmacy services. The facility failed to administer Resident #20's Midodrine (treat low blood pressure) according to doctor's orders. This failure could place residents at risk for not receiving therapeutic dosages of their medications as ordered by the physician and a potential for decreased health status, including low and high blood pressure, falls, disorientation and physical discomfort. The Findings include: Record review of Resident #20's Admission Record, dated 10/11/24, reflected a male initially admitted to the facility on [DATE]. Resident #20 had diagnoses which included Hypertension (a medical condition where the pressure of blood in your blood vessels is consistently too high), cognitive communication deficit, and need for assistance of personal care. Record review of Resident #20's Admission MDS assessment, dated 07/25/24, reflected a BIMS score of 13 out of 15, which indicated intact cognition and active diagnosis included hypertension. Record review of Resident #20's, undated, care plan reflected Hypertension to evaluate blood pressure. Resident blood pressure would be within normal limits. Record review of Resident #20's consolidated orders for October 2024, reflected an order for Midodrine oral tablet 2.5 mg, give 5 mg by mouth every 12 hours for Hypertension, Hold if SBP > 110. Record review of Resident #20's MAR for August 2024, reflected Midodrine HCl oral tablet 2.5 mg, give 5 mg by mouth every 12 hours for Hypertension, Hold if SBP > 110. these were not held on the following: 08/29/2024 at 8 AM, B/P was 141/73 and at 8 pm the B/P was 122/62. 08/31/2024 at 8 AM B/P was 146/67 and 8 PM the B/P was 127/60. Record review of Resident #20's MAR for September 2024 , reflected Midodrine HCl oral tablet 2.5 mg, give 5 mg by mouth every 12 hours for Hypertension, Hold if SBP > [greater than] 110. these were not held on the following: 09/02/2024 at 8 PM, B/P was 112/63. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	09/03/2024 at 8 PM B/P was 150/66. 09/042024 at 8 PM B/P was 123/68. 09/05/2024 at 8 PM B/P was 128/68. 09/07/2024 at 8 PM B/P was 141/3. 09/11/2024 at 8 PM B/P was 121/66. 09/12/2024 at 8 PM B/P was 134/60. 09/13/2024 at 8 AM, B/P was 139/77. 09/14/2024 at 8 AM, B/P was 135/69. 09/15/2024 at 8 AM, B/P was 116/61. 09/16/2024 at 8 AM, B/P was 129/63. 09/17/2024 at 8 PM, B/P was 128/69. 09/20/2024 at 8 AM, B/P was 144/68. 09/26/2024 at 8 PM, B/P was 145/74 . During an interview on 10/11/24 at 09:50 AM, RN F revealed Resident #20 had been prescribed Midodrine, but it was scheduled to administer it without parameters because his blood pressure always dropped. She stated she had given Midodrine not as prescribed but did not realize blood pressure parameters were added to hold medication if systolic blood pressure was greater than 110. During a combined interview with NP G and the DON on 10/11/24 at 11:53 AM, NP G revealed Resident #20 was prescribed Midodrine with no blood pressure parameters at first because his blood pressure was always so low. She stated Midodrine was now prescribed to be held if systolic blood pressure was above 110. The DON revealed they could train the nursing staff to make sure to follow the parameters of all medications . Record review of the facility's policy Administering Medications, revised April 2009, reflected Medications must be administered in accordance with the orders, including any required timeframe . The following information must be check/verified for each resident prior to administering medications: a. allergies to medications; b. vital signs, if necessary. Review of Lippincott procedures entitled, Oral Drug Administration, reviewed 5/19/2024, accessed from https://procedures.lww.com/lnp/view.do?pId=4420477&disciplineId=7734, accessed on 10/24/2024, reflected under the sub heading, Older Adult Alert: Nurses are responsible for understanding the pharmacology behind the drugs they administer to prevent potential errors and patient harm. Under the heading, Special Considerations, instructions included, Assess parameters, such as blood pressure and pulse, as needed, before administering a medication with dose-holding parameters.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 48366 Based on observation, interview, and record reviews, the facility failed to prepare puree food by methods that conserve nutritive value, flavor, and appearance for 1 of 1 kitchen observed for puree preparation. The facility failed to follow the puree diet recipe for Pureed Baked Fish or Pureed Carrots for the 10/10/24 lunch. This failure could affect residents on puree diet at risk of receiving inadequate diet that could affect their health. The findings include: During an observation and interview on 10/10/24 at 10:09 AM, [NAME] D did not have any measurements written out for 4 servings of pureed foods instead of the 20 servings that was in the recipe for pureed baked fish. [NAME] D stated he did not follow the measurements for the pureed recipe but said he was able to eyeball the measurements to get the right pureed consistency. During this observation, the Regional Executive Chef revealed he only allowed certain staff members to make the pureed foods because they knew how to create pureed foods appropriately, with the right consistency for the residents . Record review of the recipe for Pureed Baked Fish for 20 servings provided by the facility reflected, Prepare Baked Fish according to recipe . Add the hot water mixed with the base, lemon juice and Shape and Serve Thickener and process until smooth. with ingredients 2qt, 1 cup hot water, 2 cup Shape and Serve Thickener, 1 oz Seafood Base, 3 tbsp Lemon Juice, 3/4 cup Salted Butter, Melted. Record review of the recipe for Pureed Carrots for 5 servings provided by the facility reflected, Prepare carrots according to recipe . Add the Thick and Easy Thickener, water combined with the base, and butter and process until smooth. with ingredients 3 tbsp Thick and Easy Puree, Thickener, 1/4 cup hot water, 1/4 tsp vegetable base, and 1 tbsp Salted Butter, Melted Record review of the facility's policy Special Food Needs, Swallowing/Chewing Difficulties, And Food Allergies, revised 01/23, reflected, Food and Nutrition Services ensures recipes are followed during meal preparation.