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	01/23/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food for 1 of 1 kitchen and 1 of 3 residents' (Resident #8) refrigerators in accordance with professional standards for food service safety. The facility failed to ensure sanitizing buckets were not near foods. The facility failed to ensure foods in residents' refrigerators (to include Resident #8) were kept at a temperature for safe food consumption. These failures could place residents at risk for food borne illness. The findings included:Observation and interview on 01/22/26 at 10:41AM revealed there was a bag of yellow corn meal next to two sanitation buckets. The CDM revealed yellow corn meal should not be next to sanitation buckets. It was further observed in another area of the kitchen, there was a different sanitation bucket next to a carton of bananas. The CDM revealed the sanitation bucket should not be near the bananas. Interview on 01/23/26 at 05:30PM, the FSS revealed she would not store the sanitizing buckets near foods to prevent the hand sanitizer from mixing with the food. 2. Record review of Resident #8's admission record, dated 01/21/26, reflected Resident #8 was a [AGE] year-old female admitted on [DATE] with diagnoses to include dementia (loss of thinking, remembering, and reasoning skills). Record review of Resident #8's admission MDS assessment, dated 11/05/25, reflected Resident #8 had a BIMS score of 12 out of 15, indicating moderately impaired cognition. Record review of Resident #8's care plan, undated, reflected I am on hospice care related to dementia, revised 12/16/25, with intervention minimize areas of stress and anxiety for resident and family, initiated 10/29/25. Interview on 01/23/26 at 05:55PM, the ADON revealed the facility did not have a policy on checking on residents' personal refrigerators, and it was not a regulation. He revealed the families checked the refrigerators to see if the food was bad and not the facility. Interview on 01/23/26 at 06:02PM, the RD revealed the families oversaw their personal refrigerators. She revealed if a resident's refrigerator got to a temperature that was too hot for food storage, the facility asked the residents to let them know. She further revealed food storage and making sure refrigerators were at an appropriate temperature was the family's responsibility and families had thermometers to check. She revealed if the refrigerator was an unsafe temperature for foods that the food would spoil. Interview and observation on 01/23/26 at 06:05PM revealed Resident #8 was not able to contribute to an interview. Resident #8's RP revealed he did not have a thermometer in Resident #8's refrigerator, was not aware the family checked the temperatures for Resident #8's refrigerator and was not aware of what temperatures the refrigerator needed to be at so that the foods were safe for Resident #8 to eat. Resident #8's refrigerator did contain food and Resident #8's RP revealed they always used to refrigerator to bring Resident #8 food. Record Review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed, 3-305.11, Food Storage, (A) Food shall be protected from contamination by storing the food: (1) in a clean, dry location; (2) Where it is not exposited to splash, dust, or other contamination. Record review of the FDA Food Code 2022 reflected, 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under S3-501.19, and except as specified under (B) and in (C) of this (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57 C (135 F) or above, except that roasts cooked to a temperature and for a time specified in 3-401.11(B) or reheated as specified in 3- 403.11(E) may be held at a temperature of 54 C (130 F) or above; or (2) At 5 C (41 F) or less. Record review of the facility's policy Food and Supply Storage, revised 01/25, reflected Store cleaning supplies separately from food or paper. Record review of the facility's policy Use and storage of food brought to residents from the outside, revised 01/25, reflected Food brought in by family or visitors is permitted, provided care is taken to ensure food is handled property for safe and sanitary storage, and consumption. The resident has the right to the food items if there are no immediate safety concerns as noted by nursing.

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure residents had the right to voice grievances to the facility which included those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay for 1 of 8 residents (Resident #23) reviewed for grievances. Resident #23's Representative complained to RN D that Resident #23 was soiled in bed and was served her breakfast without being cleaned first. RN D did not document the grievance. This failure could place residents at risk for diminished sense of self-worth by not having their grievances heard and resolved. Findings included: A record review of Resident #23's admission record, dated 1/20/2026, revealed an admission date of 11/1/2025 with diagnoses including lung cancer which had spread to the brain, spine, liver, and bones (a disease in which some of the body's cells grow uncontrollably and spread to other parts of the body and could cause death). A record review of Resident #23's admission MDS assessment, dated 11/8/2025, revealed Resident #23 was an [AGE] year-old female admitted for supports with cancer and ADL care. Resident #23 was assessed with a BIMS score of 9 out of 15 which indicated moderate cognitive impairment. Resident #23 was assessed as being incontinent of bowel and bladder. Resident #23 was assessed as needing assistance from staff with all ADLs. Resident #23 was admitted with several wounds, which included her buttocks, complicated by her cancer and antiplatelet medications (drugs that prevent blood clots by inhibiting the aggregation of platelets, which can help reduce the risk of heart attacks and strokes). A record review of Resident #23's care plan, dated 1/20/2026, revealed, Self-care deficit, impaired bed mobility, as evidenced by decreased ability to position or reposition herself in bed . Position and reposition resident in bed for comfort, joint support, and skin . I have chronic pain related to osteoarthritis and cancer . A record review of the facility's grievance logs, dated November 2025 through January 2026, revealed no grievance for Resident #23. During an interview on 1/23/2026 at 3:17 p.m., Resident #23's Representative stated on Saturday 1/17/2026 at 9:49 a.m., Resident #23 was in bed, soiled from a bowel movement, and was served breakfast. Resident #23's Representative stated she was angered by the indignation of Resident #23 served a meal while soiled. Resident #23's Representative stated she complained to RN D and inquired why Resident #23 would be so poorly treated and demanded she be cared for better. Resident #23's Representative stated RN D stated, She (Resident #23) gets sick if we move her so I'll wait until she eats. Resident #23's Representative stated she was unaware of the facility's grievance policy and had never received any resolution to her grievance made to RN D. During an interview on 1/23/2026 at 4:42 p.m., RN D stated she recalled the Saturday Resident #23's Representative arrived in the morning and became upset that Resident #23 was soiled while served breakfast. RN D stated Resident #23 was incontinent of bowel and bladder and, related to her cancer, had frequent spontaneous small bowel movements. RN D stated resident #23 did not like to be disturbed or moved due to her bone cancer pain. RN D stated Resident #23 was soiled and had her breakfast tray placed on her bedside table but could not say if the tray was served when she was soiled. RN D stated she understood Resident #23's Representative but had not documented the grievance because Resident #23 was provided with the ADL care after the complaint was made. During an interview on 1/23/2026 at 6:00 p.m., the DON stated she learned Resident #23's Representative complained to RN D who did not document the complaint. The DON stated RN D should have documented the grievance and the potential negative outcome could be resident's grievances would go unheard and/ or resolved. A record review of the facility's Resident and Family Grievances policy, dated 12/1/2025, revealed, It is the policy of this facility to support each resident and family members right to voice grievances without discrimination, reprisal or fear of discrimination or reprisal. A resident or family member may voice grievances with respect to care and treatment which has been (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	furnished as well as that which has not been furnished, the behavior of staff and other residents, and other concerns regarding their long-term care facility stay. Information on how to file a grievance or complaint will be made available to the resident, information may include but is not limited to . the time frame that a resident may reasonably expect completion of the review of the grievance and a written decision regarding his or her grievance. Grievances may be voiced in the following forums: verbal complaint to a staff member or a grievance official.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on interview and record review, the facility failed to provide pharmaceutical services that assured the accurate acquiring, receiving, dispensing, and administering of medications for 1 of 8 residents (Residents #36) reviewed for pharmacy services. The facility failed to ensure that the telephone consent by Resident #36's RP for Resident #36's Cymbalta and Buspar to be prescribed and administered was signed by 2 nurses witnessing this consent. This failure place residents at risk of not accurately receiving the medication, resulting in worsening or exacerbation of chronic medical conditions.Findings included: Record review of Resident #36's admission record, dated 01/21/26, reflected Resident #36 was an [AGE] year-old female admitted [DATE] with diagnoses to include depression (a persistent feeling of sadness and loss of interest in things and activities you once enjoyed) and generalized anxiety disorder (a mental health condition that causes fear, worry and a constant feeling of being overwhelmed). Record review of Resident #36's quarterly MDS assessment, dated 12/05/25, reflected Resident #36 had a BIMS score of 13 out of 15, indicating intact cognition. Record review of Resident #36's Order Summary Report, dated 01/20/26, reflected Buspirone HCl (also known as Buspar) Oral Tablet 5 MG. Give 1 tablet by mouth two times a day for anxiety, with start date 11/20/25, and Duloxetine HCl (also known as Cymbalta) Oral Capsule Delayed Release Sprinkle 60 MG. Give 1 capsule by mouth one time a day for anxiety/depression, with start date 12/12/25. Record review of Resident #36's telephone consent for Cymbalta (document unnamed), dated 03/21/25, reflected LVN A was the only nurse's signature documented. Record review of Resident #36's telephone consent for Buspar (document unnamed), dated 03/21/25, reflected LVN A was the only nurse's signature documented. Interview on 01/23/26 at 05:40PM, LVN A revealed if she had a telephone consent she never had a second signature from another nurse as a witness to include consent for psychotropics. She revealed the ADON was the one that over saw that consent for psychotropics were completed appropriately. Interview on 01/23/26 at 05:49PM, the DON revealed there were consents for psychotropics that did not have 2 nurse's signatures for telephone consents and when she came to this facility, she had been working on updating these consents. Interview on 01/23/26 at 05:55PM, the ADON revealed he oversaw that 2 nurses signed consents by telephone for psychotropics. He revealed it was important for validation. Record review of facility's policy Use of Psychotropic Medication(s), revised 05/19/25, revealed 11. The facility will document that the resident or resident representative was informed in advance of the risks and benefits of the proposed care.our facility will utilize either signed consent or verbal approval with two licensed nurses witnessing.

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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** Based on observations, interviews, and record reviews, the facility failed to ensure a medication error rate below 5% for 1 of 6 residents (Resident #30) reviewed for medication administration errors, 2 errors over 27 observations. RN B failed to follow physician orders, and professional standards, during medication administration which resulted in a 7.41% medication administration error rate. On 1/22/2026 RN B administered to Resident #30 desvenlafaxine 50mg, an antidepressant, by crushing it; Desvenlafaxine is a drug which has been formulated to slowly release the dosage over a day and should not be crushed. When the drug was crushed Resident #30 received the entire dose within the hour. On 1/22/2026 RN B administered to Resident #30 Folic Acid 1mg, a form of the vitamin B essential for red blood cell production. The physician prescribed Resident #30 to receive 5mg. Resident #30 did not receive the full dosage prescribed. This failure could place residents at risk for not receiving the therapeutic effects of their medications and possible adverse reactions. This deficient practice placed residents at risk for not receiving therapeutic effects of their medications and possible adverse reactions.Findings included: A record review of Resident #30's admission record, dated 1/23/2026, revealed an admission date of 12/31/2025 with diagnoses which included stroke (a sudden disruption of blood flow to the brain, causing brain cells to die from lack of oxygen and nutrients, leading to potential brain damage, disability, or death), depression and muscle weakness. A record review of Resident #30's admission MDS assessment, dated 1/7/2026, revealed Resident #30 was a [AGE] year-old female admitted for long term care with supports for ADL care. Resident #30 was assessed with a BIMS score of 10 out of 15 which indicated mild cognitive impairment. Resident #30 was assessed with the ability to usually make herself understood and could usually understand others. Resident #30 was assessed with a swallowing disorder and had difficulty when swallowing medications. A record review of Resident #30's care plan, dated 1/22/2026, revealed, The resident uses antidepressant medication desvenlafaxine related to depression date initiated 1/8/2026 . the resident will be free from discomfort or adverse reactions related to antidepressant therapy . administer antidepressant medications as ordered by physician . I have a diagnosis of depression date initiated 1/1/2026 . the resident will remain free of signs and symptoms of distress symptoms of depression anxiety or sad mood by review date . administer medications as ordered . A record review of Resident #30's physicians orders, dated 12/31/2025, revealed Resident #30 was prescribed to receive some medications crushed, Medications may be crushed or opened except for specially coated or prolonged action and combined in pudding as long as not contraindicated. Further review revealed Resident #30 was prescribed the following medications: Folic Acid oral capsule 5 mg, give one capsule by mouth one time a day. Desvenlafaxine oral tablet extended release 24-hour 50mg give one tablet by mouth one time a day. A record review of Resident #30's pharmacy dispensed medication card, dated 1/11/2026, labeled desvenlafaxine revealed labels which stated: Resident #30, desvenlafaxine tablet 50mg extended release take one tablet by mouth every day. Swallow whole. Do not chew or crush. A record review of the United States of America's National Library of Medicine's website: https://medlineplus.gov/druginfo/meds/a608022.html#:~:text=Take%20desvenlafaxine%20exactly%20as%20d Accessed 1/23/2026, titled Desvenlafaxine revealed, How should this medicine be used? Desvenlafaxine comes as an extended-release (long-acting) tablet to take by mouth. Take once a day with or without food. Take desvenlafaxine at around the same time every day. Take desvenlafaxine exactly as directed. Do not take more or less of it or take it more often than prescribed by your doctor. Swallow the tablets whole with plenty of water; do not split, chew, crush, or dissolve them. Symptoms of overdose may include: Vomiting, agitation, hallucinations, fever, sweating, confusion, fast heartbeat, shivering, severe muscle stiffness or twitching, loss of coordination, nausea, vomiting, or diarrhea, drowsiness, coma, seizures, fast, slow, or irregular heartbeat, increased size of the pupil (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(black center of the eye), muscle pain or weakness. During an observation and interview on 1/22/2026 at 8:07 a.m., revealed Resident #30 in her room sitting at her bedside and RN B assessed Resident #30 for her vital signs. RN B prepared Resident #30's crushed medications which included: Folic acid 1mg Desvenlafaxine 50 mg RN B greeted Resident #30 and administered Resident #30's crushed folic acid and desvenlafaxine. During an interview on 1/23/2026 at 4:50 p.m., NP C stated she was the nurse practitioner for the facility. NP C stated desvenlafaxine was a medication which should not be crushed and was designed as an extended-release formulation to be dispersed into the bloodstream evenly over a prolonged period. NP C stated the potential adverse reaction to a crushed extended-release medication could be the dose immediately absorbed into the blood stream and could have potential negative outcomes from nausea to seizures. NP C stated resident #30 had not experienced those negative outcomes and was being monitored for adverse reactions. NP C stated medications should be administered as prescribed. During an interview on 1/23/2026 at 6:00 p.m., the DON stated Resident #30 was prescribed an extended release desvenlafaxine which RN B administered by crushing and folic acid 5 mg but RN B administered 1 mg. The DON stated RN B should not have crushed the desvenlafaxine and should have administered 5 mg of folic acid for Resident #30. The DON stated the potential negative outcomes for crushing medications which should not be crushed and administering a dose of medication which was less than prescribed could be adverse reactions from medication administrations. A record review of the facility's policy titled Administering Medications, dated April 2009, revealed, . Medications must be administered in accordance with the orders, including any required time frame. The individual administering the medication must check the label to verify the right medication, right dosage, right time, and write method of administration before giving the medication.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure residents were free from any significant medication errors for 1 of 6 residents (Resident #30) reviewed for medication administration errors: On 1/22/2026 RN B administered to Resident #30 desvenlafaxine 50mg, an antidepressant, by crushing it; Desvenlafaxine is a drug which has been formulated to slowly release the dosage over a day and should not be crushed. When the drug was crushed Resident #30 received the entire dose within the hour. This failure could place residents at risk of not receiving therapeutic effects of their medications and possible adverse reactions. Findings included: A record review of Resident #30's admission record, dated 1/23/2026, revealed an admission date of 12/31/2025 with diagnoses which included stroke (a sudden disruption of blood flow to the brain, causing brain cells to die from lack of oxygen and nutrients, leading to potential brain damage, disability, or death), depression and muscle weakness. A record review of Resident #30's admission MDS assessment, dated 1/7/2026, revealed Resident #30 was a [AGE] year-old female admitted for long term care with supports for ADL care. Resident #30 was assessed with a BIMS score of 10 out of 15 which indicated mild cognitive impairment. Resident #30 was assessed with the ability to usually make herself understood and could usually understand others. Resident #30 was assessed with a swallowing disorder and had difficulty when swallowing medications. A record review of Resident #30's care plan, dated 1/22/2026, revealed, The resident uses antidepressant medication desvenlafaxine related to depression date initiated 1/8/2026 . the resident will be free from discomfort or adverse reactions related to antidepressant therapy . administer antidepressant medications as ordered by physician . I have a diagnosis of depression date initiated 1/1/2026 . the resident will remain free of signs and symptoms of distress symptoms of depression anxiety or sad mood by review date . administer medications as ordered . A record review of Resident #30's physicians orders, dated 12/31/2025, revealed Resident #30 was prescribed to receive some medications crushed, Medications may be crushed or opened except for specially coated or prolonged action and combined in pudding as long as not contraindicated. Further review revealed Resident #30 was prescribed desvenlafaxine oral tablet extended release 24-hour 50 mg give one tablet by mouth one time a day. A record review of Resident #30's pharmacy dispensed medication card, dated 1/11/2026, labeled desvenlafaxine revealed labels which stated: Resident #30, desvenlafaxine tablet 50mg extended release take one tablet by mouth every day. Swallow whole. Do not chew or crush. A record review of the United States of America's National Library of Medicine's website: https://medlineplus.gov/druginfo/meds/a608022.html#:~:text=Take%20desvenlafaxine%20exactly%20as%20c Accessed 1/23/2026, titled Desvenlafaxine revealed, How should this medicine be used? Desvenlafaxine comes as an extended-release (long-acting) tablet to take by mouth. Take once a day with or without food. Take desvenlafaxine at around the same time every day. Take desvenlafaxine exactly as directed. Do not take more or less of it or take it more often than prescribed by your doctor. Swallow the tablets whole with plenty of water; do not split, chew, crush, or dissolve them. Symptoms of overdose may include: Vomiting, agitation, hallucinations, fever, sweating, confusion, fast heartbeat, shivering, severe muscle stiffness or twitching, loss of coordination, nausea, vomiting, or diarrhea, drowsiness, coma, seizures, fast, slow, or irregular heartbeat, increased size of the pupil (black center of the eye), muscle pain or weakness. During an observation and interview on 1/22/2026 at 8:07 a.m., revealed Resident #30 in her room sitting at her bedside and RN B assessed Resident #30 for her vital signs. RN B prepared Resident #30's crushed medications which included desvenlafaxine 50 mg. RN B greeted Resident #30 and administered Resident #30's crushed desvenlafaxine. During an interview on 1/23/2026 at 4:50 P.M., NP C stated she was the nurse practitioner for the facility. NP C stated desvenlafaxine was a medication which should not be crushed and was designed as an extended-release formulation to be dispersed into the bloodstream (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	evenly over a prolonged period. NP C stated the potential adverse reaction to a crushed extended-release medication could be the dose immediately absorbed into the blood stream and could have potential negative outcomes from nausea to seizures. NP C stated resident #30 had not experienced those negative outcomes and was being monitored for adverse reactions. NP C stated medications should be administered as prescribed. During an interview on 1/23/2026 at 6:00 p.m., the DON stated Resident #30 was prescribed an extended release desvenlafaxine which RN B administered by crushing. The DON stated RN B should not have crushed the desvenlafaxine. The DON stated the potential negative outcomes for crushing medications which should not be crushed and administering a dose of medication which was less than prescribed could be adverse reactions from medication administrations. A record review of the facility's policy titled Administering Medications, dated April 2009, revealed, . Medications must be administered in accordance with the orders, including any required time frame. The individual administering the medication must check the label to verify the right medication, right dosage, right time, and write method of administration before giving the medication.