STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676240	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cibolo Creek	1440 River Rd 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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38511 Based on interview and record review the facility failed to immediately consult with the resident's physician and notify, consistent with his or her authority, the resident representative when there was a significant change in the resident's physical, mental, or psychosocial status in life-threatening conditions for 1 of 5 residents (Resident #1) reviewed for change of condition, in that; The facility failed to notify Resident #1's physician and family on 11/18/2024 when she was found sleepier than usual or notify Resident #1's physician and the resident's family when the resident was found unresponsive and twitching with a significant alteration in mental status at approximately 5:00 a.m. on 11/19/2024 and was treated for altered mental status at the hospital. The noncompliance was identified as PNC. The IJ began on 11/18/2024 and ended on 11/19/2024. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk for serious harm, permanent disability and/or death. The findings were: Record review of Resident #1's face sheet dated 11/20/2024 revealed an admitted [DATE] with diagnoses which included: displaced bimalleolar fracture of left lower leg (broken bone of the ankle), subsequent encounter for closed fracture with routine healing, complete rotator cuff tear or rupture of right shoulder (muscles and tendons which surround the shoulder joint), not specified as traumatic, depression, anxiety disorder and chronic pain syndrome. Record review of Resident #1's admission MDS dated [DATE] revealed she had a BIMs score of 15 which indicated she was cognitively intact and did not have any behaviors. The MDS assessment indicated the resident had a history of frequent pain that occasionally interfered with ADL's. Record review of Resident #1's Care Plan initiated on 10/16/2024 revealed the resident had chronic pain syndrome and was followed by a pain specialist with interventions which included: administer analgesics as per orders. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676240	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/24/2024
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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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident#1's nurse assessment documented by day shift staff on 11/18/2024 at 5:22 p.m. revealed Resident #1's pain level was assessed at 1 (pain scale of 0-10). The resident was alert and oriented, communicated verbally with clear speech and was neurologically intact. The assessment reflected Resident #1 had no unwanted behaviors witnessed. Record review of Resident #1's nurse progress notes documented by LVN A on 11/19/2024 at 5:55 a.m. revealed, 0530 (5:30 a.m.) walked into room .(Resident #1) lethargic, unable to fully arouse, garbled words incomprehensible. Informed the aid [sic] on the hall .will report to oncoming shift. Record review of Resident #1's medical record revealed there were no further progress notes or assessments to indicate Resident #1's physician or family was notified regarding Resident #1's sudden change in mental status from 11/18/2024-11/19/2024. Record review of Resident #1's hospital records dated 11/19/2024 revealed the resident presented to the ER with an altered mental status. Per EMS the patient (R1) was somnolent (sleepy) when she arrived with pinpoint pupils, some hypopnea (abnormally slow and shallow breathing which decreases the amount of oxygen in the blood), with oxygen saturation in the high 80's (normal 92-100); and they administered 2 mg Narcan IM and 2 mg Narcan IV (opioid reversal agent-a medication used to treat drug overdose) with some transient (only lasting a short time) improvement in mental status. Resident #1's hospital diagnoses was AMS (altered mental status) and hypoxemia (low blood oxygen). Record review of 3613-A Provider Investigative Report dated 11/19/2024 revealed on 7/19/2024 (incorrect date, actual date 11/19/2024), the facility was notified that a nurse (LVN A) found a patient (Resident #1) unresponsive at 5:30 am and called EMS at 6:30 a.m. The facility suspended LVN A for further investigation due to a delay in care. EMS arrived and administered Narcan, and Resident #1 was taken to a local ER and kept overnight for evaluation. Resident #1 was found to have medication at her bedside and hospital records revealed marijuana in her system. Record review of a typed statement from LVN B dated 11/19/2024 indicated at 6:25 a.m. as LVN B was coming onto shift, LVN A was sitting down at the nurse's station. LVN B stated LVN A stated Resident #1 was lethargic and non-arousable since 5 am (11/19/2024). A nurse aide (unknown) from the night shift stated to LVN B that it had been reported to LVN A since 11 p.m. the night before (11/18/2024). When LVN B questioned LVN A if Resident #1 was ever able to voice any response, LVN A stated that Resident #1 was non-arousable at 5 a.m. and that she had not assessed the patient from 11 p.m.- 5 a.m. LVN B questioned LVN A if she had notified the MD (physician) about any change in condition or the family since the patient's baseline was alert and oriented x 4 (cognitively intact). LVN B indicated LVN A responded no. LVN B stated he immediately ran to room to assess the patient along with NA C and CNA E while LVN A remained at the nurse's station. LVN B wrote Resident #1 was breathing but was not arousable, a sternal rub (firm rub to a patient's sternum is a painful stimulus to test a patients consciousness level) was performed with grunting as the response sternal rub and he assured 911 was called immediately. LVN B wrote he also immediately notified the Administrator and Regional RN, and also notified the physician and the family of Resident #1. (continued on next page)

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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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of a written statement dated 11/19/2024 by LVN A indicated at 5:30 a.m. on 11/19/2024 she entered Resident #1's room to see her right leg hanging off the bed. LVN A wrote Resident #1's eyes were closed, and her respirations were even and unlabored. LVN A called the name of Resident #1 (and her response was) squinting her eyes and garbled speech. LVN A wrote the aides were outside her room and she told them about Resident #1's behaviors. LVN A wrote she had the aides search Resident #1's room and they found a small plastic box with 5-6 round pills and 3 pieces of peach-colored pills. LVN A wrote at 5:45 a. m. she told another nurse (unknown name). LVN A documented a midsternal rub with a very strong facial grimace and vital signs of 101/84 (blood pressure), 55 (unclear if it was HR or RR) and 96% on room air (oxygen saturation) (it was unclear who took vitals or when they were taken). LVN A wrote at 6:15 a.m. she gave report to LVN B. LVN A wrote LVN B did not go into Resident #1's room or assist her, so she went back into Resident #1's room to attempt to arouse Resident #1 again. LVN A wrote she told Resident #1 Look! We need to go! Let's go now! She wrote Resident #1 sat on the edge of the bed but LVN A told Resident #1 to wait and put her back to bed. LVN A wrote she called the Administrator and told the Administrator maybe she would just call 911 to have them come shake her up a bit. LVN A wrote she did call 911 (unknown time). Record review of a written statement (undated) by NA E revealed they (aides) were doing rounds at 10:00 a. m. and they went into Resident #1's room and she was alert and awake. She documented she did not round on Resident #1 during the night. NA E wrote she was in a room across the hall changing another resident when LVN A busted in asking questions about Resident #1 telling the aides to go try and wake her (Resident #1) up. NA E wrote they (aides) went to the Resident #1's room and she was not really responding. She twitched a little and moved her lips. She wrote LVN A did not do vitals or anything until the morning nurse came in. NA E wrote LVN A found Resident #1 like that at 5:00 a.m. when LVN A was passing her medicine. NA E wrote Resident #1 never sat up or spoke when she was in the room. NA E wrote LVN A proceeded to do nothing for the resident and tried to blame them (aides). Record review of a written statement (undated) by NA F wrote at 5:00 a.m. (on 11/19/2024) NA E and NA F were changing another resident when LVN A came rushing in saying Resident #1 would not respond to her. She told them to go into the room and try to wake Resident #1 up. NA F wrote Resident #1 was unresponsive, but still breathing and they found a bag of pills on her bedside table which they gave to LVN A. NA F wrote she let LVN A do the rest and continued her rounds. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Cibolo Creek		STREET ADDRESS, CITY, STATE, ZIP CODE 1440 River Rd Boerne, TX 78006	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/20/2024 at 12:04 p.m., LVN B stated on 11/19/2024 at 6:25 a.m. he came onto duty. He stated night shift nurse LVN A was seated at the nurse's station trying to give him report when he arrived. LVN B stated LVN A said she noticed a change of condition for Resident #1 related to level of consciousness. LVN B stated LVN A said the aides told her about the change of condition at 11:00 p.m. when Resident #1 had visitors and was lethargic. LVN B stated LVN A told him she assessed Resident #1 at 11:00 p.m. (11/18/2024) and found her lethargic but she did not notify anyone and did not notify the doctor. LVN B stated LVN A told him she went into Resident #1's room at 5:00 a.m. to assess the resident and she was not arousable. LVN B stated he questioned LVN A to see if she had notified the physician or transferred the resident to the hospital since Resident #1 was normally A/O x 4 (alert and oriented x 4 which indicated she was cognitively intact). LVN B stated LVN A said she had not notified anyone. LVN B stated as soon as he heard LVN A say that he ran directly to Resident #1's room. He stated he had not yet clocked into work, but he was concerned since LVN A did not seem to know what was going on. LVN B stated LVN A said she thought it might be medication related since the night aides found medication in Resident #1's room. LVN B stated he was alarmed. He stated he had two aides (unknown names) go with him. He stated when he saw Resident #1, he knew immediately something was wrong. He stated Resident #1 was very lethargic and was not able to verbalize anything. He stated she was just grunting. He stated she was breathing, and he obtained vital signs which were stable. He stated he made sure someone stayed with Resident #1 because he knew she needed to go to the hospital. LVN B stated he went to find LVN A and told her to call 911, which she did. He stated he went back to Resident #1's bedside, but LVN A went to her medication cart/ LVN A stated he notified Resident #1's physician and her family. LVN A stated he told the physician Resident #1 was minimally responsive and that EMS had been activated. He stated the physician's response was that a hospital evaluation was appropriate. During an interview on 11/20/2024 at 12:25 p.m. NA C stated on 11/19/2024 at 6:06 a.m. she arrived at the facility for her morning shift. She stated CNA D had approached her and stated she had it up to here with LVN A. NA C stated CNA D stated the LVN A was not listening to her and there was concern for Resident #1. NA C stated she clocked in and went straight to Resident #1's room to check on her. She stated Resident #1 was not responding to her voice. She stated she saw Resident #1 lying on her back with one arm on her chest. NA C stated Resident #1 was twitching. She stated at first, she saw just her lip twitching and then noted that her fingers and her toes were also twitching, and she would not respond. NA C stated she went to LVN A and asked her what was wrong with Resident #1. NA C stated LVN A responded that she had already checked on Resident #1. NA C stated she told LVN A that Resident #1 was not acting normal to which she did not get a response. NA C stated she (NA C) could at least get Resident #1's vitals since she was not acting right. NA C stated she obtained the vitals and saw LVN A talking to LVN B at the nurse's station. NA C stated LVN A was giving LVN B an update on what was going on. NA C stated LVN B was asking LVN A if she had checked on Resident #1 or if she took vitals. NA C stated she showed LVN B the vitals she just took which included an oxygen saturation of 87% (normal 92-100%). NA C stated LVN B ran into Resident #1's room and stated, She is not okay. NA C stated at approximately. 6:30 a.m., LVN B was telling LVN A she was not normal and to call 911. NA C stated LVN B asked LVN A Why did you wait?. NA C stated LVN A did not seemed concerned at all. NA C stated LVN A lied and said she just came out of the room and Resident #1 was sitting on the edge of the bed. NA C stated she walked into the room to see for herself, and Resident #1 had not moved. She was still not responsive and twitching. NA C stated CNA D was with her and also saw what was occurring. NA C stated she asked LVN A why she was lying. She stated LVN A responded that she had a rough day. NA C stated she could not do anything else for Resident #1 because she was just a nurse aide in training, but she stayed with the resident and saw when EMS got there. NA C stated Resident #1 was still unresponsive when she left the facility with EMS. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/20/2024 at 12:52 p.m., CNA D stated she overheard LVN A talking about how Resident #1 was not doing well. CNA D stated LVN A was telling LVN B that she was having issues with Resident #1, and she was not alert. CNA D stated she went to look at the resident to see if she could help. She stated Resident #1 was in bed and she looked asleep. She stated LVN A went into the room with her and was trying to wake up Resident #1. CNA D stated LVN A was lifting Resident #1's eye lids, was giving her a chest rub and was trying to get vitals. CNA D stated Resident #1 was not responding and did not respond to the chest k rub. CNA D stated she thought the chest rub was very aggressive. CNA D stated she was not sure what the vitals were, but another nurse (unknown name) said the blood pressure was not a normal reading. CNA D stated the next thing she knew LVN A was calling EMS, but LVN A was not happy about it and said the same thing had happened to the resident three times last week. CNA D stated LVN A said Resident #1 was a druggy and knew her limits. She stated she had never seen Resident #1 in any other way. CNA D stated LVN A called 911 on the phone and asked if they would come rough house the resident to wake her up. CNA D stated LVN A was neglectful and was not making Resident #1's needs a priority and making it like it was a bother rather than addressing her change of condition. During an interview on 11/20/2024 at 1:06 p.m. NA F stated she worked the overnight shift on 11/18/2024-11/19/2024. She stated she was doing rounds with NA E at approximately 11:00 p.m. and she saw Resident #1 who was normally oriented was up and moving around. NA F stated at 5:00 a.m. they were across the hall when LVN A asked, What happened to Resident #1? NA F stated they said they did not know but LVN A told them to try to help wake Resident #1 up. NA F stated Resident #1 was breathing but was not responsive. She stated she was saying her name really loud, and they were pushing on her and shaking her, but it was not working. NA F stated they found a bag of pills in the room. NA F stated at approximately 5:30 a. m. she told LVN A she should probably call 911 since Resident #1 was unresponsive. NA F stated LVN A said, Well she is a drug addict, so it doesn't matter. NA F stated LVN A then went back to the nurse's station and did not really acknowledge the situation. NA F stated they (aides) stayed with Resident #1. She stated a while later LVN B came in and assessed Resident #1 and called 911. She stated when she saw LVN B he went right into work mode. He immediately went into Resident #1's room, assessed her and took vital signs. NA F stated Resident #1 was still unresponsive, but LVN B got her help right away. She stated the ambulance came about 5 minutes later but the aides stayed with Resident #1 to make sure she did not stop breathing. NA F described Resident #1 as pale but not blue and looking like she was sleeping but would not wake up. NA F stated LVN A's actions and words were very inappropriate. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/20/2024 at 1:37 p.m., NA E stated she worked 10 p.m.- 6 am shift on 11/18/2024. She stated she last saw Resident #1 well at 11:10 p.m. when she brought her an ice pack for her leg. NA E stated she was acting like her normal self. NA E stated at 5:00 a.m., LVN A said Resident #1 was not waking up and she was trying to give her medications. NA E stated she did not know why LVN A was relying on the aides to do something about it when she was the nurse. NA E stated she went into Resident #1's room and tried to wake her up. She stated she tried calling her name, tapping her shoulder, and giving her a chest rub. NA E stated Resident #1 moved her mouth a little, like a twitch. She stated her legs twitched also and she wouldn't wake up. NA E stated Resident #1 never opened her eyes or responded in any verbal way. NA E stated she then left the room because she had other residents to attend to. NA E stated LVN A was frantic, like she did not know what to do and she was relying on the aides. NA E stated she had them search the room with flashlights and they found a small clear case with multiple pills in it which they gave to LVN A. NA E stated the whole time Resident #1 was unconscious and LVN A was not providing care, she did not take vitals, nothing. NA E stated LVN A then went and sat at the nurse's station. NA E stated the aides were lost and did not know what to do but it seemed like LVN A did not care. NA E stated when the next shift arrived, they took over and asked LVN A if she had called the doctor or called 911 and LVN A said no she did not. NA E stated LVN A admitted she did not notify the doctor or 911. NA E stated the aides were all very stressed out. She stated they were trained to notify the nurse which they did. NA E stated they had thought about calling 911 themselves but did not want to get in trouble. She stated she was trained to tell the Administrator because she was the abuse coordinator, but she couldn't think so she called the on-call person who said she would call the Administrator. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/20/2024 at 2:56 p.m., LVN A stated she had been a nurse for [AGE] years. She stated on the night of 11/18/2024 around approximately 11:00 p.m. she noted that Resident #1 was drowsier than normal but was otherwise alert and oriented. LVN A stated she couldn't remember a lot of about that night, just that she was in bed, that she did not say a lot, but she was resting quietly. LVN A stated on 11/19/2024 at 5:30 a.m. she went into Resident #1's room to give scheduled morphine and noted the resident's right leg hanging off the bed with her head of bed at 45 degrees and her head to the side. LVN A stated Resident #1 was sleeping. She stated she tried to wake Resident #1 up and noted she was hard to wake up. LVN A stated Resident #1 opened her eyes a little and was trying to talk but she could not understand her. LVN A stated she thought Oh my gosh. She stated the aides were just outside the room in the hallway. She stated she couldn't remember who the aides were but there were two of them and she wanted them to come inside the room because Resident #1 would not wake up. LVN A stated Resident #1 was drug seeking so she started searching her room and found 5-6 pills. LVN A stated at 5:45 a.m. she told another nurse (name unknown) that Resident #1 was unresponsive, but that nurse didn't get off her chair or try to help her. LVN A stated she grew up where nurses helped nurses, and they all worked together. She stated LVN B was coming in to relieve her from night shift. LVN A stated LVN B did not go into Resident #1's room one time. She stated she was so upset because no one who worked at the facility, no one helped her. LVN A stated she worked her butt off all night long and she was tired. LVN A stated Resident #1 was not unresponsive. She stated she opened her eyes and garbled something. LVN A stated she kept going in and out of the room and noted Resident #1 gave a big grimace with a sternal rub. LVN A stated when she saw the big grimace she thought Oh God, she is okay and it was the end of her shift, and she was tired. LVN A stated she did not know who to call. She stated the ADON was on vacation and the DON had walked out of the facility. LVN A stated another nurse (name unknown) gave her the phone number for the Administrator, so she called her and told her they needed to discharge Resident #1 from the facility because she was not following the rules. LVN A stated the Administrator did not tell her what to do or give her any idea what to do. LVN A stated she had 35 people to take care of and it was very stressful. LVN A stated after she got off the phone with the Administrator, she called 911 because she thought maybe they could shake her up. LVN A stated she was upset because the Administrator thought she was slow to react, so she found herself suspended. LVN A stated she did not notify Resident #1's physician about her change of condition. She stated she did not notify the physician because she was collecting information, searching her room, and looking up her medication. She stated she also did not call because she thought Resident #1 was going to be okay. She stated she was just gathering information and waiting for the next shift to take over because she herself was tired. LVN A stated was trained to assess, document the assessment, gather information and probably call the doctor for a resident change of condition. LVN A stated she did not know why she deviated from how she was trained other than she was pretty tired and had worked her butt off. She stated, We are all human, right .I was tired. When asked if she was fit for duty if she was too tired to complete her nursing duties, she stated Yes . (continued on next page)

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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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/20/2024 at 3:40 p.m., the Corporate RN (VP of Clinical Services) stated the DON left the position approximately 1 month ago and she was monitoring the facility as the RN since that time. The Corporate RN stated one of the ADON's was also an RN and was assisting. The Corporate RN stated on 11/19/2024 she was traveling to the facility and was almost there when she received a call at 7:03 a.m. from LVN B. She stated she called the Administrator and EMS was arriving. The Corporate RN stated she interviewed LVN A who told her she had given pills to Resident #1 at 11:00 p.m. (11/18/2024) and then went in at 5:00 a.m. (11/19/2024) and found the resident lethargic, reporting she did not round on the resident during the night because Resident #1 did not like it. The Corporate RN stated LVN A said she did a sternal rub on Resident #1, who grimaced and then sat up on the side of the bed. LVN A reported that she had NA E and NA F check on the resident. The Corporate RN stated LVN A said she had not made notifications and that she gave report to oncoming nurse LVN B. The Corporate RN stated she interviewed LVN B who stated he assessed Resident #1 and told LVN A to call 911. The Corporate RN stated she interviewed NA E and NA F who both said they told LVN A around 5:00 a.m. Resident #1 was lethargic and nothing was done. The Corporate RN stated the facility then reported it to HHSC because there was a delay in care to Resident #1. She stated there was a delay in providing interventions, in alerting EMS and in notifying the physician . The Corporate RN stated after she interviewed the staff, she did not believe LVN A's account of events was accurate. The Corporate RN stated after notifying HHSC of the event she facility began immediately correcting on 11/19/2024. She stated they had: 1. Immediately started staff in-services on abuse/neglect, medication orders, medication administration, opioid overdose management, responding to suspected overdose, how to use Narcan, no medications at bedside, self-administration of medications assessment in which the IDT had to determine if the resident was safe to self-administer, notifications of change of condition, and PRN medications to all staff that were working and had placed a notice on the time clock preventing any staff from clocking in until they had been in-serviced. She said this was completed immediately on 11/19/2024 and had been top priority 2. The Corporate RN stated a notice had been posted at the time clock and no staff would be allowed to clock in until the in-services had been completed. She stated at the time of this interview all staff had been educated. She stated this was prior to surveyor arrival on 11/19/2024. 3. The Corporate RN stated the facility completed a 100% assessment audit on residents assuring any change of condition was addressed before surveyor arrival on 11/19/2024. 4. The Corporate RN stated the facility completed a 100% audit of medical records to ensure any change of condition had notifications of physicians and families documented. She stated no new change of conditions were identified. She stated this was completed prior to surveyor arrival on 11/19/2024. 5. The Corporate RN stated a 100% rounding of medication carts/medication records was completed on 11/19/2024 before surveyor arrival and another was completed on 11/20/2024 to ensure there were no medication discrepancies. 6. The Corporate RN stated a text alert was sent to all family members that all medications needed to go to the nurses she stated this occurred prior to the 11/19/2024 incident when they first learned Resident #1 was bringing medication by way of visitors into the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676240	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/24/2024
NAME OF PROVIDER OR SUPPLIER Cibolo Creek		STREET ADDRESS, CITY, STATE, ZIP CODE 1440 River Rd Boerne, TX 78006	

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	7. The Corporate RN stated QA/PIP tools were put in place to include notification of physician for change of condition with actions to address included. She stated this was completed on 11/19/2024 prior to surveyor arrival. 8. The Corporate RN stated the facility notified the Medical Director of the incident and the facility's plan to correct. She stated this occurred on 11/19/2024 before surveyor arrival. 9. The Corporate RN stated LVN A was immediately suspended, and they planned to terminate her employment and refer her nurses license as soon as the investigation was complete. She stated this was completed on 11/19/2024 as soon as LVN A completed her written statement of events and she had been interviewed prior to surveyor arrival. 10. The Corporate RN stated they reviewed facility's policies and ensured they were put out for staff to review. She stated this was completed on 11/19/2024 prior to surveyor arrival. During an interview on 11/20/2024 at 4:14 p.m., the Administrator stated on 11/19/2024 she received a call from the Corporate RN about Resident #1, a suspected overdose and that EMS was on their way to the facility to pick up the resident. She stated she told the Corporate RN to interview staff and find out what was going on. The Administrator stated then LVN A called her. She stated LVN A told her it was a suspected overdose, and that EMS was at the facility because she could not get Resident #1 back to baseline. The Administrator stated she arrived at the facility on 11/19/2024 at 8:15 a.m. at which time interviews were completed and staff in-services had already been started. The Administrator stated based on staff interviews they felt there had been a delay in care and that LVN A did not act promptly so they immediately self-reported to HHSC. The Administrator stated the Corporate RN and herself immediately in-serviced staff in the facility to ensure they were aware and in compliance with facility policy for notification. She stated they worked diligently to correct the error on the morning on 11/19/2024. She stated the Corporate RN had completed the corrections prior to surveyor arrival. The Administrator stated the staff were all pretty upset so she checked on the staff. The Administrator stated she was not a medical person and was not certain what caused Resident #1's change of condition, but she did feel LVN A was neglectful of Resident #1. The Administrator stated she had been trying unsuccessfully to reach LVN A so she could terminate her employment and refer her license. The Administrator stated she had reviewed the facility surveillance video and based on that review there were some non-truths to LVN A's story. The Administrator stated LVN A had poor judgement of character. The Administrator stated she supervised her staff by ensuring monthly in-service training. She stated in meetings they talked a lot of about the facility culture, specifically related to treating people with kindness, acting on kindness and quality of care. She stated the team did a really good job in communicating with the team. She stated she was available 24/7. She stated her number was posted everywhere throughout the facility including by the time clock and on the main bulletin board of the facility and had been posted there prior to this incident. During an interview on 11/20/2024 at 5:34 p.m., Resident #1 stated she could not remember what happened on 11/18/2024-11/19/2024. She stated she normally went to bed around 10:00 p.m. She stated on 11/18/2024 she remembered lying in bed and trying to look at her phone, but her hands were shaking so bad she could not look at it. She stated she did not tell anyone at the facility that was occurring and did not ask for help. She stated she just thought it would diminish on its own and she would check on the shaking in the morning. She stated the next thing she remembered was waking up in the hospital. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/22/2024 at 11:20 a.m., the Corporate RN stated LVN A had completed nurse competencies upon hire in April 2024, although she was not part of the corporation at that time and did not participate in that assessment. She stated the competencies included change of condition and notification of physician for change of condition. The Corporate RN stated as a licensed nurse, LVN A would have to attend a school of nursing where she would be taught those skills. The Corporate RN stated she would have expected LVN A to assess a resident with change of condition and immediately notify EMS, the MD and the RP (family) if a drug overdose was suspected, and to stay with her until she was safely out of the facility. The Corporate RN stated it was important to ensure the patient was provided care and taken care of. The Corporate RN stated she was monitoring staff by looking at PCC (electronic medical record) dashboard, 24-hour reports, reviewing documentation, and frequent rounding. She stated she did not want to speculate on why the situation occurred. During an interview on 11/22/2024 at 12:39 p.m., LVN A stated she had been terminated by the Administrator on 11/22/2024. She stated the Administrator also informed her she was referring her license. During an interview on 11/22/2024 at 3:20 p.m., the MD (Resident #1's physician) stated he had been notified of Resident #1's unresponsiveness and change of condition but he could not remember when that occurred or who notified him. He stated it was just a notification and there was not much of an option at that point. He stated his expectations for the scenario was common sense. He stated unconsciousness was one of the few things they needed to send a resident out for and he would expect that to occur pretty soon. Record review of a facility policy titled Notification of Change of Condition (undated) revealed the facility must inform the resident, consult with the resident's physician and /or notify the resident's family member or legal representative when there is a change requiring such notification .2. Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status. Record review of facility documents post incident for facility correction: Record review of a facility document (undated) titled Action Plan to Ensure Relevant Recommendations are Followed revealed: 1. Notify Medical Record of Incident was documented as completed by the Administrator on 11/19/2024. 2. Complete Disciplinary Actions was documented as employee (LVN A) suspended on 11/19/2024 and was updated on 11/20/2024 as employee terminated. 3. Complete physical assessments on all residents to identify any change of condition was documented as completed on 11/19/2024. < [TRUNCATED]

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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** 38511 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objective and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 5 residents (Resident #1) reviewed for care plans, in that; The facility failed to develop a person-centered care plan with interventions that addressed Resident #1's behaviors of bringing in medications from home, from other providers and from visitors and self-medicating without telling staff. This failure could place residents at risk for not having their needs and preferences met. The findings were: Record review of Resident #1's face sheet dated 11/20/2024 revealed an admitted [DATE] with diagnosis which included: displaced bimalleolar fracture of left lower leg (broken bone of the ankle), subsequent encounter for closed fracture with routine healing, complete rotator cuff tear or rupture of right shoulder (muscles and tendons which surround the shoulder joint), not specified as traumatic, depression, anxiety disorder and chronic pain syndrome. Record review of Resident #1's admission MDS dated [DATE] revealed she had a BIMs score of 15 which indicated she was cognitively intact and did not have any behaviors. The MDS assessment indicated the resident had a history of frequent pain that occasionally interfered with ADL's. Record review of Resident #1's Care Plan initiated on 10/16/2024, revealed the resident had chronic pain syndrome and was followed by a pain specialist with interventions which included: administer analgesics as per orders. The care plan did not address behaviors of polypharmacy, having visitors bring in medications or having medications in her room and self-administering medications without staff knowledge. Record review of a provider progress note dated 11/08/2024 by PA J revealed: Patient (Resident #1) went to a pain medication doctor and had morphine prescription received, filled at outside pharmacy which she kept in her room and would self-dose. This was discovered and morphine was taken away from her .Denies alcohol, tobacco, drugs of abuse. (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's nurse progress notes dated 11/09/2024 at 8:28 a.m. documented by LVN K revealed: Guest approached nurse at nursing station expressing concern. The pharmacy had questioned the medication she was picking (up) for a resident (Resident #1), morphine tablets (narcotic) and melodic (anti-inflammatory). The resident had requested she bring her medication with codeine (hydrocodone/acetaminophen 10/325) (narcotic opioid pain reliever) a week prior from a local pharmacy. The resident (Resident #1) explained that she had received the order from her pain management doctor at a previous appointment as the current pain medication was not effective at managing her pain. The nurse educated the patient (Resident #1) to inform her nurse of any new orders from appointments or her PCP so that her doctor at the facility could adjust her medication and make orders to safely assist her healing and rehab goals. The patient expressed understanding and stated she would not self-administer medication without informing the nurse. Record review of Resident #1's nurse progress notes dated 11/10/2024 at 4:43 p.m., documented by LVN H revealed: a CNA (unknown) notified nurse of suspicious activity. A person entered Resident #1's room with a package and immediately left. The incident was reported to the Administrator. Instruction was given to search room for medication, for patient safety. Patient (Resident #1) on narcotics and has a history of asking friends to bring in narcotic(s) and other pain medication prescribed by other providers into the facility and not adhering to facility policy. Patient education given. During an interview on 11/21/2024 at 4:46 p.m., RN MDS Coordinator M stated Resident #1's care plan did not address Resident #1's behaviors of bringing in medications from outside the facility and no interventions were put in place. She stated it had never really dawned on her to put it in the care plan. She stated the floor nurses were aware of the behaviors because they were the ones who documented it and she did not believe it happened frequently. RN MDS Coordinator M stated she first learned of the behaviors during morning meeting (unknown date) when she heard the nurses talk about it. She stated in hindsight she should have done it. She stated the purpose of the care plan was to disseminate information to staff such as things the resident was at risk for and their likes/dislikes. She stated it was important because it was a behavior and should have been in the care plan when it occurred so it would have been visible on the Kardex for staff review. During an interview on 11/23/2024 at 2:06 p.m., the Regional RN stated the MDS Coordinator and herself were responsible for care plan updates and completion. She stated during her review of Resident #1's care plan post 11/19/2024 incident and hospitalization was the first time she noted issues with the care plan. She stated Resident #1's behaviors of bringing in medication was something she would have expected to be included in that care plan. She stated it was important, so everyone was aware of the what the plan of care was and how they were to take care of the resident. Record review of a facility policy, titled Comprehensive Care Plans (undated) revealed: The comprehensive care plan will be developed within 7 days after completion of the comprehensive MDS assessment. Other factors identified by the interdisciplinary team, or in accordance with the resident's preferences, will also be address in the plan of care.

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F 0684

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Provide appropriate treatment and care according to orders, resident's preferences and goals.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 38511

Based on interviews and record reviews, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices for 1 of 5 residents (Resident #1) reviewed for quality of care, in that;

The facility failed to immediately assess and intervene when Resident #1 was found unresponsive and twitching on 11/19/2024 at 5:00 a.m. by LVN A until the next shift arrived and LVN B intervened. This change of condition required treatment in a local hospital for altered mental status.

The noncompliance was identified as PNC. The IJ began on 11/19/2024 and ended on 11/19/2024. The facility had corrected the noncompliance before the survey began.

This deficient practice could affect residents who experience a change of condition and result in a delay in care, significant injury including permanent disability and death.

The findings included:

Record review of Resident #1's face sheet dated 11/20/2024 revealed an admitted [DATE] with diagnosis which included: displaced bimalleolar fracture of left lower leg (broken bone of the ankle), subsequent encounter for closed fracture with routine healing, complete rotator cuff tear or rupture of right shoulder (muscles and tendons which surround the shoulder joint), not specified as traumatic, depression, anxiety disorder and chronic pain syndrome.

Record review of Resident #1's admission MDS dated [DATE] revealed she had a BIMs score of 15 which indicated she was cognitively intact and did not have any behaviors. The MDS assessment indicated the resident had a history of frequent pain that occasionally interfered with ADL's.

Record review of Resident #1's Care Plan initiated on 10/16/2024 revealed the resident had chronic pain syndrome and was followed by a pain specialist with interventions which included: administer analgesics as per orders.

Record review of Resident #1's nurse assessment documented on 11/18/2024 at 5:22 p.m. revealed Resident #1's pain level was assessed at 1 (pain scale of 0-10). The resident was alert and oriented, communicated verbally with clear speech and was neurologically intact. The assessment documented Resident #1 had no unwanted behaviors witnessed.

Record review of Resident #1's nurse progress notes documented by LVN A on 11/19/2024 at 5:55 a.m. read 0530 (5:30 a.m.) walked into room .(Resident #1) lethargic, unable to fully arouse, garbled words incomprehensible. Informed the aid (sic) on the hall .will report to oncoming shift.

Record review of Resident #1's medical record revealed there were no further progress notes or assessments to indicate Resident #1's physician was notified or that 911 was called or that Resident #1's family had been notified of the sudden change in mental status.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's hospital records dated 11/19/2024 revealed the resident presented to the ER with an altered mental status. Per EMS the patient (R1) was somnolent (sleepy)when she arrived with pinpoint pupils, some hypopnea (abnormally slow and shallow breathing which decreases the amount of oxygen in the blood), with oxygen saturation in the high 80's. (normal 92-100) and they administered 2 mg Narcan IM and 2 mg Narcan IV (opioid reversal agent-a medication used to treat drug overdose) with some transient (only lasting a short time) improvement in mental status. Resident #1's hospital diagnoses was AMS (altered mental status) and hypoxemia (low blood oxygen). Record review of a typed statement from LVN B dated 11/19/2024 indicated at 6:25 a.m. as LVN B was coming onto shift, LVN A was sitting down at the nurse's station. LVN B stated LVN A stated Resident #1 was lethargic and non-arousable since 5 am (11/19/2024). A nurse aide (unknown) from night shift stated to LVN B that this had been reported to LVN A since 11 p.m. last night (11/18/2024). When LVN B questioned LVN A if patient (Resident #1) was ever able to voice any response, LVN A stated that she (Resident #1) was non-arousable at 5 a.m. and that she had not assessed the patient from 11 p.m.- 5 a.m. LVN B questioned LVN A if she had notified the MD (physician) about any change in condition or the family since the patient's baseline was alert and oriented x 4 (cognitively intact). LVN B indicated LVN A responded no. LVN B stated he immediately ran to the room to assess the patient along with NA C and CNA E while LVN A remained at the nurse's station. LVN B wrote Resident #1 was breathing but was not arousable, a sternal rub was performed with grunting as the response sternal rub (firm rub to a patient's sternum is a painful stimulus to test a patients consciousness level), vital signs were obtained, and he assured 911 was called immediately. LVN B wrote he also immediately notified the Administrator and Regional RN. LVN B documented he re-assessed Resident #1 prior to EMT (EMS), and no change was noted. Record review of a written statement dated 11/19/2024 by LVN A indicated at 5:30 a.m. on 11/19/2024 she entered Resident #1's room to see her right leg hanging off the bed and the head of the bed elevated 35 degrees. LVN A wrote Resident #1's eyes were closed, and her respirations were even and unlabored. LVN A called the name of Resident #1 (and her response was) squinting her eyes and garbled speech. LVN A wrote the aides were outside her room and she told them about Resident #1's behaviors. LVN A wrote she had the aides search Resident #1's room and they found a small plastic box with 5-6 round pills and 3 pieces of peach-colored pills. LVN A wrote at 5:45 a.m. she told another nurse (unknown name). LVN A wrote a midsternal rub with a very strong facial grimace and vital signs of 101/84 (blood pressure) 55 (unclear if it was HR or RR) and 96% on room air (oxygen saturation) (it was unclear who took vitals or when they were taken). LVN A wrote at 6:15 a.m. she gave report to LVN B. LVN A wrote LVN B did not go into Resident #1's room to check on the resident or assist her in LVN A in her need to be done so she went back into Resident #1's room to attempt to arouse Resident #1 again. LVN A wrote she continued going in and out of Resident #1's room. LVN A wrote she told Resident #1 Look! We need to go! Let's go now! She wrote Resident #1 sat on the edge of the bed, but LVN A told Resident #1 to wait and put her back to bed. LVN A wrote she went to get a wheelchair to assist Resident #1 to the nurse's station and told the oncoming nurse (LVN B) that she may be okay because she pulled herself to a sitting position. LVN A wrote LVN B did not want to assist her with an assessment of the situation as to not deal with the situation. LVN A wrote she decided to stay around and she called the Administrator and told the Administrator maybe she would just call 911 to have them come shake her up a bit. LVN A wrote she did call 911 (unknown time) and then went in the room to assist the EMTs in any way she could. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of a verbal statement of LVN A given to the Corporate RN which was typed (undated) revealed: at 5:30 a.m. she (LVN A) went to give Resident #1 medications and knew something was not right because the resident was lying with her leg off the bed. LVN A noted that was out of the ordinary for her and the head of the bed was up at 35 degrees. LVN A stated she gave Resident #1 a verbal command and attempted to rouse the resident, she opened her eyes and began speaking in an unclear speech and was lethargic. LVN A stated she took vitals, and they were 101/84 [blood pressure], 96% oxygen saturation 18 respirations and 55 HR (slightly lower than normal of 60-100). LVN A stated she gave Resident #1 a sternal rub and the resident had a facial grimace and then sat up on the side of the bed by herself at 6:00 a.m.LVN A stated she last left the resident around 11 p.m. (11/18/24) and did not check on the resident again until 5:30 a.m. because she was busy doing all her task for the night and the resident did not like to be bothered at night. LVN A stated she searched Resident #1's room and found medications at her bedside. LVN A stated the oncoming nurse came on and she was giving him (LVN B) a report and then he went to look at the resident and they notified 911. Record review of a written statement (undated), NA E wrote they (aides) were doing rounds at 10:00 a.m. they went into Resident #1's room and she was alert and awake. She documented she did not round on Resident #1 during the night because the resident preferred they did not wake her up all night unless she called them, so they did not make rounds on her. NA E wrote she was in a room across the hall changing another resident when LVN A busted in asking questions about Resident #1 telling us (aides) to go try and wake her (Resident #1) up. NA E wrote they (aides) went the resident's room (Resident #1) and she was not really responding. She twitched a little and moved her lips. She wrote LVN A did not do vitals or anything until the morning nurse came in. NA E wrote LVN A found Resident #1 like this at 5:00 a.m. when LVN A was passing her medicine. NA E wrote Resident #1 never sat up or spoke when she was in the room. NA E wrote they found a little box of pills while searching the room and LVN A took them. NA E wrote LVN A proceeded to do nothing for the resident and tried to blame them (aides). Record review of a written statement (undated) by NA F wrote the aides did not do rounds on Resident #1 during the night because her chart says not to as she could go the restroom and move around on her own. NA F wrote at 5:00 a.m. (on 11/19/2024) NA E and NA F were changing another resident when LVN A rushed in and said Resident #1 would not respond to her. She told them to go into the room and try to wake her (Resident #1) up. NA F wrote Resident #1 was unresponsive, but still breathing and they found a bag of pills on her bedside table which they gave to LVN A. NA F wrote she let LVN A to do the rest and continued her rounds because she was not qualified to assist with anything else. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/20/2024 at 12:04 p.m., LVN B stated on 11/19/2024 at 6:25 a.m. he came onto duty. He stated night shift nurse LVN A was seated at the nurse's station trying to give him report when he arrived. LVN B stated LVN A stated she noticed a change of condition for Resident #1 related to level of consciousness. LVN B stated LVN A stated the aides told her about the change of condition at 11:00 p.m. when Resident #1 had visitors and was lethargic. LVN B stated LVN A told him she assessed Resident #1 at 11:00 p.m. (11/18/2024) and found her lethargic but she did not notify anyone and did not notify the doctor. LVN B stated LVN A told him she went into Resident #1's room at 5:00 a.m. to assess the resident and she was not arousable. LVN B stated he questioned LVN A to see if she had notified the physician or transferred the resident to the hospital since Resident #1 was normally A/O x 4 (alert and oriented x 4 which indicated she was cognitively intact). LVN B stated LVN A stated she had not notified anyone. LVN B stated as soon as he heard LVN A say that he ran directly to Resident #1's room. He stated he had not yet clocked into work, but he was concerned since LVN A did not seem to know what was going on. LVN B stated LVN A stated she thought it might be medication related since the night aides found medication in Resident #1's room. LVN B stated he was alarmed. He stated he had two aides go with him. He stated when he saw Resident #1, he knew immediately something was wrong. He stated Resident #1 was very lethargic and was not able to verbalize anything. He stated she was just grunting. He stated she was breathing, and he obtained vital signs which were stable. He stated he made sure someone stayed with Resident #1 because he knew she needed to go to the hospital. LVN B stated he went to find LVN A and told her to call 911, which she did. He stated he went back to Resident #1's bedside but LVN A went to her medication cart. LVN B stated he asked LVN B if she if she did any interventions for Resident #1 and LVN A replied no. He stated that was why he was alarmed because LVN A did not re-assess or address Resident #1's change of condition and she did not go back into the room between 11-5 am to re-ass the resident. LVN B stated it was important to immediately assess and intervene when a resident had a decrease level of consciousness because it could be an emergency situation. He stated the resident should have an immediate assessment and interventions. LVN B stated failure to respond to a resident in need was neglect and he was trained to address the concerns immediately which he did. He stated he immediately notified the Administrator. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676240	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/24/2024
NAME OF PROVIDER OR SUPPLIER Cibolo Creek		STREET ADDRESS, CITY, STATE, ZIP CODE 1440 River Rd Boerne, TX 78006	

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/20/2024 at 12:25 p.m. NA C stated on 11/19/2024 at 6:06 a.m. she was arrived at the facility for her morning shift. She stated CNA D had approached her and stated she had it up to here with her (LVN A). NA C stated CNA D stated the nurse (LVN A) was not listening to her and there was concern for Resident #1. NA C stated she clocked in and went straight to Resident #1's room to check on her. She stated Resident #1 was not responding to her voice. She stated she saw Resident #1 laying on her back with one arm on her chest. NA C stated Resident #1 was twitching. She stated at first, she saw just her lip twitching and then noted that her fingers and her toes were also twitching, and she would not respond. NA C stated she went to LVN A and asked her what was wrong with Resident #1? NA C stated LVN A responded that she had already checked on Resident #1. NA C stated she told LVN A that Resident #1 was not acting normal to which she did not get a response. NA C stated she (NA C) could at least get Resident #1's vitals since she was not acting right. NA C stated she obtained the vitals and saw LVN A talking to LVN B at the nurse's station. NA C stated LVN A was giving LVN B an update on what was going on. NA C stated LVN B was asking LVN A if she had checked on her (Resident #1) or if she took vitals. NA C stated she showed LVN B the vitals she just took which included an oxygen saturation of 87% (normal 92-100%). NA C stated LVN B ran into the room and stated, She is not okay. NA C stated at approximately. 6:30 a.m., LVN B was telling LVN A she was not normal and to call 911. NA C stated LVN B said to LVN A Why did you wait? NA C stated LVN A did not seemed concerned at all. NA C stated LVN A lied and said she just came out of the room and Resident #1 was sitting on the edge of the bed. NA C stated she walked into the room to see for herself, and Resident #1 had not moved. She was still not responsive and twitching. NA C stated CNA D was with her and also saw what was occurring. NA C stated she asked LVN A why she was lying? She stated LVN A responded that she had a rough day. NA C stated she could not do anything else for Resident #1 because she was just a nurse aide in training, but she stayed with the resident and saw when EMS got there. NA C stated Resident #1 was still unresponsive when she left the facility with EMS. NA C stated she was trained to report resident change of condition to the nurse right away. During an interview on 11/20/2024 at 12:52 p.m., CNA D stated she overheard LVN A talking about how Resident #1 was not doing well. CNA D stated LVN A was telling LVN B that she was having issues with Resident #1, and she was not alert. CNA D stated she went to look at the resident to see if she could help. She stated Resident #1 was in bed and she looked asleep. She stated LVN A came into the room with her and was trying to wake up Resident #1. CNA D stated LVN A was lifting Resident #1's eye lids and was giving her a chest rub and was trying to get vitals. CNA D stated Resident #1 was not responding and did not respond to the chest rub. CNA D stated she thought the chest rub was very aggressive. CNA D stated she was not sure what the vitals were, but another nurse (unknown name) said the blood pressure was not a normal reading. CNA D stated the next thing she knew LVN A was calling EMS, but she was not happy about it and said the same thing had happened to the resident three times last week. CNA D stated LVN A stated Resident #1 was a druggy and knew her limits. CNA D stated she thought that comment was inappropriate. She stated she had never seen Resident #1 in any other way. CNA D stated LVN A called 911 on the phone and asked if they would come rough house the resident to wake her up. CNA D stated LVN A was neglectful and was not making Resident #1's needs a priority and making it like it was a bother rather than addressing her change of condition. CNA D stated she had been trained to notify the nurse right away for a change of condition. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/20/2024 at 1:06 p.m. NA F stated she worked the overnight shift on 11/18/2024-11/19/2024. She stated she was doing rounds with NA E at approximately 11:00 p.m. she saw Resident #1 who was oriented normally and was up and moving around. NA F stated LVN A told the aides not to go into Resident #1's room during night shift. NA F stated the resident did not need help transferring and was able to do everything on her own. She stated she might peak in at the doorway to ensure the resident was not on the floor but she did not enter the room and could not tell anything else from the doorway. NA F stated the aides were reliant on what the nurse told them to do and there was not anyway to look up the information. NA F stated on the night of the incident she did not open Resident #1's door between 11 p.m. - 5 a.m. NA F stated at 5:00 a.m. they were across the hall when LVN A asked, What happened to Resident #1? NA F stated they said they did not know but LVN A told us to try to help wake her (Resident #1) up. NA F stated Resident #1 was breathing but was not responsive. She stated she was saying her name really loud, and they were pushing on her and shaking her, but it was not working. NA F stated they found a bag of pills in the room. NA F stated at approximately 5:30 a.m. she told LVN A she should probably call 911 since Resident #1 was unresponsive. NA F stated LVN A stated, Well she is a drug addict, so it doesn't matter. NA F stated LVN A then went back to the nurse's station and did not really acknowledge the situation. NA F stated they (aides) stayed with Resident #1. She stated a while later LVN B came in and assessed Resident #1 and called 911. She stated when she saw LVN B he went right into work mode. He immediately went into Resident #1's room, assessed her and took vital signs. NA F stated Resident #1 was still unresponsive, but LVN B got her help right away. She stated the ambulance came about 5 minutes later but the aides stayed with Resident #1 to make sure she did not stop breathing. NA F described Resident #1 as pale but not blue and looking like she was sleeping but would not wake up. NA F stated LVN A's actions and words were very inappropriate. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/20/2024 at 1:37 p.m., NA E stated she worked 10 p.m.- 6 am shift on 11/18/2024. She stated she last saw Resident #1 well at 11:10 p.m. when she brought her an ice pack for her leg. NA E stated she was acting like her normal self. She stated she did not go into the resident room between 11 p.m. and 5 a.m. because the resident preferred to not be woken up. She stated they tell her goodnight, and they would see her again in the morning. NA E stated she relied on the nursing staff to tell them what to do for the resident based on the care plan. NA E stated at 5:00 a.m., LVN A said Resident #1 was not waking up and she was trying to give her medications. NA E stated she did not know why LVN A was relying on the aides to do something about it when she was the nurse. NA E stated she went into Resident #1's room and tried to wake her up. She stated she tried calling her name, tapping her shoulder, and giving her a chest rub. NA E stated Resident #1 moved her mouth a little, like a twitch. She stated her legs twitched also and she wouldn't wake up. NA E stated Resident #1 never opened her eyes or responded in any verbal way. NA E stated she then left the room because she had other residents to attend to. NA E stated LVN A was frantic, like she did not know what to do and she was relying on the aides. NA E stated she had them search the room with flashlights and they found a small clear case with multiple pills in it which they gave to LVN A. NA E stated this whole time Resident #1 was unconscious and LVN A was not proving care, she did not do vitals, nothing. NA E stated LVN A then went and sat at the nurse's station. NA E stated the aides were lost and did not know what to do but it seemed like LVN A did not care. NA E stated when the next shift arrived, they took over and asked LVN A if she had called the doctor or called 911 and LVN A said no she did not. NA E stated LVN A admitted she did not notify the doctor or 911. NA E stated the aides were all very stressed out. She stated they were trained to notify the nurse which they did. NA E stated they had thought about calling 911 themselves but did not want to get in trouble. She stated she was trained to tell the Administrator because she was the abuse coordinator, but she couldn't think so she called the on-call person who said she would call the Administrator. NA E stated she was trained to notify the nurse of change of condition. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/20/2024 at 2:56 p.m., LVN A stated she had been a nurse for [AGE] years. She stated on the night of 11/18/2024 around approximately 11:00 p.m. she noted that Resident #1 was drowsier than normal but was otherwise alert and oriented. LVN A stated she couldn't remember a lot of about that night, just that she was in bed, that she did not say a lot, but she was resting quietly. LVN A stated she did not check on Resident #1 between 11:00 p.m.-5:20 a.m. She stated the facility policy was to check on residents every 2 hours and the aides were making rounds every 2 hours she suspected although she stated she was not certain. She stated she was busy with other duties. LVN A stated on 11/19/2024 at 5:30 a.m. she went into Resident #1's room to give scheduled morphine and noted the resident's right leg hanging off the bed with her head of bed at 45 degrees with her head to the side. LVN A stated Resident #1 was sleeping. She stated she tried to wake Resident #1 up and noted she was hard to wake up. LVN A stated Resident #1 slit her eyes open a little and was trying to talk but she could not understand her. LVN A stated she thought Oh my gosh. She stated the aides were just outside the room in the hallway. She stated she couldn't remember who the aides were but there were two of them and she wanted them to come inside the room because Resident #1 would not wake up. LVN A stated Resident #1 was drug seeking so she started searching her room and found 5-6 pills. LVN A stated at 5:45 a.m. she told another nurse (name unknown) that Resident #1 was unresponsive, but that nurse didn't get off her chair or try to help her. LVN A stated she grew up where nurses help nurses, and they all work together. She stated LVN B was coming in to relieve her from night shift. LVN A stated LVN B did not go into Resident 1's room one time. She stated she was so upset because no one who worked at the facility, no one helped her. LVN A stated she worked her butt off all night long and she was tired. She stated LVN B just came in and where is his heard, he does not have one. LVN A stated she was livid that she had been suspended and LVN A still had a job. LVN A stated Resident #1 was not unresponsive. She stated she opened her eyes and garbled something. LVN A stated she kept going in and out of the room and noted Resident #1 gave a big grimace with a sternal rub. LVN A stated when she saw the big grimace she thought Oh God, she is okay and it was the end of her shift, and she was tired. LVN A stated she first obtained vitals at approximately 6:00 a.m. and reported they were normal. She stated she did not know why there was a delay in taking Resident #1's vitals signs from the time she found her with a change of condition until 6:00 a.m. She stated she was just getting information to give to day shift so they could take over. LVN A stated she did not know who to call. She stated the ADON was on vacation and the DON had walked out of the facility. LVN A stated another nurse (name unknown) gave her the phone number for the Administrator, so she called her and told her they needed to discharge Resident #1 from the facility because she was not following the rules. LVN A stated the Administrator did not tell her what to do or give her any idea what to do. LVN A stated she had 35 people to take care of and it was very stressful. LVN A stated after she got off the phone with the Administrator, she called 911 because she thought maybe they could shake her up. LVN A stated she was upset because the Administrator thought she was slow to react, so she found herself suspended. LVN A stated she did not notify Resident #1's physician about her change of condition. She stated she did not notify the physician because she was collecting information, searching her room, and looking up her medication. She stated she also did not call because she thought Resident #1 was going to be okay. She stated she was just gathering information and waiting for the next shift to take over because she herself was tired. LVN A stated was trained to assess, document the assessment, gather information and probably call the doctor for resident change of condition. LVN A stated she did not know why she deviated from how she was trained other than she was pretty tired and had worked her butt off. She stated, We are all human, right .I was tired. When asked if she was fit for duty if she was too tired to complete her nursing duties, she stated yes. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/20/2024 at 3:40 p.m., the Corporate RN (VP of Clinical Services) stated the DON left the position approximately 1 month ago and she was monitoring the facility as RN since that time. The Corporate RN stated one of the ADON's was also an RN and was assisting. The Corporate RN stated on 11/19/2024 she was traveling to the facility and was almost there when she received a call at 7:03 a.m. from LVN B. She stated she called the Administrator and EMS was arriving. The Corporate RN stated she interviewed LVN A who told her she had given pills to Resident #1 at 11:00 p.m. (11/18/2024) and then went in at 5:00 a.m. (11/19/2024) and found the resident lethargic, reporting she did not round on the resident during the night because Resident #1 did not like it. The Corporate RN stated LVN A stated she did a sternal rub on Resident #1, who grimaced and then sat up on the side of the bed. LVN A reported that she had NA E and NA F come check on the resident. The Corporate RN stated LVN A said she had not made notifications and that she gave report to oncoming nurse LVN B. The Corporate RN stated she interviewed LVN B who stated he assessed Resident #1 and told LVN A to call 911. The Corporate RN stated she interviewed NA E and NA F who both said they told LVN A around 5:00 a.m. Resident #1 was lethargic and nothing was done. The Corporate RN stated the facility then reported it to HHSC was because there was a delay in care to Resident #1. She stated there was a delay in providing interventions , in alerting EMS and in notifying the physician. The Corporate RN stated after she interviewed the staff, she did not believe LVN A's account of events was accurate. The Corporate RN stated after notifying HHSC of the event she facility began immediately correcting on 11/19/2024 and had completed the correction prior to surveyor arrival. She stated they had: 1. Immediately started staff in-services on abuse/neglect, medication orders, medication administration, opioid overdose management, responding to suspected overdose, how to use Narcan, no medications at bedside, self-administration of medications assessment in which the IDT has to determine if the resident was safe to self-administer, notifications of change of condition, PRN medications. She stated the in-service training for staff in the facility had been completed prior to surveyor arrival on 11/19/2024. 2. The Corporate RN stated a notice had been posted at the time clock and no staff would be allowed to clock in until the in-services had been completed. She stated at the time of this interview all staff had been educated before surveyor arrival on 11/19/2024. 3. The Corporate RN stated the facility completed a 100% assessment audit on residents assuring any change of condition was addressed. She stated this was completed prior to surveyor arrival on 11/19/2024. 4. The Corporate RN stated the facility completed a 100% audit of medical records to ensure any change of condition had notifications of physicians and families documented. She stated no new change of conditions were identified. She stated this was completed prior to surveyor arrival on 11/19/2024. 5. The Corporate RN stated a 100% rounding of medication carts/medication records was completed on 11/19/2024 prior to surveyor arrival and another was completed on 11/20/2024 to ensure there were no medication discrepancies. 6. The Corporate RN stated a text alert was sent to all family members that all medications need to go to the nurses. She stated this was completed prior to the incident on 11/19/2024 in the month on November when Resident #1 had been previously brought in medications from home. (continued on next page)

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F 0689

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 38511

Based on interviews and record review, the facility failed to ensure that each resident received adequate supervision to prevent accidents for 1 of 5 residents (Resident #1) reviewed for supervision, in that;

The facility failed to adequately supervise Resident #1, who had a history of bringing multiple medications including narcotics into the facility without notifying staff, when she consumed a marijuana laced brownie and was found to have both Ambien and trazadone in an unmarked unlabeled container at bedside on 11/19/2024. On 11/19/2024, Resident #1 was found unresponsive and twitching in her room after staff failed to check on her between 11:00 p.m. on 11/18/2024 to 5:00 a.m. on 11/19/2024 despite seeing an unknown visitor in Resident #1's room on the evening of 11/18/2024 .

This failure resulted in the identification of an Immediate Jeopardy (IJ) on 11/22/2024 at 12:50 p.m. The IJ template was provided to the facility on [DATE] at 1:03 p.m. While the IJ was removed on 11/23/24 the facility remained out of compliance at a scope identified as isolated and a severity level of potential for more than minimal harm until interventions were put in place to ensure resident safety because the facility needed to monitor the implementation of the plan of removal.

This failure could place residents requiring supervision at risk for consumption of unknown and unregulated medications and illegal substances and place them at risk for an altered mental status, decline in health and/or death.

The findings were:

Record review of Resident #1's face sheet dated 11/20/2024 revealed an admitted [DATE] with diagnosis which included: displaced bimalleolar fracture of left lower leg (broken bone of the ankle), subsequent encounter for closed fracture with routine healing, complete rotator cuff tear or rupture of right shoulder (muscles and tendons which surround the shoulder joint), not specified as traumatic, depression, anxiety disorder and chronic pain syndrome.

Record review of Resident #1's admission MDS dated [DATE] revealed she had a BIMs score of 15 which indicated she was cognitively intact and did not have any behaviors. The MDS assessment indicated the resident had a history of frequent pain that occasionally interfered with ADL's.

Record review of Resident #1's Care Plan initiated on 10/16/2024 revealed the resident had chronic pain syndrome and was followed by a pain specialist with interventions which included: administer analgesics as per orders. The care plan did not address behaviors of polypharmacy or having medications in her room without staff knowledge.

Record review of a provider progress note dated 11/08/2024 by PA J revealed: Patient (Resident #1) went to a pain medication doctor and had morphine prescription received, filled at outside pharmacy which she kept in her room and would self-dose. This was discovered and morphine was taken away from her .Denies alcohol, tobacco, drugs of abuse.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's nurse progress notes dated 11/09/2024 at 8:28 a.m., documented by LVN K revealed: Guest approached nurse at nursing station expressing concern. The pharmacy had questioned the medication she was picking (up) for a resident (Resident #1), morphine tablets (narcotic) and melodic (anti-inflammatory). The resident had requested she bring her medication with codeine (hydrocodone/acetaminophen 10/325) (narcotic opioid pain reliever) a week prior from a local pharmacy. The resident (Resident #1) explained that she had received the order from her pain management doctor at a previous appointment as the current pain medication was not effective at managing her pain. The nurse educated the patient (Resident #1) to inform her nurse of any new orders from appointments or her PCP so that her doctor at the facility could adjust her medication and make orders to safely assist her healing and rehab goals. The patient expressed understanding and stated she would not self-administer medication without informing the nurse. Record review of Resident #1's nurse progress notes dated 11/10/2024 at 4:43 p.m. documented by LVN H revealed: a CNA (unknown) notified nurse of suspicious activity. A person entered Resident #1's room with a package and immediately left. The incident was reported to the Administrator. Instruction was given to search room for medication, for patient safety. Patient (Resident #1) on narcotics and has a history of asking friends to bring in narcotic(s) and other pain medication prescribed by other providers into the facility and not adhering to facility policy. Patient education given. Will continue to monitor. Notified MD. Record review of a nurse progress note dated 11/11/2024 documented by LVN K revealed: Nurse notified ADON and MD (circumstances unknown). Received orders for Narcan for the patient (Resident #1). Record review of Resident #1's provider notes dated 11/14/2024 documented by PA J revealed: Notation was made that patient's family member was requesting she (Resident #1) not be given any narcotics, but no history of opioid abuse was given and patient was felt to have decision-making capacity, with no POA for involved family .Patient (Resident #1) reports her pain is controlled in her right shoulder and left ankle now that morphine prescribed by pain specialist. She has no acute complaints . 11/12 .pain MD wrote for morphine which she (Resident #1) was taking without notification of nurses, who thereafter noted some sedation and found the bottle . Record review of 3613-A Provider Investigative Report dated 11/19/2024 revealed on 7/19/2024 (incorrect date, actual date 11/19/2024), the facility was notified that a nurse (LVN A) found a patient (Resident #1) unresponsive at 5:30 am and called EMS at 6:30 a.m. The facility suspended the nurse (LVN A) for further investigation due to a delay in care. EMS arrived and administered Narcan, and the patient (Resident #1) was taken to a local ER and kept overnight for evaluation. The patient (Resident #1) was found to have medication at bedside and hospital records showed marijuana in (her) system). Record review of Resident #1's nurse assessment documented on 11/18/2024 at 5:22 p.m., revealed Resident #1's pain level was assessed at 1 (pain scale of 0-10). The resident was alert and oriented, communicated verbally with clear speech and was neurologically intact. The assessment documented Resident #1 had no unwanted behaviors witnessed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676240	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/24/2024
NAME OF PROVIDER OR SUPPLIER: Cibolo Creek		STREET ADDRESS, CITY, STATE, ZIP CODE: 1440 River Rd Boerne, TX 78006	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's nurse progress notes documented by LVN A on 11/19/2024 at 5:55 a.m. read 0530 (5:30 a.m.) walked into room, HOB 35 degrees, right leg hanging off the bed .(Resident #1) lethargic, unable to fully arouse, garbled words incomprehensible. Informed the aid (sic) on the hall. She reports to me a man went (sic) in her room at 11:00 p.m. and left. I asked if she reported to someone. She said the nurse on the Southside was told. I asked why? I am the nurse here on this side. Holding this 6 am dose (unknown medication). Will report to oncoming shift. Record review of Resident #1's medical record revealed there were no further progress notes or assessments to indicate Resident #1's physician was notified or that 911 was called or that Resident #1's family had been notified of the sudden change in mental status. Record review of Resident #1's hospital records dated 11/19/2024 revealed the resident presented to the ER with an altered mental status. Per EMS the patient (R1) was somnolent (sleepy)when she arrived with pinpoint pupils, some hypopnea (abnormally slow and shallow breathing which decreases the amount of oxygen in the blood), with oxygen saturation in the high 80's. (normal 92-100) and they administered 2 mg Narcan IM and 2 mg Narcan IV (opioid reversal agent-a medication used to treat drug overdose) with some transient (only lasting a short time) improvement in mental status. Resident #1's hospital diagnoses was AMS (altered mental status) and hypoxemia (low blood oxygen). Record review of a typed statement from LVN B dated 11/19/2024 indicated at 6:25 a.m. as LVN B was coming onto shift, LVN A was sitting down at the nurse's station. He documented LVN A handed him 6 white pills and 3 peach-colored broken pieces and stated the nurse aide obtained the pills from Resident #1's room at 11:00 p.m. last night. LVN B stated LVN A stated Resident #1 was lethargic and non-arousable since 5 am (11/19/2024). A nurse aide (unknown) from night shift stated to LVN B that this had been reported to LVN A since 11 p.m. last night (11/18/2024). When LVN B questioned LVN A if patient (Resident #1) was ever able to voice any response, LVN A stated that she (Resident #1) was non-arousable at 5 a.m. and that she had not assessed the patient from 11 p.m.- 5 a.m. LVN B questioned LVN A if she had notified the MD (physician) about any change in condition or the family since the patient's baseline was alert and oriented x 4 (cognitively intact). LVN B indicated LVN A responded no. LVN B stated he immediately ran to room to assess the patient along with NA C and CNA E while LVN A remained at the nurse's station. LVN B wrote Resident #1 was breathing but was not arousable, a sternal rub was performed with grunting as the response sternal rub (firm rub to a patient's sternum is a painful stimulus to test a patients consciousness level) and he assured 911 was called immediately. LVN B wrote he also immediately notified the Administrator and Regional RN and notified the physician and the family of Resident #1. (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of a written statement dated 11/19/2024 by LVN A indicated at 5:30 a.m. on 11/19/2024 she entered Resident #1's room to see her right leg hanging off the bed. LVN A wrote Resident #1's eyes were closed, and her respirations were even and unlabored. LVN A called the name of Resident #1 (and her response was) squinting her eyes and garbled speech. LVN A wrote the aides were outside her room and she told them about Resident #1's behaviors. One aide (unknown) said there was a man that left the residents room at 11:00 p.m. LVN A wrote she had just left (the area) at 11:08 p.m. and did not see anyone so she asked the aide if she had told someone. LVN A wrote the aide reported she told the nurse for this side (unknown). LVN A wrote all three of the staff went into Resident #1's room and searched drawers, cabinets, and closet. LVN A wrote she had the aides search Resident #1's room and they found a small plastic box with 5-6 round pills and 3 pieces of peach-colored pills. LVN A wrote at 5:45 a.m. she told another nurse (unknown name) who identified the pills as trazadone (antipsychotic medication) and tramadol (opioid analgesic used for pain). LVN documented a midsternal rub with a very strong facial grimace and vital signs of 101/84 (blood pressure) 55 (unclear if it was HR or RR) and 96% on room air (oxygen saturation) (it was unclear who took vitals or when they were taken). LVN A wrote at 6:15 a.m. she gave report to LVN B. LVN A wrote LVN B did not go into Resident #1's room or assist her so she went back into Resident #1's room to attempt to arouse Resident #1 again. LVN A wrote she told Resident #1 Look! We need to go! Let's go now! She wrote Resident #1 sat on the edge but LVN A told Resident #1 to wait and put her back to bed. LVN A wrote she called the Administrator and told the Administrator maybe she would just call 911 to have them come shake her up a bit. LVN A wrote she did call 911(unknown time). Record review of a written statement (undated) by NA E read when the (aides) were doing rounds at 10:00 p.m. at the start of their shift, a man walked out of the resident room with a to-go container in a plastic bag. She wrote they did not think anything of it. NA E wrote she told LVN A a weird guy was in the resident's room, but supposedly she did not hear what she said. NA E wrote she also reported it to the nurse on the other side (unknown). NA E wrote the man left at 11 (p.m.). NA E wrote they went into Resident #1's room and she was alert and awake. She documented she did not round on Resident #1 during the night because the resident preferred, they did not wake her up all night with every round unless she called them. NA E wrote she was in a room across the hall changing another resident when LVN A busted in asking questions about Resident #1 telling us (aides) to go try and wake her (Resident #1) up. NA E wrote they (aides) went the resident's room (Resident #1) and she was not really responding. She twitched a little and moved her lips. She wrote LVN A did not do vitals or anything until the morning nurse came in. NA E wrote LVN A found Resident #1 like this at 5:00 a.m. when LVN A was passing her medicine. NA E wrote Resident #1 never sat up or spoke when she was in the room. NA E wrote they found a little box of pills while searching and LVN A took them. NA E wrote LVN A proceeded to do nothing for the resident and tried to blame them (aides). (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of a written statement (undated) by NA F wrote she was making rounds with NA E; in another resident's room they noticed a guy walk out of (Resident #1's) room across the hall. NA F documented they saw him re-enter Resident #1's room a few minutes later with what looked like a to-go container. NA F documented she notified LVN A along with NA E that there was a man coming in and out of the resident's room. She wrote she continued making rounds and saw the man leave at approximately 11:00 p.m. NA F documented they did not make rounds on Resident #1 during the night because her chart says not to as she can go to the restroom and move around on her own. NA F documented at 5:00 a.m. (on 11/19/2024) NA E and NA F were changing another resident when LVN A rushing in saying Resident #1 would not respond to her. She told them to go into the room and try to wake her (Resident #1) up. NA F wrote Resident #1 was unresponsive, but still breathing and they found a bag of pills on her bedside table which they gave to LVN A. NA F wrote she let LVN A to do the rest and continued her rounds. During an interview on 11/19/2024 at 1:39 p.m., the Administrator stated. A nurse (identified as LVN A) found Resident #1 lethargic and not responding like she should have, so EMS was called who administered Narcan twice. She stated Resident #1 also received Narcan via IV at the hospital. The Administrator stated they found a clear container with mixed pills in the resident's room which they had locked up in the DON's office. She said some of the medications were cut in half and unidentifiable and one was trazadone. The Administrator stated a couple of weeks prior they found medications in Resident #1's room, confiscated it and gave the resident education. She stated one of the medications they found was morphine and she could not remember what the other one was. She stated they contacted the resident's physician and gave education. The Administrator stated they also gave education to visitors. She stated the education was documented in PCC under progress notes for Resident #1. She stated a nurse, LVN A was suspended because they thought there was a delay in her response time. During an interview on 11/20/2024 at 10:14 a.m., the Administrator stated they had learned Resident #1 tested positive for both opioids (she had a prescription for opioid medication, so it was an expected outcome) and marijuana. She stated based on this information they conducted another search of Resident #1's room and the strong smell of something odd that was consistent with marijuana was discovered. She stated they identified a brownie on Resident #1's TV stand that had the strong odor. She stated they notified the local police who came and destroyed the brownie. The Administrator stated the original plan was for Resident #1 to discharge tomorrow (11/21/2024) after her doctor appointment and that was still the plan. She stated the facility was accepting Resident #1 back from the hospital today (11/20/2024) because they did not believe in dumping. She stated a discharge notice had never been given to the resident. The Administrator stated she communicated with the staff in person, text and she preferred phone calls. She stated she attended both morning and clinical meetings with staff. She stated during those meetings they did discuss that a CNA found a bottle of prescription medication containing morphine in Resident #1's room. She stated they made the required notifications including to family, physician and they educated the staff and visitors. She stated they do not routinely search residents' rooms or visitors for medications. She stated the resident had both a right to receive visitors and packages. The Administrator stated in lieu of searching Resident #1's room which showed lack of character judgement, LVN A should have provided medical care to Resident #1. The Administrator stated she ensured staff had the knowledge on how to response by in-service training. She stated the facility notified the Medical Director who was also Resident #1's physician of the incident on 11/19/2024. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/20/2024 at 10:45 a.m., Resident #1's family member stated Resident #1 had an accident and broke her foot and prior to that had surgery on her shoulder. The family member stated Resident #1 was currently hospitalized because she was found very lethargic and unresponsive. He stated the doctors at the hospital said she was taking a lot of medications. He stated he was not sure what medications she was taking. He stated Resident #1 was seeing a pain medication doctor, an orthopedic surgeon and had a doctor at the facility but he didn't know who the doctors were and did not know the prescriptions. The family member stated he did not know Resident #1 was getting medications from multiple physicians and multiple pharmacies and did not know why she was now testing positive for marijuana. He stated a few days before she was admitted to the facility, she took a vacation to the Caribbean and spent some time in Chicago and may have had access to marijuana at either of those places. He stated he had no knowledge of any other illegal drug usage. He stated to his knowledge Resident #1 had not had any visitors at the facility. He stated Resident #1 did not have a significant other/boyfriend that he was aware of. He stated there was another family member locally, but that person had no contact with Resident #1. He stated he had minimal contact with Resident #1 and had only visited her twice at the facility. He stated he was unable, unwilling and did not have the capacity to give Resident #1 support. He stated Resident #1 did not leave the facility other than for doctors' appointments, but she did have local grocery and food deliveries at the facility. He stated he did not visit Resident #1 the night of the incident on 11/18/2024-11/19/2024. During an interview on 11/20/2024 at 12:04 p.m., LVN B stated on 11/19/2024 at 6:25 a.m. he came onto duty. He stated night shift nurse LVN A was seated at the nurse's station trying to give him report when he arrived. LVN B stated LVN A stated she noticed a change of condition for Resident #1 related to level of consciousness. LVN B stated LVN A stated the aides told her about the change of condition at 11:00 p.m. when Resident #1 had visitors and was lethargic. LVN B stated LVN A told him she assessed Resident #1 at 11:00 p.m. (11/18/2024) and found her lethargic but she did not notify anyone and did not notify the doctor. LVN B stated LVN A told him she went into Resident #1's room at 5:00 a.m. to assess the resident and she was not arousable. LVN B stated he questioned LVN A to see if she had notified the physician or transferred the resident to the hospital since Resident #1 was normally A/O x 4 (alert and oriented x 4 which indicated she was cognitively intact). LVN B stated LVN A stated she had not notified anyone. LVN B stated as soon as he heard LVN A say that he ran directly to Resident #1's room. He stated he had not yet clocked into work, but he was concerned since LVN A did not seem to know what was going on. LVN B stated LVN A stated she thought it might be medication related since the night aides found medication in Resident #1's room. LVN B stated he was alarmed. He stated he had two aides go with him. He stated when he saw Resident #1, he knew immediately something was wrong. He stated Resident #1 was very lethargic and was not able to verbalize anything. He stated she was just grunting. He stated she was breathing, and he obtained vital signs which were stable. He stated he made sure someone stayed with Resident #1 because he knew she needed to go to the hospital. LVN B stated he went to find LVN A and told her to call 911, which she did. He stated he went back to Resident #1's bed side but LVN A went to her medication cart. LVN B stated he notified Resident #1's physician and her family. LVN A stated he told the physician Resident #1 was minimally responsive and that EMS had been activated. He stated the physician's response was that a hospital evaluation was appropriate. LVN A stated he had never witnessed any medications in Resident #1's room and had never smelled or identified marijuana in her room. (continued on next page)

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F 0689

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

During an interview on 11/20/2024 at 12:25 p.m., NA C stated on 11/19/2024 at 6:06 a.m. she arrived at the facility for her morning shift. She stated CNA D had approached her and stated she had it up to here with her (LVN A). NA C stated CNA D stated the nurse (LVN A) was not listening to her and there was concern for Resident #1. NA C stated CNA D said a random guy went into Resident #1's room but she did not know what happened. NA C stated she clocked in and went straight to Resident #1's room to check on her. She stated Resident #1 was not responding to her voice. She stated she saw Resident #1 laying on her back with one arm on her chest. NA C stated Resident #1 was twitching. She stated at first, she saw just her lip twitching and then noted that her fingers and her toes were also twitching, and she would not respond. NA C stated she went to LVN A and asked her what was wrong with Resident #1? NA C stated LVN A responded that she had already checked on Resident #1. NA C stated she told LVN A that Resident #1 was not acting normal to which she did not get a response. NA C stated she (NA C) could at least get Resident #1's vitals since she was not acting right. NA C stated she obtained the vitals and saw LVN A talking to LVN B at the nurse's station. NA C stated LVN A was giving LVN B an update on what was going on. NA C stated LVN B was asking LVN A if she had checked on her (Resident #1) or if she took vitals. NA C stated she showed LVN B the vitals she just took which included an oxygen saturation of 87% (normal 92-100%). NA C stated LVN B ran into the room and stated, she is not okay. NA C stated at approximately. 6:30 a.m., LVN B was telling LVN A she was not normal and to call 911. NA C stated LVN B said to LVN A Why did you wait? NA C stated LVN A did not seemed concerned at all. NA C stated LVN A lied and said she just came out of the room and Resident #1 was sitting on the edge of the bed. NA C stated she walked into the room to see for herself, and Resident #1 had not moved. She was still not responsive and twitching. NA C stated CNA D was with her and also saw what was occurring. NA C stated she asked LVN A why she was lying? She stated LVN A responded that she had a rough day. NA C stated she had never seen any medications or drugs lying around in any resident room. She stated they were not able to identify the visitor. She stated the front doors are locked at night and require a code to access the facility. NA C stated if she saw medications lying around, she was trained to give them to the nurse. She stated she had training in opioid abuse, administration of Narcan and what to do in case of change of condition.

During an interview on 11/20/2024 at 12:52 p.m., CNA D stated she overheard LVN A talking about how Resident #1 was not doing well. CNA D stated LVN A was telling LVN B that she was having issues with Resident #1, and she was not alert. CNA D stated she went to look at the resident to see if she could help. She stated Resident #1 was in bed and she looked asleep. She stated LVN A came into the room with her and was trying to wake up Resident #1. CNA D stated LVN A was lifting Resident #1's eye lids and was giving her a chest rub and was trying to get vitals. CNA D stated Resident #1 was not responding and did not respond to the chest rub. CNA D stated she thought the chest rub was very aggressive. CNA D stated she was not sure what the vitals were, but another nurse (unknown name) said the blood pressure was not a normal reading. CNA D stated the next thing she knew LVN A was calling EMS, but she was not happy about it and said the same thing had happened to the resident three times last week. CNA D stated LVN A stated Resident #1 was a druggy and knew her limits. CNA D stated she thought that comment was inappropriate. She stated she had never seen Resident #1 in any other way. CNA D stated LVN A told 911 on the phone and asked if they would come rough house the resident to wake her up. CNA D stated LVN A was neglectful and was not making Resident #1's needs a priority and making it like it was a bother rather than addressing her change of condition. CNA D stated the whole situation was a surprise to her. She stated Resident #1 was normally independent, up and about, and alert. She stated she had never seen the resident in any other way. She stated she had never seen any medications or drugs lying around in resident rooms. She stated she was trained to notify the nurse and go up the chain of command if necessary. She stated she had received in-service training on abuse/neglect, medication administration and change of condition following the event.

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/20/2024 at 1:06 p.m., NA F stated she worked the overnight shift on 11/18/2024-11/19/2024. She stated she was doing rounds with NA E at approximately 11:00 p.m. she saw a man they did not know come out of Resident #1's room. She stated she also saw Resident #1 who was oriented normally and was up and moving around and asked for ice for her ankle. NA F stated at 5:00 a.m. they were across the hall when LVN A asked, What happened to Resident #1? NA F stated they said they did not know but LVN A told us to try to help wake her (Resident #1) up. NA F stated Resident #1 was breathing but was not responsive. She stated she was saying her name really loud, and they were pushing on her and shaking her, but it was not working. NA F stated they found a bag of pills in the room. NA F stated at approximately 5:30 a.m. she told LVN A she should probably call 911 since Resident #1 was unresponsive. NA F stated LVN A stated, Well she is a drug addict, so it doesn't matter. NA F stated LVN A then went back to the nurse's station and did not really acknowledge the situation. NA F stated they (aides) stayed with Resident #1. She stated a while later LVN B came in and assessed Resident #1 and called 911. She stated when she saw LVN B he went right into work mode. He immediately went into Resident #1's room, assessed her and took vital signs. NA F stated Resident #1 was still unresponsive, but LVN B got her help right away. She stated the ambulance came about 5 minutes later but the aides stayed with Resident #1 to make sure she did not stop breathing. NA F described Resident #1 as pale but not blue and looking like she was sleeping but would not wake up. NA F stated LVN A's actions and words were very inappropriate. NA F stated it was her first overnight shift. She stated she did not know the typical protocol door nighttime, just what LVN A had told her. She stated LVN A told her the aides not to go into Resident #1's room during the night, that it was on her chart not to go in because she was independent, and she could do everything on her own. She stated they might peak into her room from the door but wouldn't enter the room if it looked like the resident was sleeping. NA F stated she didn't have any way to verify what LVN A told her about the chart, they just had to take her word for it. She stated she did not open Resident #1's door between 11 p.m. - 5 am. NA F stated since the incident she had received training on opioid abuse, how to handle an overdose, change of condition and abuse/neglect. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/20/2024 at 1:37 p.m., NA E stated she worked 10 p.m.- 6 am shift on 11/18/2024. She stated at the beginning of her shift she saw a gentleman visitor come from outside to Resident #1's room. She stated she did not question the visitor because other staff had said the visitor had been there since 6:00 p.m. NA E stated the outside doors of the facility are locked and require a code to access or Resident #1 may have given the code to the visitor. NA E stated she saw the visitor leave and come back in with a food to go box in a clear plastic bag. She stated she assumed it was food that was delivered to the facility for her. She stated families do it all the time. NA E stated the visitor left at approximately 10:45 p.m. She stated she last saw Resident #1 well at 11:10 p.m. when she brought her an ice pack for her leg. NA E stated she was acting like her normal self. NA E stated at 5:00 a.m., LVN A said Resident #1 was not waking up and she was trying to give her medications. NA E stated she did not know why LVN A was relying on the aides to do something about it when she was the nurse. NA E stated she went into Resident #1's room and tried to wake her up. She stated she tried calling her name, tapping her shoulder, and giving her a chest rub. NA E stated Resident #1 moved her mouth a little, like a twitch. She stated her legs twitched also and she wouldn't wake up. NA E stated Resident #1 never opened her eyes or responded in any verbal way. NA E stated she then left the room because she had other residents to attend to. NA E stated LVN A was frantic, like she did not know what to do. NA E stated she had them search the room with flashlights and they found a small clear case with multiple pills in it which they gave to LVN A. NA E stated this whole time Resident #1 was unconscious and LVN A was not proving care, she did not do vitals, nothing. NA E stated LVN A then went and sat at the nurse's station. NA E stated the aides were lost and did not know what to do but it seemed like LVN A did not care. NA E stated when they next shift arrived, they took over and asked LVN A if she had called the doctor or called 911 and LVN A said no she did not. NA E stated LVN A admitted she did not notify the doctor or 911. NA E stated the aides were all very stressed out. She stated they were trained to notify the nurse which they did. NA E stated they had thought about calling 911 themselves but did not want to get in trouble. She stated she was trained to tell the Administrator because she was the abuse coordinator, but she couldn't think so she called the on-call person who said she would call the Administrator. During an interview on 11/20/2024 at 2:56 p.m., LVN A stated she had been a nurse for [AGE] years. She stated on the night of 11/18/2024 around approximately 11:08 p.m. she noted that Resident #1 was drowsier than normal but was otherwise alert and oriented. LVN A stated she couldn't remember a lot of about that night, just that she was in bed, that she did not say a lot, but she was resting quietly. LVN A stated on 11/19/2024 at 5:30 a.m. she went into Resident #1's room to give scheduled morphine and noted the resident's right leg handing off the bed with her head of bed at 45 degrees with her head to the side. LVN A stated Resident #1 was sleeping. She stated she tried to wake Resident #1 up and noted she was hard to wake up. LVN A stated Resident #1 slit her eyes open a little and was trying to talk but she could not understand her. LVN A stated she thought Oh my gosh. She stated the aides were just outside the room in the hallway. She stated she couldn't remember who the aides were but there were two of them and she wanted them to come inside the room because Resident #1 would not wake up. LVN A stated Resident #1 was drug seeking so she started searching her room and found 5-6 pills a piece of peach-colored pills. She stated she thought the white one [TRUNCATED]

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NAME OF PROVIDER OR SUPPLIER Cibolo Creek		STREET ADDRESS, CITY, STATE, ZIP CODE 1440 River Rd Boerne, TX 78006	

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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** 38511 Based on observation, 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 2 of 6 residents (Residents #2 and #3) reviewed for medications and pharmacy services, in that: The facility failed to ensure Resident #2 clobetasol propionate 0.05% prescription shampoo and over-the-counter polysporin were secured when they were left in the resident's room. The facility failed to ensure Resident #3's Simbrinza ophthalmic suspension x 2 bottles and 5 medication cups of an unknown ointment were secured when the resident was not in the room. These deficient practices could put residents at risk for inaccurate or inappropriate administration of medications. The findings were: 1. Record review of Resident #2's face sheet dated 11/23/2024 revealed an admitted [DATE] with diagnoses which included: atrial fibrillation (irregular heart rhythm), adult failure to thrive (weight loss and general decline) and muscle weakness. Record review of Resident #2's care plan initiated on 11/10/2024 revealed no relevant care areas. Record review of Resident #2's admission MDS revealed it was still in progress and had not been completed. Record review of Resident #2's physician order summary dated 11/23/2024 revealed he did not have orders for clobetasol shampoo or over-the-counter polysporin. Record review of Resident #2's medical record revealed he had not been assessed for self-administration of medication. During an observation and interview on 11/19/2024 at 1:57 p.m., Resident #2 was observed in bed awake without staff in attendance. A box of clobetasol propionate 0.05% prescription shampoo and over-the-counter polysporin ointment (antibiotic ointment) was observed on his dresser. Resident #2 did not answer any questions about the medications and it was unclear if he was cognitively intact. He stated, leave those there please. During an observation and interview on 11/19/2024 at 3:12 p.m., LVN B stated Resident #2 could not keep the clobetasol shampoo in his room or the polysporin. He confirmed the shampoo was a prescription. He stated the staff inspect the rooms and teach the patients, so they know to bring medications to the nurses. He described Resident #2 was cognitively intact. LVN B took the shampoo and polysporin ointment with him while exiting the room and informed Resident #2 he needed to talk to his doctor about the medications. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident #3's face sheet dated 11/21/2024 revealed an admitted [DATE] with readmitted [DATE] with diagnoses which included: epilepsy, pain in right knee, right shoulder and dementia. Record review of Resident #3's quarterly MDS dated [DATE] revealed a BIMs score of 14 which indicated the resident was cognitively intact and without behaviors. Record review of Resident #3's Self-Medication Administration assessment dated [DATE] revealed the resident had been assessed and determined to be able to self-administer medications. Record review of Resident #3's Care Plan initiated on 8/02/2024 revealed the resident could self-administer specific medications with interventions which included: keep medications in a lockbox. Remind as needed to use box only for medication and to lock up in between uses. Record review of Resident #3's physician order summary revealed the following orders: 1. Simbrinza ophthalmic suspension 1-0-2% (brinzolamide-brimonidine tartrate) instill 1 drop in both eyes two times a day for glaucoma. 2. Voltaren arthritis pain external gel 1% (diclofenac sodium) topical ointment: apply to knees, painful sites topically two times a day every Tues, Thurs, Sat for pain as unsupervised self administration whenever patient reports pain, 3. Zoryve External cream 0.3% (roflumilast) topical, apply to right thigh topically every day shift for rash During an observation on 11/19/2024 at 2:33 p.m. two bottles of prescription Simbrinza ophthalmic suspension 1-0-2% and 5 medication cups labeled with different body parts such as groin, knee, leg with a white creamy substance assumed to be a medicated ointment were on the over bed table. Resident #3 was not in the room and no staff were in the room. Multiple gloves were also noted on the table. There was a small clear lockbox on the over bed table that had the key in the lock. The clear lockbox contained individual jelly packets too numerous to count. During an observation and interview on 11/19/2024 at 2:43 p.m. CNA D stated medications were to be administered by the med tech or the nurse. She stated she did not know what the medications were in Resident #3's room. She stated she was not aware of any residents in the facility who were self-administering medication. She stated she was trained to take up the medications and notify the nurse. She stated those medications (referring to the eye drops and multiple medication cups of ointment) need to be picked up. She exited the room leaving the medications in the room unattended. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 11/19/2024 at 2:51 p.m., LVN P stated Resident #3 self-administered some of his medications. She stated he had been assessed for self-administration. LVN P stated they could leave medications in Resident #3's room but the medications should be in a locked drawer and the resident keeps the key. She stated the nursing staff did not have to observe Resident #3 administering his medication. She stated Resident #3 had pain medication and eye drops that he kept in his room. She stated the rest of his medications were kept in the locked medication cart. She stated unless a resident had been assessed for safe self-administration all medications were to be locked up. Upon observing the eye drops and multiple medication cups with the white gel in them, LVN P stated the white medication was either knee pain gel, a prescription cream for his thighs or moisturizer but she was not certain what was in the medication cups. She stated Resident #3 should be keeping his medications in the locked box and keeping the key with him and not using it to lock up jelly. She stated she was not certain why he had two bottles of the Simbrinza in his room. LVN P stated it was important to keep medications locked up because they have some residents who wander who might be confused and think medications were candy. She stated the eye drops and ointment/pain gel should also be locked up whenever the resident was not in the room. She exited the room and left the medication on the overhead table. During an interview on 11/22/2024 at 8:02 a.m., RN ADON L stated the CNAs should report any medications found in a resident room to the nurse. She stated any medications in a resident room should be removed. Record review of a facility policy titled Medication Administration (undated) revealed the policy did not address storage of medications. Record review of a facility policy titled Resident Self-Administration of Medication (undated) revealed: 3. When determining if self-administration is clinically appropriate for a resident, the interdisciplinary team should at minimum consider the following: g. The residents ability to ensure that medication is stored safely and securely.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38511 Based on interviews, and record review, the facility failed to maintain medical records, in accordance with accepted professional standards and practices, that are complete; and accurately documented for 1 of 5 residents (Resident #1) reviewed for medical records, in that; The facility failed to ensure staff documented Resident #1's unresponsiveness and SBAR assessment, the pills found in her room on 11/19/2024 or interventions for her change of condition including notification/activation of 911 and transfer to the hospital for treatment. This failure could result in residents not having an accurate overall view of their care and services. The findings were: Record review of Resident #1's face sheet dated 11/20/2024 revealed an admitted [DATE] with diagnosis which included: displaced bimalleolar fracture of left lower leg (broken bone of the ankle), subsequent encounter for closed fracture with routine healing, complete rotator cuff tear or rupture of right shoulder (muscles and tendons which surround the shoulder joint), not specified as traumatic, depression, anxiety disorder and chronic pain syndrome. Record review of Resident #1's Care Plan initiated on 10/16/2024 revealed the resident had chronic pain syndrome and was followed by a pain specialist with interventions which included: administer analgesics as per orders. The care plan did not address behaviors of polypharmacy or having medications in her room without staff knowledge. Record review of Resident #1's admission MDS dated [DATE] revealed she had a BIMs score of 15 which indicated she was cognitively intact and did not have any behaviors. The MDS assessment indicated the resident had a history of frequent pain that occasionally interfered with ADL's. Record review of Resident #1's nurse progress notes documented by LVN A on 11/19/2024 at 5:55 a.m. read 0530 (5:30 a.m.) walked into room, HOB 35 degrees, right leg hanging off the bed .(Resident #1) lethargic, unable to fully arouse, garbled words incomprehensible. Informed the aid (sic) on the hall. She reports to me a man went (sic) in her room at 11:00 p.m. and left. I asked if she reported to someone. She said the nurse on the Southside was told. I asked why? I am the nurse here on this side. Holding this 6 am dose (unknown medication). Will report to oncoming shift. Record review of Resident #1's medical record revealed there were no further progress notes or assessments to indicate any further assessments or that 911 was called or that Resident #1 was transferred to the hospital for a significant change in mental status. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of 3613-A Provider Investigative Report dated 11/19/2024 revealed on 7/19/2024 (incorrect date, actual date 11/19/2024), the facility was notified that a nurse (LVN A) found a patient (Resident #1) unresponsive at 5:30 am and called EMS at 6:30 a.m. The facility suspended the nurse (LVN A) for further investigation due to a delay in care. EMS arrived and administered Narcan, and the patient (Resident #1) was taken to a local ER and kept overnight for evaluation. The patient (Resident #1) was found to have medication at bedside and hospital records showed marijuana in (her) system). During an interview on 11/20/2024 at 12:04 p.m., LVN B stated on 11/19/2024 at 6:25 a.m. he came onto duty. He stated night shift nurse LVN A was seated at the nurse's station trying to give him report when he arrived. LVN B stated LVN A stated she noticed a change of condition for Resident #1 related to level of consciousness. LVN B stated LVN A stated the aides told her about the change of condition at 11:00 p.m. when Resident #1 had visitors and was lethargic. LVN B stated LVN A told him she assessed Resident #1 at 11:00 p.m. (11/18/2024) and found her lethargic. LVN B stated LVN A told him she went into Resident #1's room at 5:00 a.m. to assess the resident and she was not arousable. LVN B stated he questioned LVN A to see if she had notified the physician or transferred the resident to the hospital since Resident #1 was normally A/O x 4 (alert and oriented x 4 which indicated she was cognitively intact). LVN B stated LVN A stated she had not notified anyone. LVN B stated as soon as he heard LVN A say that he ran directly to Resident #1's room. He stated he had not yet clocked into work, but he was concerned since LVN A did not seem to know what was going on. LVN B stated LVN A stated she thought it might be medication related since the night aides found medication in Resident #1's room. LVN B stated he was alarmed. He stated he had two aides go with him. He stated when he saw Resident #1, he knew immediately something was wrong. He stated Resident #1 was very lethargic and was not able to verbalize anything. He stated she was just grunting. He stated she was breathing, and he obtained vital signs which were stable. He stated he made sure someone stayed with Resident #1 because he knew she needed to go to the hospital. LVN B stated he went to find LVN A and told her to call 911, which she did. He stated he went back to Resident #1's bedside but LVN A went to her medication card. LVN A stated he notified Resident #1's physician and her family. LVN A stated he told the physician Resident #1 was minimally responsive and that EMS had been activated. During an interview on 11/20/2024 at 2:56 p.m., LVN A stated on the night of 11/18/2024 around approximately 11:08 p.m. she noted that Resident #1 was drowsier than normal but was otherwise alert and oriented. LVN A stated on 11/19/2024 at 5:30 a.m. she went into Resident #1's room to give scheduled morphine and noted the resident's right leg handing off the bed with her head of bed at 45 degrees with her head to the side. LVN A stated Resident #1 was sleeping. She stated she tried to walk Resident #1 up and noted she was hard to wake up. LVN A stated Resident #1 slit her eyes open a little and was trying to talk but she could not understand her. LVN A stated she thought Oh my gosh. She stated the aides were just outside the room in the hallway. She stated she couldn't remember who the aides were but there were two of them and she wanted them to come inside the room because Resident #1 would not wake up. LVN A stated Resident #1 was drug seeking so she started searching her room and found 5-6 pills a piece of peach-colored pills. LVN A stated Resident #1 was not unresponsive. She stated she opened her eyes and garbled something. LVN A stated she kept going in and out of the room and noted Resident #1 gave a big grimace with a sternal rub. LVN A stated when she saw the big grimace she thought Oh God, she is okay and it was the end of her shift, and she was tired. LVN A stated she called 911 because she thought maybe they could shake her up. LVN A stated was trained to assess, document assessment for resident change of condition. LVN A stated she did not know why she deviated from how she was trained other than she was pretty tired and had worked her butt off. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/21/2024 at 9:56 a.m., LVN B stated there was no SBAR or other assessment documented in Resident #1's medical record for her change of condition that occurred on 11/19/2024 or any notifications. He stated he was trained to do an SBAR assessment with change of condition and document it in the medical record. He stated he was also trained to document in the progress notes the assessment and assessed vitals. He stated he did not document his assessment because he gave the information to LVN A. He stated he should have documented when Resident #1 was transferred to the hospital. LVN B stated it was important to document pertinent information in the medical record because it was a confirmation of work done. He stated he had received training by the facility on documentation on an unknown date. During an interview on 11/22/2024 at 11:20 a.m., the Regional RN stated staff were trained to document the SBAR assessment located under documents for resident change of condition. She stated they were trained to document change of condition which included the assessment, vitals, and notifications also in the progress notes. She stated the whole chain of events should be included in the notes including any new orders, transfers, etc. She stated it was important to document so there was continuity of care. Record review of a facility policy, titled Documentation in the Medical Record (undated) revealed: Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. 1. Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. 2. Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation or care service occurred. 4. Principles of documentation include but are not limited to: a. Documentation shall be factual, objective, and resident centered i. False information shall not be documented.