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Form Approved OMB
No. 0938-0391

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 08/02/2024

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 0558

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Reasonably accommodate the needs and preferences of each resident.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 44020

Based on observation, interview and record review the facility failed to ensure residents received services in the facility with reasonable accommodation of resident needs for 3 of 8 residents (Residents #19, #21 and #49) who were observed for call light placement.

The facility failed to ensure the call light was within reach for Residents #19, #21, and #49.

This deficient practice could affect any resident and keep them from calling for help as needed.

The findings included:

Record review of Resident #19's face sheet, dated 08/01/2024, reflected she was admitted to the facility on [DATE] with diagnoses which included: unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, and anxiety, age-related osteoporosis without current pathological fracture, hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting, unspecified side, weakness, and other abnormalities of gait and mobility.

Record review of Resident #19's Quarterly MDS assessment, dated 06/24/2024, reflected the resident's BIMS score was 03, which indicated severe cognitive impairment. The Quarterly MDS assessment further revealed Resident #19 required substantial/maximal assistance (helper does more than half the effort) for mobility roll left and right, sit to lying, sit to stand, chair/bed to chair transfer, lying to sitting on side of bed, dependent (helper does all the effort) for toileting hygiene, shower/bathe self, lower body dressing.

Record review of Resident #19's care plan, revision date of 07/31/2024, reflected Focus: [resident name] is High risk for falls history of falls dementia, generalized weakness, left sided weakness . with Interventions: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed, the resident needs prompt response to all requests for assistance.

Observation on 08/01/24 4:28 p.m. revealed Resident #19 with her call light located on the floor under the side of her bed near the nightstand.

During an interview on 08/01/2024 at 4:31 p.m. MA D stated Resident #19 did use her call light sometimes and placed resident's call light back on the bed. MA D further stated whoever assisted residents or laid them down were supposed to make sure residents could reach them. MA D stated residents used call lights if they need anything or had an emergency for their safety.

(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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676240	A. Building B. Wing	08/02/2024

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #21's face sheet, dated 08/01/2024, reflected she was admitted to the facility on [DATE] with diagnoses which included: Alzheimer's disease, acute kidney failure, unspecified, weakness, and cognitive communication deficit. Record review of Resident #21's Quarterly MDS assessment, dated 07/25/2024, reflected the resident's BIMS score was 02, which indicated severe cognitive impairment. The Quarterly MDS assessment further revealed Resident #21 required substantial/maximal assistance (helper does more than half the effort) for mobility sit to lying, sit to stand, chair/bed to chair transfer, lying to sitting on side of bed, shower/bathe self, lower body dressing and dependent (helper does all the effort) for toileting hygiene. Record review of Resident #21's care plan, revision date of 07/19/2024, reflected Focus: [resident name] is High risk for falls history of falls r/t cognitive impairment, wears glasses, unsteady gait/balance. with Interventions: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed, the resident needs prompt response to all requests for assistance. Observation and interview on 07/30/2024 at 11:12 a.m. revealed Resident #21's call light was on the floor next to her bed. CNA C stated she did not believe Resident #21 used her call light, but the call light should have been within reach of Resident #21. CNA C placed call light under Resident #21's hand after picking it up off the floor. Observation on 08/01/2024 at 4:28 p.m. revealed Resident #21 with call light located on the floor near the head of bed. During an interview on 08/01/2024 at 4:31 p.m. MA D stated Resident #21 did use her call light sometimes and placed resident's call light back on the bed. MA D further stated whoever assisted residents or laid them down were supposed to make sure residents could reach them. MA D stated residents used call lights if they need anything or had an emergency for their safety. Record review of Resident #49's face sheet, dated 07/10/2024, reflected she was admitted to the facility on [DATE] with diagnoses which included: metabolic encephalopathy, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, unsteadiness on feet, and other abnormalities of gait and mobility. Record review of Resident #49's Admission MDS assessment, dated 06/03/2024, reflected the resident's BIMS score was 03, which indicated severe cognitive impairment. The Admission MDS assessment further revealed Resident #49 required substantial/maximal assistance (helper does more than half the effort) for sit to lying, dependent (helper does all the effort for toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, roll left and right, lying to sitting on the side of bed, and chair/bed-to-chair transfer. Record review of Resident #49's care plan, revision date of 07/29/2024, reflected Focus: The resident is at risk for falls r/t advanced dementia with associated risk of decreased safety awareness and impulsivity, Deconditioning, Gait/balance problems, Incontinent episodes (highly prefers having BM in toilet potential risk for self-transfer attempt) . with Interventions: Be sure The resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 07/30/2024 at 10:50 a.m. revealed Resident #49 sitting in w/c next to her bed wearing her oxygen with her soft touch call light hanging on the quarter rail of her bed behind Resident #49. Resident #49 stated she did push it sometimes and further stated she could not reach it right then. During an interview on 07/30/2024 at 10:58 a.m. CNA C stated Resident #49 she did not believe used the call light, however, the residents were to always have it with them. CNA C further stated it was important for residents to be able to reach their call lights so the residents could call for help. Observation and interview on 08/01/2024 at 4:37 p.m. revealed Resident #49 lying in bed with the head of her bed elevated and call light on the floor next to the bed. ADON A entered the room, picked up the call light off the floor and placed across resident. ADON A stated Resident #49 would not have been able to reach it, and this was why she picked it up and gave it to Resident #49. During an interview on 08/01/2024 at 5:15 p.m. the DON stated anybody who was in the room should ensure the call lights were in reach when leaving the rooms. The DON further stated call lights are part of their fall prevention measures. The DON stated call lights were used by residents for emergencies, in any situation they needed assistance, and she knew many did not use the call light, but the call light should still be in place. Record review of facility's Call Lights: Accessibility and Timely Response policy, no revised date, read Policy the purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistances . Policy Explanation and Compliance Guidelines: 5. Staff will ensure the call light is within reach of resident and secured, as needed. 6. The call system will be accessible to residents while in their bed or other sleeping accommodations within the resident's room.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34788 Based on observation, interview, and record review, the facility failed to ensure residents have a right to personal privacy for 1 of 6 residents (Resident #18) reviewed for privacy, in that: ADON A did not close completely Resident #18's privacy curtain while providing wound care. This deficient practice could place residents at-risk of loss of dignity due to lack of privacy. The findings include: 1. Record review of Resident #18's face sheet, dated 08/01/2024, reflected an admitted [DATE] and, a readmitted [DATE], with diagnoses which included: Osteomyelitis (infection of bone) left ankle and foot, Moderate intellectual disability, Osteoporosis (Systemic loss of bone mass resulting in fragile bones), Pressure ulcer of heel, stage 4 (wound exposing the bone). Record review of Resident #18's Significant change of status MDS assessment, dated 07/25/2024, reflected the resident had a BIMS score of 05, indicating she was severely cognitively impaired. Resident #18 was always incontinent of bladder and bowel and, required extensive assistance to total care with her ADLs. Record review of Resident #18's care plan, dated 06/23/2024, reflected a problem of The resident is at risk for pressure injury related to History of Pressure Injuries, Incontinence, Reduced Mobility, Sheering/ friction problems, with an intervention of Perform and document weekly assessment form of skin for changes or observations. Observation on 08/01/2024 at 10:14 a.m. reflected ADON A did not completely close the privacy curtains while she provided wound care for Resident #18, exposing the resident who could be seen from the room's door. Further observation revealed a Hospice services nurse entered the room during care and was able to see the resident receiving wound care. During an interview with ADON A on 08/01/2024 at 10:40 a.m., ADON A verbally confirmed the privacy curtains was not completely closed while she provided care for Resident #18, but it should have been. She stated she received resident rights training within the year. During an interview with the DON on 08/01/2024 at 4:18 p.m., the DON stated privacy must be provided during nursing care and Resident #18's privacy curtains should have been closed completely. She stated the staff had received training on resident rights within the year and the training was provided by the DON. They also check the staff skills annually and as needed. Review of the facility's policy titled Promoting/Maintaining Resident Dignity, undated, reflected, Maintain resident privacy.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34788 Based on interviews and record reviews, the facility failed to ensure the assessment accurately reflected the resident's status for 1 of 18 residents (Resident #52) whose assessments were reviewed, in that: Resident #52's Significant change MDS, dated [DATE], incorrectly documented the resident as receiving an injection of insulin. This failure could place residents at-risk for inadequate care and services due to an inaccurate assessments. The findings were: 1. Record review of Resident #52's face sheet, dated 07/31/2024, revealed an admitted [DATE] and, a readmitted [DATE] with diagnoses that included: Dementia (General decline in cognitive ability), Hemiplegia (Weakness of one entire side of the body), Alpers disease (Genetic disorder causing brain and liver damages), Type 2 diabetes mellitus (High blood sugar levels). Record review of Resident #52's Physician orders and Medication administration record for June 2024 revealed orders for: Trulicity Subcutaneous Solution Pen-injector 1.5 MG/0.85ML (Dulaglutide) Inject 1 application subcutaneously one time a day every Thursday for Diabetes Mellitus. Record review of Resident #52's Medication Administration Record for the month of June 2024 revealed Resident #52 received Trulicity Subcutaneous Solution Pen-injector once, as per order, between 06/13/2024 and 06/20/2024. Record review of Resident #52's Significant change MDS, dated [DATE], revealed the assessment indicated Resident #52 received an injection of insulin. During an interview with the MDS nurse E on 08/02/2024 2:30 p.m., MDS nurse E verbally confirmed Resident #52's Significant change MDS was coded as the resident having received an injection of insulin when Resident #52 had received Trulicity (not an insulin) . She verbally Trulicity was not an insulin and should not have been coded as an insulin. The MDS nurse stated the RAI was used as reference for the MDS and she had access electronically to the RAI on her computer. Record review of, Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1. 18.11, October 2023, revealed, Enter in Item N0350A, the number of days during the 7-day look-back period (or since admission/entry or reentry if less than 7 days) that insulin injections were received.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41651 Based on observation, interview, and record review, the facility failed to store and prepare food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed, in that: 1. [NAME] I was not wearing a moustache or beard guard while preparing food. 2. The walk-in refrigerator and walk in freezer both contained improperly stored food items. These deficient practices could place residents who consumed meals and/or snacks from the kitchen at risk for food borne illness. The findings were: 1. Observation on 07/30/2024 at 9:36 a.m. revealed [NAME] I was standing at the kitchen range and preparing the lunchtime meal. Further observation revealed three containers of food were on the kitchen range and were uncovered. Additional observation revealed [NAME] I had a moustache and a beard and was not wearing a moustache restraint or a beard restraint. During an interview, at the same time as the observation, [NAME] I stated that he does not wear moustache or beard restraints, had never been directed to do so, and said, I don't know if we have any [restraints]. During an interview with the Dietary Manager on 07/30/2024 at 9:45 a.m., the Dietary Manager stated that it was the policy for kitchen staff to utilize moustache and beard restraint to cover facial hair while inside the kitchen. Record review of the facility policy, Dietary Employee Personal Hygiene, undated, revealed, 4. Hair Restraints a. All dietary staff must wear hair restraints (e.g., hairnet, hat, and/or beard restraint) to prevent hair from contacting food. Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2017, U.S. Department of H&HS, 2-402.11, revealed, (A) Except as provided in (B) of this section, Food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single service and single-use articles. Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2017, U.S. Department of H&HS, 3-305.14 Food Preparation, During preparation, unpackaged food shall be protected from environmental sources of contamination. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Observation on 08/01/2024 at 3:00 p.m. inside the walk-in refrigerator revealed a cardboard container of lunchmeat on the top shelf. The bottom and part of the lower section on the side of the container were wet and the cardboard was coming apart. Further observation inside the walk-in refrigerator revealed a cardboard container with approximately 10 blocks of butter wrapped in wax paper. The cardboard container did not have a lid and there were multiple loose pieces of butter on the inside of the container and on the wrapped blocks of butter. Observation on 08/01/2024 at 3:05 p.m. inside the walk-in freezer revealed three unsealed cardboard containers: one with tater tots, one with vegetable medley, and the last with cinnamon roll pinwheels. Each food item was inside a plastic bag which was also unsealed, and the food items were exposed to the air. During an interview with the Dietary Manager on 08/01/2024 at 3:15 p.m., the Dietary Manager stated that the above listed food items should have been stored in sealed containers to protect them from freezer burn and contaminates. Record review of the facility policy, Food Safety Requirements, undated, revealed, Food will also be stored, prepared, distributed, and served n accordance with professional standards for food service safety. Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2017, U.S. Department of H&HS, revealed 3-305.1, Food Storage, (A) Food shall be protected from contamination by storing the food: (1) in a clean, dry location; (2) Where it is not exposited to splash, dust, or other contamination.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34788 Based on observation, interview, and record review, the facility failed to maintain an Infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infection for 3 of 9 residents (Residents #4, #30 and, #24) reviewed for infection control, in that: 1. Medication Aide F did not sanitize the blood pressure cuff between Residents #4 and #30. 2. While providing catheter care for Resident #24, CNA G and CNA H did not change their gloves or wash their hands after touching the privacy curtain and the environment outside of the room. These deficient practices could place residents at-risk for infection due to improper care practices. The findings include: 1. Record review of Resident #4's face sheet, dated 08/01/2024, revealed an admitted [DATE] with diagnoses which included: Dementia (General decline in cognitive ability), Major depressive disorder (Mood disorder characterized by pervasive low mood, low self-esteem, and loss of interest in doing activities), Hypertension (High blood pressure). Record review of Resident #4's physician's orders for August 2024 revealed an order for hydroCHLOROthiazide Tablet 12.5 MG Give 1 tablet by mouth one time a day for Hypertension, edema hold for Systolic Blood Pressure less than 110. Record review of Resident #30's face sheet, dated 08/01/2024, revealed an admitted [DATE], and a readmitted [DATE] with diagnoses which included: Major depressive disorder (Mood disorder characterized by pervasive low mood, low self-esteem and loss of interest in doing activities), Hypertension (High blood pressure), Hypothyroidism (Thyroid gland does not produce enough thyroid hormone), Hyperlipidemia (High level of lipids(fat) in the blood). Record review of Resident #30's physicians' orders for August 2024 revealed an order for, Losartan Potassium Tablet 100 MG. Give 1 tablet by mouth one time a day for hypertension HOLD IF Systolic Blood Pressure less than 110 Observation on 08/01/2024 at 8:38 a.m. revealed, while administering medications, Medication Aide took the blood pressure and pulse of Residents #30, and #21 with the same blood pressure/pulse cuff. Medication Aide A did not sanitize the blood pressure/pulse cuff in between the residents. During an interview with Medication Aide F on 08/01/2024 at 9:04 a.m., Medication Aide F confirmed she used the blood pressure cuff on the 2 residents to measure their blood pressure. Medication Aide F confirmed she forgot to use a disinfecting wipe to disinfect the blood pressure cuff in between each resident but should have done it to avoid risk of cross contamination. Medication Aide F confirmed receiving infection control within the year. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/01/2024 at 4:18 p.m., the DON verbally confirmed the medication aide should have sanitized the blood pressure/pulse cuff in between the residents to avoid cross contamination. The DON revealed infection control training was provided to the staff multiple times a year. The DON revealed the staff's skills were checked annually. The DON further stated the ADONs did spot check of the staff for skills and infection control knowledge. Review of facility policy, titled Cleaning and disinfection of resident -care equipment, undated, revealed Multiple-resident use equipment shall be cleaned and disinfected after each use. 2. Record review of Resident #24's face sheet, dated 08/01/2024, revealed an admitted [DATE] with diagnoses which included: Osteomyelitis (infection of the bone) of left and right ankle and foot, Type 2 diabetes mellitus (High level of sugar in the blood), Hypothyroidism (Thyroid gland does not produce enough thyroid hormones), Hyperlipidemia (High level of lipids(fat) in the blood), Parkinson's disease (progressive disorder affecting the nervous system and causes movement problems), Hypertension (High blood pressure). Record review of Resident #24's MDS Admission assessment, dated 06/10/2024, revealed the resident had a BIMS score of 12, indicating moderate impairment. Resident #24 required limited to extensive assistance, had an indwelling catheter and, was always incontinent of bowel. Record review of Resident #24's care plan revealed a care plan initiated 06/04/2024 with a problem of resident is on Enhanced Barrier Precautions related to Indwelling Medical device (Foley), +VRE (Infection with bacteria that are resistant to antibiotic called vancomycin), Wound. with a goal of will remain on Enhanced Barrier Precautions with no complications through next review. Observation on 08/01/2024 10 a.m., revealed while providing catheter care for Resident #24, CNA G and CNA H went to wash their hands in the common bathroom (outside of Resident #24's room), opened the door of the bathroom then went to the resident room. They put their gowns and gloves on without sanitizing their hands (resident is on enhanced barrier protection). They, then opened the door of the resident room, closed it and closed the privacy curtain. Without changing gloves and sanitizing their hands they started to provide care to Resident #24. During an interview on 08/01/2024 at 10:10 a.m., CNA G and CNA H confirmed they touched the bathroom door after washing their hands. The confirmed they should have sanitized their hands prior to don their gloves and gown. CNA G and CNA H confirmed they touched the privacy curtain after putting their gloves on. CNAs G and H confirmed the environment around the resident was considered dirty and they should have changed their gloves and sanitized their hands. CNA G and CNA H confirmed receiving infection control training within the year. During an interview on 08/01/2024 at 4:18 p.m., the DON confirmed the environment outside of the resident's room and around the residents was considered contaminated and the staff should have changed gloves and wash their hands after touching the doors and privacy curtain prior to touching the resident. The DON revealed infection control training was provided to the staff multiple times a year. The DON revealed the staff's skills were checked annually and sport checked by the ADONs. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility policy, titled Hand Hygiene, undated, revealed, Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standard of practice. Interview with the DON, on 08/02/2024 at 9 a.m. revealed the hand hygiene was the only policy the facility had regarding hand hygiene during care.