STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675371	A. Building B. Wing	11/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverview Nursing & Rehabilitation	1102 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 Based on observation, interview, and record review the facility failed to provide a safe, clean, comfortable and homelike environment for 1 of 1 women's secured unit reviewed for safe /clean environment. 1. Staff failed to ensure the floors throughout the women's secured unit and the main shower room remained clean. 2. Staff failed to ensure that all windows in the dining room had window blinds, that the remaining window blinds were replaced as a result of broken slats and that the walls were repaired and painted as needed in the dining room; that the damaged window blinds in resident rooms #20, #21, #25 and #27 were replaced; that the missing pieces of tile in the shower stall were replaced; that the piece of drywall behind the toilet was attached to the wall; that the handle to the toilet in the shower room was replaced for flushing; that the handle on the faucet in the shower stall was secured so that it did not fall off; that the drain in the shower room did not clog, cleaning supplies were not available for nursing staff and that the furniture was repaired or replaced as needed in the lounge room. These deficient practices could affect all residents in the secured unit and could contribute to feelings of dissatisfaction and low self-esteem. The findings were: Observation on 11/9/21 at 9:44 AM revealed 2 windows in the dining room did not have window blinds and the remaining blinds had broken slats. The walls had chair height scrape marks down both walls and along the bottom over the baseboards. Observation on 11/9/21 at 9:50 AM revealed the floors in the dining room, down the hallways and in resident rooms were dirty with scraps of paper and other debris and the floors were sticky. Observation on 11/9/21 at 10 AM in room [ROOM NUMBER] revealed both window blinds had broken slats. Observation on 11/9/21 at 10:05 AM in room [ROOM NUMBER] and room [ROOM NUMBER] revealed the window blinds on the right side had broken slats. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 11/9/21 at 10:06 AM in room [ROOM NUMBER], in the bathroom, revealed 2 plastic bags full of paper towels on the floor and a towel wrapped around the toilet base. Observation on 11/9/21 at 10:08 AM in room [ROOM NUMBER] revealed the water in the toilet ran continuously. Observation and interview on 11/8/21 at 10:11 AM with CNA G and CNA L confirmed the findings regarding there not being any window blinds on 2 windows and the broken slats on the remaining window blinds in the dining room and the broken slats on the window blinds in resident rooms #20,, #21, #25 and #27. Interview with CNA L revealed she had to jiggle the toilet handle in room [ROOM NUMBER] so the tank would fill up with water. She stated it had been like that for at least a couple of weeks. Interview on 11/8/201 at 10:15 AM with CNA G and CNA L revealed the resident in room [ROOM NUMBER] would put the paper towels in the plastic bags. They stated housekeeping would not throw out the trash, clean the bathrooms, would not clean resident rooms consistently and would basically only clean the dining room and the hallway. In addition, CNA G and CNA L stated the toilet in room [ROOM NUMBER] had been leaking and the water was reaching the TV room at the front of the unit. They stated this was why they had the towel around the toilet. CNA G and CNA L stated they were agency staff and would let the nurse's know of any problems in the unit. They stated nursing staff was aware of the leak and stated the MS was supposed to fix the leak. Observation and interview with CNA G and CNA L on 11/9/21 at 10:20 AM, in the shower room, revealed approximately 4 small pieces of missing tile at the bottom left hand side of the shower stall upon entering the shower; the toilet tank did not have water to flush the toilet and there were 2 plastic bags, 1 filled with dirty linens and 1 filled with trash in the corner of the shower floor. Interview at this same time with CNA L confirmed the missing tile and she stated residents could sustain skin tears on their legs if they rubbed against the area. CNA G stated the nurse's had told her she could not have barrels for the linens and trash in the bathroom so she had to use the plastic bags. She stated the barrels were stored outside the main dining room and she could not leave the unit to go back and forth to dispose of trash and to put dirty linens in one of the barrels. CNA G stated there were 3 residents who showered independently and they would have to move the plastic bags so they could use the shower. CNA L showed how she had to jiggle the handle to get running water in the toilet; showed the piece of drywall behind the toilet that was not attached to the wall exposing the water lines in the wall; that the handle to the shower faucet came off and the water drained slowly in the shower and water would accumulate on the bottom of the shower stall during showers. CNA G and CNA L stated they did not have a broom, mop or disinfectant to mop the bathroom floor if a resident had an accident or in between showering residents. CNA L pointed out that the bathroom floor was dirty and sticky because they did not have cleaning supplies. Observation of the cabinets in the shower room, at this same time, confirmed there were no cleaning supplies. CNA L stated she had used bed sheets to clean feces off the shower room floor and then wipe the floor with saniwipes. CNA L stated that she felt bad for the residents because they had to use the shower room in the condition it was in. She stated she would hate it if she had to shower in it and would not want to shower any family member in it either. CNA L and CNA G stated they had reported all stated problems to the MS and to the nurse's and nothing seemed to change. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of the shower room in the women's unit and interview with Resident #23 on 11/11/21 at 2:47 PM revealed she complained about the condition of the shower room. Resident #23 stated she wanted to take a shower on this date but could not because staff stored the 2 plastic bags in the shower stall, the knob on the faucet would come off and the drain in the shower would clog. She stated trash and other debris would come up the drain after running the shower for about 5 minutes. Resident #23 looked in the plastic bags and questioned how she was supposed to shower when there was trash and dirty linen in the plastic bags. She stated she would have to move the bags. Resident #23 pointed out the piece of drywall that was behind the toilet that looked like it had come off the opening exposing the water lines in the wall. Resident #23 stated it was disgusting and stated the facility did not put money needed to maintain the building. Resident #23 commented, this is a total lack of respect for me and everyone else who lives here. She further commented they paid good money and did not understand why repairs were not made as needed. Resident #23 stated she had talked to nursing staff about the condition of the bathroom and nothing was ever done about it. She stated the problem with the bathroom had been on-going since she was first admitted to the facility about one year ago. Interview on 11/11/21 at 3:25 PM with the DON revealed the full time staff would orient agency staff to the women's secured unit. The DON stated that she would make rounds in the unit 4 to 5 times a day during her shift. She stated she had not really noted any housekeeping issues and confirmed that housekeeping staff and CNA's shared a responsibility to keep the unit clean. She stated no one had expressed any concerns to her about housekeeping or maintenance problems. The DON stated she understood there were many cosmetic issues that would be addressed when the unit was renovated but the date to start the process had not been set yet. Observation on 11/11/21 at 3:37 PM in the women's lounge/TV room revealed a broken recliner and a brown chair and brown couch. The plastic covering on the brown chair and couch was peeling. Observation in the women's unit and interview on 11/12/21 at 10:08 AM with the MS revealed he would make repairs and addressed problem areas as nursing staff wrote them in the maintenance log. The MS confirmed the floors had an accumulation of debris in the dining room, hallway and in the lounge area. He confirmed the 2 missing window blinds in the dining room; the broken slats on the remaining blinds and the broken slats on the window blinds in resident rooms #20 #21, #25 and #27. The MS stated he had been buying 2 wooden blinds a week to replace broken blinds because most of the rooms throughout the facility needed new window blinds. He stated he did not do rounds every day because he did not have time and did not have an assistant. The MS confirmed the women's shower room had a slow drain and had not been able to get a company to look at it because of their COVID outbreak but stated he would call them back. The MS stated they had a small snake he could also use to clean out the drain until the company ran the auger. He stated he did not know the shower handle came off but would tighten it. The MS confirmed the toilet did not flush because the handle needed to get replaced. He stated the piece of drywall in front of the opening behind the toilet had come loose and he would have to reattach it. He confirmed the 2 plastic bags on the shower floor and stated staff should be using the barrels. He further confirmed the barrels were outside the main dining room but staff could store them in the closet in the lounge/TV room. The MS stated the toilet float needed replacing and that was why the water kept running in room [ROOM NUMBER]. He stated he did not have time to fix every little thing that was wrong. The MS confirmed the blue recliner in the TV room was broken and the plastic covering on the brown couch and chair was peeling. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 11/12/21 at 10:35 AM with Housekeeper M while in the women's secured unit revealed she started her shift at 6 AM and would start cleaning in the common area; then moved to A Hall, then the main dining room and would start cleaning B Hall (the women's secured unit) about 10:30 AM. Housekeeper M stated she would clean the dining room after lunch. She sated she swept and mopped all floors, would clean the resident rooms, bathrooms and mirrors. She stated her shift ended by 3 PM and did not have time to sweep, mop or clean any other areas again in the unit until the next day. She stated most residents used the main shower room and would make sure they were stocked with all supplies. She stated if a resident peed or had a bowel movement on the floor, the CNA would clean the area and she (housekeeping) would disinfect. She stated they kept extra disinfectant in the shower room to use as needed. She looked in the cabinet in the shower room and confirmed there were no cleaning supplies available. Interview on 11/12/21 at 2:50 PM with the Housekeeping Supervisor revealed cleaning the women's unit was a constant battle because the residents were so active and would constantly move throughout the unit. She stated there seemed to be a battle between the aides and housekeeping in keeping the shower room clean. The Housekeeping Supervisor stated the aides were supposed to clean up urine or bowel movement from the floors and then housekeeping would disinfect afterwards. She stated many times there was only 1 aide in the unit so it was difficult for the aide to keep up. She stated there was a supply room right outside the unit but she understood it was hard for the aides in the women's unit to break away. Housekeeping staff would get upset so then the battle continued. The Housekeeping Supervisor stated she attended morning meetings and would tell the ADM about the broken blinds, the clogged drain in the shower, the condition of the resident furniture, struggles with keeping the women's unit and shower room clean and all the problems in the shower room but nothing ever changed. The Housekeeping Supervisor stated she had worked at the facility for years and had seen a decline in the overall maintenance of the building. She commented she also felt bad for the residents because she understood it was their home. Interview on 11/12/21 at 5:05 p.m. with the ADM revealed they had QAPI meetings once a month and the environment had come up as a trending problem. He stated they discussed problem areas during morning meetings and the IDT members were supposed to note any problems during their morning rounds. The ADM stated the department heads did not always turn in their rounding sheet. Review of a facility policy, Quality of Life-Homelike Environment revised April 2014 read in part: Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. 1. Staff shall provide person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences. 2. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect personalized, homelike setting. These characteristics include: a. Cleanliness and order. Review of a facility posture provided by HHSC, dated April 2019 read in part: Dignity and Respect. You have the right to: live in safe, decent and clean conditions. Be treated with dignity, courtesy, consideration and respect.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26869 Based on interview and record review the facility failed to ensure that all alleged violations involving injuries of unknown source, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 1 of 8 incidents in that: The Administrator did not report Resident #54's unwitnessed fall with fracture within 4 hours. This could affect and result in residents' late reports. The findings were: Record review of the HHSC Nursing Facility Abuse, Neglect, Exploitation, Misappropriation for Resident Property, and the incident that must be reported to the TX HHSC date 5/3/2017 revealed Abuse, A NF must report incidents of alleged abuse and all situations in which it has cause to believe that eh physical or mental or welfare or a resident had been or may be adversely affected by abuse caused by another person, to HHSC. A certified NF must ensure that all alleged visitations of abuse are reported to the NF administrator and to the officials in accordance with Texas law not later than 2 hours after the allegation is made. 8. Suspicious injuries of unknown source, A NF must report to HHSC any suspicious injury to a resident of unknown source. A certified NF must ensure that all suspicious injuries of unknown source are reported to the NF administrator and to other officials in accordance with Texas law not later than 2 hours after the allegation is made, if the event that cause the allegation result in serious bodily injury. An injury should be classified as an :injury of unknown source when both of the following conditions are met: The source of the injury was not observed by any person or the source of the injury could not be explained by the resident: and The injury is suspicious because of the extent of the injury or the locations on the injury (e.g. the injury is located in an area not generally vulnerable to trauma) or the number of injurie observed at the particular point in time of the incidence of injuries over time. Record review of Resident #54's face sheet dated 11/12/2021 revealed he was admitted on [DATE] with diagnoses of dementia, diabetes II, Parkinson's (a brain disorder that leads to shaking, stiffness, and difficulty with walking, balance, and coordination), heart failure, seizures, and repeated falls. Record review of Resident #54's Quarterly MDS dated [DATE] revealed for Section C-Cognitive Pattern was severely impaired (3/15), Section J Health Conditions, J1700-Fall history on admission-none, J1800-Any falls since admission or prior to assessment-no-no injuries. A significant change was not done due to Resident #54's discharge per family request. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #54's Care plan dated 11/3/2021 revealed he was a risk for falls due to cognitive impairment, poor safety awareness, dementia, Parkinson's, seizures, and muscle weakness. The interventions were medication/treatment review of MD, assist resident with hygiene and maintain clean wound, lab orders, monitor resident closely an assist with sitting to standing. [NAME] by until resident is stabilized, orthostatic hypotension evaluation, remind resident not to run, keep uncluttered/free of spills and clean up promptly, therapy referral, encourage and remind resident to request assist for transfers, fall assessment policy, monitor increased confusion and redirect as appropriate, Record review of incident intake #312146 by Administrator involved Resided #54 had fallen and had a fracture to his thumb. Review of the incident revealed on 10/27/21, Resident #54 had an unwitnessed fall in the dining room. Resident #54's was assessed and did not complain of any pain and no injuries. On 10/28/21 at 9:57 p.m., Resident #54 complained of pain and had x-rays ordered and the results date was 10/29/2021 at 8 a.m. showed results of a fracture of distal dorsal base of the thumb (fracture of thumb). Resident #54 was assessed on 10/28/2021 at 9:57 p.m. Resident #54 did have an order for a splint to the thumb on his right hand/thumb. The physician and the RP were notified of results. The MD orders were to wear a device for thumb. Review of the provider investigation intake #312146 revealed this incident date was 10/28/2021 at 8 p.m., When, as written on incident report (Administrator was aware fo the thumb fracture) was dated 10/29/2021 at 8:05 AM, and the date reported was 10/29/2021 at 7:40 p.m. by the Administrator. During an interview on 11/12/21 at 05:32 p.m. the Administrator stated he first was aware of Resident #54's fracture on 10/29/2021 at 9 a.m. in the morning meeting. The Administrator stated this incident should have been reported by the facility admistrator within 2 hours and was an unwitnessed fall. The Administrator stated Resident #54 fell in the secure unit A dining room and was found by staff in the dining room by staff. The Administrator stated he conducted in-services with staff. The Administrator stated he used the incident reporting required by the STATE.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 Based on interview and record review the facility failed to thoroughly investigate an allegation of abuse for 1 of 3 Residents (Resident (#50) whose records were reviewed for abuse. The ADM failed to thoroughly investigate an injury of unknown origin involving Resident #50. This deficient practice could affect all residents and could contribute to further resident abuse. The findings were: Review of Resident #50's face sheet (undated) revealed she was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease with early onset and Dementia in other disease classified with behavior disturbance. Review of progress note dated 10/29/21 revealed Resident #50 presented with a swollen nose and facial grimacing. X-rays were ordered and revealed Resident #50 had a fractured nose. Further review of progress note did not reveal any incidents which might have resulted in Resident #50 sustaining a fractured nose. Review of incident/accident reports from 7/21 to 11/21 revealed Resident #50 had several falls prior to 10/29/21. The last fall was on 10/19/21. Review of the Provider Investigation Report dated 11/5/21 revealed on 10/29/21 at 1:30 PM MA J noted Resident #50 with swollen nose and was painful to touch. LVN K assessed Resident #50, x-rays were ordered and the results were received at 4:49 PM for fractured nose. The ADM made a self-report to HHSC at 7:00 PM. The findings were confirmed for Resident Abuse. Further review there was no documentation of resident or staff interviews. Review of the incident report dated 10/29/21 confirmed the details provided in the Provider Investigation Report. Further review revealed there were no witness statements attached. Observation on 11/8/21 at 1:02 PM in the in women's secured unit revealed Resident #50 walking up and down the hallway, into the dining room, into the common room and back out into the hallway. Resident #50 did not respond to questions, did not make eye contact or engage with staff or residents. Resident #50 was not interviewable. Interview on 11/9/21 at 3:26 PM with LVN C revealed she was the supervising nurse from 2 PM to 10 PM in the women's secured unit when she received report that Resident #50 fell and broke her nose. LVN C stated Resident #50 walked constantly, would loose her balance and fall or would walk into furniture or other items. LVN C stated administrative staff did not interview her about the injury or incident. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/9/21 at 4:34 PM with MA J revealed the CNA on duty told her about Resident #50's injury. MA J stated she looked at Resident #50's nose and noted it was crooked and did not feel attached. She stated the CNA on duty and the floating CNA L did not report any falls. In addition LVN C did not report any falls either so no one knew what happened. MA J stated LVN K told her Resident #50 had an incident earlier in the week but there were no reported falls within that day. MA J stated she had seen Resident #50 bump into walls and trip over chairs because she did not know what she was doing and was also visually impaired. MA J stated no one interviewed her about how Resident #50 might have been injured. She stated the DON only asked where they found Resident #50. MA J stated she did not provide a written statement either. MA J stated the ADM was the Abuse Coordinator and he never talked with her about the incident. Interview on 11/9/21 at 4:51 PM with the ADM revealed he was the Abuse Coordinator and responsible for investigating allegations of resident Abuse. He stated the DON and ADON would also assist with the investigation. The ADM stated he did not remember who told him about Resident #50's injury whether it was the DON or ADON. The ADM confirmed he considered resident abuse because Resident #50 sustained an injury of unknown origin, but stated he did not interview staff or residents in order to rule out abuse. He stated he did not interview other staff or residents to determine what happened or to establish a time line. He stated the residents in the unit were not interviewable. The ADM stated he would have to talk with the ADON or DON to determine how they assisted with the investigation process; if they interviewed staff or residents and or if they collected statements. Interview on 11/9/21 at 4:58 PM with the ADON revealed she was not part of the investigation related to Resident #50's injury. She stated the charge nurse should complete an incident report and gather written statements in trying to determine what could have happened and to establish a time line. Interview on 119/21 at 5:00 PM with the DON reveled she was not present and was not part of the investigation process regarding Resident #50. She stated the charge nurse should complete the incident report and collect at least 2 witness statements. Interview on 11/10/21 at 9:19 AM with LVN K revealed she was the charge nurse when Resident #50 sustained a fractured nose and worked from 6 AM to 2 PM . She stated she completed the incident report and thought she provided witness statements to the aides on duty but did not remember collecting them. LVN K stated no one interviewed her about the incident. Review of facility policy, Abuse Investigations (undated) read in part: All reports of abuse, neglect and injuries of unknown source shall be promptly and thoroughly investigated by facility management.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 26869 Based on observation, interview and record review the facility failed to ensure the resident environment remained free of accident hazards as is possible and that each resident received adequate supervision to prevent accidents for 2 of 22 Residents (Resident #10 and Resident #65) reviewed for accidents and supervision. There was not adequate supervision for Residents #65 who had a history of wandering and was at risk for elopement and there were inadequate interventions in place while the facility's exit door to the women's secured unit did not function properly. The facility failed to repair or replace the exit door in the women's secured unit and to provide the necessary supervision to prevent Resident #65 from eloping from the secured unit. An Immediate Jeopardy (IJ) was identified on 11/10/21. While the IJ was removed on 11/12/21, the facility remained out of compliance at no actual harm with potential for more than minimal harm that was not an immediate jeopardy and a scope was a pattern while they continued to monitor their Plan of Removal. These deficient practices could place residents at risk for avoidable avoidable incidents and injury. The findings were: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of a facility policy, Safety and Supervision of Residents revised December 2007 read in part as follows: Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Facility-Oriented Approach to Safety. 1. Our facility-oriented approach to safety addresses risk for groups of residents. 2. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring,, and reporting processes; QA&A reviews of safety and incident/accident reports; and a facility-wide commitment to safety at all levels of the organization. 3. When accident hazards are identified, the QA & A/Safety Committee shall evaluate and analyze the causes(s) of the hazards and developer strategies to mitigate or remove the hazards to the extent possible. 4. Employees shall be trained and inserviced on potential accident hazards and how to identify and report accident hazards and try to prevent avoidable accidents. 5. The QA&A Committee and staff hall monitor intervention to mitigate accident hazards inn the facility and modify as necessary. Systems Approach to Safety. 1. The facility-oriented and resident-oriented approaches to safety are used together to implement a systems approach to safety, which considers the hazards identified inn the environment and individual resident risk factors, and then adjusts interventions accordingly. 2. Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individuals resident's assessed needs and identified hazards in the environment. 3. The type and frequency of resident supervision may vary among residents and over time for the same resident. For example, resident supervision may need to be increased when there are temporary hazards in the environment (such as construction) or if their is a change in the resident's condition. Resident Risks and Environment hazards: 1. Due to their complexity and scope, certain resident risk factors and environmental hazards are addressed in dedicated policies and procedures. These risk factors and environmental hazards include: e. unsafe wandering. Review of a work order from a local fire and safety company dated 9/13/21 revealed they checked secure unit doors. Review of notes revealed A hall left side hall door into secure unit was unlocking when force applied to door from inside the unit adjusted armature and tested hard locked. No comments were noted. Review of Resident #65's face sheet, dated 11/12/21 revealed she was admitted to the facility on [DATE] with diagnoses which included Parkinson's disease (disorder of the central nervous system that affects movement, including tremors), Type 2 diabetes mellitus with diabetic polyneuropathy, Alzheimer's disease, unspecified, Schizoaffective disorder, bipolar type, Major depressive disorder, recurrent, unspecified and Generalized anxiety disorder, Review of Resident #65's admission MDS, dated [DATE], revealed her BIMS was 2 indicating severe cognitive impairment; she exhibited verbally and physically aggressive towards others; wandered; had a fall since her admission and was receiving anti-depressant, anti-anxiety and anti-psychotic medications. Review of Resident #65's Care Plan, dated 10/25/21, revealed Resident resided in secure unit and was at risk for injury from wandering in an unsafe environment related to impaired safety awareness. One of the Interventions included included to keep environment free from possible hazards. Further review revealed the CP was updated on 11/3/21 after Resident #65 was identified as potential/ high risk for injury related to identified elopement risk factors and or exit seeking behavior. One of the interventions included to supervise the Resident closely and make regular compliance rounds whenever resident is in room. (continued on next page)

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	675371	A. Building B. Wing	11/12/2021

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of an event report dated 11/1/21 revealed that Resident #65 was found by local police down the street. It was noted that Resident #65 had been repeatedly opening doors/setting off alarms of secured doors; resisting redirection, wandering with no rational purpose and attempting to open doors. Her mental status was noted as confused and restless; possible contributing factors were Dementia, Psychiatric Diagnosis of Schizophrenia. Further review revealed Resident #65 was taken to the ER. Review of Provider Investigation Report dated 11/5/21 revealed that on 11/1/21 at 1:02 PM the facility received a phone call from local police department that Resident #65 was across the street at a nearby restaurant. The DON went across the street to meet with local police department and Resident #65. The DON observed Resident #65 to have a scrape to her right knee. Resident #65 was taken to the ER and returned to the facility on the same date and had a bandage to her right knee as a result of a fall during her elopement. Further review revealed after investigation staff last saw Resident #65 in the TV room about 12:30 PM. The facility believed Resident #65 opened the window to her room, removed the screen, went out the window, replaced the screen and walked about 50 yards from the facility and was found at a nearby restaurant. Review of the time sheets for the CNA's from 11/1/21 to 11/10/21 revealed that the following aides working the women's secured unit: 11/1/21, CNA L was the only aide working from 6 AM to 6 PM. The Housekeeping Supervisor was added to the schedule as floating because she was a CNA as well. On 11/2/21 CNA G was the only aide assigned to the unit from 6 AM to 6 PM. Management was also added as floating. CNA O was the only aide working the night shift 6 PM to 6 AM. On 11/3/21 revealed CNA G worked alone in the unit from 6 AM to 11:30 AM until CNA P reported to work. On 11/4/21 CNA O was the only staff working the unit from 6 PM to 6 AM. On 11/9/21 CNA O was the only staff working the unit from 6 PM to 6 AM. On 11/10/21 CNA G and CNA Q were assigned to work from 6 AM to 6 PM. CNA Q had not submitted her time sheet for verification as of 11/12/21 at 6 PM. Observation on 11/8/21 at 9:35 AM revealed the nurse's station for the women's secured unit was located outside the unit. Upon entering the secured unit, CNA G was the only staff in the women's unit. Further observation revealed CNA G entered the shower room with a resident. CNA G remained in the shower with the resident about 5 minutes. CNA G then escorted a 2nd resident into the shower room and where she remained for 6 minutes. Observation on 11/8/21 at 9:40 AM revealed six residents in the TV room; three residents were asleep and two other residents were sitting in their wheelchairs in the hallway. Interview on 11/8/21 at 9:47 AM with CNA G confirmed she was the only staff on duty at the time. She stated CNA L was on break. CNA G confirmed she toileted two residents in the main shower room and that she was unable to supervise the other residents in the unit while assisting residents in the bathroom. CNA G stated she often worked alone in the unit and and it was impossible to provide care and supervise the remaining residents at the same time. CNA G stated that the nurse's would come into the unit to pass out medications but would then leave the unit again. She stated she did not get support from anyone else. Observation on 11/8/21 at 9:56 AM revealed CNA L returned from break and entered the women's secured unit. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 11/8/21 at 10:15 AM with CNA L revealed she worked when Resident #65 eloped. She stated she was working alone in the unit and providing pericare for another resident in the shower room. She stated she heard the alarm but could not leave the resident because the resident was full of feces. CNA L stated the alarm sounded for about 15 to 20 minutes. When she stepped out of the shower room she saw LVN N running down the hall. CNA L stated she saw the back door was opened and when she went outside she saw a blue A frame ladder by the fence right outside the women's unit. She stated she walked the inside parameter of the courtyard and did not see any broken slats and then checked the 2 gates and they were both locked. CNA L stated she heard Resident #65 was across the street at a restaurant. She stated the problem was that the back door did not close properly and would open on it's own. CNA L pushed out on the door and showed how the door remained open (ajar) and did not return to the closed position. The 3 second warning alarm sounded, after 3 seconds it activated the 15 second alarm and it released the door. CNA L stated there were a few residents including Resident #65 who would often push on the door. She stated she often worked alone and if she was busy with another resident she would not be able to get to the alarm fast enough and the resident could get out. CNA L stated the charge nurses were also supposed to respond to the alarm but would not always respond. CNA L stated she was agency and she had been working the door had been a problem. She stated nursing staff was aware the door did not close properly. Review of a picture sent to Surveyor's work cell phone on 11/10/21 at 6:12 PM revealed a blue 5 or 6 foot A frame aluminum ladder in the open position located by the fence on the right side exiting the door. Interview on 11/09/21 at 9:37 AM with Resident #65 revealed she did not remember leaving the facility. Resident #65 repeatedly stated she did not know when asked about her leaving the unit, the facility or walking across the street. Resident #65 was not interviewable. Interview on 11/10/21 at 8:35 AM with the MS revealed he had been in his position for about 4 weeks and with the company for about 1 year. He stated the back door to both the women's and men's unit were warped. He stated they were mag doors and there was too much spacing between the magnet components. The door would not stay locked/latched when there was any movement (wind blows) or when a resident pushed on the door it would open. The MS stated any movement or push would activate the 3 sec alarm and then then the 15 sec egress alarm opened the door. The MS stated a fire and safety company went out to the facility 2 to 3 weeks prior. They recommended the facility replace the door because they had adjusted the mag hardware as much as they could by bringing the mag hardware as close together as possible. The MS stated the closer the mag hardware was the greater the magnetic pull which was kept the door closed. The MS stated staff told him that the residents often triggered the alarm and that the door would open. He stated that there was nothing that he could do and stated staff was supposed to respond to the alarm making sure the residents did not get out. The MS confirmed this would be difficult if there was only one aide working the women's unit. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Observation on 11/10/21 at 8:45 AM of the courtyard enclosing the back of the women's and men's unit revealed a table base with a table top that was detached from the base located right outside the women's unit by the door. Interview with the MS at this same time revealed he did not know who put the table base and table top outside and did not know how long it had been outside. Further observation revealed the fence pickets were all in intact and the gates were locked and secured. Observation outside the fence parameter revealed the women's unit backed up to a walking trail. The walking trail was enclosed with trees, tall grass and rock terrain. Further interview with the MS revealed the walking trail lead to the restaurant across an intersection where Resident #65 was located. The distance from the back door of the women's unit to the restaurant across the street was approximately 1/4 mile. Resident #65 had to cross a 3 lane lane busy intersection. The MS stated he was not involved in the investigation related to Resident #65's and did not know anything or anyone saying anything about a ladder located in the courtyard. The MS stated the facility would be renovating the women's secured unit and they would be replacing the door at that time but stated it was still in the planning phase. In the mean time, he stated there was not a contingency plan other than the assigned aide or aides would have to respond to the alarm to ensure residents did not get out. The MS again stated it would be difficult for one aide to provide care and the necessary supervision for the other residents. Interview on 11/10/21 at 9:19 AM with LVN K revealed she was the charge nurse from 6 AM to 2 PM Monday through Friday for the women's secured unit. LVN K stated she was not on duty when Resident #65 eloped. She stated staff suspected that Resident #65 got out through a window although she stated the windows did not open more than about 6 inches. LVN K confirmed that the back door did not work properly. She stated staff had to pull on the back door to close it and then enter the code to lock it. LVN K stated the door would open on windy days or if a resident pushed on the door. She stated the alarm would sound and if it was quiet she could hear it from the nurse's station. LVN K stated she and the aides on the unit would use their personal cell phones to communicate or one of the aides would holler from the door. LVN K stated two CNA's usually worked the unit but there were times when only 1 CNA worked the unit. She stated they would try to get a second aid and if not she would help as much as possible. Although, she stated she was the charge nurse for the women's and men's unit. Observation on 11/10/21 at 9:50 AM revealed LSC Surveyor and the MS were testing the exit door in the women's unit for functionality. LSC Surveyor demonstrated the egress component on the door worked properly meaning, when the release bar was pushed out or any part of the door was pushed out it activated the 3 second warning alarm. The 15 second alarm followed and then the door was released and opened. LSC Surveyor stated the problem was the door was warped so when the door was pushed out, if a resident leaned on it, if the wind caused movement, the door would get stuck and would remain ajar instead of returning to the closed position once the pressure when pushing on it was released. He stated the 3 second alarm would shut off when pressure was released, the door would return to the closed position and it would remain locked. He stated, in this case, because the door remained ajar, it automatically activated the 3 second alarm and then the 15 second alarm to release the door. The LSC Surveyor stated if staff was not available or did not immediately respond to the alarm sounding residents would be able to exit the door. Interview with the MS at this same time confirmed these findings. Observation on 11/10/21 at 10:32 AM revealed two yellow barrels, an orange ladder and a blue ladder located right outside the main dining room. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 11/10/21 at 10:42 AM with LVN N revealed he was the charge nurse over the women's and men's unit when Resident #65 eloped from the facility. He stated he had been back and forth between the men's and women's unit during lunch and he last saw Resident #65 about 12:30 PM. She had finished eating her lunch. LVN N stated he was sitting at the nurse's station located outside the women's unit and the ADON told him she thought the alarm to the exit door to the women's unit was sounding. He stated the sound of the alarm from the nurse's station was faint. He stated he went to check the unit and noticed the back door was opened. He went outside and saw a ladder right outside the women's unit. It was propped up against the fence and thought it was green in color. LVN N stated he checked the parameters of the inside of the courtyard and did not see any broken fence pickets and made sure the doors were secured. He stated he went back to the nurse's station and found out that local police department notified the DON and reported they possibly had one of their resident's; Resident #65. The police were with Resident #65 across the street at a local restaurant. He stated Resident #65 had to cross a busy intersection to get to the restaurant. LVN N stated he returned to the unit, completed a head count and confirmed Resident #65 was not in the unit. LVN N stated he and CNA L were the only staff working the women's unit and stated there was usually only one aide assigned to the unit. He stated he would make routine rounds about every 2 hours or so and believed one aide could manage the unit unless the aide was busy with a resident providing care. Then she would not be able to supervise the other residents. LVN N also confirmed the back door was not working properly and Resident #65 and at least 2 other residents would often push on the back door activating the alarm. He re-iterated the problem they had with the exit door as reported by CNA L and stated all administrative staff was aware the door was not working properly. LVN N stated Resident #65 was in the last room on the left side by the exit door. He stated other staff reported Resident #65 had tried getting out before through a window. She had torn the screen. LVN N stated the problem with the back door not working made it challenging for the staff to work the unit. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 11/10/21 at 11:37 AM with the DON confirmed the events provided in the Provider Investigation Report related to Resident #65's elopement. The DON stated they speculated Resident #65 got out through a window because staff reported Resident #65 had previously torn or cut the screen to another room and staff believed Resident #65 wanted to get out. In reviewing progress notes the DON confirmed that staff had not documented on this incident. The DON confirmed local police called her about 1:02 PM on the date of the incident and reported they possibly had one of their residents at a restaurant across the street. The DON stated she met the police and confirmed it was Resident #65. She noted Resident #65 had a superficial scrape to her right knee and did not seem to have any other injuries but was taken to the local ER for evaluation. The DON stated Resident #65 returned to the facility from the ER later that afternoon and no other injuries were noted. The DON stated she and the ADM walked the parameter of the inside of the courtyard and did not see anything propped up against the fence, any broken fence pickets and stated the gates were secured/locked. She stated they could not figure out how Resident #65 got out other than through a window. The DON confirmed the exit door to the women's unit was not working properly and reiterated what all other staff had reported including that a gust of wind would open the door. The DON stated they had a couple of companies look at the door within the last several months but did not know the outcome. She stated the MS had been in charge of that and she did not ask him about any recommendations if any had been made about fixing the exit door. The DON stated she started working for the facility since March 2021 and the doors had been a problem since that time. She further stated the windows in the women's unit only opened about 6 inches and they had been like that the entire time she worked. They had the MS ensure that all windows were secured with a screw only allowing the window to open about 6 inches. She stated since Resident #65's elopement their contingency plan to ensure the residents did not elope from the women's unit. was to assign two aides to the women's unit during the day so they could monitor the back door and provide the supervision as needed. The DON stated that one other resident had got out through the exit door into the courtyard but staff redirected the resident inside. She stated no other residents had eloped from the unit. Interview on 11/10/12 at 12:01 PM with the ADM confirmed the exit door to the women's unit was warped but stated the egress door worked properly. He stated the door only opened when someone continuously pushed on the handle for 15 seconds. The ADM stated they speculated Resident #65 got out through a window because she had previously poked or cut a hole through a window screen and then opened the window in another resident's room. He stated he met with department heads after Resident #65's elopement and they could not figure out how else she could have got out. The ADM stated he had the MS secure all windows in the unit adding a screw on the frame which only allowed the window to open about 6 inches. The ADM stated he had a company come out on 9/13/21 and they adjusted the mag locks on the door as much as possible. He stated they planned to renovate the women's unit and would be replacing the door at that time. He stated the Corporate engineer was in the process of securing contractors for the job. Interview on 11/10/12 at 12:25 PM with the ADM revealed he checked the exit door to the women's secured unit for functionality. He confirmed the egress alarm was activated without continuously pushing out on the handle. He stated when he pushed on the door it did not return to the closed position because the door was warped and the door remained ajar. The ADM confirmed the egress door would release and open and stated it posed a threat for the residents because they could exit the door if staff did not respond to the alarm on a timely basis. Interview on 11/10/21 at 2:45 PM with the DON revealed all 15 residents in the women's unit were in the unit because they were wanderers and an elopement risk. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 11/10/21 at 2:46 PM with the ADM revealed they had cameras in the women's unit but stated he did not know how long it recorded. He stated he had looked at the footage because he would have to have an approximate time for the date he was searching. The ADM confirmed the last time staff saw Resident #65 on 11/1/21 in the unit was approximately 12:30 PM and the local police called the DON about 1:02 PM. The ADM stated he would review the footage and would get back with Surveyor. The ADM never returned with any information before exit on 11/12/21. Interview on 11/10/21 at 6:16 PM with LVN N revealed on 11/1/21 he, the ADM, the DON and the MS walked the women's secured unit after Resident #65 eloped. He stated he showed them the exit door was opened and the ladder was located right outside the women's unit propped up by the fence. LVN N stated he took a picture and clarified that the ladder was blue and not green. LVN N stated he did not know why staff speculated that Resident #65 got out through a window because the windows only opened up about 6 inches. LVN N stated there was no way Resident #65 would fit through an opening that size. Interview on 11/10/21 at 2:47 PM with Resident #23 (who was located about 4 to 5 rooms away from the back door) revealed the alarm on the exit door in the women's secured unit went off all the time and the staff would slam it shut. Resident #23 stated sometimes the alarm would go off and staff was not available to respond to it right away. She stated there were 2 or 3 residents that would often push on the door. She stated she had seen two residents exiting the unit into the courtyard but staff was able to redirect them back into the unit. Resident #23 stated the alarm would go off and then the door would open so if staff was not available then the residents could walk out of the unit. Interview on 11/12/21 at 5:05 p.m. with the ADM revealed the issue with the door had been addressed during QAPI meetings since November 2020. He stated they identified the exit doors to the women's and men's unit were warped and it affected their functionality. The ADM stated the exit doors had become warped over time by the weather; rain and wind. The ADM stated they had a plan to fix the doors as of July 2020 but it was placed on hold after the onset of the COVID pandemic. An IJ was identified on 11/10/21 at 5:09 PM per the above findings. The ADM, the DON, and the Corporate Nurse were provided with a copy of the IJ Template and a Plan of Removal was requested. Review of the Plan of Removal, dated 11/12/21, revealed: Immediate Action Residents #65 is safely residing in the facility female locked and secured unit. Resident #65 was taken to the emergency room after the incident to make sure she had no injuries requiring treatment and returned shortly thereafter without further incidence. Resident #65 and both the male and female secured units had their elopement assessments completed in the month of October 2021, all were identified to have wandering/exit seeking behaviors and a diagnosis of dementia. Resident #65's elopement assessment was again completed on 11/10/21 and no changes were identified. The doors exiting the secured unit into the courtyard were checked by HHSC Life Safety Surveyor and facility contract engineer technician at 2:00 PM on 11/10/2021 and the door was found to be functioning properly. Contract Fire Technician from Total Fire and Safety came to the facility at 7:30 PM on 11/10/2 and checked all secured unit doors and documented they were all functioning correctly. Staff was posted at the exit door on the women ' s secured unit until the door was checked and cleared by Total Fire and Safety. The staff monitoring the door has the responsibility to monitor those residents do not exit the door unseen until Total Fire and Safety can clear as functioning properly. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Report of Employee Education on Elopement dated 11/10/21 revealed 49 staff signatures. Review of In-service dated 11/12/21 for breaks for secured unit/coverage revealed 13 staff signatures. Review of email dated 11/12/21 from AC Doors Specialties revealed they will take dimensions on the doors and provide a price on Monday, 11/15/21. Review of elopement assessments for residents in the women's secured unit revealed all 15 residents were wanderers and an elopement risk. In an interview on 11/12/2021 09:43 am with Housekeeping supervisor, she stated she was in-serviced in the last 24-hours on fire and elopement alarms and what her role and responsibility would be in those situations. She stated that when an alarm sounds, she was to surveil the area to ensure any resident attempting elopement was redirected back to the correct area. If there were no residents in the area she was to report to the area where the elopement alarm was sounding to assist with conducting head count procedures. She stated she was also a certified nurse aide (CNA). In an interview on 11/12/2021 09:46 am with RN B, she stated she was in-serviced in the last 24-hours on fire and elopement alarms and what her role and responsibility would be in those situations. She stated that when an alarm sounded, she was to surveil the area to ensure any resident attempting elopement was redirected back to the correct area. If there were no residents in the area she was to report to determine if any resident was missing based on the reported head count. If the head count indicated a resident was missing, an exterior search would be initiated, the DON, administrator and the local police depart would be notified. In an interview on 11/12/2021 09:47 am Assistant Business Office Manager, she stated she was in on the same in-servicing. She stated her task was to surveil her area to ensure any resident attempting elopement was redirected back to the correct area. If there were no residents in the area, she was to report to the nurses' station for further instructio [TRUNCATED]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675371	A. Building B. Wing	11/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26481 Based on observation, interview and record review, the facility failed to ensure a resident who needs respiratory care, is provided such care, consistent with professional standards of practice for 1 of 2 residents (Resident #63) reviewed for oxygen therapy, in that: Resident #63's oxygen concentrator filters were dirty with white particles for 3 of 5 days. This deficient practice affects residents who received oxygen therapy and could result in an increase in respiratory complications and respiratory infections. Findings included: Record review of Resident #63's face sheet revealed she was admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (lung disease resulting in difficulty breathing), respiratory disorders (breathing difficulty), absence of part of the lung and heart failure. Record review of Resident #63's undated electronic consolidated physician orders revealed an order with a start date of 8/4/21 for oxygen at 2-6 liters per minute to keep oxygen saturations (level of oxygen in the blood) above 92%. Record review of Resident #63's MDS, a Quarterly assessment dated [DATE], revealed a BIMS score of 14 which indicated her cognitive skills for daily decision making were intact and received oxygen. Observation on 11/08/21 at 11:10 a.m. revealed Resident #63 was lying in bed asleep wearing a nasal cannula (device used to deliver supplemental oxygen from the oxygen concentrator to the nose), with the oxygen concentrator set at 4 LPM. Further observation revealed the oxygen filters on both sides of the oxygen concentrator were dirty and completely covered with white particles. Observation on 11/08/21 at 3:16 p.m. revealed Resident #63 was lying in bed asleep wearing a nasal cannula with the oxygen concentrator set at 4 LPM. Further observation revealed the oxygen filters on both sides of the oxygen concentrator were dirty and completely covered with white particles. Observation and interview on 11/08/21 at 3:49 p.m. with LVN E revealed Resident #63 received oxygen at 4 LPM via nasal cannula and the oxygen filters on both sides of the oxygen concentrator were dirty and completely covered with white particles. Interview with LVN E at this time confirmed the filters were dirty, covered with white particles and stated he thought the filters were cleaned every Sunday when the oxygen tubing was changed, and did not specify who changed the filters. Further interview and observation on 11/08/21 at 3:56 p.m. LVN E stated Resident #63 had orders for oxygen at 2-6 LPM and he would clean the oxygen filter and donned gloves to clean the filter. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 11/08/21 at 4:05 p.m. revealed Resident #63 received oxygen at 4 LPM via nasal cannula and the oxygen concentrator filter on the side visible from the door had been cleaned. Further observation of the concentrator revealed the filter on the side by Resident #63's bed was dirty and completely covered with white particles and had not been cleaned. Observation on 11/09/21 at 9:13 a.m. revealed Resident #63 was lying in bed, received oxygen at 4 LPM via nasal cannula and the oxygen concentrator filter by the bed was dirty and completely covered with white particles. Observation on 11/10/21 at 9:26 a.m. revealed Resident #63 was lying in bed, received oxygen at 4 LPM via nasal cannula and the oxygen concentrator filter by the bed was dirty and completely covered with white particles. In an observation and interview on 11/10/21 at 9:28 a.m., the ADON looked at Resident #63's oxygen concentrator and confirmed the filter on the side by the resident's bed was dirty. The ADON stated she did not know Resident #63's oxygen concentrator had two filters, thought it only had one filter and revealed the oxygen concentrator filters would be cleaned once a week. In an interview on 11/11/21 at 3:51 p.m. the DON revealed the oxygen concentrator filters were to be cleaned every Thursday by the nurses, and the dust/lint on the filter could cause the concentrator to malfunction. In an interview on 11/11/21 at 4:07 p.m. the Administrator stated he leaves it to the nurses to be checking the oxygen filters, they know how to do it, it is easy to do when asked how he ensures the oxygen concentrator filters were cleaned. Record review of the facility's policy titled Oxygen Administration revised October 2010, revealed The purpose of this procedure is to provide guidelines for safe oxygen administration. Under Steps in the Procedure was 12. Check the mask, tank humidifying jar, etc., to be sure they are in good working order and are securely fastened.

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	675371	A. Building B. Wing	11/12/2021

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 26481 Based on interview and record review, the facility failed to use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week for 7 days out of 184 days reviewed for nursing services, in that: The facility failed to maintain RN coverage 8 hours a day/7 days a week. This deficient practice could affect all residents of the facility and could result in residents not receiving necessary care and services. Findings included: Record review of the facility's undated Employee List revealed there were two RNs (RN B and DON) employed in the facility. Record review of the RN Salaried Log from 05/01/2021 to 10/31/2021 revealed 7 of 184 days there was no RN coverage on 7/25/21, 8/8/21, 9/26/21, 10/10/21, 10/17/21, 10/26/21 and 10/31/21. In an interview on 11/11/21 at 3:51 p.m., the DON confirmed the facility did not have an RN in the facility on 7/25/21, 8/8/21, 9/26/21, 10/10/21, 10/17/21, 10/26/21 and 10/31/21. The DON stated she had been out on medical leave during that time, RN B worked as many days as she could, and the nurse staffing agencies the facility had contracts with did not have RNs available to work. In an interview on 11/11/21 at 4:07 p.m., the Administrator stated we do the best we can with staffing, we do have telehealth. The DON is salary and is here Monday through Friday. Saturday and Sunday, we do the best we can to get an RN here. The Administrator stated, Our other RN B was here [when the DON was out on medical leave] but she can't work 7 days a week. In an end-of-day meeting on 11/9/21 at 6:42 p.m., the Regional Nurse revealed the facility did not have a policy on RN coverage 8 hours a day/7 days a week.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675371	A. Building B. Wing	11/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937 Based on observations, interviews, and record reviews the facility failed to ensure their medication error rate was below 5% [10 of 32 medications were given late which is an error rate of 31.25%, for 2 of 8 residents (Resident #14 and #62) reviewed for medication error rate, in that: 1. Licensed Vocational Nurse K (LVN K) administered Benztropine, Buspirone, Carbidopa-levodopa, Trazadone, Divalproex, and Clonazepam late to Resident #62 (Benztropine is a medication used to treat a type of movement disorder, Buspirone is used to treat depression, Carbidopa-levodopa is medication is used to treat symptoms of Parkinson's disease (such as shakiness, stiffness, difficulty moving), Trazadone is used to treat depression, Divalproex is used to treat seizure disorders, mental/mood conditions (such as manic phase of bipolar disorder), Clonazepam is used to prevent and control seizures). 2. LVN K administered Divalproex, Metformin, Lorazepam, and Metoprolol late to Resident #14 (Divalproex is used to treat seizure disorders, Metformin is used to control high blood sugar, it is used in patients with type 2 diabetes, Lorazepam is used to seizures and decrease anxiety, Metoprolol is used to treat chest pain, heart failure, and high blood pressure). These deficient practices placed residents at risk for harm by not receiving their medications as the physician ordered and pharmacist dispensed. The findings: 1. Record review of Resident #62's admission record revealed an admitted [DATE] with diagnoses which included extrapyramidal and movement disorder (a group of nervous system conditions that cause you to have abnormal voluntary or involuntary movements, or slow, reduced movements), schizophrenia (a serious mental disorder in which people interpret reality abnormally), and anxiety disorder. Record review of Resident #62's physicians orders' summary dated 11/12/2021, revealed orders for, Benztropine tablet 2mg, give 1 tab oral, twice a day 7:00 am, 7:00 pm, Buspirone 10mg 1 tablet oral, twice a day, 7:00 am and 7:00 pm, Clonazepam 1mg, 1 tablet oral, twice a day at 7:00 am and 7:00 pm, Depakote sprinkles 125mg, give 4 capsules = 500mg, oral, three times a day, give at 7:00 am, 1:00 pm, and at 7:00 pm, Carbidopa Levodopa 25mg 1 tablet oral, three times a day, give at 7:00 am, 1:00 pm, and at 7:00 pm, Trazadone 50mg, 1 tablet, oral, three times a day, give at 7:00, 1:00 pm, and at 7:00 pm. Observation on 11/12/21 at 8:20 am revealed LVN K revealed she dispensed and administered Benztropine 2mg 1 tablet, Buspirone 10mg 1 tablet, Clonazepam 1mg 1 tablet, Depakote sprinkles 125mg 4 capsules, Carbidopa Levodopa 25mg 1 tablet, and Trazadone 50mg, 1 tablet, to Resident #62. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675371	A. Building B. Wing	11/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/12/21 at 11:38 am LVN K stated she dispensed and administered Benztropine 2mg 1 tablet, Buspirone 10mg 1 tablet, Clonazepam 1mg 1 tablet, Depakote sprinkles 125mg 4 capsules, Carbidopa Levodopa 25mg 1 tablet, and Trazadone 50mg, 1 tablet, to Resident #62 at 8:20 am on 11/12/2021. LVN K stated Resident #62's Benztropine, Buspirone, Clonazepam, Divalproex, Carbidopa-levodopa, and Trazadone were ordered and scheduled to be administered at 7:00 am. LVN G stated the medications can be administered 1 hour prior or after the 7:00 am scheduled time. LVN K stated she was late in administering the medications to Resident #62 due to her late notice to pass medications. LVN K stated the DON assigned her to take over the role of the medication aide and pass medications due to several staff did not present to work. LVN K confirmed her training is to report to her supervisors any potential or actual late medication administration and she did not report the late medication pass to her supervisor Assistant Director of Nursing R (ADON R) but would do so. 2. Record review of Resident #14's admission record revealed an admitted [DATE] with diagnoses which included dementia, diabetes type II, and hypertension (high blood pressure). Record review of Resident #14's physicians orders' summary dated 11/12/2021,revealed orders, Depakote [divalproex] sprinkles capsule 125mg give 2 capsules at 7:00 am and 7:00 pm, Metformin tablet 500mg give 1 at 7:00 am and at 7:00 pm, Lorazepam tablet 0.5mg give 1 at 7:00 am and at 7:00 pm, Metoprolol tablet 25mg give 1 at 7:00 am and at 7:00 pm. Observation on 11/12/21 at 8:30 am revealed LVN K dispensed and administered divalproex 125mg two capsules, Metformin 500mg 1 tablet, Lorazepam 0.5mg 1 tablet, and Metoprolol 25mg 1 tablet to Resident #14. During an interview on 11/12/21 at 11:38 am LVN K stated she dispensed and administered Divalproex 125mg two capsules, Metformin 500mg 1 tablet, Lorazepam 0.5mg 1 tablet, and Metoprolol 25mg 1 tablet to Resident #14 at 8:30 am on 11/12/2021. LVN K stated Resident #14's Divalproex, Metformin, Lorazepam, and Metoprolol were ordered and scheduled to be administered at 7:00 am. LVN K stated the medications can be administered 1 hour prior or after the 7:00 am scheduled time. LVN K stated she was late in administering the medications to Resident #14 due to her late notice to pass medications. LVN K stated the DON assigned her to take over the role of the medication aide and pass medications due to several staff did not present to work. LVN K confirmed she did not report the late medication pass to her supervisor ADON R but would do so. During an interview on 11/12/21 at 11:44 am with the ADON R stated she did not know the medications were being administered late for residents #14 and #62 and would look into the incident. During an interview on 11/12/2021 at 11:50 am with the Director of Nursing stated the expectations are for staff who have a possibility of medications being administered late are to report the incident to their supervisors and the facility would utilize leadership nurses to step in and administer medications to residents on time. Record review of the facility's policy titled Medication Administration General Guidelines, dated 2007, revealed, Medication Administration: 14. Medications are administered within 60 minutes of scheduled time,

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	675371	A. Building B. Wing	11/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 26481 Based on observations, interviews, and record reviews the facility failed to store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys, for 1 of 7 medication carts (D Hall) reviewed for drugs and biologicals in locked compartments, in that: The D Hall nurses' medication cart was left unlocked and unattended. This deficient practice could place residents at risk for loss of prescribed medications. Findings included: Observation on 11/12/21 at 3:15 p.m. revealed the D Hall medication cart was parked in front of the nurses' station unlocked with the drawers facing out and anyone who walked by could have opened the drawers with resident's medications. Three unidentified residents were near the medication cart and two nurses (RN B and LVN E) were behind the nurses' station on the phone with the medication cart out of their line of sight and they could not see if a resident had opened one of the drawers. Observation and interview on 11/12/21 at 3:19 p.m. revealed as the DON walked by the unlocked D Hall medication cart, the surveyor opened the top drawer which had over-the-counter medications (paint medications and supplements) and showed the DON it was unlocked. Interview with the DON at this time, confirmed it was unlocked, and the cart should always be locked when not in use and revealed it was the D Hall medication cart. In an interview on 11/12/21 at 3:23 p.m. LVN E revealed he and RN B were in the middle of verifying count of the medications in the D Hall medication cart when they stepped away to take a phone call and confirmed they did not lock it and should had. Observation on 11/12/21 at 3:25 p.m. revealed when the surveyor walked behind nurses' station, where RN B and LVN E had stood and the D Hall medication cart was parked on the other side of the nurses' station, the surveyor was only able to see the top of the medication cart, could not see if a drawers to the medication cart were open. In an interview on 11/12/21 at 3:59 p.m. the Administrator revealed he and other department heads would check the medication carts when they walked by them to ensure they were locked and confirmed the D Hall medication cart should had been locked when it was left unattended by LVN E and RN B. Record review of the facility's policy titled Storage of Medications, revised April 2007, revealed The facility shall store all drugs and biologicals in a safe, secured and orderly manner. Under Policy Interpretation and Implementation was 7. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675371	A. Building B. Wing	11/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverview Nursing & Rehabilitation	1102 River Rd Boerne, TX 78006

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 26481 Based on interview and record review, the facility failed to employ staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition services for 1 of 1 dietary manager reviewed for qualified dietary staff. The facility failed to employ a certified dietary manager as required. This failure could place residents who consumed food prepared by staff in the kitchen at increased risk of food borne illness and not receiving adequate nutrition. Findings included: Record review of the facility's undated Dietary Manager job description revealed under Education/Experience was Credentialed in Dietary Management. Record review of the Active Employee List, dated 9/22/21, revealed Employee I was listed as the Dietary Manager with a hire date of 4/3/2019. Record review of Employee I's personnel file revealed he was hired on 4/3/2019 as a cook, was moved to Maintenance Director position on 7/22/2020. Further review of his employee file revealed it did not indicate when he became the dietary manager and he had not completed a dietary manager's training course. Review of Employee I's Employment Application revealed his prior work experience was as a cook and he did not have any certification or degrees. In an interview on 11/8/21 at 10:28 a.m., Employee I revealed he had been the dietary manager since March 2021 and started a dietary manager training course in August 2021. In an interview on 11/9/21 at 4:22 p.m. Employee I (the Dietary Manager) confirmed he was hired as a cook, then was the maintenance director for a while and when the previous dietary manager left in March, he became the dietary manager. In an interview on 11/10/21 at 2:21 p.m., the Human Resources Employee revealed Employee I worked as the Maintenance Director and Dietary Manager at the same time from March 2021 to October 2021 until the facility was able to hire another Maintenance Director. In an interview on 11/11/21 at 4:07 p.m. the Administrator confirmed Employee I had not completed a dietary manager training course.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675371	A. Building B. Wing	11/12/2021

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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. 26481 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen, in that: 1. Multiple food items (4 five-pound containers of cottage cheese, 2 five-pound containers of sour cream, and 36 four-ounce containers of strawberry flavored yogurt) were kept beyond their Best if Used By dates. 2. Dietary Aide H did not wash his hands after handling soiled dishware before he touched sanitized dishware. 3. A pitcher of health shake was not labeled or dated. These failures could place residents who received meals and/or snacks from the kitchen at risk for food borne illness. Findings included: 1. Observation on 11/08/21at 10:20 a.m. revealed inside Refrigerator #2 were: -2 full five-pound containers of cottage cheese with a Best if Used By 9/24/21 date on both containers, -2 full five-pound containers of cottage cheese with Best if Used By 11/6/21 on both containers, -2 five-pound containers of sour cream with Best if Used By 10/26/21 on both containers, and -36 four-ounce containers of strawberry flavored yogurt with Best if Used by 10/26/21 date on each container. In an interview on 11/08/21 at 10:22 a.m. the Dietary Manager revealed he was responsible for going through the refrigerators to check dates on food items. The Dietary Manager confirmed the 2 five-pound containers of cottage cheese with Best if Used By 9/24/21 date on both containers, the 2 five-pound containers of cottage cheese with Best if Used By 11/6/21 date on both containers, the 2 five-pound containers cartons of sour cream with Best if Used By 10/26/21 date on both containers, and the 36 four-ounce containers of strawberry flavored yogurt with Best if Used by 10/26/21 dates were in the refrigerator beyond the Best if Used By dates. Record review of the Texas Food Establishment Rules (TFER) 2015, page 71, section S228.75(g)(2)(B) revealed the day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675371	A. Building B. Wing	11/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverview Nursing & Rehabilitation	1102 River Rd Boerne, TX 78006

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2017, U.S. Department of H&HS, revealed 3-501.17, Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking, revealed (A) . food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold or discarded when held at a temperature 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. And (B) .refrigerated, ready-to-eat time/temperature controlled for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24-hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations . and .(2) The day or date marked by the food establishment may not exceed a manufacturer's used-by date if the manufacturer determined the use-by date based on food safety. 2. Observation on 11/08/21 at 10:07 a.m. revealed Dietary Aide H load soiled dishes into a dishrack with his bare hands, then without washing his hands, removed clean sanitized built-up divided plates from a dish rack placed them on a cart. With same unwashed soiled hands, Dietary Aide H grabbed sanitized plates and placed them on a cart. In an interview on 11/10/21 at 3:37 p.m. the Dietary Manager confirmed Dietary Aide H should had washed his hands after touching the soiled dishware before he handled the clean sanitized dishware. The Dietary Manager stated employees should wash their hands after they touch the soiled dishware before they touch the clean dishware. Record review of the facility's policy titled Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices, revised December 2008, revealed 6. Employees must wash their hands: f. After handling soiled equipment or utensils Review of the TFER 2015, page 36, section S228.38(d)(1-9) indicated food employees shall clean their hand immediately before working with exposed food, clean equipment and utensils after touching bare human parts other than clean hands and clean exposed portions of arms; after using the toilet room; after care for or handling service animals or aquatic animals; after coughing, sneezing, using a handkerchief or disposable tissue, using tobacco, eating or drinking; after handling soiled equipment or utensils; during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; when switching between working with raw food and working with ready-to-eat food; before donning gloves to initiate a task that involves working with food; and after engaging in other activities that contaminate the hands. Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2017, U.S. Department of H&HS, revealed 2-301.14, When to Wash [hands], revealed Food employees shall clean their hands and exposed portions of their arms .immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and: .(E) After handling soiled equipment or utensils. 3. Observation on 11/08/21 at 10:10 a.m. revealed inside a 2-door refrigerator was an unlabeled/undated pitcher with a red top with a milky-white liquid. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675371	A. Building B. Wing	11/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverview Nursing & Rehabilitation	1102 River Rd Boerne, TX 78006

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 11/08/21 at 10:11 a.m. the Dietary Manager revealed the pitcher with the red top in the 2-door refrigerator contained health shake, confirmed it was not labeled or dated and stated it was prepared that morning. In an interview on 11/10/21 at 3:37 p.m. the Dietary Manager confirmed the pitcher with the health shake should had been labeled and dated. Record review of the facility's policy titled Food Receiving and Storage, revised 12/2008, revealed Foods shall be received and stored in a manner that complies with safe food handling practices. Under Policy Interpretation and Implementation was 7. All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date). Record review of the TFER 2015, page 72, section S228.75(g)(4)(B) revealed prepared food was to be marked with the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises or discarded. Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2017, U.S. Department of H&HS, revealed 3-501.17, Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking, revealed (A) . food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold or discarded when held at a temperature 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. And (B) .refrigerated, ready-to-eat time/temperature controlled for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24-hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations . and .(2) The day or date marked by the food establishment ay not exceed a manufacturer's used-by date if the manufacturer determined the use-by date based on food safety.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675371	A. Building B. Wing	11/12/2021

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 Based on observation, interview and record review the ADM failed to administer the facility in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical and psychosocial well-being of each resident for 1 of 2 Residents (Resident #65) reviewed for administration. The ADM and the Maintenance Supervisor failed to ensure the exit door to the women's secured unit was working properly, remained closed and locked to prevent Resident #65 from eloping from the facility. This deficient practices could affect any resident and placed them at risk of improper facility management. The findings were: Review of Resident #65's face sheet, dated 11/12/21 revealed she was admitted to the facility on [DATE] with diagnoses which included Parkinson's disease, Type 2 diabetes mellitus with diabetic polyneuropathy, Alzheimer's disease, unspecified, Schizoaffective disorder, bipolar type, Major depressive disorder, recurrent, unspecified and Generalized anxiety disorder, Review of Resident #65's admission MDS, dated [DATE], revealed her BIMS was 2 indicating severe cognitive impairment; she exhibited verbally and physically aggressive towards others; wandered; had a fall since her admission and was receiving anti-depressant, anti-anxiety and anti-psychotic medications. Review of Resident #65's Care Plan, dated 10/25/21, revealed Resident resided in secure unit and was at risk for injury from wandering in an unsafe environment related to impaired safety awareness. One of the Interventions included included to keep environment free from possible hazards. Further review revealed the CP was updated on 11/3/21 after Resident #65 was identified as potential/ high risk for injury related to identified elopement risk factors and or exit seeking behavior. One of the interventions included to supervise the Resident closely and make regular compliance rounds whenever resident is in room. Review of an event report dated 11/1/21 revealed that Resident #65 was found by local police down the street. It was noted that Resident #65 had been repeatedly opening doors/setting off alarms of secured doors; resisting redirection, wandering with no rational purpose and attempting to open doors. Her mental status was noted as confused and restless; possible contributing factors were Dementia, Psychiatric Diagnosis of Schizophrenia. Further review revealed Resident #65 was taken to the ER. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Provider Investigation Report dated 11/5/21 revealed that on 11/1/21 at 1:02 PM the facility received a phone call from local police department that Resident #65 was across the street at a nearby restaurant. The DON went across the street to meet with local police department and Resident #65. The DON observed Resident #65 to have a scrape to her right knee. Resident #65 was taken to the ER and returned to the facility on the same date and had a bandage to her right knee as a result of a fall during her elopement. Further review revealed after investigation staff last saw Resident #65 in the TV room about 12:30 PM. The facility believed Resident #65 opened the window to her room, removed the screen, went out the window, replaced the screen and walked about 50 yards from the facility and was found at a nearby restaurant. Review of a picture sent to Surveyor's work cell phone on 11/10/21 at 6:12 PM revealed a blue 5 or 6 foot A frame aluminum ladder in the open position located by the fence on the right side exiting the door. Interview on 11/8/21 at 10:15 AM with CNA L revealed she worked when Resident #65 eloped. She stated she was working alone in the unit and providing pericare for another resident in the shower room. She stated she heard the alarm but could not leave the resident because the resident was full of feces. CNA L stated the alarm sounded for about 15 to 20 minutes. When she stepped out of the shower room she LVN N running down the hall. CNA L stated she saw the back door was opened and when she went outside she saw a blue A frame ladder by the fence right outside the women's unit. She stated she walked the inside parameter of the courtyard and did not see any broken slats and then checked the 2 gates and they were both locked. CNA L stated nursing staff told her Resident #65 was across the street at a restaurant. She stated the problem was that the back door did not close properly and would open on it's own. CNA L pushed out on the door and showed how the door remained open (ajar) and did not return to the closed position. The 3 second warning alarm sounded, after 3 seconds it activated the 15 second alarm and it released the door. CNA L stated there were a few residents including Resident #65 who would often push on the door. She stated she often worked alone and if she was busy with another resident she would not be able to get to the alarm fast enough and the resident could get out. CNA L stated the charge nurses were also supposed to respond to the alarm but would not always respond. CNA L stated she was agency and she had been working the door had been a problem. She stated nursing staff was aware the door did not close properly. Interview on 11/10/21 at 8:35 AM with the MS revealed he had been in his position for about 4 weeks and with the company for about 1 year. He stated the back door to both the women's and men's unit were warped. He stated they were mag doors and there was too much spacing between the magnet components. The door would not stay locked/latched when there was any movement (wind blows) or when a resident pushed on the door it would open. The MS stated any movement or push would activate the 3 sec alarm and then then the 15 sec egress alarm opened the door. The MS stated a fire and safety company went out to the facility 2 to 3 weeks prior. They recommended the facility replace the door because they had adjusted the mag hardware as much as they could by bringing the mag hardware as close together as possible. The MS stated the closer the mag hardware was the greater the magnetic pull which was kept the door closed. The MS stated staff told him that the residents often triggered the alarm and that the door would open. He stated that there was nothing that he could do and stated staff was supposed to respond to the alarm making sure the residents did not get out. The MS confirmed this would be difficult if there was only one aide working the women's unit. (continued on next page)

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	675371	A. Building B. Wing	11/12/2021

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 11/10/21 at 9:19 AM with LVN K revealed she was the charge nurse from 6 AM to 2 PM Monday through Friday for the women's secured unit. LVN K stated she was not on duty when Resident #65 eloped. LVN K confirmed that the back door did not work properly. She stated staff had to pull on the back door to close it and then enter the code to lock it. LVN K stated the door would open on windy days or if a resident pushed on the door. She stated the alarm would sound and if it was quiet she could hear it from the nurse's station. Interview on 11/10/21 at 8:45 AM with the MS revealed the facility would be renovating the women's secured unit and they would be replacing the doors at that time but stated it was still in the planning phase. In the meantime, he stated there was not a contingency plan other than the assigned aide or aides would have to respond to the alarm to ensure residents did not get out. Observation on 11/10/21 at 10:32 AM revealed two yellow barrels, an orange ladder and a blue ladder located right outside the main dining room. Interview on 11/10/21 at 10:42 AM with LVN N revealed he confirmed the back door was not working properly and Resident #65 and at least 2 other residents would often push on the back door activating the alarm. He re-iterated the problem they had with the exit door as reported by CNA L and stated all administrative staff was aware the door was not working properly. LVN N stated the problem with the back door not working made it challenging for the staff to work the unit. Interview on 11/10/21 at 11:37 AM with the DON confirmed the exit door to the women's unit was not working properly and reiterated what all other staff had reported including that a gust of wind would open the door. The DON stated they had a couple of companies look at the door within the last several months but did not know the outcome. She stated the MS had been in charge of that and she did not ask him about any recommendations if any had been made about fixing the exit door. The DON stated she started working for the facility since March 2021 and the doors had been a problem since that time Interview on 11/10/12 at 12:01 PM with the ADM confirmed the exit door to the women's unit was warped but stated the egress door worked properly. He stated the door only opened when someone continuously pushed on the handle for 15 seconds. He stated they planned to renovate the women's unit and would be replacing the door at that time. He stated the Corporate engineer was in the process of securing contractors for the job. Interview on 11/10/12 at 12:25 PM with the ADM revealed he checked the exit door to the women's secured unit for functionality. He confirmed the egress alarm was activated without continuously pushing out on the handle. He stated when he pushed on the door it did not return to the closed position because the door was warped and the door remained ajar. The ADM confirmed the egress door would release and open and stated it posed a threat for the residents because they could exit the door if staff did not respond to the alarm on a timely basis. Interview on 11/10/21 at 2:45 PM with the DON revealed all 15 residents in the women's unit were in the unit because they were wanderers and an elopement risk. (continued on next page)

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	675371	A. Building B. Wing	11/12/2021

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 11/10/21 at 2:47 PM with Resident #23 revealed the alarm on the exit door in the women's secured unit went off all the time and the staff would slam it shut. Resident #23 stated sometimes the alarm would go off and staff was not available to respond to it right away. She stated there were 2 or 3 residents that would often push on the door. She stated she had seen two residents exiting the unit into the courtyard but staff was able to redirect them back into the unit. Resident #23 stated the alarm would go off and then the door would open so if staff was not available then the residents could walk out of the unit. Resident #23 stated this problem had been going on since she was admitted to the facility about one year ago. Interview on 11/12/21 at 5:05 p.m. with the ADM revealed the issue with the door had been addressed during QAPI meetings since November 2020. He stated they identified the exit doors to the women's and men's unit were warped and it affected their functionality. The ADM stated the exit doors had become warped over time by the weather; rain and wind. The ADM stated they had a plan to fix the doors as of July 2020 but it was placed on hold after the onset of the COVID pandemic. The ADM further stated they did not have a policy for the administration of the facility.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 27520 Based on observations, interviews, and record reviews the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition for 1 of 1 laundry department reviewed for operation of all mechanical, electrical, and patient care equipment, in that: 1. Laundry equipment was inoperable. a. The commercial washer and dryer were inoperable. b. The only wired light source in the soiled washroom presented inoperable. c. The exterior entrance door on the clean side of the laundry department presented with a 1 gap where the door meets the floor threshold. d. The hand wash sink in the dirty laundry side of the laundry department presented corroded and without hot water service. e. The emergency eyewash station attached to the wash sink presented inoperable. These deficient practices placed residents at risk for having equipment that is not in operable condition. The findings are: 1. a. Observation on 11/12/2021 beginning at 9:00 am revealed the facility's laundry department presented with the following: 2 commercial grade 40 lb. capacity washers, one of the washers presented inoperable. The laundry department presented with 3 commercial dryers with 1 inoperable. b. The soiled side of the laundry department where the washers were housed presented with the only wired light source inoperable. the fixture was in place but could not illuminate; c. The hand wash sink presented with the faucet corroded and without hot water service. The hot water handle would turn but did not produce any hot water; D; (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The emergency eye wash station plumbed into the hand wash sink water service presented inoperable. the maintenance director attempted to utilize the emergency eye wash station and the equipment did not produce any water; and e. The laundry department presented with 2 exterior doors, one door on the soiled side and the other on the clean side. The exterior door on the clean side presented with a 1 gap at the bottom of the door where the door meets the threshold. Further observation revealed the exterior threshold was below the exterior grade and could allow water in the building via the 1 gap. Interview on 11/12/2021 at 9:00 am with Laundry Aide Q (LA Q) confirmed the commercial washer and dryer were inoperable, the light in the washer room was inoperable, the hand wash sink did not work with hot water and the eye wash station was inoperable, and the exterior door on the clean side had a 1 gap at the bottom. LA Q stated, we do laundry constantly to meet the needs of the residents with only 1 washer and 2 dryers and there isn't enough light to see what we are doing. The hand wash sink doesn't work well and it does not provide hot water, only cold. The department floods when it rains due to the gap at the bottom of the exterior door and we [laundry department staff] got our own temporary light fixture and hung it on the wall and plugged it into the electrical receptacle. When asked how long these maintenance issues have existed LA Q replied months. During a joint interview on 11/12/2021 at 9:15 am with the Housekeeping Supervisor (HK S), the Maintenance Director (MD), and the Director of Nursing (DON) confirmed the laundry department had 2 commercial grade 40 lb. capacity washers, one of the washers presented inoperable. The laundry department presented with 3 commercial dryers with 1 inoperable. The soiled side of the laundry department where the washers were housed presented with the only wired light source inoperable. The hand wash sink presented with the faucet corroded and without hot water service. The emergency eye wash station plumbed into the hand wash sink water service presented inoperable. The laundry department presented with 2 exterior doors, one door on the soiled side and the other on the clean side. The exterior door on the clean side presented with a 1 gap at the bottom of the door where the door meets the threshold. The HK S stated she had made the facility leadership [Administrator] aware of the issues on several facility morning meetings for some time now. When asked how long the issues were present the HK S stated for months maybe even a year. The MD stated he has worked for the facility as an as needed contractor since July 2021 and became the full time Maintenance Director just 4 weeks ago [10/15/2021]. The maintenance director stated he was aware of all the issues since July 2021. The MD stated he was addressing many facility wide issues and would address the laundry issues as soon as possible. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 11/12/2021 at 3:23 pm with the facility Administrator confirmed the facility was without a dedicated Maintenance Director and he and the Dietary Food Manager would fill in with Maintenance duties as needed. The Administrator confirmed the laundry department had 2 commercial grade 40 lb. capacity washers, one of the washers presented inoperable. The laundry department presented with 3 commercial dryers with 1 inoperable. The soiled side of the laundry department where the washers were housed presented with the only wired light source inoperable. The hand wash sink presented with the faucet corroded and without hot water service. The emergency eye wash station plumbed into the hand wash sink water service presented inoperable. The laundry department presented with 2 exterior doors, one door on the soiled side and the other on the clean side. The exterior door on the clean side presented with a 1 gap at the bottom of the door where the door meets the threshold. The Administrator stated the laundry department has flooded in the past and in June 2021 he initiated a maintenance work order to install a rain gutter over the exterior door to the laundry department. The Administrator confirmed he had requested an estimate for laundry equipment repairs from the laundry equipment contractor and the contractor failed to arrive and provide the service. Observation on 11/21/2021 at 4:48 pm of the laundry department revealed a repairman from the laundry equipment maintenance contractor on site assessing the inoperable equipment. Interview on 11/12/2021 at 4:49 pm with the contractor confirmed the washer and dryer were inoperable and the purchase of a new washer would be more economical than the repair. Record review of the facility's maintenance request log for the period 12/2009 to 11/ 2021 did not reveal any requests for repairs for the laundry department other than 1 request made by the Administrator dated 6/4/2021 revealed Laundry - needs rain gutters. Record review of the facility facilities policy for maintenance of laundry equipment was requested on 11/2021 at 3:23 pm from the Administrator and not provided.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 26869 Based on observations, interviews and record reviews the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public for 2 of 2 units (Secure unit A and B) in that: 1. Secure unit A had missing privacy curtains, blinds were torn off, torn privacy curtain, shower room missing tile, the middle of wooden foot board torn off bed, and no curtains/blinds on the windows. 2. Secure unit B had missing blinds/curtains, shower room, and privacy curtains not in rooms. This could affect residents and place them at risk of low self-esteem and a lack of privacy. The Findings were: 1. Secure unit A men's unit: Blinds: Observation on 11/08/21 at 9:59 a.m. in RM3 the blinds on the window were torn at the bottom and missing slates. Observation on 11/08/21 at 10:11 a.m. in the tv lounge the window blinds were torn and missing slats on two windows, Observation on 11/08/21 at 10:12 a.m. in RM7 had no blinds/curtain on windows. Observation on 11/08/21 at 10:16 a.m. in RM10 had no curtains/blinds on window Observation on 11/08/21 at 10:18 a.m. in RM11 window blinds were torn or missing. Observation on 11/08/21 at 10:26 a.m. in RM15 had blinds torn or missing slates. Shower room: Observation on 11/08/21 at 10:05 a.m. in shower room tile was rusted on the wall and missing tiles. Curtains: Observation on 11/08/21 at 10:06 a.m. in RM 4 had no privacy curtain to separate the resident room between two residents and the middle privacy curtain torn across and only had about a foot of curtain on top. Observation on 11/08/21 at 10:14 a.m. in RM8 had privacy curtain missing to go across the room. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 11/08/21 at 10:26 a.m. in RM15 had missing privacy curtain that goes across both beds. Foot board: Observation on 11/08/21 at 10:20 a.m. in RM12 had the middle of foot board torn off the bed and left two wooden sharp pieces. 2. Secure unit B-women's unit: privacy curtain: Observation on 11/08/21 at 10:42 a.m. in RM19 had no privacy curtains for room. Shower: Observation on 11/08/21 10:43 AM shower revealed the toilet was running, the tiles in the shower wall was rusty, back of toilet baseboard exposed the wall. Blinds: Observation on 11/08/21 at 10:46 a.m. in RM20 had blinds missing for window. Observation on 11/08/21 at 10:47 a.m. in RM21 had no blinds/curtain for the window. Observation on 11/09/21 at 11:33 a.m. with LVN K revealed the resident rooms were missing blinds/curtain, missing privacy curtain, shower room had baseboards exposed, resident shower chair had brown substance, tile missing (5) in shower. Observation on 11/9/2021 at 11:35 a.m. in RM 8 had no curtain/blinds on window and no privacy curtain. Interview on 11/08/21 at 10:23 a.m. with CNA V revealed staff had not come to fix the resident rooms. Interview on 11/08/21 at 10:39 a.m. in dining room with the ADON stated the windows missing blinds were being replaced, they are in the process of refurbishing building. (did not provide a plan/time). The ADON had not addressed this question. Interview on 11/09/21 at 11:33 a.m. with LVN K confirmed the resident rooms were missing blinds/curtain, missing privacy curtain, shower room had baseboards exposed, resident shower chair had brown substance, tile missing (5) in shower. Interview on 11/9/2021 at 11:36 a.m. with CNA X revealed the staff had not fixed resident rooms after discussing the nurses. The CNA X stated she informed the nurse and then reports to the Maintenance Supervisor. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 11/11/2021 at 12:28 p.m. with Maintenance supervisor confirmed the resident rooms in units were missing blinds/curtains on windows, tile missing and rusty in showers, baseboard exposed wall, foot board was broken and stated he was not aware of resident's rooms required fixing. The Maintenance supervisor stated staff write items that need to be fixed in a folder at the nurse's station. Interview on 11/11/21 at 12:36 p.m. with the Administrator stated all the showers need to be updated, the window blinds were being replaced twice a week and rooms being refurbished but did not have a plan or time period these rooms will be fixed. The Administrator stated did not say how long the environment issues were in the unit A and unit B. The Administrator did not provide policy before exit. Record review of the Maintenance log dated 10/29/2021 revealed unit A shower room A hall was missing baseboard by toilet. Further review revealed no signature that the shower room was fixed.