STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675371	A. BUILDING _____ B. WING _____	06/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIVERVIEW NURSING AND REHABILITATION LP	1102 RIVER RD BOERNE, TX 78006

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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** Based on interview and record review, the facility failed to ensure that all alleged violations involving abuse and neglect 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, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency) in accordance with State law through established procedures (for) 1 of 9 residents (Resident #2) whose care was reviewed, in that: The facility did not report to State Survey Agency (HHSC) allegations of sexual abuse observed by a facility staff for Resident #2 (perpetrated by Resident #1), reported to the facility management on 5/28/2020 by a facility staff. This deficient practice could place residents at risk for abuse and neglect. The findings were: Record review of Resident #2's face sheet (not dated), revealed an admission date of [DATE], with [DIAGNOSES REDACTED]. Record review of Resident #2's Quarterly MDS, dated [DATE], revealed a BIMS of 1, which indicated the resident's cognitive status was severely impaired. Record review of Resident #2's Care Plan, dated 2/18/2019 (last reviewed 4/22/2020), stated, (Resident #2) has a [DIAGNOSES REDACTED]. The Goal for Resident #2 stated, Resident will be free of injury over the next 90 days. Record review of Resident #1's face sheet (not dated), revealed an admission date of [DATE], readmitted [DATE], with [DIAGNOSES REDACTED]. Record review of Resident #1's Readmission MDS, dated [DATE], revealed a BIMS of 4, which indicated the resident's cognitive status was severely impaired. Interview and observation on 6/16/2020 at 1:14 PM, Resident #2 was observed in his room, standing over his bed and then sitting on his bed repeatedly and appeared confused and in distress. During an attempted interview at this time, it was revealed Resident #2 was unable to be interviewed as he did not respond to this investigator's questions. Interview and observation on 6/16/2020 at 1:21 PM, Resident #1 was observed in his room in the men's secured unit. During an interview at this time, Resident #1 stood up and started responding to this investigator's questions with disorganized and non-related answers, asking this investigator, am I in trouble? and, are you my doctor, are you my psychiatrist? Interview on 6/16/2020 at 1:25 PM, RN B stated she had heard Resident #1 had sexually assaulted Resident #2 and said Resident #1, was very sexually preoccupied. RN B stated Residents #1 and #2 were roommates but had been recently separated following the allegation of sexual assault. Interview on 6/16/2020 at 1:34 PM, the Social Worker (SW) stated CNA claimed witnessing Resident #1 with his hands over Resident #2's clothed groin area. The SW said she interviewed Resident #1 to ask about the allegation and he explained he had attempted to touch Resident #2 on his groin area but that Resident #2 had hit his hand away. Interview on 6/16/2020 at 1:43 PM, the DON stated she had heard that there was a sexual encounter with Resident #1 and another male Resident, but said she interviewed both residents and said they both denied the allegation. Interview on 6/16/2020 at 2:18 PM, RN C stated she was made aware Resident #1 had touched Resident #2 on his groin area over the resident's pants. Interview on 6/16/2020 at 2:36 PM, Medication Aide D (MA D) stated she was familiar with both Residents #1 and #2. MA D stated she had heard Resident #1 touched Resident #2's groin area and that Resident #2, freaked out. She further stated she had heard Resident, #1, .talk inappropriately ., in a sexual nature. Telephone interview on 6/17/2020 at 3:00 PM, Resident #2's Responsible Party (RP) revealed she was not made aware of the allegation that Resident #2 had been sexually assaulted. Telephone interview on 6/17/2020 at 3:25 PM, Resident #1's Responsible Party (RP) revealed she had not been made aware that Resident #1 had been alleged to have inappropriately touched another male resident. The RP said the Resident #1 was [MEDICAL CONDITION] and would typically be ok if he was taking his medications. The RP said Resident #1 told her on occasion that when other male residents would get close to him he would interpret it in a way that led him to believe that the other residents liked him, and that he had urges to make sexual advancements toward them. Telephone interview on 6/17/2020 at 4:10 PM, RN E, stated CNA F informed him Resident, #1 was observed touching Resident #2 on the groin area over his pants. RN E stated he submitted an incident report to RN C who forwarded the incident report to the DON and Administrator. Record review of the Facility's Abuse and Neglect policy, titled, Nursing Policy and Procedure, revised 1/2018, stated, . Abuse - As defined in 42 CFR 483.5 - The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish .It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Neglect - as defined in 42 CFR 483.5 - The failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, and mental anguish or emotional distress . 7. Reporting: a. All alleged allegations of abuse will be reported to the appropriate state agency and to all other agencies as required by regulation. c. After investigation, administration will analyze the occurrence to determine what changes, if any, are needed to the policies and procedures to prevent further occurrences.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that all allegations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source were thoroughly investigated for 2 of 9 residents (Resident #1 and #2) reviewed for abuse and neglect, in that: The facility was not able to provide documented evidence that the incident between Resident #1 and Resident #2 was investigated. This deficient practice could affect residents at the facility and place them at risk of being abused neglected or exploited. The findings were: Record review of Resident #2's face sheet (not dated), revealed an admission date of [DATE], with [DIAGNOSES REDACTED]. Record review of Resident #2's Quarterly MDS, dated [DATE], revealed a BIMS of 1, which indicated the resident's cognitive status was severely impaired. Record review of Resident #2's Care Plan, dated 2/18/2019 (last reviewed 4/22/2020), stated, (Resident #2) has a [DIAGNOSES REDACTED]. The Goal for Resident #2 stated, Resident will be free of injury over the next 90 days. Record review of Resident #1's face sheet (not dated), revealed an admission date of [DATE], readmitted [DATE], with [DIAGNOSES REDACTED]. Record review of Resident #1's Readmission MDS, dated [DATE], revealed a BIMS of 4, which indicated the resident's cognitive status was severely impaired. Interview and observation on 6/16/2020 at 1:14 PM, Resident #2 was observed in his room, standing over his bed and then sitting on his bed repeatedly and appeared confused and in distress. During an attempted interview at this time, it was revealed Resident #2 was unable to be interviewed as he did not respond to this investigator's questions. Interview and observation on 6/16/2020 at 1:21 PM, Resident #1 was observed in his room in the men's secured unit. During an interview at this time, Resident #1 stood up and started responding to this investigator's questions with disorganized and non-related answers, asking this investigator, am I in trouble? and, are you my doctor, are you my psychiatrist? Interview on 6/16/2020 at 1:25 PM, RN B stated she had heard Resident #1 had sexually assaulted Resident #2 and said Resident #1, was very sexually preoccupied. RN B stated Residents #1 and #2 were roommates but had

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

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) been recently separated following the allegation of sexual assault. Interview on 6/16/2020 at 1:34 PM, the Social Worker (SW) stated CNA claimed witnessing Resident #1 with his hands over Resident #2's clothed groin area. The SW said she interviewed Resident #1 to ask about the allegation and he explained he had attempted to touch Resident #2 on his groin area but that Resident #2 had hit his hand away. Interview on 6/16/2020 at 1:43 PM, the DON stated she had heard that there was a sexual encounter with Resident #1 and another male Resident, but said she interviewed both residents and said they both denied the allegation. Interview on 6/16/2020 at 2:18 PM, RN C stated she was made aware Resident #1 had touched Resident #2 on his groin area over the resident's pants. Interview on 6/16/2020 at 2:36 PM, Medication Aide D (MA D) stated she was familiar with both Residents #1 and #2. MA D stated she had heard Resident #1 touched Resident #2's groin area and that Resident #2, freaked out. She further stated she had heard Resident, #1, .talk inappropriately ., in a sexual nature. Telephone interview on 6/17/2020 at 3:00 PM, Resident #2's Responsible Party (RP) revealed she was not made aware of the allegation that Resident #2 had been sexually assaulted. Telephone interview on 6/17/2020 at 3:25 PM, Resident #1's Responsible Party (RP) revealed she had not been made aware that Resident #1 had been alleged to have inappropriately touched another male resident. The RP said the Resident #1 was [MEDICAL CONDITION] and would typically be ok if he was taking his medications. The RP said Resident #1 told her on occasion that when other male residents would get close to him he would interpret it in a way that led him to believe that the other residents liked him, and that he had urges to make sexual advancements toward them. Telephone interview on 6/17/2020 at 4:10 PM, RN E, stated CNA F informed him Resident, #1 was observed touching Resident #2 on the groin area over his pants. RN E stated he submitted an incident report to RN C who forwarded the incident report to the DON and Administrator. Record review of the Facility's Abuse and Neglect policy, titled, Nursing Policy and Procedure, revised 1/2018, stated, . Abuse - As defined in 42 CFR 483.5 - The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish .It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Neglect - as defined in 42 CFR 483.5 - The failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, and mental anguish or emotional distress . 7. Reporting: a. All alleged allegations of abuse will be reported to the appropriate state agency and to all other agencies as required by regulation. c. After investigation, administration will analyze the occurrence to determine what changes, if any, are needed to the policies and procedures to prevent further occurrences.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet residents' medical, nursing, and mental and psychosocial needs for 1 of 9 residents (Resident #1) reviewed for Care Plans. Resident #1's Comprehensive Care Plan failed to address his other sexual disorders, despite a history of sexualized behaviors. This failure could place residents at risk of receiving care that is substandard, unable to meet their needs, or inadequate to prevent complications. Findings include: Record review of Resident #1's face sheet (not dated), revealed an admission date of [DATE], readmitted [DATE], with [DIAGNOSES REDACTED]. Record review of Resident #1's Readmission MDS, dated [DATE], revealed a BIMS of 4, which indicated the resident's cognitive status was severely impaired. Record review of Resident #1's Care Plan, start date 3/24/2020, stated: Category: Behavioral Symptoms - I have socially inappropriate/disruptive behavioral symptoms as evidence by yelling in my room especially when I see people walk by. - Goal - Long Term Goal Target Date 6/24/2020 - I will not exhibit socially inappropriate/disruptive behavior. Further review revealed no mention of this resident's sexualized behaviors or interventions for such behaviors. Interview on 6/16/2020 at 1:25 PM, RN B stated she had heard Resident #1 had sexually assaulted Resident #2 and said Resident #1, was very sexually preoccupied. RN B stated Residents #1 and #2 were roommates but had been recently separated following the allegation of sexual assault. Interview on 6/16/2020 at 1:34 PM, the Social Worker (SW) stated CNA claimed witnessing Resident # 1 with his hands over Resident #2's clothed groin area. The SW said she interviewed Resident #1 to ask about the allegation and he explained he had attempted to touch Resident #1 on his groin area, but that Resident #1 had hit his hand away. Interview on 6/16/2020 at 1:43 PM, the DON stated she had heard that there was a sexual encounter with Resident #1 and another male Resident, but said she interviewed both residents and said they both denied the allegation. Interview on 6/16/2020 at 2:18 PM, RN C stated she was made aware Resident #1 had touched Resident #2 on his groin area over the resident's pants. Interview on 6/16/2020 at 2:36 PM, Medication Aide D (MA D) stated she was familiar with both Residents #1 and #2. MA D stated she had heard Resident #1 touched Resident #2's groin area and that Resident #2, freaked out. She further stated she had heard Resident, #1, .talk inappropriately ., in a sexual nature. Telephone interview on 6/17/2020 at 3:00 PM, Resident #1's Responsible Party (RP) revealed she was not made aware of the allegation that Resident #2 had been sexually assaulted. Telephone interview on 6/17/2020 at 3:25 PM, Resident #1's Responsible Party (RP) revealed she had not been made aware that Resident #1 had been alleged to have inappropriately touched another male resident. The RP said the Resident #1 was [MEDICAL CONDITION] and would typically be ok if he was taking his medications. The RP said Resident #1 told her on occasion that when other male residents would get close to him he would interpret it in a way that led him to believe that the other residents liked him, and that he had urges to make sexual advancements toward. Telephone interview on 6/17/2020 at 4:10 PM, RN E, stated CNA F informed him Resident, #1 was observed touching Resident #2 on the groin area over his pants. RN E stated he submitted an incident report to RN C who forwarded the incident report to the DON and Administrator. Telephone interview on 6/18/2020 at 3:24 PM, The DON confirmed there was no mention of Resident #1's sexual disorder or related behaviors and agreed that there had been an oversight. The DON was asked who was in charge of care plans and indicated that it was both she and the MDS Coordinator. The DON expressed understanding that given Resident #1's history related to his sexual behaviors that the issue should have been included in his care plan. Record Review of the RAI guidelines at https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf, revealed: 4.6 .it facilities are responsible for assessing and addressing all care issues that are relevant to individual residents, regardless of whether or not they are covered by the RAI (42 CFR 483.20(b)), including monitoring each resident's condition and responding with appropriate interventions.