STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455796	A. BUILDING _____ B. WING _____	**09/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TOWN AND COUNTRY NURSING AND REHABILITATION CENTER	**625 N MAIN ST 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 0637 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Assess the resident when there is a significant change in condition** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to complete a significant change MDS assessment within 14 days after a significant change of condition for 1 (Resident #64) of 24 residents reviewed for comprehensive assessments. The facility did not complete a significant change MDS for Resident #64 after she had a significant decline. This failure could place residents at risk of not having their individual needs met when a significant change in condition occurs. Findings included: Record review of Resident #64's face sheet dated 09/11/20 revealed she was admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. Record review of Resident #64's Quarterly Minimum Data Set ((MDS) dated [DATE], located in the resident's electronic record, revealed the resident required extensive assistance by 1 staff member for bed mobility, dressing eating, toilet use, personal hygiene and bathing. Record review of Resident #64's Initial MDS dated [DATE] revealed the resident required supervision with set up only for bed mobility, transfers, ambulation, dressing, eating and personal hygiene. The MDS also revealed the resident did not use any mobility device to ambulate. Record review of Resident #64's MDS's revealed a Significant change MDS had not been done. Record review of Resident #64's nursing note dated 08/28/20 revealed the resident was a 2 person transfer and was difficult to transfer because she did not follow commands. The nursing note further revealed Resident #64 was difficult to toilet requiring 2 staff members due to the resident not being steady. Record review of Resident #64's Nurse Practitioner's progress note, located in the resident's electronic chart, dated 08/31/20 revealed the resident had a continued decline over the past month and was no longer able to feed herself or ambulate independently, as she was before. The Nurse Practitioner's progress note further revealed she had contacted the resident's responsible party and reported a significant change in status which included Resident #64 not eating well, loss of weight and loss of ambulatory and functional abilities. Observation on 09/10/20 at 1:20 p.m. revealed Resident #64 was in a recliner Geri chair and was being fed by staff. Resident #64 had difficulty following commands by staff. In an interview on 09/11/20 at 2:58 p.m. the DON, after reviewing Resident #64's medical record, revealed that she used to do MDS' in the past and stated a Significant Change in Condition MDS should have been done for Resident #64. The DON further said the resident's physician was aware of the decline and had recommended palliative care. The DON said she had spoken to the family about it. In an interview on 09/11/20 at 3:02 p.m. the LVN Case Manager, with the DON present, confirmed that she had completed the MDS's for Resident #64 and that she should have done a Significant Change in Status MDS instead of a Quarterly MDS on 08/04/20. In an interview on 09/11/20 at 5:01 p.m. the RN Case Manager revealed she had spoken to the LVN Case Manager and they did not have a policy for when a Change of Status MDS should be done. The RN Case Manager said the MDS' go by the Long-Term Care Resident Assessment Instrument (RAI) User's Manual from the Center for Medicare & Medicaid Services (CMS).
F 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that PRN (as needed) orders for [MEDICAL CONDITION] drugs were limited to 14 days for 1 (Resident #78) of 24 residents whose drug regimen was reviewed, in that: Resident #78 had a PRN order for [MEDICATION NAME] (an anti-anxiety medication) for more than 14 days. This deficient practice could place residents who receive PRN [MEDICAL CONDITION] medications at risk of receiving duplicate or unnecessary medications. Findings Include: Record review of Resident #78's face sheet, dated 09/10/20, revealed the resident was admitted to the facility 09/15/17 with [DIAGNOSES REDACTED]. Record review of Resident #78's consolidated physician orders [REDACTED].#78's September 2020 Medication Administration Record [REDACTED]. Record review of the Pharmacy Consultants report revealed the pharmacist was at the facility on 08/26/20 and reviewed Resident #78's medical record but did not address the resident's PRN [MEDICATION NAME]. In an interview on 09/10/20 at 4:46 p.m. the DON reviewed Resident #78's medical record and the Pharmacy Consultant report and confirmed there was not a stop date for Resident #78's PRN [MEDICATION NAME]. DON said there should have been a stop date for the PRN [MEDICATION NAME]. Record review of the facility's policy for Medication Management, revised 10/01/19, section E, regarding PRN orders, paragraph c. revealed, PRN orders for [MEDICAL CONDITION] medications are limited to 14 days and if the physician wanted to extend beyond the 14 days a rationale and duration for the medication should be indicated.
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to assure drugs and biologicals were labeled, and not expired, in 1 (West Nurse Medication Cart) of 7 Medication carts observed, in that: In the West Nurse Medication Cart, a bottle of [MEDICATION NAME] (anxiolytics/sedatives) had best by dates of 7/2020, and 8 tablets of [MEDICATION NAME][MEDICATION NAME] HCI ([MEDICATION NAME]) in individual blister packs had expiration date of 8/2020. This deficient practice could place residents who receive medications from the medication cart at risk for not receiving the intended therapeutic benefit of their medications. Findings include: Observation 09/10/20 at 3:28 p.m. of the West Nurse Medication cart revealed a bottle of [MEDICATION NAME] 1 mg with a Best By Date 7/20 and 8 tablets of [MEDICATION NAME][MEDICATION NAME] HCI 25 mg in individual blister packs with EXP (expiration) Date 08/20 on the back of the packs. In an interview on 9/10/2020 at 2:30 p.m. with the ADON, she confirmed the bottle of [MEDICATION NAME] 1 mg on the West Nurse Medication Cart was opened, had a Best By Date 7/20, and the 8 tablets of [MEDICATION NAME][MEDICATION NAME] HCI 25 mg in blister packs had an expiration date of 08/20. Record review of the Consultant Pharmacist Policy, titled Expiration Dating and Expired Medications, revised 10/1/2019, revealed Drugs, which have been dispensed for individual residents, are not to be used beyond the expiration date indicated by the manufacturer . The policy also indicated under Procedure. 7. If the expiration date is expressed in terms of month and year only, the medication will not be utilized after the last day of the month.
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,**

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) **distribute and serve food in accordance with professional standards.** Based on observation, interview and record review the facility failed to facility failed to serve and store food in accordance of professional standards for food service safety, in that: 1. CNA D touched the bread products with her bare hands for Residents #9, #40, #36 and one unknown resident. 2. The tortilla soup was stored in the refrigerator without a use by date. Findings include: Observation on 09/08/20 at 12:29 p.m. during meal service on the traditions unit, CNA D took Resident #9's dinner roll out of the resident's hand, placed the roll on the bed side table and cut the roll in half. Further observation revealed CNA D then picked up the roll with her bare hands, used a dinner knife to spread butter on the open roll, closed it and gave it back to Resident #9. Observation on 09/10/20 at 12:31 p.m. revealed CNA D was preparing Resident #40 lunch tray before serving it to the resident. Observation revealed CNA D retrieved the lunch tray from the cart, placed it on a nearby counter, and removed the covers over the plate and drinks. Further observation revealed CNA D picked up a slice of bread from Resident #40's tray with her bare hands, buttered the bread with a knife, folded the bread in half with her bare hands before placing the bread back on Resident #40's tray. CNA D was observed taking the tray to Resident #40. Observation on 09/10/20 at 12:35 p.m. revealed CNA D removed a lunch tray from the cart and placed it on the counter. Further observation revealed CNA D put hand sanitizer on her hands before removing the plate and drink covers. Further observation revealed CNA D picked up a slice of bread on the tray with her bare hands, placed it in her left hand while using her right hand to butter the bread. The CNA then folded the bread in half, laid it on the plate, and served it to Resident #36. Observation on 9/10/20 at 12:39 p.m. revealed CNA D removed another tray from the cart and placed it on the counter. Continued observation revealed CNA D rubbed hand sanitizer on her hands before removing the covers off the plate and drinks. Further observation revealed CNA D left the bread on the plate while she buttered the bread. CNA D then picked up the buttered bread with her bare hands and folded the bread in half before placing back on the tray. CNA D was observed serving the tray to an unknown resident. Observation on 9/10/20 at 12:50 p.m. revealed CNA D retrieved another tray from the cart, placed in on the counter, then rubbed hand sanitizer on her hands before removing the covers from the food and drinks. Further observation revealed CNA D picked up a slice of bread with her bare hands, placed the bread in her left hand while she used a knife in her right and spread the mechanical soft meat that was on the plate onto the bread. CNA D then folded the bread in half, placed the bread back on the tray and delivered the tray to Resident #9. Observation on 09/10/20 at 1:15 p.m. revealed Resident #9 had eaten over half of her bread on her plate and Resident #40 had eaten a third of the bread on her plate. In an interview on 09/10/20 at 1:33 PM CNA D revealed she sometimes leaves the bread on the tray when she buttered it but sometimes I pick the bread up with my hands and butter the bread. CNA D confirmed she was aware she should not have been touching the residents bread with her bare hands. 2. Observation on 09/08/20 at 10:24 a.m. during initial rounds in the facility kitchen revealed inside a large reach-in refrigerator was a plastic container filled with tortilla soup. Further observation revealed the soup had a cellophane cover that revealed the date 9/3/20, which was when the soup was prepared but did not have a use by date. In an interview on 09/08/20 at 10:24 a.m. the Food Service Supervisor (FSS) revealed she kept prepared food in the refrigerator for 3-5 days, depending on what it was, before discarding it. The FSS reported she should have discarded the tortilla soup already. Interview and record review on 09/11/20 at 4:53 p.m. the FSS revealed the Diet Manual she used was provided by their corporate company and revealed there was nothing noted regarding the number of days prepared food could be stored in the refrigerator. The FSS reported at that time the facility's former management company's Diet Manual read prepared food had to be discarded after 4 days. In an interview on 09/11/20 at 5:25 p.m. the FSS revealed she had spoken to their management company and they did not have a policy on the amount of time prepared food could be stored in the refrigerator. Further interview with the FSS revealed she did not refer to the Texas Food Establishment Rules (TFER) that was developed by the Department of State Health Services. Record review of the Texas Food Establishment Rules (TFER) 2015, page 71, section 228.75(f)(1)(a) revealed 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 held at a temperature of 41 degrees Fahrenheit or less 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 .(A) the day the original container is opened in the food establishment shall be counted as Day 1 .(I) A food specified in subsection (g) (1) or (2) of this section shall be discarded if it .(B) is in a container or package that does not bear a date or day, or (C) is appropriately marked with a date or day that exceeds a temperature and time combination as specified in subsection (g) (1) of this subsection.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and transmission of communicable diseases and infections for 1 of 1 laundry room and failed to store and process linens to prevent the spread of infection for 1 (Renew Unit) of 6 halls, in that: 1. The laundry room did not have a barrier between the soiled and clean linen. 2. The quarantine section (Renew Unit) had PPE polyester mesh totes hanging from resident doors in the quarantine hall and was not cleaned with proper cleaning chemicals for totes made of porous materials. This deficient practice could affect all residents and could result in transmission of communicable diseases and infections. Findings include: 1. Observation on 09/10/20 at 12:40 p.m., in the laundry room, revealed a soiled linen cart that was covered by a sheet. Inside the laundry area, near the two dryers (clean side) and a small wall dividing them. The dirty linen carts were placed adjacent to the two washers. Further observation revealed the two washer machines (soiled side), 2 dryers (clean side) did not have a barrier dividing each side and were approximately 3-4 feet adjacent to each other. In an interview on 09/10/20 at 12:41 p.m. the Laundry Supervisor confirmed there was not a division between soiled and clean. Laundry Supervisor stated they were grandfathered in and was not sure if they had a waiver. In an interview on 09/10/20 at 12:48 p.m. the Administrator stated that the laundry room was grandfathered in and there was no division between the soiled and clean linen. Record review of past compliance revealed no waivers in place for facility. 2. Observation on 9/11/2020 at 9 a.m. in the quarantined hall (Renew Unit) had 3 residents, that had PPE supplies, in a tote hanging (looked like a hanging shoe bag) on front doors outside the room and it was an interwoven hard porous material. In an interview on 9/11/20 at 9:15 a.m. LVN B revealed the hanging PPE totes were used every time there was a patient in the room, quarantine hall. LVN B stated when the residents were discharged or transferred to another hall, the PPE hanging mesh tote's were given to ADON C. The LVN B stated all residents admitted or readmitted were in the quarantine (10-14 days) hall. In an interview on 09/11/20 at 09:55 a.m. ADON C stated she cleaned the PPE hanging tote bags twice daily and used the Microkill Disinfectant, purple top wipes, to wipe the PPE hanging totes. ADON C stated that if the PPE hanging totes were visibly soiled then the PPE hanging totes would go in the wash. In an interview on 9/11/20 at 11:30 a.m. the Administrator provided information from the manufacturer that produced the PPE hanging tote's. The PPE hanging totes were made of Sunsure polyester mesh. The Administrator revealed the quarantined hall (Renew Unit) had no positive COVID-19 residents and the residents were recent admissions, re-admissions and [MEDICAL TREATMENT] residents. In an interview on 09/11/20 at 03:32 p.m. the Administrator stated the PPE hanging totes were a sunscreen mesh material, which was documented on the ordering site for the hanging mesh tote, and she further said the hanging tote was non-porous. Review of the Microkill Disinfectant One, Germicidal Alcohol Wipes stated disinfecting wipe for hard, nonporous surfaces, patient care equipment and point-of-care equipment. The Microkill wipes disinfecting instructions, To disinfect hard, non-porous surfaces. Review of the PPE tote manufacturer's instructions, undated, for use read use your in-house disinfectant to spray and wipe clean all pipe, fittings, and surfaces. Review of definition of polyester woven mesh was Polyester Woven Mesh from Industrial Netting for elevated temperatures-Monofilament synthetic fibers can be woven very precisely to create industrial textiles with narrow pore distribution. This precision weaving process creates fine mesh woven fabrics with apertures (hole sizes). This reference means the totes was made of porous materials and the Microkill Disinfectant is not the appropraite cleaner to use. (https://www.industrialnetting.com/woven-polyester.html).