STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455724	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterside Nursing & Rehabilitation	1213 Water St Kerrville, TX 78028

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46447 Based on observation, interview, and record review the facility failed to ensure that each resident received adequate supervision and assistance devices to prevent accidents for 1 (Resident #1) of 4 residents reviewed for accidents. NA I failed to ask for assistance on 04/28/2024 when leaving Resident #1 unattended, that resulted in a fall with injury. This failure could place residents at risk of accidents and potential harm. Findings include: Record review of Resident #1's Resident Face Sheet, dated 05/07/2024, revealed a [AGE] year-old female who was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Parkinson's disease with dyskinesia (a disorder of the nervous system that affects movement, including tremors), Dementia (a general term for impaired ability to remember, think, or make decisions), Ataxic gait (impaired balance or coordination when walking), and age-related physical debility (weakness). Resident #1 was noted as on Hospice. Record review of Resident #1's quarterly MDS, assessment dated [DATE], revealed her cognitive status was mildly impaired and she required supervision or touching assistance while eating, when going from sitting to standing, and while transferring from chair to chair. (continued on next page)

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

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #1's care plan revealed, on start date of 08/08/2024, Resident #1 was noted as requiring assist of 1 staff to transfer and was unable to obtain and maintain a sitting balance with an approach for frequent turning and repositioning. A problem with start date of 08/09/2023, Resident #1 was noted to be at risk for falls due to a diagnosis of Parkinson's disease and an approach was noted on the same date for increased staff supervision with intensity based on resident need. Another problem with start date 08/09/2023, edited 04/20/2024 was noted as Resident #1 with potential for complications related to diagnosis of Parkinson's disease, including poor balance, .poor coordination, tremors, .and gait disturbances. Approaches dated 08/09/2023 included assess/ record/ report to MD prn s/sx of Parkinson's complications: poor balance, .poor coordination, .tremors . and a second to encourage daily exercise, mobility as tolerated. A problem and approach with start date of 09/15/2023 indicated Resident #1 had a prior fall on 09/15/2023. The approach included staff were to provide assistance as needed for Resident #1 when transferring and staff were to document Resident #1's ADL performance and the assistance provided by staff per facility policy. On problem start date of 02/22/2024 and edited 04/20/2024, Resident #1 was noted to be at risk for pressure ulcer due to activity and being chairfast and an approach was noted on 02/22/2024 to consider posture alignment, weight distribution, balance stability, and pressure relief when positioning in chair or wheelchair. Record review of Resident #1's Fall Risk note, dated 01/02/2024 revealed her mental status was with intermittent confusion, poor recall, judgement, and safety awareness; had adequate vision, required assistive devices, had impaired mobility, received antihypertensive medication (medication to treat high blood pressure), had no falls in the past three months, and had a psychiatric or cognitive condition such as dementia. Her fall risk score was calculated at 11.0, indicating she was at risk. Record review of Resident #1's hospice visit note, dated 03/20/2024 and written by Hospice RN E, revealed She is found in dining room with her head on dining room table and is asleep Pt is unaware of her surroundings and dependent of all her care .she tires easily and prefers to sleep over anything else. Record review of Resident #1's hospice visit note, dated 03/27/2024 and written by Hospice RN E, revealed she is being assisted up and into her wc for her lunch meal upon arrival. She is unaware of her surroundings and usually only says she wants to lay down .She is max assist during transfers as she can no longer assist. She is dependent of all ADLs, incontinent of B/B without awareness and requires hands on assist during meals .She is assisted into the dining room in her wc, she cannot self propel. Record review of Resident #1's hospice comprehensive assessment and plan of care update report, dated 03/27/2024 and written by Hospice SW F, revealed Pt needs assistance with most ADLs. She is no longer able to make needs known or follow simple commands. Pt is bed bound. When staff do get her out of bed, she is max assist due to weakness a not being able to bear weight. Record review of Resident #1's nursing note, dated 04/18/2024 and written by LVN G, revealed Pt tends to lean to R side of w/c . Record review of Resident #1's nursing note, dated 04/19/2024 and written by LVN H, revealed Resident noted to lean heavily to right side while up in wheelchair. Has arm 'dangling' over the arm of the wheelchair. Has to be repositioned by staff often. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #1's nursing note, dated 04/28/2024 at 12:52 p.m. and written by LVN G, revealed Pt was at dining room table in her w/c when she leaned over forward and fell to the floor. Pt has large hematoma to L side of forehead and open wound on top of her head. Pt in and out of conscious. Applied pressure to stop bleeding, called 911 and sent pt to ER for eval. Attempted to notify family, [RP's] voicemail was full. Notified [Hospice D] Hospice, [ADON A]. Record review of Resident #1's nursing note, dated 04/28/2024 at 05:35 p.m. and written by LVN G, revealed Pt has laceration to top of L side scalp that has been glued. New order to monitor s/s of infection. Pt also has bruising to R knee and hand. Pt is alert and answers questions appropriately .Notified Hospice that pt has arrived and they will come and eval today. Record review of Resident #1's local hospital documentation, dated 04/28/2024, revealed CT scans of the brain and spine were performed and revealed a large left frontal scalp contusion/hematoma (bruise including from larger blood vessels) without a fracture on the scalp and no acute spine abnormality. Discharge instructions were noted for a closed head injury and for a laceration (cut in the skin) repair of the scalp. Record review of Resident #1's Neurological Record, dated 04/28/2024 to 04/30/2024, revealed neuros were started on 04/28/2024 at 05:00 p.m. and completed on 04/30/2024. During an observation and interview on 05/02/2024 at 02:23 p.m. revealed Resident #1 lying in bed with her eyes closed. Resident #1 with visible bruising to face from distance of doorway. Upon closer inspection, Resident #1 noted to have had bruising to face, eyes, and a large bump on her forehead. She was observed to have hair matted with appearance of dried blood in the front and dark purple spots visible through the hair. Attempted interview revealed she was capable of nodding head for yes and no but was unable to answer questions regarding what happened to her. Resident #1 indicated she had pain and then placed her hand on the large bump with bruise on her forehead. No bruising, scratches, or injuries were noted to the back of her head. A laceration with dried blood was observed from mid-scalp to front of where her forehead met her hair line. An additional laceration or possibly only dried blood noted to extend from the right side of the scalp to approximately one inch above her ear. No active bleeding noted. Bruising was noted on both of Resident #1's hands and forearms. No other skin injuries noted. During an observation on 05/07/2024 at 02:24 p.m. revealed Resident #1 lying in bed and provided care by nursing staff. Resident appeared dressed, groomed, and clean. Resident #1 observed to be repositioned in her bed following the provision of care. Resident #1 was not observed out of bed, including in Geri chair during observation period. During an interview on 05/02/2024 at 02:43 p.m. CNA B revealed Resident #1 could make her needs known and could answer questions. CNA B revealed Resident #1 had a fall and had been kept in bed to rest since the injury. CNA B revealed Resident #1 was normally up in her wheelchair but had lately been falling asleep really easily in her wheelchair. CNA B stated that she did not witness Resident #1's fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 05/02/2024 at 02:45 p.m. LVN G revealed Resident #1 tended to lean forward in her wheelchair and liked to lean her head on the table. LVN G stated that Resident #1 was not falling asleep, it was just something she liked to do. LVN G stated Resident #1 had dementia and responded when spoken to and was capable of making her needs known. She revealed Resident #1 was wheelchair bound and unable to self-propel, reliant on staff to push her. LVN G stated Resident #1 had a habit of pushing herself away from the table when she was finished. LVN G revealed Resident #1 had a fall the other day (date unknown) while she was on duty. LVN G stated that she was seated in the nurses' station when she heard a sudden commotion and staff yelling for assistance. LVN G revealed she immediately ran to the dining room (located in close proximity to the nurses' station) to see what happened. LVN G stated that a CNA was present in the room with multiple other staff. LVN G revealed that she did not see the fall but did hear the commotion and when she arrived in the dining room, Resident #1 was lying on the ground. LVN G stated that Resident #1 was rolled over and immediately started to bleed from her head. LVN G stated that she grabbed supplies, applied pressure to the wound to stop the bleeding, and completed an assessment while checking for additional injuries. LVN G revealed another staff member called 911 while she was assessing the resident. LVN G revealed Resident #1 was sent out to the hospital without delay but that she had noted Resident #1 to have a laceration to her scalp and a large bump on her forehead. LVN G stated the wheelchair should have been locked while the resident was eating but did not know if it was or not. LVN G revealed that Resident #1's laceration was closed with glue at the hospital and that she started neuro checks on Resident #1 the same night as her return from the hospital. LVN G revealed Resident #1 was unable to say what had happened and did not answer when asked. During an interview on 05/02/2024 at 03:12 p.m. the Resident #1's RP stated that there was no neglect in this situation. He stated that the family was upset because the facility would not provide them with information. He stated that Resident #1 was declining, and she falls asleep a lot. He stated that she fell asleep and rolled out of her chair. He did not respond when asked if he witnessed the fall but stated that this was what she did, she falls. During an interview on 05/07/2024 at 11:16 a.m. NA I revealed she had placed Resident #1, who was in her wheelchair, a small distance away from the dining room table on 04/28/2024 but had noted that Resident #1 was leaning forward. NA I stated that she had locked Resident #1's wheelchair but then stepped away with the plan to quickly see if Resident #1 had anything in her room to prop her up. She revealed that by the time she had returned, Resident #1 had fallen. NA I did not mention having requested another staff member to monitor Resident #1 upon leaving her in the wheelchair, but stated that a CNA was present in the dining room. NA I stated that from where she was when Resident #1 fell , she was able to hear a loud bang and the CNA call out to the nurse. NA I revealed Resident #1 fell around 2 minutes after she left her. NA I revealed that upon her return to the dining room, the nurses were checking Resident #1's vitals and putting pressure to the injury on her head. NA I revealed that it appeared that Resident #1 only hit her head on the floor and did not hit the table because there was only blood found on the floor. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 05/07/2024 at 12:07 p.m. LVN G revealed Resident #1 tended to lean herself over and did not have trunk control (the ability to control her upper body). LVN G stated that staff were always having to bring her back up. LVN G revealed that fall interventions for Resident #1 included Resident #1 to have some padding on the side of her when sitting in the wheelchair and was to be pushed up to the table. LVN G revealed her observations of Resident #1 when responding to her fall on 04/28/2024 was that Resident #1 was alert, opening her eyes, and had not passed out. LVN G stated she knew that the wheelchair had been locked but was unsure on Resident #1's position to the table, but that Resident #1 had to have been far enough away from the table to fall forward and hit her head on the floor under the table and not hit the table. LVN G revealed she was aware that one of the aides had gone to get Resident #1 something to stop her from falling but that Resident #1 fell immediately after. During an interview on 05/07/2024 at 01:31 p.m. the Hospice RN E revealed she was contacted on 04/28/2024 of Resident #1's fall and transfer to the emergency department for further evaluation on a laceration that was bleeding on the top of her head. Hospice RN E revealed that she requested the weekend hospice nurse be contacted for further updates, specifically if Resident #1 was to return to the facility because she would need to be assessed by the weekend hospice nurse upon return. The Hospice RN E revealed the weekend hospice nurse reassessed Resident #1 on 04/28/2024 upon her return from the hospital and a scheduled over the counter pain medication was ordered. She revealed that she was able to see Resident #1 on the next day and the hospice doctor ordered a controlled pain medication at that time for one week. During an interview on 05/07/2024 at 01:31 p.m. the Hospice SW F revealed she had gone to see Resident #1 monthly since her admission onto Hospice D but that when she would see her Resident #1 was either in bed or in the dining room with her head on the table. During an interview on 05/07/2024 at 05:53 p.m. the DON revealed she was not present in the facility at the time of Resident #1's fall but that her fall was due to Resident #1's lack of trunk control, which was progressive (developing gradually) and causing her to become weaker and weaker. The DON revealed that Resident #1's posturing (ability to hold a posture) continued to decline (worsening) and that she thought that Resident #1 did not like to be alone. The DON revealed that even when Resident #1 appeared exhausted or weak, she would be adamant about being up. She stated that prior to the fall, she felt Resident #1 was at risk for a fall but not to the point that the wheelchair was identified as having been inappropriate. The DON stated that prior to Resident #1's fall on 04/28/2024, Resident #1's focus had been on her having had a poor appetite and not on her posturing or concerns for fall risk. The DON stated that immediately after being notified of Resident #1's fall, she called the rehabilitation director and the Hospice RN E regarding Resident #1's positioning and they decided that a Geri chair was the safest option for Resident #1. The DON stated that she interviewed staff after the fall and CNA C had stated that she was in the dining room at the time of the fall, had just looked at Resident #1, turned around to pick up meal tickets at the table, and when she turned around again, she could see Resident #1 falling but was not able to get to her fast enough. The DON stated that it was not uncommon for residents to be seated at the tables by themselves as staff are getting trays and tickets prepped for meal service. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #1's Fall Risk note, dated 05/02/2024 at 03:22 p.m. was noted to be related to her fall on 04/28/2024. The note revealed her mental status was with alert and oriented or comatose or persistent vegetative state, had poor vision, had decreased muscular coordination, required assistive devices, had impaired mobility, received antidepressants, cardiovascular medication, and narcotics; had one or two falls in the past three months, and had a neuromuscular/functional condition such as decline in functional status, Parkinson's, and unsteady gait. Her fall risk score was calculated at 16.0, indicating she was at risk. Referral was noted as other- fall interventions in place, hospice updated and plan of care was noted as updated with note the resident was provided with a Geri-chair related to the progression of weakness and poor trunk control. Record review of Resident #1's nursing note, dated 05/02/2024 at 03:13 p.m. and written by LVN G, revealed Fall discussed with IDT team in morning meeting. Discussed benefits versus risks of resident being up in wheelchair due to her forward/ hunched posture and poor trunk control. Both therapy and nursing determined resident's current wheelchair, or even a high back wheelchair is not safe at this time. Resident's trunk and core control strength has continued to slowly decline which ultimately is the cause of the fall on 4/28/24. Team will continue to reach out to [family member] to discuss his input on her current plan of care and concerns regarding positioning and safety in her wheelchair. Neuro checks in place related to fall with head laceration. Will continue to refrain from getting resident up to wheelchair until continued discussion is had with resident's husband and hospice. Record review of Resident #1's hospice visit note report, visit date noted as 05/03/2024 and written by Hospice RN E, revealed All care is being provided to the pt in bed, she does have a Geri chair in the room when she is able and willing to try and get out of bed though currently recommended to rest so she is able to heal .Teaching done with [family member] regarding fall prevention and EOL care. Advised the pt is no longer able to hold her torso in upright position and has poor judgement. Record review of facility policy, Falls and Fall Risk, Managing, dated revised March 2018, revealed Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling .2. Resident conditions that may contribute to the risk of falls include: .c. delirium and other cognitive impairment; .i. functional impairments; .3. Medical factors that contribute to the risk of falls include: .e. balance and gait disorders; etc. Record review of in-service document on facility policy Falls and Fall Risk, Managing, provided to the investigator on 04/06/2024 and reported to have been completed on 04/28/2024 revealed signatures for 7 of 9 Nurse Aides, 10 of 10 Certified Nurse Aides, 2 of 3 Certified Medication Aides, 9 of 11 Licensed Vocational Nurses, 3 of 3 Registered Nurses, both the DON and the Director of Rehabilitation, and 22 of 31 non-clinical staff with those missing either in housekeeping or the dietary departments. NA I was noted as having completed the training. Resident #1's care plan revealed, on problem start date of 09/15/2023, revealed inclusion of notation 04/28/2024- Fall from wheelchair with a laceration to head with two approaches with start date of 05/02/2024, I will be evaluated for the most appropriate type of wheelchair related to poor trunk control and unsafe self-positioning while sitting up in a wheelchair. and I will utilize a Geri chair (rolling chair designed for someone with difficulty sitting upright) instead of a regular wheelchair for increased safety. I lack core strength, which puts me at a higher risk for falls in a wheelchair versus a Geri chair. Time of care plan entry unable to be determined due to lack of time stamp and care plan not accessed by investigators until 05/07/2024. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 05/07/2024 at 11:16 a.m. NA I revealed Resident #1's current fall preventions included a Geri chair and because it had been observed that she leans forward, staff were trying to not get her out of bed except upon her or her family member's request.