

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455724	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/07/2025
NAME OF PROVIDER OR SUPPLIER Waterside Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>(continued on next page)</p>

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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide pharmaceutical services (including procedures that assure for accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 7 residents (Resident #14) reviewed for medications and pharmacy services. The facility failed to ensure Resident #14 morning meds were disposed of appropriately when the resident refused the medications on 9/06/2025 by MA P. The facility failed to ensure Resident #1's hydrocodone was appropriately wasted and documented when it was removed from original container on 8/29/2025 by LVN A. These deficient practices could put residents at risk for medication errors. The findings included: Record review of Resident #14's face sheet, dated 9/06/2025 revealed an [AGE] year-old male admitted on [DATE] with diagnoses which included severe dementia, anxiety disorder, restlessness and agitation. Record review of Resident #14's modified quarterly MDS dated [DATE] revealed a BIMS score of 4 which indicated a severe cognitive impairment with no behavior symptoms. His ADL function was listed as set up assistance. Record review of Resident #14's care plan revealed was on hospice care with interventions which included administer medications and treatments as ordered. A plan of care for behavior problems with intervention which included administer medications as ordered and behavior monitoring. A plan of care for resistance to care such as care refusals related to dementia with interventions which included: if resident resists with ADL's, reassure resident, leave and return 5-10 minutes later and try again. Record review of Resident #14's September MAR revealed the following medications were marked as refused by MA P: Fluoxetine 20 mg-give 2 capsules by mouth one time a day for depressionLisinopril 2.5 mg-give one tablet by mouth in the morning for hypertension.Provera 2.5 mg-give one tablet by mouth one time a day for lower testosterone levels related to dementia. Depakote Sprinkles delayed release 125 mg-give 3 capsules by mouth two times a day related to dementiaLorazepam 0.5 mg-give one tablet by mouth three times a day for anxiety and agitations related to anxiety disorder. During an observation on 9/06/2025 at 4:05 pm of the medication cart on 100 hallway assigned to MA P revealed a medication cup with pudding and crushed meds mixed with the pudding in the second drawer of the medication cart. The medication cup had the Resident #14's first name handwritten on the cup. During an interview on 9/06/2025 at 4:11 p.m., MA P stated the medication in the pudding belonged to Resident #14 and it was his morning medications. She stated Resident #14 had allowed her to take his vital signs this morning but when she went to administer the medication he refused, pushed it away and tried to hit her. She stated she put it in the medication cart to give it later. MA P stated the medication included Depakote, fluoxetine, lisinopril, Provera and lorazepam 0.5mg (controlled substance). She stated she had signed the medication off in the medical record. MA P stated she had received the in-service training on medication administration. She stated she thought as long as the name was on the cup it was okay to keep it. MA P stated she told LVN C what she was doing and the LVN said it was fine. MA P stated she learned in training as long as the resident name was on the cup that it was fine to keep and hold on to. During an interview on 9/06/2025 at 4:22 p.m., LVN C stated MA P had informed her Resident #14 had refused medication. She stated she did not know MA P held the meds mixed in pudding in the cart. She stated she should have had MA P and herself wasted (disposed) the medications together because of the risk for medication error with pre-dispensed medications. 2. Record review of Resident #1's face sheet dated 9/03/2025 revealed a [AGE] year-old female admitted on [DATE] and readmitted on [DATE] with diagnoses which included: epilepsy, hypotension (low blood pressure), cardiomyopathy (disease of the heart muscle) and schizophrenia (serious mental health condition that affects how people think feel and behave). Record review of Resident #1's quarterly MDS dated [DATE] revealed a BIMS score of 3, which indicated a severe cognitive impairment with behaviors that included rejection of care less than daily. Resident #1's functional status was listed partial assistance showering/bathing and supervision for oral care and eating. Record review of Resident #1's care plan dated 7/15/2025 revealed she was on hospice care with interventions to observe for pain and administer pain medications as ordered by a physician. Record review of Resident #1's BIMS evaluation dated 9/02/2025 revealed a score of 15 which indicated the resident was cognitively intact. Record review of Resident #1's physician order summary for August 2025 revealed the following medication order: Hydrocodone-acetaminophen oral tablet 10/325 mg, give 0.5 tablet by mouth every 8 hours as needed for pain with a start date 8/29/2025. Record review of Resident #1's Narcotic Administration Record for hydrocodone-acetaminophen 10/325 mg revealed LVN A</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>(continued on next page)</p>

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure resident were free of significant medication errors for 1 of 7 (Resident #1) reviewed for pharmacy services. The facility failed to ensure Resident #1 was free of significant medication errors and received medication as prescribed by a physician on 8/29/2025. LVN A administered Resident #2's medications to Resident #1. This resulted in administration of two schedule IV-controlled substances: non prescribed medications: Temazepam 22.5 mg, Phenobarbital 129.6 mg, levothyroxine 75 mcg, Tamsulosin 0.4 mg, Levetiracetam 1250 mg, Oxcarbazepine 300 mg, Mirtazapine 7.5 mg, Risperdal 1 mg and prescribed Quetiapine (Seroquel) 800 mg which was a dose 32 times greater than prescribed for Resident #1. This medication error resulted in a change of condition, hospitalization and ICU stay for hypothermia, hypotension, and metabolic encephalopathy. The resident returned to the facility on 8/31/2025. This failure resulted in the identification of an Immediate Jeopardy (IJ) on 9/04/2025 at 6:00 p.m. The IJ template was provided to the facility on 9/04/2025 at 6:07 p.m. While the IJ was removed on 9/07/2025 the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with a potential for more than minimal harm that is not immediate jeopardy because the facility needed to monitor the implementation of the plan of removal. This failure could place residents at risk for medication errors and could result in side effects, a decline in health, hospitalization and/or death. The findings included: Record review of Resident #1's face sheet dated 9/03/2025 revealed a [AGE] year-old female admitted on [DATE] and readmitted on [DATE] with diagnoses which included: epilepsy, hypotension (low blood pressure), cardiomyopathy (disease of the heart muscle) and schizophrenia (serious mental health condition that affects how people think feel and behave). Record review of Resident #1's quarterly MDS dated [DATE] revealed a BIMS score of 3, which indicated a severe cognitive impairment with behaviors that included rejection of care less than daily. Resident #1's functional status was listed partial assistance showering/bathing and supervision for oral care and eating. Record review of Resident #1's BIMS evaluation dated 9/02/2025 revealed a score of 15 which indicated the resident was cognitively intact. Record review of Resident #1's progress notes dated 8/29/2025 at 7:50 p.m. as a late entry revealed the DON documented: Medication given to wrong Resident. She documented normal vital signs, alert and oriented with no change to mentation (Mental activity or the process of thinking). Hospice RN notified with new orders to hold all medications for the rest of the evening and for the next morning. Monitor for 72 hours for any complications or reactions. Record review of Resident #1's progress notes dated 8/29/2025 at 8:35 p.m. documented as a late entry revealed: Medication Error with blood pressure 70/40 (low), HR 72 (normal), oxygen saturation 98% on room air. A temperature was not documented. Level of consciousness: not arousable. Resident not responsive to voice or touch, called 911, hospice and DON. Record review of an incident report for Resident #1 dated 8/29/2025 written by the DON revealed: Resident was accidentally given the wrong medication during med-pass. Nurse (LVN A) mistakenly administered the wrong medication, I thought I handed her the right pill cup then I turned around and saw her medication on the med cart. Immediate action taken immediately assessed Resident #1 for complications and none noted, called DON and she stated to call hospice and RP. RN from hospice stated to monitor resident. Vital signs BP 110/72 (normal), HR 74 (normal) respirations 16 (normal) oxygen saturation 98% on room air (normal) with no injuries noted post incident. The documentation indicated Resident #1 was oriented to person, place, time and situation (normal cognition). Record review of Resident #1's Hospice notes dated 8/30/2025 revealed on Friday 8/29/2025 at 7:59 p.m. LVN A reported a medication error. Hospice physician notified.hold meds except carbidopa/levodopa and monitor Q1hr (every hour). Send to ED if vital signs change or sedation occurs. 9:03 p.m. LVN A reported EMS activated, secondary to hypotension. (low blood pressure). Record review of Resident #1's physician order summary for August 2025 revealed the following medication orders:Carbidopa-Levodopa 25/100 mg give 3 tablets four times a day related to neuroleptic induced parkinsonism with a start date of 6/17/2025.Divalproex (Depakote) sodium oral tablet delayed relates 500 mg, give 2 tablets by mouth two times a day for seizures with a start date of 8/15/2025Entacapone oral tablet 200 mg, give one tablet by mouth four times a day for Parkinson's disease with a start date of 5/08/2025. Lacosamide oral tablet 50 mg, give tablet by mouth two times a day with a start date of 6/17/2025.Quetiapine fumarate oral tablet 25 mg, give 1 tablet by mouth at bedtime for depression.Hydrocodone-acetaminophen oral tablet 10/325 mg, give 0.5 tablet by mouth every 8 hours as needed for pain with a start date 8/29/2025</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain medical records that were complete and accurately documented in accordance with accepted professional standards and practices for 1 (Resident #1) of 7 residents reviewed for medical records 1. The facility failed to ensure LVN A documented Resident #1s medication error, medications given, assessment, vitals, change of condition, contact with MD and RP, follow up orders, or transfer to the hospital by EMS on 8/29/2025. 2. The facility failed to upload Resident #1's hospital records from the 8/29/2025 hospital stay into the permanent medical record. 3. The facility failed to ensure LVN A documentation of medication administration accurately reflected any medications given on 8/29/2025. These failures placed residents at risk for delayed or inaccurate medical information which could result in a lack of continuity of care. The findings included:Record review of Resident #1's face sheet dated 9/03/2025 revealed a [AGE] year-old female admitted on [DATE] and readmitted on [DATE] with diagnoses which included: epilepsy, hypotension (low blood pressure), cardiomyopathy (disease of the heart muscle) and schizophrenia (serious mental health condition that affects how people think feel and behave). Record review of a handwritten statement (not part of the medical record) dated 8/29/2025, signed by LVN A revealed:7:25 p.m.-realized meds given to (Resident #1) were meds for (Resident #2).7:30 p.m.-called DON. Was instructed to call the resident's physician and RP.7:40 p.m.-hospice was called, talked to RN. Was instructed to monitor resident and wait for RN to call back with orders.7:50 p.m. RN from hospice called back with orders from hospice physician. Orders were to hold all medications, monitor for 72 hours, hold morning medications. If any adverse reactions occur call 911.8:00 p.m.-Checked on Resident #1. Resident woke up easily, talked to this nurse, went back to sleep. Vitals taken BP 110/72 (normal), HR 74 (normal), oxygen saturation 98% on room air (normal).8:35 p.m.- Checked on resident again. Resident was difficult to wake. Not responsive to voice or touch. Manual BP 70/40 (low), HR 72 (normal) oxygen 97% on room air (normal). 8:50 p.m.- Called 911, notified DON, notified RN hospice9:00 p.m.-Paramedics arrived at 9:00 p.m., left at 9:10 p.m. Record review of Resident #1's permanent medical record revealed no entries were made by LVN A for events on 8/29/2025 about the resident's medication error, which medications she gave to Resident #1, her assessment, follow up assessments, vitals, change of condition, contact with hospice MD and RP or follow up orders, or transfer to the hospital by EMS as viewed on 9/03/2025. A late entry was made by the DON on 9/03/2025. Record review of Resident #1's progress notes revealed on 8/31/2025 Resident #1 returned to the facility from a local hospital. Record review of Resident #1's medical record revealed the hospital records for 8/29/2025 had not been uploaded into the electronic record when viewed on 9/03/2025 and again on 9/04/2025. During an interview on 9/04/2025 at 11:11 a.m., LVN B reviewed Resident #1's medical record and stated she did not see the events of 8/29/2025 documented by LVN A. She stated there was an entry of events made on 9/03/2025 by the DON (surveyor arrived at facility on 9/03/2025). She stated she was unable to locate the hospital records for Resident #1 in the medical record. LVN B stated she had reviewed paper copies of the hospital records. She stated they were most likely in the DON's office. She stated the facility did not have a medical records person. She stated their process was to give any documents for upload to a member of management. She stated she wasn't sure who was responsible. LVN B stated they didn't have a basket or folder to put the medical records in at the nurse's station. LVN B stated they were trained to document events when they happen. She stated having accurate medical records was important for continuity of care, so they know what was going on with the patient (resident) at the time. During an interview on 9/04/2025 at 11:27 a.m., ADON N stated she was not certain where Resident #1's hospital records were located and would have to look for them. During an interview on 9/04/2025 at 1:30 p.m., LVN A stated she did not document on Resident #1's medical record the medication error, assessment, vitals signs, notifications of hospice or RP, or transfer to the hospital because she was not sure what to write in the medical record. She stated she thought she was not supposed to document the error. She stated she wrote out a statement with the same information. She acknowledged by stating that her statement was not part of the medical record. She stated on 9/03/2025 (after surveyor arrival) she sat with the DON and reviewed what should be documented. She stated the DON helped write in the medical record. LVN A stated she was trained to document in the patient's (Resident's) medical record. She stated a change of condition should be document so they know what happened, so they keep good records, to document changes and so they could track improvement or decline. During an interview on 9/04/2025 at 1:39 p.m. the DON stated she</p>		