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	07/31/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. (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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(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 - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public for 1 (Resident #69) out of 8 residents reviewed for environmental concerns. Resident #69's window blind was broken, and it could not cover the window fully. This failure could place residents at risk of a diminished quality of life due to exposure to an environment that is unpleasant, unsanitary, and unsafe. The findings were: Record review of Resident #69's admission record, dated 07/31/2025, revealed the resident was a [AGE] year-old, initially admitted [DATE] and re-admitted to the facility on [DATE] with diagnoses to include insomnia (a common sleep disorder that can make it hard to fall asleep or stay asleep), major depressive disorder, and generalized anxiety disorder. Record review of Resident #69's quarterly MDS assessment, dated 07/17/2025, revealed the resident's BIMS score was 09 out of 15, indicating moderate cognitive impairment. Record review of Resident #69's comprehensive care plan, undated, reflected focus [Resident #69] has little or no activity involvement r/t disinterest, resident wishes not to participate, initiated 10/17/2024, with intervention [Resident #69] preferred activities are: spending time in room and reading bible. Interview and observation on 07/23/2025 at 08:43 AM, Resident #69 was on her bed with a window at bedside, and the window had a blind, but the blind was broken so that it could not cover the window. She revealed she had asked staff (unable to name them) for forever to fix them and it was at least more than a week. She revealed at night it bothered her that her blinds were broken because the lights from the parking lot would shine inside her room, disrupting her sleep. Interview and observation on 07/24/25 at 08:12 AM, Resident #69 revealed her blinds were still broken. Interview on 07/24/25 at 10:06 AM, LVN AD and NA G revealed some of their residents in 300-hallway (to include Resident #69) did have blinds that were broken, and they had let maintenance know. LVN AD revealed Resident #69 was always in her room and could see how broken blinds would bother her. They both revealed they had not heard any complaints from residents about their blinds being broken. Interview on 07/24/25 at 08:15 AM, HSK AF and HSK AG revealed they reported any issues that they saw in residents' rooms to include broken blinds. They revealed they reported this to the HSK supervisor. They had not heard of any residents complaining about their blinds. Interview on 07/25/25 at 10:34 AM, HSK Supervisor revealed she oversaw ordering blinds for residents, and it felt like she was ordering blinds every 2 weeks because they were broken so frequently. She revealed blinds had always been an issue at this facility. She revealed they were working on getting better blinds for about a week, because the blinds broke easily. HSK supervisor revealed having functioning window blinds would be important to residents for the privacy of residents and providing a homelike environment for the residents. Interview on 07/25/25 at 10:50 AM, the Maintenance Director (worked at this facility for about 2 months) revealed there had been problems with the blinds needing to be replaced since he had been working at this facility, sometimes frequently, so he had been searching for more sturdy blinds that won't be broken as easily. Observation on 07/31/25 at 12:51 PM reflected Resident #69's blinds were still broken. Record review of facility's policy Safe and Homelike Environment, dated 06/15/25, reflected 3. Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment.

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident's right to be free from abuse, neglect, misappropriation of resident property and exploitation for 7 of 7 residents (Residents #65, #19, #20, #44, #54, #23, and Unknown) reviewed for abuse. The facility failed to ensure Resident #65 was not injured after entering Resident #19's room on 6/23/2025, when Resident #19 had known aggressive behaviors related to other residents entering his room. The facility failed to ensure Resident #20 was protected from abuse after entering Resident #19's room on 7/5/2025. The facility failed to ensure Resident #44 was not injured after entering Resident #19's room on 7/5/2025. An IJ was identified on 7/24/2025 related to Resident #19 (items 1-3). The IJ template was provided to the facility on 7/24/2025 at 4:24 PM. While the IJ was removed on 7/26/2025 at 10:20 PM, the facility remained out of compliance at a scope of pattern and a severity level of potential for more than minimal harm without immediacy because the facility needed to evaluate the effectiveness of corrective actions. The facility failed to protect Resident #54 from physical abuse by Resident #23 on 6/18/2025. The facility failed to protect an unknown resident from verbal abuse by Resident #23. These failures lead to physical injury, psychosocial harm, continued abuse, and decreased quality of life. Findings included: 1. Record review of Resident #19's face sheet, dated 7/22/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included anxiety disorder, vascular dementia (a progressive disorder that impairs a person's reasoning, memory, and other thinking abilities), and post-traumatic stress disorder (a mental disorder resulting from experienced trauma that causes flashbacks, severe anxiety, and/or uncontrollable thoughts). Record review of Resident #19's quarterly MDS submitted 4/19/2025 reflected a BIMS score of 03, indicating severe cognitive impairment. Section E (behavior) of the MDS revealed Resident #19 exhibited no behavioral symptoms, including physical behaviors directed towards others. Record review of Resident #19's comprehensive care plan, date printed 7/22/2025, revealed the following:Focus: [Resident #19] is/has potential to be physically aggressive r/t anger, dementia, poor impulse control. 2/10/25- ambulating in hallway with peer, peer punched resident in right shoulder. immediately separated. unable to verbalize details of event. stated no no no one hit me. I'm the one who is mad. Resident involved in an altercation with another resident. [sic] date initiated 11/14/2024, revision on 3/09/2025 Interventions: Administer medications as ordered . assess and anticipate resident's needs . provide physical and verbal cues to alleviate anxiety . [Resident #19] and peer immediately separated . psych doctor to review meds . psychiatric/psychogeriatric consult as indicated . report to provider any changes in behavior related to altercation . when [Resident #19] becomes agitated or is the receiver of peer aggressions: intervene before agitation escalates . The comprehensive care plan did not contain interventions related to maintaining the personal space of Resident #19 or known triggers of aggression. Record review of Resident #65's face sheet, dated 7/25/2025 reflected resident was a male age [AGE] admitted on [DATE] and discharged (aggression with another resident-sent to Psychiatric Hospital Unit) 4/18/2025 and re-admitted on [DATE] with diagnoses that included: Alzheimer's (a progressive neurological disease that primarily affects memory, thinking , and behavior), dementia, (loss of cognitive functioning-thinking, remembering and reasoning) HTN (hypertension), and pseudobulbar affect (changes in mood). The face sheet also indicated Resident #65 was discharged from the facility on 7/11/2025 at 15:37 to other. Record review of Resident #65's Quarterly MDS, dated [DATE] reflected the resident's BIMS score was 3, indicative of severe impairment in cognition. The resident was ambulatory with no range of motion impairment. Record review of Resident #65's Care Plan, undated, revealed, the goals and interventions included: Goal: behavior management: interventions-minimize triggers, anticipate needs, de-escalate, and medication management. Also, seek alternate placement (6/24/25). As needed [6/23/25], 1:1 monitoring during episodes of increased behaviors and aggression. Record review of Resident #65's MAR, dated June 2025 reflected, psychotropic given medications given as ordered. Record review of Resident #65's Nurse Note dated 6/24/25 at 3:32 AM, authored by LVN J read, Resident entered other resident ['] s room [R#19] when we [LVN J and CNA K] heard noise of a loud bang. Upon entering he [R#65] was still holding on to other residents' shirt [R#19] and they went to the ground landing on [there] bottom. I told them to stop and let go. They did and got up without incident. [R#65] noted to have open laceration] . to top of head. We walked him into his room. I cleaned and dressed it. Decision was made to send him to local E.D. He came back with 12 staples which will need to be removed in 5 to 7 days. Report given to me was his CT scan of head was

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure each resident's drug regimen must be free from unnecessary drugs without adequate indications for its use for 1 of 3 Resident (Resident #46) whose records were reviewed for unnecessary medications. Resident #46 had an order for a psychotropic medication (Buspirone HCl) without adequate indications for its use. This failure could place residents at risk for adverse drug consequences and receiving unnecessary medications. The findings included: Record review of Resident #46's admission Record, dated 07/25/2025, reflected a [AGE] year-old resident initially admitted on [DATE] with diagnoses which included alcoholic cirrhosis of liver with ascites (advanced scarring of the liver caused by excessive alcohol use) and hepatitis C (an infection caused by a virus that attacks the liver and leads to inflammation). Record review of Resident #46's Quarterly MDS, dated [DATE], reflected Resident #46 had a BIMS score of 7, indicating severe cognitive impairment. Further review of Section I - Active Diagnoses did not reflect a diagnosis of any psychiatric mood disorder. Record review of Resident #46's Comprehensive Person-Centered Care Plan, undated, reflected, [Resident #46] uses anti-anxiety medications Ativan, Buspar r/t anxiety disorder with a date initiated of 07/15/2025. Further review reflected, [Resident #46] uses antidepressant medication Citalopram r/t Depression with a date initiated of 07/15/2025. Record review of Resident #46's Order Summary Report, dated 07/25/2025, reflected the order, LORazepam Oral Tablet 1 MG (LORazepam) Give 1 tablet by mouth every 6 hours as needed for anxiety,; busPIRone HCl Oral Tablet 10 MG (Buspirone HCl Give 2 tablet by mouth three times a day for Mood; and Citalopram Hydrobromide Oral Tablet 10 MG (Citalopram Hydrobromide) Give 1 tablet by mouth one time a day for depression. Record review of Resident #46's Order Audit Report, dated 07/25/2025, reflected an order for, busPIRone HCl Oral Tablet 10 MG (Buspirone HCl) Give 2 tablet by mouth three times a day for Mood with an order date of 06/19/2025. Interview on 07/25/2025 at 3:39 PM, the DON stated that an order for buspirone is typically for anxiety. The DON stated that an order for a psychotropic medication should have a diagnosis attached to it. Record review of facility policy titled, Use of Psychotropic Medication(s) dated 05/07/2025, reflected, Psychotropic medications are to be used only when a practitioner determines that the medication(s) is appropriate to treat a resident's specific, diagnosed, and documented condition and the medication(s) is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication.

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement written policies and procedures that: S483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property for 5 of 16 residents (Residents #5, #19, #23, #44, and #65) reviewed for abuse and neglect. 1.The facility did not make a report to local law enforcement or State Survey Agency (HHS) of an allegation on [DATE] when Resident #65 suffered a scalp laceration requiring 12 staples from a resident-to-resident altercation with Resident #19 on [DATE].2. The facility failed to report an unwitnessed fall resulting in a femur fracture for Resident #5 on [DATE].3. The facility failed to report an incident of witnessed abuse from Resident #23 on [DATE].4. The facility failed to report an incident in which Resident #44 sustained an injury of unknown source on [DATE]. These failures could place residents at risk for abuse/neglect and could lead to a diminished quality of life and psychosocial harm. The findings included: 1. Record review of R#19's face sheet, dated [DATE], reflected resident was a male age [AGE] admitted on [DATE] with diagnoses that included: dementia, HTN (hypertension), anxiety and DM (diabetes). The RP was listed as: family member. Record review of Resident #19's Quarterly MDS, dated [DATE] reflected: the resident's BIMS score was 3, indicative of severe impairment in cognition. The resident was ambulatory and had no range of motion impairment. Record review of Resident #19's Care Plan, undated, reflected, the goals and interventions included the following:Goal: behavior management. Interventions included: monitoring for safety of resident and others, medication review, monitoring behaviors, and for staff to report any change in behaviors. Record review of Resident #19's Physician' Orders, dated [DATE] reflected the following psychotropics: hydroxyzine (for anxiety and agitation), 50 mg tab, given twice per day. Depakote (for mood) 125 mg, 3 tablets daily. And, Zoloft (for anxiety), 25 mg, 1 tablet once per day. Record review of Resident #19's MAR, dated [DATE], reflected, the psychotropic medications were given as ordered. Record review of Resident #19's incident report dated [DATE] at 9:36 PM authored by LVN A reflected: resident was involved in an altercation with R#65 in R#19's room in the secured unit. During the altercation both residents were on the ground involved in a struggle. LVN A assessed and examined R#19 and no injuries were noted to R#19. LVN A observed that the window in R#19's room was broken. Record review of Resident #19's risk management note dated [DATE] authored by LVN A reflected vitals were normal (BP was 121/66 (normal), pulse was 89 (normal), respiration was 19 (normal), temp was 98.2 (normal), and O2 was 96% (normal). No first aide was given to R#19. Record review of Resident #65's face sheet, dated [DATE] reflected resident was a male age [AGE] admitted on [DATE] and discharged (aggression with another resident-sent to Psychiatric Hospital Unit) [DATE] and re-admitted on [DATE] with diagnoses that included: Alzheimer's (a progressive neurological disease that primarily affects memory, thinking , and behavior) , dementia, (loss of cognitive functioning-thinking, remembering and reasoning) HTN (hypertension), and pseudobulbar affect (changes in mood). The RP (responsible party) was listed as: family member. Record review of Resident #65's Quarterly MDS, dated [DATE] reflected the resident's BIMS score was 3, indicative of severe impairment in cognition. The resident was ambulatory with no range of motion impairment. Record review of Resident #65's Care Plan, undated, revealed, the goals and interventions included:Goal: behavior management: interventions-minimize triggers, anticipate needs, de-escalate, and medication management. Also, seek alternate placement ([DATE]). As needed [[DATE]], 1:1 monitoring during episodes of increased behaviors and aggression. Record review Resident #65's Care Plan prior to incident on [DATE] reflected the following interventions for aggressive behaviors: monitor, re-direct, and provide visual reminders of the resident's room. Record review of Resident #65's Physician' Orders, dated [DATE], reflected the only psychotropic was risperidone, 1.5 mg, at morning and bedtime to control behaviors. Also, the physician's order on behaviors reflected the interventions of monitoring for restless, hitting, kicking, biting, elopement seeking, delusions, hallucinations, and psychosis. [Note: no order for close monitoring or 1:1 supervision until the incident on [DATE]] Record review of Resident #65's MAR, dated [DATE] reflected, psychotropic given medications given as ordered. Record review of Resident #65's Nurse Note dated [DATE] at 3:32 AM, authored by LVN J read, Resident entered other resident [’] s room [R#19] when we [LVN J and CNA K] heard noise of a loud bang. Upon entering he [R#65] was still holding on to other residents' shirt [R#19] and they went to the ground landing on [there] bottom. I told them to stop and let go. They did and got up without incident. [R#65] noted to have open laceration] , to top of head. We walked him into his room. I cleaned and

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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 observation, interview, and record review, the facility failed to ensure all allegations involving abuse, neglect, and misappropriation were reported immediately, but no later than 2 hours after the allegation was made to the State Survey Agency and law enforcement entities for 5 of 16 residents (Residents #5, #19, #23, #44, and #65) reviewed for abuse and neglect. The facility did not make a report to local law enforcement or State Survey Agency (HHS) of an allegation on [DATE] when Resident #65 suffered a scalp laceration requiring 12 staples from a resident-to-resident altercation with Resident #19 on [DATE].The facility failed to report an unwitnessed fall resulting in a femur fracture for Resident #5 on [DATE].The facility failed to report an incident of witnessed abuse from Resident #23 on [DATE].The facility failed to report an incident in which Resident #44 sustained an injury of unknown source on [DATE]. These failures could place residents at risk for abuse/neglect and could lead to a diminished quality of life and psychosocial harm. The findings included: 1. Record review of R#19's face sheet, dated [DATE], reflected resident was a male age [AGE] admitted on [DATE] with diagnoses that included: dementia, HTN (hypertension), anxiety and DM (diabetes). The RP was listed as: family member. Record review of Resident #19's Quarterly MDS, dated [DATE] reflected: the resident's BIMS score was 3, indicative of severe impairment in cognition. The resident was ambulatory and had no range of motion impairment. Record review of Resident #19's Care Plan, undated, reflected, the goals and interventions included the following:Goal: behavior management. Interventions included: monitoring for safety of resident and others, medication review, monitoring behaviors, and for staff to report any change in behaviors. Record review of Resident #19's Physician' Orders, dated [DATE] reflected the following psychotropics: hydroxyzine (for anxiety and agitation), 50 mg tab, given twice per day. Depakote (for mood) 125 mg, 3 tablets daily. And, Zoloft (for anxiety), 25 mg, 1 tablet once per day. Record review of Resident #19's MAR, dated [DATE], reflected, the psychotropic medications were given as ordered. Record review of Resident #19's incident report dated [DATE] at 9:36 PM authored by LVN A reflected: resident was involved in an altercation with R#65 in R#19's room in the secured unit. During the altercation both residents were on the ground involved in a struggle. LVN A assessed and examined R#19 and no injuries were noted to R#19. LVN A observed that the window in R#19's room was broken. Record review of Resident #19's risk management note dated [DATE] authored by LVN A reflected vitals were normal (BP was 121/66 (normal), pulse was 89 (normal), respiration was 19 (normal), temp was 98.2 (normal), and O2 was 96% (normal). No first aide was given to R#19. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #65's face sheet, dated [DATE] reflected resident was a male age [AGE] admitted on [DATE] and discharged (aggression with another resident-sent to Psychiatric Hospital Unit) [DATE] and re-admitted on [DATE] with diagnoses that included: Alzheimer's (a progressive neurological disease that primarily affects memory, thinking , and behavior) , dementia, (loss of cognitive functioning-thinking, remembering and reasoning) HTN (hypertension), and pseudobulbar affect (changes in mood). The RP (responsible party) was listed as: family member. Record review of Resident #65's Quarterly MDS, dated [DATE] reflected the resident's BIMS score was 3, indicative of severe impairment in cognition. The resident was ambulatory with no range of motion impairment. Record review of Resident #65's Care Plan, undated, revealed, the goals and interventions included:Goal: behavior management: interventions-minimize triggers, anticipate needs, de-escalate, and medication management. Also, seek alternate placement ([DATE]). As needed [[DATE]], 1:1 monitoring during episodes of increased behaviors and aggression. Record review Resident #65's Care Plan prior to incident on [DATE] reflected the following interventions for aggressive behaviors: monitor, re-direct, and provide visual reminders of the resident's room. Record review of Resident #65's Physician' Orders, dated [DATE], reflected the only psychotropic was risperidone, 1.5 mg, at morning and bedtime to control behaviors. Also, the physician's order on behaviors reflected the interventions of monitoring for restless, hitting, kicking, biting, elopement seeking, delusions, hallucinations, and psychosis. [Note: no order for close monitoring or 1:1 supervision until the incident on [DATE]] Record review of Resident #65's MAR, dated [DATE] reflected, psychotropic given medications given as ordered. Record review of Resident #65's Nurse Note dated [DATE] at 3:32 AM, authored by LVN J read, Resident entered other resident ['] s room [R#19] when we [LVN J and CNA K] heard noise of a loud bang. Upon entering he [R#65] was still holding on to other residents' shirt [R#19] and they went to the ground landing on [there] bottom. I told them to stop and let go. They did and got up without incident. [R#65] noted to have open laceration] . to top of head. We walked him into his room. I cleaned and dressed it. Decision was made to send him to local E.D. He came back with 12 staples which will need to be removed in 5 to 7 days. Report given to me was his CT scan of head was negative. Record review of Resident #65's risk management reported dated [DATE] at 10:36 PM authored by LVN J reflected: vitals were normal: BP was 134/59, pulse was 90, respiration was 22, temperature was 98, and O2 was 97 %. LVN J provided first aide to Resident #65. LVN J assessed for injury; cleaned and dressed the wound. Record review of Resident #65's elopement evaluation dated [DATE] reflected: resident had wandering behaviors that were likely to affect the safety or well-being of self/others. Record review of Resident #65's Care Plan dated [DATE] for the focus of wandering behavior listed the interventions as: monitoring, provide one to one care if the resident was agitated or triggered. Also, other interventions included: redirection, and visual reminders outside the resident's room to assist with correct room location. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident#65's ER record, dated [DATE] at 11:14 PM reflected: R#65 presented at ER with laceration to the left frontal scalp from an altercation with another resident (R#19). CT scan performed was negative. Treatment given to R#2 was 12 staples to the head laceration and discharged back to the facility. Discharge diagnosis was Laceration of scalp. Record review of R#19's and R#65's law enforcement report dated [DATE] reflected: Given both residents had dementia, law enforcement made no arrests or charged a resident with a crime. Criminal investigation reflected R#2 fell and hit his head on the window resulting in a scalp laceration. Law Enforcement Officer stated in the report, . [had] concerns regarding .[facility] Waiting over nine hours before reporting a violent altercation at their facility to law enforcement . Based on interview on [DATE] at 2:30 PM with the ADON Q and record review of facility's incident report dated [DATE], there was the following timeline authored by LVN J (charge nurse): [DATE] at 9:36 PM was the date and time of the incident. CNA K while monitoring another resident in the common area in the secured unit heard a noise coming from room [room number]. [4 staff were on the night shift in the secured unit for a census of 23;1 LVN, 2 CNAs on men's section and 2 CNAs at women's section], When the LVN J and CNA K entered R#19's room R#19 and R#65 were holding each other's shirt while standing. LVN J completed assessments on both residents with R#65 being sent to ER for evaluation for head laceration. LVN J provided first aide to R#65 and stopped the bleeding to the scalp. LVN J discovered that R#19's room had a broken window. Interview of R#19 by LVN reflected that R#19 alleged that R#65 came into the room and He threw a cup and started beating me up. [DATE] between 9:36 PM and 10:00 PM, LVN J notified family, and left a message at the physician call center. [DATE] at 10:01 PM-facility [ADON Q] became aware of the incident from phone call from LVN J and had advised her to send the resident to ER immediately. LVN J was unsuccessful in a getting physician's orders from 9:36 PM to 10:01 PM. [DATE] between 9:36 PM and 10:00 PM, LVN J notified family, physician call center and message left. [DATE] around 10:30 PM-10:45 PM EMS arrived to take R#65 to the ER. [DATE] around 1:45 AM, R#65 returned from ER with 12 staples on scalp and placed on 1:1 monitoring. [DATE]: starting around 8:00 AM in-service training on ANE, de-escalation and calming techniques for residents with dementia. [total number of staff based on staff list dated [DATE] reflected 103 employees] [DATE] around 8:30 AM, law enforcement was notified of the incident. [LVN J stated she did not call law enforcement] [DATE] around 9:30 AM: self-report to HHS. Record review of R#65's 30-day notice dated [DATE] reflected an involuntary discharge for the reason listed as safety of other residents. Notice was issued to the RP. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on [DATE] at 11:17 AM, R#65 was ambulatory and walking in the secure unit halls; there were 12 staples present on left side of scalp; with old blood present, dark red to black in color. R#65 was alert and oriented to self. The Resident stated, I hit my head .someone push me or hit my head . someone pushed me down .do not remember when it happened .I feel safe here Yes, they watch me . The resident stated that he had pain to is head. [The resident could not describe the level of the head pain.] The resident stated he had no complaints about the secure unit or his safety. Observation revealed 1:1 monitoring by CNA AR. Observation and interview on [DATE] at 11:30, R#19 was in his room, lying in bed, alert and oriented person and place. The resident had no injuries, skin tears or bruises present. Call light was in reach; room was cleaned; there were no fall hazards; and the room was homelike. Observation further revealed the window blind was not present; and there was a new top portion of windowpane. The Resident stated, he felt safe. The resident stated that staff checked on him to keep him safe. At first, the resident denied that he had an altercation with another resident and could not explain why law enforcement made a visit to him yesterday ([DATE]). The resident recalled that he and another resident named [R#65] had an argument and struggled on the floor; and resident [R#65] fell on the window and hit his scalp; blood was present. The resident stated he could not remember the actions taken by the staff. The resident stated the window broke and was replaced. The resident stated that the resident [R#65] just walked into my room and started fighting with me . I tried to grab him .no time to ask for help .during the fight . he hit the window. The resident stated that it was the first time he had an altercation with R#65. R#19 denied he had any past altercations with Resident #65. The resident repeated that he felt safe and denied any ANE. During interview on [DATE] at 11:39 AM, the Maintenance Supervisor stated, the window in room R#19's was shattered and an indention in the bottom of the window was present; and the window blind was broken. The Maintenance Director stated he replaced the window yesterday ([DATE]) and would replace the blind today ([DATE]). The Maintenance Director stated he needed to replace the window blind in R#1's s room because there was an altercation between two residents. During interview on [DATE] at 11:57 AM, CNA AR stated R#2 was placed on 1:1 when he returned from the hospital on [DATE] in the morning. CNA AR stated the residents were kept safe by checking every hour. CNA AR stated the resident was on 1:1 for safety for his safety and the safety of other residents [1:1 was in place prior to the surveyor's arrival of [DATE]]. CNA AR stated that he attended ANE, and highlight was to report immediately to the abuse coordinator any abuse. During interview on [DATE] at 12:12 PM, LVN A stated she was not a witness to the incident on [DATE]. LVN A stated R#65 liked to pace the hallways in the secure unit; and it was the first time an altercation occurred in the past month (she had been on duty only one month). LVN A stated that residents were kept safe by monitoring and routine checks. LVN A stated she attended the ANE training in the past and the message was to report immediately. LVN A stated once the situation was safe, the facility needed to call the MD and the RP. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on [DATE] at 12:24 PM, CNA U stated residents were kept safe by having call lights in reach, meet the resident's needs, and observe residents walking the hallways. CNA U stated that if a resident was injured in an altercation resulting in a head or scalp injury with blood, the facility needed to call 911 immediately because a head injury could be serious and result in trauma. During an interview on [DATE] at 3:10 PM, the ADON Q stated the resident-to-resident altercation resulting in R#65 sustaining a scalp laceration requiring 12 staples should have been reported to law enforcement as soon as possible. ADON Q stated that law enforcement was called the next morning, and she could not explain the delay call to law enforcement. Further, the ADON stated when there was an injury in an alleged abuse case HHS should have been notified within 2 hours. ADON Q could not give an explanation why HHS was not notified within 2 hours of the incident. During an interview on [DATE] at 3:22 PM, the DON stated that law enforcement should be called within a timely manner. The DON stated the facility wanted to wait on the results of the ER visit before notifying law enforcement. The DON stated she was not fully aware of the 2-hour HHS regulation for reporting abuse when a resident suffered an injury during a resident-to-resident altercation. The DON stated there was an injury but it was not an emergency because the resident did not lose a lot of blood [R#65] and was conscious .vital signs were stable .and CT scan was negative . During telephone interview on [DATE] at 4:05 PM, LVN J stated the timeline was correct. LVN J stated that she was making assessments of both residents and providing first aide to R#65 and vitals were stable for both residents. LVN J stated that it did not come to my head to call the police. Attempted call to CNA K on [DATE] at 4:25 PM, message left. Call not retuned by time of exit on [DATE] at 5:30 PM. During an interview on [DATE] at 4:35 PM, the Administrator stated reports to HHS were based on PL 2019-17. The administrator stated he would report a serious injury or immediate abuse to law enforcement and HHS. The Administrator stated there was no serious injury or immediate abuse that had to be reported to law enforcement at the time of the incident or immediately to HHS [2-hour time limit]. The Administrator stated that given the information he had he waited 9 hours before notifying law enforcement. The Administrator stated R#65 was at the hospital during the 9-hour delay before notifying law enforcement. During interview on [DATE] at 9:15 AM, Law Enforcement Officer stated law enforcement needed to be contacted immediately when there was an altercation between two residents in a nursing home resulting in an injury to one resident. The Officer stated law enforcement's immediate involvement in the incident involving R#19 and R#65 on [DATE] would have allowed law enforcement to investigate and determine whether an assault occurred that constituted a crime. The Law Enforcement Officer stated that notification to law enforcement after nine hours after the incident on [DATE] could result in evidence disappearing in a commission of a crime. The Law Enforcement Officer repeated that law enforcements required an immediate report when an assault or altercation occurred between residents resulting in an injury to one resident. During an interview on [DATE] at 10:24 AM, the DON stated that staffing on the night shift (6P-6A) on [DATE] was more than adequate and the staff quickly responded when the incident occurred at 9:36 PM. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 3:24 PM, the DON stated R#65 was given a 30-day notice via the RP for a different placement because the facility could not control the resident's behaviors and to ensure the safety of other residents. The DON stated it was not an appropriate setting for the resident and the resident was on 1:1 monitoring pending a placement. During telephone interview on [DATE] at 4:45 PM, Psychiatric NP stated medication adjustments had been attempted various times to control R#65's behavior with mixed results. The NP stated that the resident's aggression was likely due to impulsivity which medications could not control. The NP stated the resident likely required a smaller secured unit with little stimulation or a group home with few residents. The NP stated the resident was not neglected and interventions were in place to attempt to control the resident's behaviors. Record review of R#65's incident reports since admissions ([DATE]) to the present ([DATE]) reflected there was only one resident-to-resident altercation which occurred on [DATE]. Record review of facility's PPD staffing for the date of [DATE] of the secure unit was 3.2 [normal/average staffing based on a rating of 1 through 5 with 1 being poor and 5 excellent staffing.] 2. Record review of Resident #5's face sheet, dated [DATE], reflected a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included unspecified dementia (a progressive disorder that impairs thought processes, including memory and reasoning), other lack of coordination, and anxiety. Record review of Resident #5's admission MDS, submitted [DATE], reflected a BIMS score of 03, indicating severely impaired cognition. Record review of Resident #5’s completed assessments revealed the earlier documented fall risk evaluation was completed on [DATE], with a score of 15 and the category of at risk. Record review of Resident #5's progress notes revealed the following documentation dated [DATE] at 5:26 AM: Resident was found on floor at 2:45. Checked vitals wnl noted to have a small cut on left palm. He denied pain and no abrasions or redness noted anywhere else. At about 3:45 resident noted to be restless and sitting complaining of a [NAME] horse to left leg. Upon further assessment left upper thigh noted to be deformity to contour. He was notably tender to touch. I called family member and made aware of this. [Provider] notified and adon also. [sic] Record review of Resident #5's scanned documents revealed discharge documentation from a hospital visit dated [DATE]. The hospital discharge documentation included notation of a surgical repair of a femur fracture to Resident #5's left leg on [DATE]. Due to cognitive decline, Resident #5 was not able to participate in an attempted interview on [DATE] at 7:45 PM. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the DON on [DATE] at 3:54 PM, she stated she was made aware of the incident by nursing staff around the time the incident occurred on [DATE]. She stated the incident was investigated by the facility, and no deficiencies in care were found. She stated Resident #5 had poor safety-awareness due to the progression of dementia. She stated falls with injury are self-reported by the facility if the fall is unwitnessed and results in a serious injury. The DON stated this incident was not reported to the SSA because the facility determined during their investigation this incident did not meet the criteria for self-reporting as the resident had a prior, similar injury before admission. In an interview with the Admin on [DATE] at 11:27 AM, he stated that investigations of falls were investigated by the DON, and he was only made aware of incidents that involve abuse/neglect. The Admin also stated that the facility does not have a policy directly related to self-reporting incidents/accidents, and that their policy is to adhere to the provider letter and guidelines set forth by the SSA. 3. Record review of Resident #23's face sheet, dated [DATE], reflected a [AGE] year-old female initially admitted to the facility on [DATE]. Relevant diagnoses included disruptive mood dysregulation disorder (chronic irritability and frequent temper outbursts), bipolar disorder (mood instability), and unspecified dementia. Record review of Resident #23's quarterly MDS, submitted [DATE], reflected a BIMS score of 14, indicating intact cognition. Record review of Resident #23's progress notes revealed the following documentation entered on [DATE] at 3:58 PM by LVN W: Pt was in dining room and another resident was sitting at the table where pt normally sits. Pt went up to other resident and told her to get out from her table and go back to hers and called her a Bitch. She followed other pt and continued to call her names. Pt was redirected out of the dining room. [sic] Record review of the facility incident reports from [DATE] to [DATE] did not reveal a report related to the incident. Record review of the self-reported incidents from the facility to the State Survey Agency also did not reveal a report related to the incident. Resident #23 declined to participate in an attempted interview on [DATE] at 1:00 PM. In an interview on [DATE] at 2:35 PM, LVN W recalled the event she narrated in the progress note. LVN W stated Resident #23 became agitated when she discovered a resident sitting in the seat Resident #23 typically uses during dining. LVN W stated Resident #23 told the other resident to get out of her seat and began cursing and following the other resident around the dining room. Resident #23 was directed out of the dining room by LVN W due to the behavior. LVN W could not recall the identity of the other resident. She also could not recall the response from the other resident to the incident. LVN W was unsure if she reported the incident to her supervisors or the abuse coordinator. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with ADON Q on [DATE] at 4:48 PM, she stated she was unsure if she was told about the incident. After reading the progress note, she stated she felt like this incident qualified as abuse by Resident #23 of another resident. In an interview with the DON on [DATE] at 6:05 PM, she stated she was unaware of the incident. She was unsure if the incident qualified as abuse but felt it should have investigated by the facility. In an interview with the Admin on [DATE] at 7:45 PM, he stated he did not feel this incident qualified as abuse as the Resident #23 had known behaviors and was not aware of her actions. He stated that SSA was not helping residents by classifying the behavior enacted by Resident #23 as abuse and leaving the facility no choice but to discharge a resident who displayed similar behavior. 4. Record review of Resident #44’s admission Record, dated [DATE], reflected the resident was a [AGE] year-old male initially admitted to the facility on [DATE] with diagnoses which included unspecified dementia (a general term for impaired ability to remember, think, or make decisions), depression, and history of falling. Record review of Resident #44’s Comprehensive Person-Centered Care Plan, undated, reflected, “Resident has experienced a fall R/T weakness, Impaired mobility, cognitive impairment and is at risk for further falls.”, and “Resident is at risk of alter psychosocial well-being related to altercation with another resident.” Record review of Resident #44’s Significant Change MDS, dated [DATE], reflected the resident had a BIMS score of 0, indicating severe cognitive impairment. Further review reflected the resident had a fall in the last month, but did not reflect that the resident had a major injury such as a bone fracture. Record review of Resident #44’s incident report, dated [DATE], reflected, “Resident had an un-witnessed fall in peer’s room. Nursing staff observed resident in the seated position on the floor with his legs out in front of him.” An interview was attempted with Resident #44 on [DATE] at 10:30 AM. Resident #44 was not able to answer questions related to his care at the facility due to severe cognitive impairment. Interview on [DATE] at 10:35 AM, LVN A stated Resident #44 had been found on the floor by a CNA in another resident’s room. LVN A stated no one saw the resident fall. LVN A stated she assessed Resident #44 on the floor of another resident’s room and the resident said his back hurt. LVN A stated she assessed for pain on Resident #44’s backs and legs and the resident did not complain about pain during assessment. LVN A stated shortly later, Resident #44 was walking and complained of pain to his leg and was sent to the hospital where they found a fracture on his left hip. LVN A stated she informed her ADON and DON of the incident. Record review of Resident #44’s Emergency Department Report, dated [DATE], reflected, in part, “There is an acute nondisplaced fracture through the posterior cortex of the left femur on the subtrochanteric region”. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #44’s Orthopedic Surgeon Visit, dated [DATE], reflected there was a “small fracture within the greater trochanter” with the “assessment/plan” stating, “He may weight-bear as tolerated with a walker and needs to be supervised as he had a difficult standing with me at bedside today”. Interview on [DATE] at 11:27 AM, the Administrator stated that the incident was handled by nursing. The Administrator stated that the resident fell, so it was an explainable injury. The Administrator stated that nursing staff inform him of incidents of abuse and neglect. When asked if the fall had been unwitnessed, the Administrator stated “I couldn’t tell you, I’m not looking at it. All I know is that it was a fall. We have provided all of that information to you.”. The Administrator stated that they follow the provider letter [Texas Health and Human Services Provider Letter PL 2024-14] to determine what to report. Record review of Texas Health and Human Services PL 2024-14, date issued [DATE], reflected, “an incident that results in serious bodily injury and that involves any of the following: Neglect Exploitation Mistreatment Injuries of unknown source Misappropriation of resident property When to Report: Immediately, but not later than two hours after the incident occurs or is suspected.” Further review reflected, “an injury should be classified as an “injury of unknown source” when ALL of the following conditions are met: The source of the injury was not observed by any person; and 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 location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma); or the number of injuries observed at one point in time; or the incidence of injuries over time.” (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of facility's Abuse Prevention Program, dated revised [DATE] read: .Investigate and report any allegations within timeframes required by federal requirements . Record review of State regulations (N3568) on reporting ANE read: A local or state law enforcement agency must be notified of reports described in subsection (a) of this section, that allege that: (1) a resident's health or safety is in imminent danger. (2) a resident has recently died because of conduct alleged in the report of abuse or neglect or other complaint. (3) a resident has been hospitalized or treated in an emergency room because of conduct alleged in the report of abuse or neglect or other complaint. (4) a resident has been a victim of any act or attempted act described in the Texas Penal Code, §§21.02,21.11, 22.011, or 22.021; or (5) a resident has suffered bodily injury, as that term is defined in the Texas Penal Code, §1. 07, because of conduct alleged in the report of abuse or neglect or other complaint. Record review of website: https://www.dfps.texas.gov/contact_us/report_abuse.asp, mandates in the State of Texas, Resource Code, Chapter 48, reporting of elder abuse. Further, .in Texas, anyone with reasonable cause to believe a child, an adult with a disability, or a person 65 or older is being abused, neglected, or exploited in a nursing home must report it to the Texas Department of Family and Protective Services (DFPS). While the report should be made to DFPS, law enforcement may also be involved depending on the nature of the abuse . Record review of facility policy titled, “Abuse, Neglect and Exploitation” dated [DATE], reflected, “An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur.” And, “The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timelines. a. 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. a. Verbal abuse means the use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability. b. The facility will designate an abuse prevention coordinator in the facility who is responsible for reporting allegations of suspected abuse, neglect, or exploitation to the state survey agency and other officials in accordance with state law.

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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** Based on observation, interview, and record review, the facility failed to, in response to allegations of abuse or neglect, have evidence that all allegations are thoroughly investigated and to report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken, for 2 of 5 residents (Residents #23 and #44) investigated for abuse and neglect. The facility failed to investigate an incident of witnessed abuse from Resident #23 on 5/25/25.The facility failed to investigate an incident in which Resident #44 sustained an injury of unknown source on 7/23/25. These failures could lead to abuse and/or neglect of residents and decreased quality of life. The findings included: 1. Record review of Resident #23's face sheet, dated 7/22/2025, reflected a [AGE] year-old female initially admitted to the facility on [DATE]. Relevant diagnoses included disruptive mood dysregulation disorder (chronic irritability and frequent temper outbursts), bipolar disorder (mood instability), and unspecified dementia (a progress disorder that impairs thought processes, including memory and reasoning). Record review of Resident #23's quarterly MDS, submitted 4/29/2025, reflected a BIMS score of 14, indicating intact cognition. Record review of Resident #23's progress notes revealed the following documentation entered on 5/25/2025 at 3:58 PM by LVN W: Pt was in dining room and another resident was sitting at the table where pt normally sits. Pt went up to other resident and told her to get out from her table and go back to hers and called her a Bitch. She followed other pt and continued to call her names. Pt was redirected out of the dining room. [sic] Record review of the facility incident reports from 1/22/2025 to 7/22/2025 did not reveal a report related to the incident. Record review of the self-reported incidents from the facility to the State Survey Agency also did not reveal a report related to the incident. Resident #23 declined to participate in an attempted interview on 7/22/2025 at 1:00 PM. In an interview on 7/25/2025 at 2:35 PM, LVN W recalled the event she narrated in the progress note. LVN W stated Resident #23 became agitated when she discovered a resident sitting in the seat Resident #23 typically uses during dining. LVN W stated Resident #23 told the other resident to get out of her seat and began cursing and following the other resident around the dining room. Resident #23 was directed out of the dining room by LVN W due to the behavior. LVN W could not recall the identity of the other resident. She also could not recall the response from the other resident to the incident. LVN W was unsure if she reported the incident to her supervisors or the abuse coordinator. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with ADON Q on 7/25/2025 at 4:48 PM, she stated she was unsure if she was told about the incident. After reading the progress note, she stated she felt like this incident qualified as abuse by Resident #23 of another resident. In an interview with the DON on 7/25/2025 at 6:05 PM, she stated she was unaware of the incident. She was unsure if the incident qualified as abuse but felt it should have investigated by the facility. 2. Record review of Resident #44’s admission Record, dated 06/24/2025, reflected the resident was a [AGE] year-old male initially admitted to the facility on [DATE] with diagnoses which included unspecified dementia (a general term for impaired ability to remember, think, or make decisions), depression, and history of falling. Record review of Resident #44’s Comprehensive Person-Centered Care Plan, undated, reflected, “Resident has experienced a fall R/T weakness, Impaired mobility, cognitive impairment and is at risk for further falls.”, and “Resident is at risk of alter psychosocial well-being related to altercation with another resident.” Record review of Resident #44’s Significant Change MDS, dated [DATE], reflected the resident had a BIMS score of 0, indicating severe cognitive impairment. Further review reflected the resident had a fall in the last month, but did not reflect that the resident had a major injury such as a bone fracture. Record review of Resident #44’s incident report, dated 07/23/2025, reflected, “Resident had an un-witnessed fall in peer’s room. Nursing staff observed resident in the seated position on the floor with his legs out in front of him.” An interview was attempted with Resident #44 on 07/24/2025 at 10:30 AM. Resident #44 was not able to answer questions related to his care at the facility due to severe cognitive impairment. Interview on 07/28/2025 at 10:35 AM, LVN A stated Resident #44 had been found on the floor by a CNA in another resident’s room. LVN A stated no one saw the resident fall. LVN A stated she assessed Resident #44 on the floor of another resident’s room and the resident said his back hurt. LVN A stated she assessed for pain on Resident #44’s backs and legs and the resident did not complain about pain during assessment. LVN A stated shortly later, Resident #44 was walking and complained of pain to his leg and was sent to the hospital where they found a fracture on his left hip. LVN A stated she informed her ADON and DON of the incident. Record review of Resident #44’s Emergency Department Report, dated 07/24/2025, reflected, in part, “There is an acute nondisplaced fracture through the posterior cortex of the left femur on the subtrochanteric region”. Record review of Resident #44’s Orthopedic Surgeon Visit, dated 07/25/2025, reflected there was a “small fracture within the greater trochanter” with the “assessment/plan” stating, “He may weight-bear as tolerated with a walker and needs to be supervised as he had a difficult standing with me at bedside today”. (continued on next page)

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/29/2025 at 11:27 AM, the Administrator stated that the incident was handled by nursing. The Administrator stated that the resident fell, so it was an explainable injury. The Administrator stated that nursing staff inform him of incidents of abuse and neglect, because he is the abuse coordinator. When asked if the fall had been unwitnessed, the Administrator stated “I couldn’t tell you, I’m not looking at it. All I know is that it was a fall. We have provided all of that information to you.”. The Administrator stated that they follow the provider letter [Texas Health and Human Services Provider Letter PL 2024-14] to determine what to report and investigating. Record review of Texas Health and Human Services PL 2024-14, date issued 08/29/2024, reflected, “an incident that results in serious bodily injury and that involves any of the following: Neglect Exploitation Mistreatment Injuries of unknown source Misappropriation of resident property When to Report: Immediately, but not later than two hours after the incident occurs or is suspected.” Further review reflected, “an injury should be classified as an “injury of unknown source” when ALL of the following conditions are met: The source of the injury was not observed by any person; and 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 location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma); or the number of injuries observed at one point in time; or the incidence of injuries over time.” (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility policy titled, “Abuse, Neglect and Exploitation” dated 06/30/2025, reflected, “An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur.” And, “The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timelines: a. 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. a. Verbal abuse means the use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability. b. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure assessments accurately reflected the residents' status for 2 of 18 residents (Residents #19, #46) reviewed for assessments. The facility failed to ensure Resident #19's MDS accurately reflected the known diagnosis of PTSD.The facility failed to ensure Resident #46's MDS assessment accurately reflected the known diagnoses of depression and anxiety. These failures could place residents at risk of improper or incorrect care and services as necessary for their physical, mental, and psychosocial well-being. The findings included:1.Record review of Resident #19's face sheet, dated 7/22/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included anxiety disorder (excessive worry), vascular dementia (a progressive disorder that impairs thought processes, such as memory, reasoning, and decision making), and post-traumatic stress disorder (a mental health condition resulting from the experience of trauma, characterized by uncontrollable flashbacks, anxiety, and thoughts of the trauma). Record review of Resident #19's quarterly MDS, submitted 4/19/2025, revealed a BIMS score of 03, indicating severely impaired cognition. Section I of the MDS (active diagnoses) did not include a check mark next to item I6100 (post-traumatic stress disorder) to indicate Resident #19 had an active diagnosis of PTSD in the 7-day period preceding the submission of the MDS. Record review of Resident #19's comprehensive care plan, date printed 7/22/2025, reflected a focus area of [Resident #19] has a psychosocial well-being problem r/t post-traumatic stress disorder (date initiated 3/28/2025). Record review of a progress note written by NP D on 3/26/2025 reflected an active diagnosis of PTSD. In an interview with the MDS nurse on 7/24/2025 2:41 PM, she stated she was unsure why the PTSD diagnoses had not been indicated in the MDS. She stated all active diagnoses in the 7-day look-back period should be included in the MDS submission. She reported the potential harm to the resident was not receiving all of the care needed for the diagnosis. In an interview with the DON on 7/25/2025 at 6:15 PM, she indicated she was unsure if Resident #19 had been formally diagnosed with PTSD. She stated if the diagnosis had been made, then the information should have been included on the MDS. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2.Record review of Resident #46’s admission Record, dated 07/25/2025, reflected a [AGE] year-old resident initially admitted on [DATE] with diagnoses which included alcoholic cirrhosis of liver with ascites (advanced scarring of the liver caused by excessive alcohol use) and hepatitis C (an infection caused by a virus that attacks the liver and leads to inflammation). Record review of Resident #46’s Quarterly MDS, dated [DATE], reflected Resident #46 had a BIMS score of 7, indicating severe cognitive impairment. Further review of “Section I – Active Diagnoses” did not reflect a diagnosis of any psychiatric mood disorder. Record review of Resident #46’s Comprehensive Person-Centered Care Plan, undated, reflected, “[Resident #46] uses anti-anxiety medications Ativan, Buspar r/t anxiety disorder” with a date initiated of 07/15/2025. Further review reflected, “[Resident #46] uses antidepressant medication Citalopram r/t Depression” with a date initiated of 07/15/2025. Record review of Resident #46’s Order Summary Report, dated 07/25/2025, reflected the order, “LORazepam Oral Tablet 1 MG (LORazepam) Give 1 tablet by mouth every 6 hours as needed for anxiety,”; “busPIRone HCl Oral Tablet 10 MG (Buspirone HCl Give 2 tablet by mouth three times a day for Mood”; and “Citalopram Hydrobromide Oral Tablet 10 MG (Citalopram Hydrobromide) Give 1 tablet by mouth one time a day for depression”. Interview on 07/24/2025 at 11:36 PM, the MDS nurse stated she was responsible for ensuring MDS Assessments were accurate. The MDS nurse stated diagnoses were added to the MDS by her through looking at orders, misc. medical records that come from off-site visits, psych services, or hospice, and that each time a new MDS is completed she completes these record reviews to ensure the MDS is accurate. Interview on 07/24/2025 at 07/25/2025 at 3:39 PM, the DON stated diagnoses related to psychotropic medication should be on the MDS assessment. The DON stated that there have been discussions on responsibility of staff and who was and would be responsible for things such as entering diagnoses in the future. Record review of the facility policy titled Conducting an Accurate Resident Assessment (revised 6/30/2025) revealed the following: 3. The appropriate, qualified health professional will correctly document the resident's medical, functional, and psychosocial problems .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, 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 a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1of 16 Residents (Resident #70) reviewed for comprehensive person-centered care plans. The facility failed to revise Resident #70's comprehensive care plan to reflect the resident's ADL self-care performance. This failure placed all residents at risk of not receiving the care and services to maintain their highest practicable physical, mental, and psychosocial well-being.The findings were: Record review of Resident #70's quarterly MDS assessment, dated 05/25/2025, reflected resident had a BIMS score of 04 out of 15, indicating severely impaired cognition. It reflected Resident #70 needed supervision for eating, partial/moderate assistance for oral hygiene, partial/moderate assistance for toileting hygiene, substantial/maximal assistance for shower/bathe self, partial/moderate assistance for upper body dressing, substantial/maximal assistance for lower body dressing, substantial/maximal assistance for putting on/taking off footwear, partial/moderate assistance for personal hygiene, partial/moderate assistance for sit to stand, partial/moderate assistance to toilet transfer, supervision or touching assistance for roll left and right, supervision or touching assistance for sit to lying, and partial/moderate assistance for chair/bed-to-chair transfer. It further revealed there have been no weight changes in the last 6 months and Resident #70 have had no falls since admission/entry or reentry with major injury. Record review of Resident #70's comprehensive care plan, undated, revealed the following: Focus area indicating: Risk for Falls”, initiated 01/22/2025, with an intervention “Assist [Resident #70] with ambulation and transfers, utilizing therapy recommendations”, initiated 01/22/2025. Focus area indicating: [Resident #70] is dependent on staff for meeting emotional, intellectual, physical and social needs r/t cognitive deficits, dementia”, initiated 05/20/2025, with an intervention “[Resident #70] needs assistance/escort to activity functions”, initiated 05/20/2025, and “[Resident #70] needs assistance with ADLs as required during the activity”, initiated 05/20/2025. Focus area indicating: “The resident has limited physical mobility and utilizes a rollator”, initiated 01/22/2025, with an intervention AMBULATION: The resident uses rollator for walking”, initiated 01/22/2025, and “Provide supportive care, assistance with mobility as needed.”, initiated 01/22/2025, “Provide gentle range of motion as tolerated with daily care.”, initiated 01/22/2025. There was no focus are for ADL self-care performance. Combined interview on 07/25/25 at 05:46 PM, ADON Q revealed Resident #70’s care plan should be updated to reflect how he was transferred so staff knew how to care for resident. ADON Q revealed the care plan reflected following therapy recommendations but could not identify a section in the care plan for Resident #70’s ADL self-care performance. The MDS nurse revealed transfers for tasks like bed mobility (rolling left to right) was not in the care plan. The MDS nurse revealed this needed to be in the care plan to show how to care for the resident, whether Resident #70 was independent or needed assistance. The MDS nurse revealed Resident #70’s care plan did not reflect how to help Resident #70 with eating. She revealed anytime a resident required assistance, this needed to be care planned. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/25/25 at 06:36 PM, CNA AE revealed he used Kardex to review residents’ care plans for how to care for residents. He revealed if he had a question about care for any resident, like transfers, he would ask his nurse or the CNA from the previous shift. He revealed sometimes residents’ care changed from shift to shift so it was important to stay updated with other nursing staff. He revealed sometimes Resident #70 was weak and required extensive assistance. He revealed Resident #70 had had no recent falls or injuries. Interview on 07/25/25 at 06:38 PM, LVN V revealed when she helped care for residents, she looked at care plans in the resident’s’ medical record. She revealed she also communicated with nursing staff to include previous shift and her CNAs to ensure the resident care was most up to date. She revealed she was not aware of how Resident #70 was transferred but had asked CNA AE for more information. She revealed she had not typically worked with Resident #70. Interview on 07/25/25 at 06:52 PM, the DON revealed residents’ care plans should be updated for how to care for resident. She revealed Resident #70’s care plan should have his ADLs updated in his care plan to include how resident should be transferred to ensure he was supposed to be transferred the way that he should. Record review of facility policy titled, Comprehensive Care Plans, dated 6/30/2025, reflected, “Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions initially and when changes are made.”

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 of 8 residents (Resident #79) reviewed for personal hygiene. Resident #79 received 1 shower from the time of his admission on [DATE] to 07/24/2025. This failure could place residents who require assistance from staff for personal hygiene at risk of not receiving care and services contributing to overall poor hygiene, risk of experiencing a diminished quality of life, and possible skin infections. The findings included: Record review of Resident #79's admission Record, dated 07/24/2025, reflected a [AGE] year-old resident with an initial admission date of 07/12/2025. No diagnoses were listed on Resident #79's admission Record. Record review of Resident #79's Comprehensive Person-Centered Care Plan, dated 07/24/2025, reflected no interventions or focus areas relating to ADL's or showers. Record review of Resident #79's initial MDS, dated [DATE], reflected a BIMS score of 0, indicating severe cognitive impairment. Further review reflected that Resident #79 required Partial/Moderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort for, Tub/Shower transfer. There was no data entered to describe Resident #79's ability to Shower/bathe self. Record review of Resident #79's ADL Task in their POC titled, ADL - Bathing (Prefers: SPECIFY), dated 07/25/2025, reflected that Resident #79 was bathed on 07/20/2025 at 4:52 PM. No other bathing record was provided to the surveyor . Interview and observation on 07/25/2025 at 10:23 AM, CNA Z stated he primarily worked on the male's locked unit and when he worked, he was the CNA responsible for providing men on the locked unit with showers as scheduled. CNA Z stated he could not recall showering Resident #79 since he had been admitted on [DATE]. CNA Z stated there was a list of residents and their shower schedule on the door inside of the shower room. Observation and record review of the list did not reflect Resident #79 as being listed for showers at any time. CNA Z stated he did not see Resident #79 on the shower list inside of the shower room, and that it should be updated with any new admission. Interview and observation on 07/25/2025 at 10:35 AM, Resident #79 could not state whether he remembered if he had been showered since he had been at the facility . Resident #79's hair was observed to be greasy. Interview on 07/25/2025 at 10:42 AM, LVN AI stated she typically walks the hall to ensure each resident seems appropriately bathed. LVN AI stated the POC will flag when the showers are. LVN AI stated she was not certain if Resident #79 had been showered, but she was not confident he had not been showered . Interview on 07/25/2025 at 3:39 PM, the DON stated her expectation was for residents to receive showers as scheduled, at least 3 times a week, unless the resident refuses. The DON stated the only shower record was in the resident's electronic health record. The DON stated she could look into showers for Resident #79, but never followed up with the surveyor. Record review of facility policy titled, Resident Showers, dated 06/10/2025, reflected, Residents will be provided showers in accordance with the resident's preferences, care plan, and safety needs, as well as the facility's scheduled bathing protocol.

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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. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure each resident receives adequate supervision and assistance devices to prevent accidents for 2 of 3 residents (Residents #19 and #44) investigated for accidents. The facility failed to ensure Resident #19 received adequate supervision to prevent physical aggression towards other residents. The facility failed to ensure Resident #44's received adequate supervision to prevent falls with interventions to prevent further injury when the resident had falls at the facility on 05/12/2025, 05/19/2025, 05/23/2025, and on 07/23/2025 and unwitnessed injuries on 05/01/2025 and 07/05/2025. The falls on 05/12/2025 and 07/23/2025 both resulted in hip fractures. An Immediate Jeopardy was identified on 07/29/2025. The IJ template was provided to the facility on 7/29/2025 at 4:46 PM. While the IJ was removed on 7/31/2025, the facility remained out of compliance at a scope of pattern and a severity level of potential for more than minimal harm without immediacy because the facility needed to evaluate the effectiveness of corrective actions. This failure could lead to physical injury, psychosocial harm, and decreased quality of life. Findings included:1.Record review of Resident #19's face sheet, dated 7/22/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included anxiety disorder, vascular dementia (a progressive disorder that impairs a person's reasoning, memory, and other thinking abilities), and post-traumatic stress disorder (a mental disorder resulting from experienced trauma that causes flashbacks, severe anxiety, and/or uncontrollable thoughts). Record review of Resident #19's quarterly MDS submitted 4/19/2025 reflected a BIMS score of 03, indicating severe cognitive impairment. Record review of Resident #19's comprehensive care plan, date printed 7/22/2025, revealed the following:Focus: [Resident #19] is/has potential to be physically aggressive r/t anger, dementia, poor impulse control. 2/10/25- ambulating in hallway with peer, peer punched resident in right shoulder. immediately separated. unable to verbalize details of event. stated no no no one hit me. I'm the one who is mad. Resident involved in an altercation with another resident. [sic] date initiated 11/14/2024, revision on 3/09/2025Interventions: Administer medications as ordered . assess and anticipate resident's needs . provide physical and verbal cues to alleviate anxiety . [Resident #19] and peer immediately separated . psych doctor to review meds . psychiatric/psychogeriatric consult as indicated . report to provider any changes in behavior related to altercation . when [Resident #19] becomes agitated or is the receiver of peer aggressions: intervene before agitation escalates .The comprehensive care plan did not contain interventions related to maintaining the personal space of Resident #19 or known triggers of aggression. Record review of the facility's incident reports from 1/22/2025 through 7/22/2025 revealed the following:On 6/23/2025 around 9:30 PM, Resident #65 wandered into Resident #19's room. Staff walked in and found both residents holding each other's shirts, and Resident #65 had a 7centimeter bleeding laceration to his head that required 12 stitches to repair. Resident #65 told staff he was assaulted by Resident #19.On 7/05/2025 at 4:06 PM, Resident #20 entered Resident #19's room. Staff walked in and witnessed Resident #20 getting up off of the floor. Both residents stated that Resident #19 pushed Resident #20. On 7/05/2025 at about 9:00 PM, Resident #44 went into Resident #19's room. Resident #44 obtained an unwitnessed head injury while in Resident #19's room that required 10 staples to repair. Neither Resident #19 nor #44 were able to explain to staff what occurred to cause the injury. Record review of the facility census revealed Resident #19 resided in the men's secured unit during the above listed incidents, and he was moved to an unsecured, mixed gender hall on 7/09/2025. In an interview with Resident #19 on 7/22/2025 at 11:24 AM, he was unable to recall any incidents with other residents and denied any negative interactions. In an interview with LVN A on 7/23/2025 at 3:35 PM, she stated that all staff are aware of Resident #19's territorial behavior. She recalled the two incidents on 7/5/2025 and attributed both to aggression from Resident #19 as a result of the other residents entering Resident #19's room. She was unsure what interventions were in Resident #19's care plan related to preventing aggression. LVN C was interviewed on 7/23/2025 at 5:16 PM and reported awareness of Resident #19's history of aggressive behavior. She stated she observed aggressive behavior including facial expression and posturing from Resident #19 toward another resident on the previous day (7/22/2025) but had not witnessed any other behaviors since Resident #19 had moved into the unsecured hall. LVN C stated Resident #19's aggressive behavior towards other residents was unpredictable and unable to be prevented. She stated all staff, and most residents were aware that they should not enter Resident #19's room. She was unsure what interventions were in Resident #19's care plan related to

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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** Based on observation, interview, and record review the facility failed to ensure that respiratory care was provided in accordance with professional standards of practice, the comprehensive care plan, or the residents' goals and preferences for one of one resident reviewed (Resident #69) reviewed for respiratory care. RT P failed to listen to all lobes in Resident #69's lungs prior to the administration of a respiratory medication (albuterol inhaler). This failure placed residents at risk of improper assessment, inaccurate identification of concerns with the respiratory system, and hospitalization. Findings included: Record review of Resident #69's admission Record, dated 7/25/25 reflected a [AGE] year-old female with an original admission date of 06/20/2024 and a current admission date of 11/01/2024. Record review of Resident #69's Diagnosis Report, dated 07/25/2025 reflected diagnoses including other specified interstitial pulmonary disease and unspecified systolic (congestive) heart failure. Record review of Resident #69's MDS dated [DATE], reflected a BIMS score of 9 out of 15, which suggested a moderate cognitive impairment (some difficulty making decisions about care and other areas of daily life). Continued review of the same MDS reflected Resident #69 had debility and cardiorespiratory conditions. Record review of Resident #69's Order Summary Report, dated 07/25/2025 reflected an order dated 07/23/2025, for Albuterol Sulfate HFA Inhalation Aerosol Solution 108 (90 Base) MCG/ACT (Albuterol Sulfate) 2 puff inhale orally four times a day related to other specified interstitial pulmonary diseases. Record review of Resident #69's Respiratory Therapy Administration Record for July 2025, reflected the albuterol inhaler had been signed out as given for the 8:00 a.m. dose. During an observation on 07/25/2025 at 8:49 AM RT P prepared to administer Resident #69's respiratory inhaler, RT P proceeded to assess Resident #69's lungs, but only used the stethoscope over the front top left and right lobes on each side of the chest or on each side of the top of the chest before administration of inhaler. There was no attempt to listen from the back of the resident or the other three lobes from the front of the resident. RT P did not assess Resident #69 for pain at that time. During an interview on 07/25/2025 at 8:55 AM RT P stated he only listened to the top left and right side of Resident #69's chest because she had complained of pain at another unspecified date and time, but was supposed to check the resident lung sounds in the back, and he should listen to four lobes on the left, and five on the right. When asked if he was trained on how to assess resident lung sounds in the facility, RT P stated he was checked off on listening to all lobes and not only the top of the chest. When asked what some of the risks of an incomplete lung assessment were, RT P stated not getting an accurate assessment of lung sounds. During an interview on 07/25/2025 at 9:10 AM with RN M, when asked what the expectation was for how many lobes should be assessed over the lungs before administration of a respiratory medication RN M stated all lobes, three lobes on one side, and two on the other. When asked what some of the risks of an incomplete lung assessment were, RN M stated missed resident breathing concerns and inaccurate assessments. Record review of the facility's policy titled Airway Inhalation Treatment: Metered-Dose Inhaler and dated 11/01/2024, reflected no guidance on respiratory assessment. Record review of the facility provided form titled Clinical Skills Competency Validation Checklist, dated 07/24/2025, showed competencies for respiratory therapy patient assessment included demonstrates auscultation with a stethoscope. performs pre-assessment and post-assessment of patient vital signs, breaths sounds, and respiratory status. Record review of an email sent from the Administrator on 07/25/2025 at 1:54 PM in response to a policy request regarding respiratory assessment, reflected We don't have a policy for that specifically.

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	455724	A. Building B. Wing	07/31/2025

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

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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. Based on record reviews and interviews the facility failed to ensure the services of a Registered Nurse (RN) for at least 8 consecutive hours a day, 7 days a week, for 1 of 1 facility's reviewed for nursing staffing. 1.The facility failed to have the services of an RN on 02/22/2025, 02/23/2025, 03/09/2025, 06/01/2025, and 06/14/2025. 2.The facility failed to have at least 8 consecutive hours of RN coverage on 03/22/2025, 03/23/2025, 04/19/2025, 04/20/2025, 05/02/2025, 05/03/2025, 05/04/2025, 05/12/2025, 05/13/2025, 05/17/2025, 05/31/2025, and 06/15/2025. These failures could have placed residents at risk of not having the critical skills of a RN. The findings were: Record review of the facility's census report for the date of 07/22/2025 revealed a census of 76 residents daily. 1.Record review of the facility's RN staff payroll hours for the period from 1/1/2025 through 6/27/2025 revealed no RN Services on the following dates: 02/22/2025 02/23/2025 03/09/2025 06/01/2025 06/14/2025 2.Further review reflected less than 8 hours of RN Services on the following dates: On 03/22/2025, there were 7.75 hours of RN coverage. On 03/23/2025, there were 6. 5 hours of RN coverage. On 04/19/2025, there were 4 hours of RN coverage. On 04/20/2025, there were 6 hours of RN coverage. On 05/02/2025, there were 2 hours of RN coverage. On 05/03/2025, there were 5 hours of RN coverage. On 05/04/2025, there were 6 hours of RN coverage. On 05/12/2025, there were 4 hours of RN coverage. On 05/13/2025, there were 4 hours of RN coverage. On 05/17/2025, there were 7 hours of RN coverage. On 05/31/2025, there were 5 hours of RN coverage. On 06/15/2025, there were 6 hours of RN coverage. Interview on 07/26/2025 at 2:43 PM, the Administrator stated there were 3 days in the last 6 months that there was no RN coverage. The Administrator stated he did not know why there was not an RN working on these days. The Administrator stated he did not have any other record to show an RN worked the dates that did not have RN coverage, and that all of the dates occurred before he was an administrator. The Administrator stated it was important to have an RN working each day for, assessments. Record review of Facility Policy titled, Nursing Services-Registered Nurse (RN), dated 05/30/2025, reflected, The facility will utilize the services of a Registered Nurse for at least 8 consecutive hours per day, 7 days per week.

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F 0729 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining. (continued on next page)

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F 0729 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure it received registry verification for 3 (CNA AB, NA G, NA AH) of 24 employees reviewed for registry verification prior to allowing an applicant to serve as a nurse aide in that: The facility failed to ensure CNA AB, NA G, NA AH had a current nurse aide certification while employed at the facility while actively providing care for residents. This failure could result in residents being provided care by staff who have not provided documentation of training and competency in providing care. The findings included: 1. Record review of Licensure worksheet for survey, completed by HR, reflected CNA AB reflected CNA had a hire date of [DATE] and her nurse aide certification expired on [DATE]. Record Review of Nurse Aide Registry, accessed [DATE] at 09:57 AM, for CNA AB reflected NAR status was expired on [DATE]. Record review of CNA AB's Time Clock History from [DATE] to [DATE] revealed CNA worked [DATE] and [DATE], clock in and clock out times not noted. Interview on [DATE] at 07:03 PM, the ADM revealed HR oversaw making sure licenses were up to date, but he took responsibility of this oversight as he oversaw tasks being done appropriately by his staff. Combined interview on [DATE] at 08:55PM, the DON revealed CNA AB worked [DATE] and [DATE]. The ADM revealed he found out that CNA AB attempted to re-instate the first or the second of July and thought she was re-instated. Unable to leave voicemail for CNA AB on [DATE] at 11:19AM with no answer or call back and sent CNA AB a text message with no response. Interview on [DATE] at 11:05AM, HR revealed she oversaw ensuring CNAs were certified. She revealed she was currently reviewing all CNAs to ensure they were up to date. She revealed CNAs must renew their certification every 2 years. Interview [DATE] at 03:37 PM, CNA AB revealed she was actively working on getting her CNA certification renewed. She revealed she accidentally let it expire and thought she had it renewed in time. 2. Record review of Licensure worksheet for survey, completed by HR, reflected NA G had a hire date of [DATE]. Record review of Certificate of Completion for LTCR-NATCEP reflected NA G completed this program on [DATE]. Interview on [DATE] at 08:40AM, NA G revealed she was doing CNA duties but had to be working while a CNA oversaw her work. She revealed she had been working as a NA for about a year and had not become a CNA yet. Interview on [DATE] at 05:53PM, the DON and ADM revealed NA G had been working on the floor as a nurse aide. The corporate nurse revealed NA G should not be working on the floor as a nurse aide and should be working a hospitality aide until she got certified. 3. Record Review of Nurse Aide Registry, accessed [DATE] at 06:45 PM, for NA AH reflected NAR status was expired on [DATE]. Record review of NA AH's hours worked reflected NA AH was working as a full time CNA. It further reflected she worked 152.5 hours in [DATE] with her last day she clocked in was [DATE]. Interview on [DATE] at 06:10PM, the HR revealed they were looking for another facility for NA AH when the previous administrator hired her to work at this facility. She revealed they never continued NA AH's education or progress towards becoming a CNA. HR revealed she repeatedly told NA AH that she needed to become a CNA or she would not be able to work at the facility as a CNA. HR further revealed NA AH was working full time (40 hours per week) since she was hired on [DATE]. She further revealed NA AH no longer worked at the facility. Interview on [DATE] at 06:16 PM, the DON revealed it was important for nurse aides to get certified to provide resident care. She revealed nurse aides had to become certified 4 months after the LTCR NATCEP was completed. Record review of the Certified Nursing Assistant Job Description, undated, reflected Certificates, Licenses, Registrations. Must be a Certified Nursing Assistant as required by state and federal law. Record review of the facility's policy License Verification, dated [DATE], reflected All personnel that require a license or certification shall be verified through the appropriate issuing agency. 1. The Human Resources Director, or designee, is responsible for maintaining and ensuring the validity and current status of individual certification/licensure. 2. An individual will not be employed and or will be terminated from employment (whichever case may apply) if: a. The individual has lost licensure/certification for any reason.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from significant medication errors for 2 of 2 residents (Residents #8 and #20) reviewed for unnecessary medications. The facility failed to ensure Resident #8 received a hypertension medication based on the physician's order for the specific medication. The facility failed to ensure Resident #20 received a hypertension medication based on the physician's order for parameters for the specific medication (metoprolol). These failures could result in unintended side effects or residents not receiving the intended therapeutic effects of the medication regimen. The findings included: 1.Record review of Resident #8's face sheet, dated 7/23/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included essential hypertension (high blood pressure) and hypertensive heart disease without heart failure. Record review of Resident #8's quarterly MDS, submitted 7/22/2025, reflected a BIMS score of 09, indicating moderately impaired cognition. Record review of Resident #8's active physician orders revealed the following order: Entresto oral tablet 24-26 MG (sacubitril-valsartan) Given 1 tablet by mouth two times a day for HTN related to essential (primary) hypertension (order date 3/4/2025) Record review of Resident #8's MAR reflected the following documentation for the administration of the Entresto: 7/2/2025 AM dose not given, code 4 documented by MA Y 7/3/2025 AM dose not given, code 4 documented by MA Y 7/7/2025 PM dose not given, code 4 documented by MA Y 7/12/2025 AM dose not given, code 4 documented by MA Y 7/13/2025 AM dose not given, code 4 documented by MA Y 7/17/2025 AM dose not given, code 4 documented by MA Y 7/17/2025 PM dose not given, code 4 documented by MA Y The included key on the MAR for the chart codes reflected 4 to indicate vitals outside of parameters for administration. Record review of Resident #8's progress notes for July 2025 did not reveal documentation related to the Entresto being withheld. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #8's recorded blood pressures for July 2025 did not reveal any documented systolic blood pressures greater than 180 or diastolic blood pressures greater than 110, which would constitute a hypertensive emergency, according to guidelines published by the American Heart Association in May 2024. In an interview with Resident #8 on 7/22/2025 at 12:17 PM, he denied any concerns, side effects, or other issues related to his medication regimen. In an interview with MA Y on 7/25/2025 at 10:25 AM, she stated she held Resident #8's Entresto on the dates indicated by code 4 due to the blood pressure reading obtained prior to medication administration. She stated Resident #8 has defined parameters for administering other medications related to hypertension, so she applies the parameters to the Entresto as well. She also stated she reports the blood pressure reading to the primary nurse for guidance regarding administering the Entresto when the blood pressure reading is lower than or close to the parameters for the other hypertension medications. She stated the medication order does not need parameters specific to the medication because the medications are in the same class of drugs and the parameters apply to all of the medications. In an interview with LVN AD on 7/25/2025 at 10:31 AM, he stated he has instructed MA Y to hold the Entresto on previous instances due to a low blood pressure reading. He stated the physician's order should include parameters for administration. He stated he did not always notify the provider when the Entresto was held due to the resident's blood pressure. LVN AD denied any periods of hypotension or hypertension for Resident #8 resulting from administration or withholding of the Entresto. In an interview with the DON on 7/25/2025 at 6:05 PM, she stated medications should absolutely have defined parameters if the staff are routinely holding the medication administration due to vital signs. She also stated if a medication is not administered due to nursing judgement (and not predefined parameters), a progress note should be documented indicating the reason the medication was withheld, and the prescribing provider should be notified. 2.Record review of Resident #20’s admission Record, dated 07/25/2025, reflected a [AGE] year-old resident with an initial admission date of 02/28/2014, and a most recent admission date of 02/02/2025, with diagnoses which included dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgement), hypertension (a condition in which the force of the blood against the artery walls is too high), and schizoaffective disorder (a mental health condition including schizophrenia and mood disorder symptoms). Record review of Resident #20’s Quarterly MDS Assessment, dated 05/19/2025, reflected Resident #20 had a BIMS score of 0, indicating severe cognitive impairment. Further review reflected Resident #20 had a diagnosis of Hypertension. Record review of Resident #20’s comprehensive person-centered care plan, undated, did not reflect any information related the residents diagnosis of hypertension. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #20’s July Medication Administration Record, dated 07/23/2025, reflected that Resident #20 had the order “Metoprolol Tartrate Oral Tablet 50 MG (Metoprolol Tartrate) Give 1 tablet by mouth two times a day related to ESSENTIAL (PRIMARY) HYPERTENSION hold for SBP less than 120 and or DBP less than 80. Pulse less than 60bpm” with a start date of 04/02/2025, provided once in the morning and once in the evening. Further review reflected that Resident #20 could have been provided Metoprolol Tartrate 61 times from 07/01/2025 through 07/31/2025 and was administered Amlodipine Besylate out of parameters as follows: On 07/01/2025, MA AJ administered Amlodipine Besylate to Resident #20 while his DBP was 75 in the morning. On 07/03/2025, LVN J administered Amlodipine Besylate to Resident #20 while his DBP was 78 in the evening. On 07/04/2025, MA AJ administered Amlodipine Besylate to Resident #20 while his DBP was 70 in the morning. On 07/04/2025, RN B administered Amlodipine Besylate to Resident #20 while his SBP was 114 and his DBP was 78 in the evening. On 07/05/2025, MA AJ administered Amlodipine Besylate to Resident #20 while his DBP was 61 in the morning. On 07/05/2025, MA AJ administered Amlodipine Besylate to Resident #20 while his DBP was 67 in the evening. On 07/06/2025, MA AJ administered Amlodipine Besylate to Resident #20 while his DBP was 70 in the morning. On 07/07/2025, LVN AK administered Amlodipine Besylate to Resident #20 while his DBP was 77 in the morning. On 07/07/2025, LVN V administered Amlodipine Besylate to Resident #20 while his DBP was 76 in the evening. On 07/08/2025, LVN AK administered Amlodipine Besylate to Resident #20 while his DBP was 76 in the morning. On 07/08/2025, LVN V administered Amlodipine Besylate to Resident #20 while his DBP was 74 in the evening. On 07/09/2025, MA AJ administered Amlodipine Besylate to Resident #20 while his DBP was 75 in the morning. On 07/09/2025, MA AJ administered Amlodipine Besylate to Resident #20 while his DBP was 75 in the morning. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/12/2025, RN M administered Amlodipine Besylate to Resident #20 while his DBP was 74 in the evening. On 07/13/2025, LVN AK administered Amlodipine Besylate to Resident #20 while his DBP was 74 in the morning. On 07/15/2025, MA AJ administered Amlodipine Besylate to Resident #20 while his DBP was 60 in the morning. On 07/16/2025, MA AL administered Amlodipine Besylate to Resident #20 while his DBP was 70 in the morning. On 07/16/2025, LVN J administered Amlodipine Besylate to Resident #20 while his DBP was 76 in the evening. On 07/17/2025, LVN J administered Amlodipine Besylate to Resident #20 while his DBP was 79 in the evening. On 07/18/2025, MA AJ administered Amlodipine Besylate to Resident #20 while his DBP was 70 in the morning. On 07/19/2025, MA AJ administered Amlodipine Besylate to Resident #20 while his DBP was 70 in the morning. On 07/20/2025, RN B administered Amlodipine Besylate to Resident #20 while his SBP was 115 and his DBP was 73 in the evening. On 07/21/2025, LVN AK administered Amlodipine Besylate to Resident #20 while his SBP was 115 and his DBP was 73 in the morning. On 07/21/2025, LVN J administered Amlodipine Besylate to Resident #20 while his DBP was 73 in the evening. On 07/22/2025, LVN AK administered Amlodipine Besylate to Resident #20 while his DBP was 76 in the morning. On 07/22/2025, LVN J administered Amlodipine Besylate to Resident #20 while his SBP was 116 and his DBP was 73 in the evening. On 07/23/2025, MA AJ administered Amlodipine Besylate to Resident #20 while his SBP was 119 and his DBP was 73 in the morning. On 07/24/2025, MA AJ administered Amlodipine Besylate to Resident #20 while his DBP was 70 in the morning. On 07/25/2025, LVN J administered Amlodipine Besylate to Resident #20 while his DBP was 71 in the evening. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/26/2025, LVN AK administered Amlodipine Besylate to Resident #20 while his DBP was 71 in the morning. On 07/26/2025, LVN J administered Amlodipine Besylate to Resident #20 while his DBP was 78 in the evening. On 07/27/2025, LVN AK administered Amlodipine Besylate to Resident #20 while his DBP was 78 in the morning. On 07/27/2025, LVN J administered Amlodipine Besylate to Resident #20 while his SBP was 117 and his DBP was 76 in the evening. On 07/28/2025, MA AJ administered Amlodipine Besylate to Resident #20 while his DBP was 70 in the morning. On 07/29/2025, MA AJ administered Amlodipine Besylate to Resident #20 while his DBP was 70 in the morning. On 07/30/2025, LVN J administered Amlodipine Besylate to Resident #20 while his DBP was 79 in the evening. On 07/31/2025, LVN AK administered Amlodipine Besylate to Resident #20 while his DBP was 79 in the morning. Interview on 07/25/2025 at 3:39 PM, the DON stated her expectation for medications with parameters is that the parameters were followed. The DON stated she was not aware of Resident #20 receiving medications out of parameters. The DON stated if staff gave medications outside of parameters, her expectation would be for staff to inform the necessary parties such as the DON, Physician, RP, and any other necessary parties as well as monitoring the resident for any adverse side effects. Record review of the facility policy titled Medication Monitoring, revised 5/9/2025, revealed the following: Licensed nurses, with periodic oversight by nurse managers, shall . b. adhere to facility policies and current standards of practice for administration and monitoring of medications. c. Report refusals of medications, frequent holding of medications, or signs of adverse consequences of medications to the physician. Record review of facility policy titled, “Medication Administration”, dated 05/07/2025, reflected, “Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician’s prescribed parameters.”

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation, interview, and record review, the facility failed to store all drugs and biologicals in locked compartments under proper temperature controls for 2 of 4 medication carts (200 hall medication cart and 300 hall treatment cart) reviewed for medication storage. The facility failed to ensure 2 medications requiring refrigeration (promethazine suppositories and Latanoprost eye drops) were stored in the refrigerator. The facility failed to ensure the 300 hall medication cart was locked when not in use. These failures could lead to residents not receiving the intended therapeutic effects of medication or unintended access to medications and ingestion. The findings were: 1. In an observation of the 200-hall medication cart on 7/24/2025 at 11:35 AM, the medication Latanoprost 0.0005% ophthalmic solution was observed in a drawer. The medication was labeled with a blue sticker that indicated refrigeration was required for storage. A second medication, promethazine 25mg suppositories, was also observed being stored in a drawer with a blue label indicating refrigeration was required. ADON R was interviewed on 7/24/2025 at 11:35 AM. She stated both medications should be stored in the medication refrigerator and not in the medication cart. She stated the potential harm to residents of medications not being stored at proper temperature was infection or any number of things. 2. In an observation on 7/25/2025 at 7:43 PM, the 300-hall medication cart was observed to be stored in the hallway near the nurses' station, unlocked. Four residents were present in the hall in the area immediately surrounding the unlocked medication cart, but no staff were present during the observation. No residents were observed accessing the medication cart during the period the cart was unattended by facility staff. LVN V was observed returning to the nurse's station on 7/25/2025 at 7:49 PM from the parking lot, and she was interviewed at that time. She stated that she was responsible for the unlocked medication cart. She stated the facility policy is the cart will be locked when not in use, and that she accidentally left it unlocked when she stepped outside. She reported the potential harm to residents of leaving the medication cart unlocked was the possibility of residents accessing the medications inside of the cart. Record review of the facility policy titled Medication Storage, date revised 5/9/2025, revealed the following:a. During medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage/area cart. b. All medications requiring refrigeration are stored in refrigerators located in the pharmacy and at each medication room.

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

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 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 3 of 3 beverage carts and 1 of 1 ice machines. 1. The facility failed to properly label beverage pitchers with the date of preparation and contents on 3 of 3 beverage carts during the dinner meal service on 7/25/2025. 2. In one of the freezers there was raw ground beef stacked on top of raw chicken drumsticks, which was stacked on top of pasta. 3. In the freezer in the dry storage area, there were 2 products that were undated and unlabeled. 4. The facility failed to keep the ice machine clean. 5. The facility failed to ensure there was a fan that was clean that was blowing towards the 3-compartment sink for cleaning dishes. 6. The facility failed to not store sanitizing buckets near food products. 7. The facility failed to not store personal beverages in the food preparation area. 8. Dietary Aide AP failed to take the temperature for milk for the 07/24/25 breakfast. These failures could lead to illness and decreased quality of life. The findings included: In an observation on 7/25/2025 at 5:46 PM, the beverage cart in the 300 hall was observed to contain 3 pitchers of liquid that were not labeled with the contents of the pitcher or the date which the beverages were prepared. In an observation on 7/25/2025 at 5:48 PM, the beverage cart in the main dining area was observed to contain 4 pitchers of liquid that were not labeled with the contents of the pitcher or the date which the beverages were prepared. In an observation on 7/25/2025 at 5:54 PM, the beverage cart in the 100 hall was observed to contain 3 pitchers of liquid that were not labeled with the contents of the pitcher or the date which the beverages were prepared. In an interview with the Dietary Manager on 7/25/2025 at 5:49 PM, she stated all of the pitchers of the beverage cart should be labeled with the contents and the date of preparation. She reported the staff member preparing the beverages was new and had been trained on the labeling procedure. The Dietary Manager stated the potential harm to residents from not labeling the beverage pitchers was residents receiving the wrong drink or ingesting caffeine unintentionally. Record review of the facility policy titled Food Safety Requirements, revised 6/30/2025, revealed the following: Practice to maintain safe refrigerated storage include . labeling, dating, and monitoring refrigerated food . Interview and observation on 07/22/25 at 10:24 AM, in one of the freezers there was raw ground beef stacked on top of raw chicken drumsticks, which was stacked on top of pasta. The DM and [NAME] AM revealed these foods should not be set up this way. [NAME] AM revealed there was a previous dietary cook that placed the foods like this. Interview and observation on 07/22/25 at 10:24 AM, in the freezer in the dry storage area, there were 2 products that were undated and unlabeled. The DM revealed one to be ham and did not know what the other food product was. The DM and [NAME] AM revealed foods that are stored in the freezer or refrigerator needed to be labeled and dated so staff knew what food product it was and when to use it by. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview and observation on 07/22/25 at 10:24 AM, there were black spots on the side of the inside of the ice machine and rust on the top, inside the ice machine. The DM revealed she had to order a new ice machine, but residents still got ice because the machine was still working. She revealed she cleaned the outside of the ice machine, but did not clean the inside of the ice machine. The DM was able to wipe the inside of the ice machine and a black substance was on a towel she was using to clean the machine. Interview and observation on 07/22/25 at 10:24 AM, it was observed there was a fan that was blowing towards the 3-compartment sink for cleaning dishes. It was observed that this fan had debris and some type of object that appeared to look like a string blowing from it. The CDM revealed the fan should probably not be in use in the kitchen and asked another kitchen staff member to remove it. Interview and observation on 07/22/25 at 10:24 AM, there was a sanitation bucket near a bucket of thickener. The CDM revealed it was okay to place the sanitizing bucket near the bucket of thickener because it was a closed container. She placed the sanitizing bucket near a carton of bananas and carton of potatoes, where there was another sanitizing bucket placed. The CDM revealed she placed the sanitizing buckets here because there needed to be a sanitizing bucket below each workstation. Interview and observation on 07/22/25 at 10:24 AM, there was a personal beverage on a lower shelf below a food preparation table. Dietary AN revealed it was okay to have this personal beverage here because the health department said it was okay if there was a cover over the beverage with a straw put in. It was observed that this personal food beverage was located on the same shelf as 2 sanitizing buckets, a carton of bananas, and a carton of potatoes. Interview on 07/25/25 at 02:30 PM, Dietary Aide AP revealed he did not check the temperature for the milk for 07/24/2025 breakfast. He revealed it was important to ensure the food was good for the residents to eat/drink. The DM revealed she oversaw this process and should have caught this missing temperature. Interview on 07/25/25 at 01:57 PM, the DM revealed she oversaw all the processes that were found to have deficient practices. She further revealed the kitchen staff kept personal beverages in DM’s office, and she told Dietary Aide AN about this but Dietary Aide AN was adamant it was okay due to the health department. The DM revealed keeping personal beverages near food products could cause cross contamination. The DM revealed she was trying to fix their refrigerator and freezer walk-ins to improve their cold storage. She revealed in the meantime, it was hard to stay on top of where staff stored food products. She further revealed it was important for proper dating on food products to make sure food products did not go bad, they provided the freshest food possible, and there was no food waste. The DM revealed they got rid of fan that was blowing in the area where they cleaned dishes because it was not clean, and it could be a source of cross contamination on dishes. She further revealed there was a thread coming out of this fan. The DM revealed there needs to be one sanitizing bucket underneath each station, however the bucket should not be near food because it could spill on the nearby foods. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 07/25/25 at 04:45 PM, Dietary Aide AO, Dietary Aide AP, Dietary [NAME] AQ revealed they knew to label food products with their name and discard dates to make sure foods were edible. They revealed they needed to store raw proteins appropriately to prevent cross contamination. They revealed they knew to not have their personal beverages in the food preparation area so it did not spill into food products. They further revealed they did not keep sanitizing buckets by food products so it did not touch food products. Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed, 3-305.11, Food Storage, (A) Food shall be protected from contamination by storing the food: (1) in a clean, dry location; (2) Where it is not exposited to splash, dust, or other contamination. Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed, 3-305.11, Food Storage, (A) Food shall be protected from contamination by storing the food: (1) in a clean, dry location; (2) Where it is not exposited to splash, dust, or other contamination. Record review of the FDA Food Code 2022 reflected, 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under §3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57°C (135°F) or above, except that roasts cooked to a temperature and for a time specified in 3-401.11(B) or reheated as specified in 3- 403.11(E) may be held at a temperature of 54°C (130°F) or above; or (2) At 5°C (41°F) or less. Record review of facility’s policy “Sanitization”, undated, reflected “2. All utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair…12. Ice machines and ice storage containers will be drained, cleaned, and sanitized per manufacturer’s instructions and facility policy” Record review of facility’s policy “Food Preparation and Service”, undated, reflected, “Food Preparation, Cooking and Holding Temperatures and Times 1. The “danger zone” for food temperatures is between 41 F and 135 F. This temperature range promotes the rapid growth of pathogenic microorganisms that cause foodborne illness.” Record review of facility’s policy “Food Receiving and Storage”, undated, reflected “8. All foods stored in the refrigerator or freezer will be covered, labeled, and dated (“use by” date)… 13. Uncooked and raw animal products and fish will be stored separately in drip-proof containers and below fruits, vegetables and other ready-to-eat foods… 16. Soaps, detergents, cleaning compounds or similar substances will be stored in separate storage areas from food storage and labeled clearly.”

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain medical records in accordance with accepted professional standards and practices that are complete and accurately documented for 2 of 6 residents (Residents #44 and #79) reviewed for clinical documentation and medical records accuracy. 1.The facility failed to ensure Resident #44's skin assessment accurately reflected staples to the resident's forehead 3 days after they were placed. 2.The Electronic Health Record for Resident #79 did not reflect any medical diagnoses. This failure could place residents at risk for incomplete or inaccurate clinical records, which could lead to miscommunication, a delay in services, or a potential decline in the resident's health. The findings included: 1.Record review of Resident #79's admission Record, dated 07/24/2025, reflected a [AGE] year-old resident with an initial admission date of 07/12/2025. No diagnoses were listed on Resident #79's admission Record. Record review of Resident #79's Comprehensive Person-Centered Care Plan, dated 07/24/2025, reflected no care areas related to diagnoses or medication monitoring related to diagnoses. Record review of Resident #79's initial MDS, dated [DATE], reflected a BIMS score of 0, indicating severe cognitive impairment. Further review reflected no active diagnoses on, Section I - Active Diagnoses. Record review of Resident #79's Diagnosis Report, dated 07/23/2025, reflected, No Records Found. Record review of Resident #79's Order Summary Report, dated 07/23/2025, reflected the following orders with related diagnoses as indications for use: Advair Diskus Inhalation Aerosol Powder Breath Activated 100-50 MCG/ACT (Fluticasone-Salmeterol) 1 puff inhale orally two times a day for COPD with the start date 07/12/2025.Atenolol Oral Tablet 25 MG (Atenolol) Give 1 tablet by mouth in the morning for HTNZoloft Oral Tablet 25 MG (Sertraline HCl) Give 1 tablet by mouth one time a day for anxiety and agitation. Record review of Resident #79's Hospital Discharge Records, dated 07/11/2025, reflected that Resident #79 had the following diagnoses:Acute UTIAcute metabolic encephalopathyDementiaHyperlipidemiaCADCOPD 2.Record review of Resident #44's admission Record, dated 06/24/2025, reflected the resident was a [AGE] year-old male initially admitted to the facility on [DATE] with diagnoses which included unspecified dementia (a general term for impaired ability to remember, think, or make decisions), depression, and history of falling. Record review of Resident #44's Significant Change MDS, dated [DATE], reflected the resident had a BIMS score of 0, indicating severe cognitive impairment. Record review of Resident #44's Incident Injury Report, dated 07/05/2025, reflected that Resident #44 was, witnessed bleeding, with a vertical laceration approximately 2-2.5 inches in the middle of his forehead, and the resident was sent to the hospital via EMS. Interview on 07/26/2025, Resident #44's RP stated that Resident #44 had to receive staples on his forehead after the incident on 07/05/2025. Record review of Resident #44's Medication Administration Record for July of 2025, revealed an order stating, Monitor laceration/staples to forehead for s/s of infection every day and night shift for wound care for 10 days with a start date of 07/07/2025. Record review of Resident #44's Weekly Skin Assessment, dated 07/08/2025, reflected, No new skin issues with no skin issues noted under, Note all skin issues. Interview on 07/24/2025 at 11:36 AM, the MDS Nurse stated that at the very least, the diagnoses which correspond to a medication should be added during the admissions process. The MDS nurse stated that when she works on the initial MDS, she will add any diagnoses that aren't on the diagnosis list in the electronic health record. The MDS Nurse stated that Resident #79's MDS had not been completed, as the last day to complete it was on 07/25/2025 and she would be working on it. The MDS Nurse stated her expectation that she had discussed with the DON was the admitting nurse adding in any diagnoses and orders. Interview on 07/25/2025 at 3:39 PM, the DON stated that typically medications and diagnoses on the medical record were attached to one another, and there should be diagnoses in every medical record when the resident was admitted , and orders were input into their electronic health record. Additionally, the DON stated her expectation was for skin assessments to be completed accurately. Record review of Facility Policy titled, Documentation in Medical Record, dated 06/06/2025, reflected, Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation.

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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 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Hire a qualified full-time social worker in a facility with more than 120 beds. Based on interviews and record review, the facility with more than 120 beds failed to employ a qualified social worker on a full-time basis, for 1 of 1 social services staff reviewed for qualifications of Social Worker. The facility, licensed for 179 beds, did not employ a full-time social worker. This failure could place residents at risk of social service and psychosocial needs not being met.The findings included: Record review of the facility's Daily Census Report, dated 07/22/2025, noted the facility had a total licensed bed capacity of 179. Record review of the Facility Summary Report from the Texas Unified Licensure Information Portal (TULIP) noted the facility had a total licensed capacity of 179 beds. During an interview on 07/23/2025 at 1:47 PM, the Administrator stated he believed the need for a social worker was based on census, not licensed beds. The Administrator stated there was a remote, as needed social worker, who did not work for the facility on a full-time basis. The Administrator stated he terminated the last social worker and the position had not been filled. The Administrator stated the last day of work for the previously employed social worker was 05/20/2025. Record review of facility policy titled, Social Services dated 06/10/2025, reflected, in part, A facility with more than 120 beds will employ a qualified social worker on a full-time basis.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure they established and maintained an infection prevention program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 out of 6 (Residents #46 and #33), reviewed for infection control, in that: 1.LVN N put a pill back in Resident #46's pill cup after it fell into her bare hand and gave them to the resident. 2.CNA O cleaned/wiped Resident #33's penis towards the urinary opening (from dirty to clean) during peri care. These failures placed residents at risk of transmission of communicable diseases and infections, a decline in overall health, and hospitalization. Findings included: 1.Record review of Resident #46's admission Record dated 07/25/2025 reflected a [AGE] year-old female with an admission date of 04/14/2025. Record review of Resident #46's Diagnosis Report dated 07/25/2025 reflected diagnoses including alcoholic cirrhosis of the liver with ascites, hepatitis C, and chronic obstructive pulmonary disease (COPD). Record review of Resident #46's MDS dated [DATE] reflected a BIMS score of seven out of 15, which suggested a severe cognitive impairment (lots of difficulty making decisions about care and activities that affected daily life). Record review of Resident #46's Care Plan reflected the following:-A focus dated 07/21/2025, for Resident #46 being at risk for developing an infection related to the medical diagnoses of hepatitis C, COPD, and use of a drain for ascites, with interventions including administer medications as ordered and monitor for side effects. Record review of Resident #46's Order Summary Report dated 07/25/2025, reflected the following orders for the morning medication pass:- Potassium Oral Tablet (Potassium) Give 20 mEq by mouth one time a day, dated 05/28/2025- Amoxicillin-Pot Clavulanate Tablet 500-125 MG Give Verbal 1 tablet by mouth three times a day, dated 07/23/2025- busPIRone HCl Oral Tablet 10 MG (Buspirone HCl) Verbal Give 2 tablet by mouth three times a day, dated 06/19/2025- Furosemide Oral Tablet 40 MG (Furosemide) Give 1 tablet by mouth in the morning, dated 06/13/2025- HYDROcodone-Acetamlnophen Oral Tablet 10-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth four times a day, dated 07/09/2025- Omeprazole Oral capsule Delayed Release 20 MG (Omeprazole) Give 1 capsule by mouth in the morning, dated 04/14/2025- Lactulose Oral Solution 10 GM/15ML (Lactulose) Give 30 ml by mouth two times a day Record review of Resident #46's Medication Administration Record for July 2025 reflected Omeprazole oral capsule delayed release 20 MG was signed out as given by LVN N on 07/25/2025. During an observation on 07/25/2025 at 8:06 AM Resident #46's Omeprazole capsule fell into LVN N's bare hand during the medication administration process. LVN N put the capsule back into the pill cup with the potassium tablet, Amoxicillin-Pot Clavulanate tablet, buspirone tablets, furosemide tablet, and the hydrocodone-acetaminophen tablet, then Resident #46 swallowed the capsule and other pills with water. During an interview on 07/25/2025 at 8:06 AM when asked what the expectation was when a pill/capsule fell or was contaminated, LVN N stated she would usually repull the medication (s) and waste (throw away) the medication that fell. When asked what the risks of giving a resident a potentially contaminated pill was, LVN N said a risk of infection from her hand or gastrointestinal (GI [stomach]) upset. LVN N stated she had recent training on medication administration within the past year. During an interview on 07/25/2025 at 8:25 AM, when asked the expectation for during medication administration if a pill fell into a nurse's hand, RN M, an Assistant Director of Nursing stated staff were not supposed to place medication back into a pill cup and administer to any residents, staff should discard the contaminated pill/capsule, wash their hands, replace the medication, and restart the process, RN M continued, if the pill/capsule was placed back into a pill cup with other medications, all pills in the cup should be replaced, because they were all potentially contaminated. When asked about the risks to the resident if they were given a contaminated pill/capsule, RN M stated the risk to residents was infection. Record review of the facility's policy titled Medication Administration, last revised/reviewed on 05/07/2025, reflected under Policy Explanation and Compliance Guidelines section: . 14. Remove medication from source, taking care not to touch medication with bare hand. Review of an email from the Administrator on 07/25/2025 at 12:43 PM in response to a request for the facility's infection control policy, with the subject Infection Control, reflected an attachment with a policy titled Infection Prevention and Control Risk Assessment Procedure, last reviewed/revised on 04/02/2025. Further review reflected no information regarding infection control during resident procedures such as medication administration or the risks associated with cross-contamination during medication administration. 2.Record review of Resident

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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a resident environment that was free of pests for 1 of 1 facility reviewed for effective pest control. The facility failed to provide a resident environment that was free from pests, as flies, gnats, and a roach was observed in the facility. This failure could result in illness and/or psychosocial harm for residents living in areas with insects. The findings included: 1.Record review of Resident #80's admission record, dated 07/25/2025, reflected the resident was an [AGE] year-old, initially admitted [DATE] and with diagnoses to include depression. Record review of Resident #80's admission MDS assessment, dated 07/21/2025, revealed the resident's BIMS score was 10 out of 15, indicating moderate cognitive impairment. Interview and observation on 07/23/25 at 08:37 AM, Resident #80 had black flying beings around his breakfast meal tray. He revealed it did bother him that gnats were flying around him and sometimes it affected his eating like a gnat will be in his orange juice, so it prevented him from eating or drinking food items. Interview on 07/23/25 at 08:40AM, NA G revealed there were a few rooms in the 300-hallway that had gnats in their rooms. She revealed they tried to grab the residents’ meal trays right away to try to prevent gnats. She revealed she had not known if residents were affected. She revealed when she saw pest control issues in resident rooms, she would let her CNA supervisor know. Interview on 07/23/25 at 08:45 AM, CNA AC revealed the facility did have gnats and even more during the summer months. He revealed the way they were trying to prevent this issue by taking the residents’ meal trays out of the room right away. He revealed he was not aware if residents were affected by gnats. He revealed when she saw pest control issues in resident rooms, she would let her CNA supervisor know. Interview on 07/25/25 at 10:50 AM, the Maintenance Director (worked at this facility for about 2 months) revealed the facility had a problem with gnats and he oversaw contacting pest control for any pest control issues. He revealed he called pest control 2 days ago (07/23/25) to come in for their pest control problem. He further revealed pest control came in yesterday to take care of the pest control. Interview on 07/25/25 at 06:58 PM, the ADM revealed gnats had been a new problem since the flood occurred on 07/05/2025. He revealed he had been working at this facility since March. He revealed the only thing he could do to address the pests would be to allow pest control to come in and treat the facility. He revealed there were months that the facility was here every week. 2. Observation on 07/22/2025 at 10:35 AM, a live roach was observed crawling on the floor in Resident #55’s room. (continued on next page)

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	07/31/2025

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview was attempted on 07/22/2025 at 10:40 AM. Resident #55 did not understand the question due to her level of cognitive function and was unable to answer any questions about pests in her room. Record review of Resident #55’s Quarterly MDS Assessment, dated 06/16/2025, reflected that Resident #55 had a BIMS Score of 0, indicating severe cognitive impairment. Observation on 07/24/2025 at 12:04 PM, the medication room on the 200 hallway was observed to have approximately 6-8 flies in an approximately 6 foot by 10 foot room. Record review of facility document titled, “Concern/Grievance Form”, dated 02/19/2025, reflected a concern of, “Bug located in resident’s room”. Record review of facility policy titled, “Pest Control”, dated revised May 2008, reflected, “Our facility shall maintain an effective pest control program”.