STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676114	A. Building B. Wing	09/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Hills Health and Rehabilitation Center	2091 Bandera Hwy 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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38511 Based on interviews and record review, the facility failed to implement their written policies and procedures to report, prohibit, and prevent abuse for 2 of 2 residents (Resident #1 and #2) and 1 of 3 staff(CNA E) reviewed for developing and implementing abuse and neglect policies 1. The facility failed to develop and implement abuse policies for reporting abuse to the State Reporting Agency. 2. The facility failed to develop and implement abuse policies for review of an employee EMR and criminal history at least once every 12 months. These failures could place residents at risk of abuse, neglect, and misappropriation of property. The findings included: 1. Record review of a facility policy, titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program last revised [DATE] revealed the policy did not address reporting of incidents. Record review of Resident #1 face sheet dated [DATE] revealed an admitted [DATE] with readmitted [DATE] and discharge date of [DATE] with diagnoses which included: atherosclerotic heart disease of native coronary artery without angina pectoris , Alzheimer's disease and chronic kidney disease. Record review of Resident #1's Care Plan dated [DATE] revealed the resident used wheelchair for mobility: encourage and monitor independence, keep area free from clutter and monitor proper body alignment, staff to monitor prn and offer assistance as needed/requested. Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed a BIMS could not be assessed/severe cognitive impairment. The assessment also revealed the resident was wheelchair bound, dependent on staff. Record review of Resident #1's progress notes dated [DATE] revealed the resident had an unwitnessed fall where she was observed on the floor with a laceration and hematoma to her forehead. LVN A documented Resident #2 had been moving around in her room in her wheelchair and appears to have been reaching for her doll when she fell . The resident was nauseated and spitting blood and she was unable to determine where the bleeding was coming from. LVN G documented she notified the MD, ADON and sent the resident to the hospital for evaluation. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	Record review of Resident #1's hospital records dated [DATE] revealed the resident had dementia with a progressive neurological decline who presented to the ER after a fall from a wheelchair. A CT of her head shows subluxation of C1 and C2 fracture and displacement (Type II dens fracture with 55 mm retropulsion into the spinal canal) (fracture of upper part of neck nearest the brain type II fractures are often the result of traumatic axial load such as diving into shallow water, falling or motor vehicle accident). She was evaluated by neurosurgery and surgical intervention was discussed with family for fusion of C2 fracture. The MPOA (RP) .was not interested in any surgical intervention at this time .opting instead for palliative care and transferring her to SNF with hospice. During an interview on [DATE] at 11:38 a.m., LVN A stated on [DATE] she was passing medication when someone told her Resident #1 was on the floor in her room. LVN A stated Resident #1 had blood coming from her forehead and she was scared and confused. She stated Resident #1 was spitting out a small amount of blood from her mouth, so she called 911 and notified the ADON. She stated 20 minutes prior to the incident she had applied a medicated cream to Resident #1's back. She stated Resident #1 had been sitting in her wheelchair with her doll in her room, which was typical for the resident. She stated Resident #1 had been properly positioned in the wheelchair at the time. LVN A stated Resident #1 was able to self-propel the wheelchair and carried her doll most of the time but was unable to say what happened, but her doll was found on the floor with her and it seemed she might have been reaching for her doll. During an interview on [DATE] at 1:15 p.m., the ADON accompanied by the Operations Manager stated she was the on-call person on [DATE]. The ADON stated she was notified by staff (unknown) they had found Resident #1 on the floor, and they were not sure what happened. The ADON stated staff found Resident #1 lying flat on the floor by the door (to her room). The ADON stated LVN A informed her she had called 911 because Resident #1 had started complaining of nausea, was gagging, and was coughing up blood. The ADON stated the facility first found out Resident #1 had a fracture to her neck was on [DATE] at approximately 12:45 p.m. She stated LVN A received an update from a local hospital that Resident #1 was transferred to a larger hospital for a spinal fracture. The ADON stated Resident #1 was not able to state how she fell and there were no staff witnesses. She stated she notified the leadership team of Resident #1's spinal injury which included the Operations Manager, DON and department heads via text chat. The ADON stated she the facility management team then participated in a conference call with the Administrator and Corporate RN. The ADON stated on the conference call the leadership acknowledged they were praying for Resident #1. She stated she did not get any further direction from management. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 2:17 p.m., the Operations Manager/AIT stated she was the facility abuse coordinator. The Operations Manager stated anything that gets reported to her received oversite from the Administrator who oversawit all. She stated in her role as Abuse Coordinator she did not make the decision to report or not. She stated the Administrator made the decision on reportables. The Operations Manager stated the ADON had been communicating with the hospital when she found out Resident #1 had been transferred to another hospital for a higher acuity. She stated they had a conference that included the ADON, the Corporate RN, and the Administrator. The Operations Manager stated the facility followed PL ,d+[DATE] (abuse provider letter) on when to report. She stated the PL indicated abuse should be reported to the State Survey Agency within a 2-hour window. She stated injuries of unknown origin should also be reported within 2 hours. She stated she did not consider this circumstance to be an injury of unknown origin because LVN A had been in Resident #1's room [ROOM NUMBER] minutes prior to the incident and no one else had been in the room. She stated no one else had been in the room because LVN A had been working on the hallway and had not seen anyone else in the hallway. She stated she felt like the facility knew what had happened, that Resident #1 fell which resulted in a broken neck. She stated after reviewing PL ,d+[DATE] for reporting requirements of injuries of unknown origin that Resident #1's incident did meet the category of injury of unknow origin. She stated she had not previously reviewed the decision tree for reporting in the provider letter, but after reviewing she agreed it should have been reported. She stated she had communicated with the Administrator about the incident, and he said since they knew it was a fall in her room, they made the decision not to report. During an interview on [DATE] at 3:19 p.m. the Administrator stated her with the company COO and interim facility Administrator had delegated the responsibility of abuse coordinator to the Operations Manager. He stated the Operations Manager was an AIT. The Administrator stated there are no decisions that are made without his knowledge. The Administrator stated he was first notified of Resident #1's injury on [DATE] via phone call. He stated he was told she had a fracture to her neck. He stated based on information in her notes, Resident #1 had been in her room; a nurse saw her 20 minutes before the incident and her doll was next to her which she reached for and fell . The Administrator stated he did not think her injury was suspicious because she had a history of reaching for things. He stated the location of her injury (neck) was vulnerable to trauma. He stated Resident #1's incident was not witnessed by staff and Resident #1 was not able to tell him what happened. He stated based on PL ,d+[DATE] which the facility utilizes for guidance on reporting, the 3rd part of the requirement for reporting included suspicion and this injury did not meet the criteria. The Administrator stated a fractured neck was a significant injury but was not suspicious because of the way she fell . He stated he came to that conclusion because Resident #1 had a hematoma on her forehead, was nauseated and was spitting out blood although the facility was unable to determine where the blood was found (coming from). He stated after completing the investigation of the incident, the Operations Manager and himself came to the conclusion it was not reportable. The Administrator stated the facility policy did not address reportable timeframes and the facility utilized HHSC abuse PL for guidance to reporting (PL , d+[DATE]). 1b. Record review Resident #2's face sheet dated [DATE] revealed an admitted [DATE] with readmitted [DATE] with diagnoses which included: unspecified dementia, depression and unsteadiness on feet. Record review of Resident #2's quarterly MDS dated [DATE] revealed a BIMS of 7 which indicated a severe cognitive impairment. (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of Resident #2's r annual MDS dated [DATE] revealed a BIMS of 12 which indicated a moderate cognitive impairment. Record Review of Resident #2's of Care Plan revealed on [DATE] revealed Resident #2 had behaviors which included: self-transferring from chair to bed and toilet causing bruising and risk for falls, causes self to hit head on wall during self-transfers with interventions which included anticipate and meet Resident #2's needs, intervene as needed. The care plan revealed Resident #2 had dementia and impaired cognitive function with interventions to monitor and report any changes in cognitive function. Record review of a typed statement by PTA D dated [DATE] revealed: Patient (unknown name) was approached for physical therapy and reported that her shoulder was hurting her because of a transfer she was assisted with early this morning. The patient states She slapped me on the chest and on my face with my pillow. She just throws me around and then I hit my head on the wall in the bathroom. During an attempted interview on [DATE] at 2:05 pm Resident #2 was confused and unable to provide any information. During an interview on [DATE] at 2:20 p.m. CNA B stated on Monday, [DATE] she went into Resident #2's room to get her ready for lunch and Resident #2 was very upset. CNA B stated Resident #2 stated a nighttime staff member who used to work in a jail and who treated women likes men grabbed her arms and was shaking her during the night. CNA B stated Resident #2 was able to describe the staff member as a CNA that was pretty, tall, slim with long dark hair. CNA B stated that description fit CNA C. CNA B stated she reported the incident to the Unit Manager, but the ADON came to talk to her about it. During an interview on [DATE] at 1:39 p.m. the ADON stated she received a written statement from a contract worker who worked in physical therapy indicating Resident #2 was hit against the wall during a transfer by an unknown staff member. The ADON stated Resident #2 was upset and her speak and explanation was all over the place. The ADON stated Resident #2 said she put her hands up there and the staff just put her up there. She stated she and the SW were trying to figure out what she meant. The ADON stated Resident #2 was also talking about her sister having died the day before which was not accurate information. The ADON stated the written statement was given to the Operations Manager and Administrator and abuse was implied in the statement. The ADON stated she also interviewed LVN B. She stated she gave all the information to the Operations Manager and then had a conference call about the interviews with staff and residents, residents' statements, BIMS assessment which was low. She stated they had the SW do a bedside BIMS the same day to assesses cognition and the assessment was 4 (which indicated a severe cognitive impairment). The ADON stated Resident #2 was normally alert and oriented x 2. She knew who she was and where she was but could not state date or time of day and had some confusion at baseline. The ADON stated as a team they discussed the findings and unsubstantiated the allegations. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 2:52 p.m., the Operations Manager stated Resident #2 reported that on night shift a really pretty CNA came into toilet her and she did not like that the CNA moved too quickly and when she stood up with her grab bar, the CNA moved too quickly and she bumped her head on the wall. The Operations Manager stated during the investigation it was noted Resident #2 had a lower-than-normal BIMS score and they completed a change of condition for the resident and followed up with her physician. She stated they got orders for a UA because Resident #2 was saying weird staff that was out of character and there was obviously something going on. The Operations manager stated she talked to the Administrator about Resident #2's change of condition and UA. She stated the Administrator did not feel like the incident needed to be reported. The Operations Manager stated after reviewing PL ,d+[DATE] (abuse provider letter) that the abuse with or without serious bodily injury should be reported. She stated she did not make the decision whether to report. During an interview on [DATE] at 3:44 p.m. the Administrator stated the facility follows HHSC guidelines for reporting. He stated he did not agree that the incident with Resident #2 needed to be reported because the investigation revealed the resident had a change of condition that was addressed by the facility. Record review of a facility policy, titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program last revised [DATE] revealed the policy did not address reporting of incidents. Record review of PL ,d+[DATE] titled Abuse, neglect, Exploitation, Misappropriation of Resident Property and Other Incidents that a Nursing Facility Must Report to the Health and Human Services Commission (HHSC) dated [DATE] revealed: 2.1 Incidents that a NF Must Report to HHSC; abuse, neglect, suspicious injuries of unknown source .immediately, but not later than two hours after the incident occurs or is suspected. Attachment #1: Injuries of unknown source: note: 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. Attachment 2 (Decision Tree) Does it involve resident to resident sexual activity-no-Did the event that caused the allegation involve suspected abuse or serious bodily injury? Yes- report the incident within two hours. 2. Record review of a facility policy, titled Abuse, neglect, Exploitation and Misappropriation Prevention Program last revised [DATE] revealed: 4. Conduct employee background checks . The policy did not address when or what checks were included or the time frames when the checks should occur. Record review of CNA E's personnel file revealed the staff member had not had an annual criminal background check or a NAR/EMR check . A review of proof of last criminal background check revealed her last review was dated [DATE] which was more than 17 month prior. A review of CNA's last NAR/EMR check revealed it was last completed [DATE] which was more than 17 months prior. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 5:50 p.m. with the HR Manager with the Operations Manager in attendance and the Administrator from a sister facility in attendance revealed the company completed EMR/NAR and criminal background checks on a yearly basis which occurred in November and December. The HR Manager stated CNA last criminal check was completed ,d+[DATE] and would not be completed again until November or December of 2024. She stated the facility policy was to run them before the staff hit the floor. She stated CNA E's checks were not run in November or December of 2023 but should have been. During an interview on [DATE] at 3:44 p.m., the Administrator stated the HR Director was responsible for ensuring staff met licensing requirements. He stated he provided oversite, but the HR department was the HR Directors department to manage. He stated the facility ran criminal background, EMR/NAR checks annually but not in a calendar year. He stated CNA E had a check completed in 2023 and the checks for 2024 had not been done because they do not do them exactly yearly (as in 12 calendar months). He stated because of the way the HR Director runs the checks CNA E would not receive a new review until end of 2024. He stated CNA E did not get checks in November/[DATE] at the annual review because she already had a review run in the year 2023. He stated he could not answer the question about whether or not that met regulatory requirements until he reviewed the TAC. During further interview on [DATE] at 5:23 p.m., the Administrator with DON in attendance stated the TAC stated the EMR should be reviewed upon hire and on an annual basis although he thought it was vague. The Administrator stated the took the regulation to mean annually as in calendar year and they did them in 2023 and thought the regulation vague in context. The Administrator stated the facility abuse policy does not address time frames for EMR and criminal background checks, nor does the abuse policy mention that the facility utilized HHSC guidelines in the abuse policy. The Administrator stated he TAC 561.2 chapter 561, number 9 for EMR and also utilized TAC for criminal background checks for guidance. The Administrator stated policies are reviewed by the QAPI commit which included the Administrator, DON, HR, department manager, MD and whole QAPI membership. He stated the abuse policy would be required and compared to the TAC to ensure nothing had changed on an annual basis. He stated if something had changed, the policy would change. Record review of an untitled document which the Administrator indicated came from the employee handbook (undated) revealed: Background Checks: .the company is required to conduct criminal history checks on it's employees. Employees will undergo a background check prior to beginning work for the Company, and then will undergo annual background checks once a year thereafter . Record review of a facility document titled Background Screening Investigations last revised [DATE] revealed: 2. The Director of Personnel, or designee, conducts background checks per HHSC guidelines for EMR, reference checks and criminal conviction checks (including fingerprinting as may be required by state law) on all potential direct access employees and contractors. Background and criminal checks are initiated within two days of an offer of employment or contract agreements and completed prior to employment. This policy does not include annual criminal or EMR checks.

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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** 38511 Based on interview and record review, the facility failed to ensure all alleged violations involving abuse, and neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately but not later than 24 hours if the events that caused the allegation did not involve abuse and did not result in serious bodily injury to the State Survey Agency in accordance with State law through established procedures for 2 of 2 residents (Resident #1 and Resident #2) reviewed for reporting. 1. The facility failed to report to the State Survey Agency when Resident #1 had an unwitnessed fall and broke her neck. 2. The facility failed to report to the State Survey Agency when Resident #2 made allegations of being shaken by a staff member These failures could affect place residents by resulting in at risk of a delay of identification of abuse or neglect and lack of timely follow-up on recommended interventions to prevent harm, or impairment. The findings included: 1. Record review of Resident #1 face sheet dated [DATE] revealed an admitted [DATE] with readmitted [DATE] and discharge date of [DATE] with diagnoses which included: arteriosclerotic heart disease of native coronary artery without angina pectoris, Alzheimer's disease and chronic kidney disease. Record review of Resident #1's Care Plan dated [DATE] revealed the resident used wheelchair for mobility: encourage and monitor independence, keep area free from clutter and monitor proper body alignment, staff to monitor prn and offer assistance as needed/requested Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed a BIMS could not be assessed/severe cognitive impairment. The assessment also revealed the resident was wheelchair bound, dependent on staff. Record review of Resident #1's progress notes dated [DATE] revealed the resident had an unwitnessed fall where she was observed on the floor with a laceration and hematoma to her forehead. LVN A documented Resident #2 had been moving around in her room in her wheelchair and appears to have been reaching for her doll when she fell . The resident was nauseated and spitting blood and she was unable to determine where the bleeding was coming from. LVN G documented she notified the MD, ADON and sent the resident to the hospital for evaluation. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's hospital records dated [DATE] revealed the resident had dementia with a progressive neurological decline who presented to the ER after a fall from a wheelchair. A CT of her head shows subluxation of C1 and C2 fracture and displacement (Type II dens fracture with 55 mm retropulsion into the spinal canal) (fracture of upper part of neck nearest the brain type II fractures are often the result of traumatic axial load such as diving into shallow water, falling or motor vehicle accident). She was evaluated by neurosurgery and surgical intervention was discussed with family for fusion of C2 fracture. The MPOA (RP) .was not interested in any surgical intervention at this time .opting instead for palliative care and transferring her to SNF with hospice. During an interview on [DATE] at 8:02 am Resident #1's RP stated the resident had Alzheimer's dementia, was unable to talk or express her needs directly. The RP stated Resident #1 used a wheelchair to move around the facility by pushing the wheelchair with her feet in the hallways and in her room. The RP stated Resident #1 liked to hold a doll most of the time. The RP stated on [DATE] she received a call from LVN A notifying her Resident #1 fell from her wheelchair, hit her head, was nauseated, and was sent to the hospital. The RP stated at the hospital she found out Resident #1 had broken her neck but did not have a concussion or any head injuries. The RP stated because of Resident #1's dementia she was not able to state there was a fall or what had happened to her. During an interview on [DATE] at 11:38 a.m., LVN A stated on [DATE] she was passing medication when someone told her Resident #1 was on the floor in her room. LVN A stated Resident #1 had blood coming from her forehead and she was scared and confused. She stated Resident #1 was spitting out a small amount of blood from her mouth, so she called 911 and notified the ADON. She stated 20 minutes prior to the incident she had applied a medicated cream to Resident #1's back. She stated Resident #1 had been sitting in her wheelchair with her doll in her room, which was typical for the resident. She stated Resident #1 had been properly positioned in the wheelchair at the time. LVN A stated Resident #1 was able to self-propel the wheelchair and carried her doll most of the time but was unable to say what happened, but her doll was found on the floor with her and it seemed she might have been reaching for her doll. (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 1:15 p.m., the ADON accompanied by the Operations Manager stated she was the on-call person on [DATE]. The ADON stated she was notified by staff (unknown) they had found Resident #1 on the floor, and they were not sure what happened. The ADON stated staff found Resident #1 lying flat on the floor by the door (to her room). The ADON stated LVN A informed her she had called 911 because Resident #1 had started complaining of nausea, was gagging, and was coughing up blood. The ADON stated the facility first found out Resident #1 had a fracture to her neck was on [DATE] at approximately 12:45 p.m. She stated LVN A received an update from a local hospital that Resident #1 was transferred to a larger hospital for a spinal fracture. The ADON stated Resident #1 was not able to state how she fell and there were no staff witnesses. She stated she notified the leadership team of Resident #1's spinal injury which included the Operations Manager, DON and department heads via text chat. The ADON stated she the facility management team then participated in a conference call with the Administrator and Corporate RN. The ADON stated on the conference call the leadership acknowledged they were praying for Resident #1. She stated she did not get any further direction from management. She stated she notified Resident #1's physician of the C2 fracture at approximately 6:30 p.m The ADON stated she did not have any concerns about the care of Resident #1 or the response of staff to her fall. She stated staff completed assessments, neurons and responded appropriately when Resident #1 had a change of condition. She stated Resident #1 had not had any other falls that she could remember. She stated her care plan did have fall precautions that were followed, and the facility reviewed and revised her care plan after the fall. The ADON stated Resident #1 was a busybody who roamed around in her wheelchair with her babydoll. She stated she does not think the fall could have been prevented . (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 2:17 p.m., the Operations Manager/AIT stated she was the facility abuse coordinator. She stated if something happens at the facility staff call her. She stated she had been trained to be the Abuse Coordinator from working with previous Administrators on abuse. She stated she was also a licensed SW. She stated reportables in the leadership role was closely tied with her previous role as a SW. The Operations Manager stated anything that gets reported to her received oversite from the Administrator who oversaw it all. She stated in her role as Abuse Coordinator she did not make the decision to report or not. She stated the Administrator made the decision on reportables. The Operations Manager stated she did complete interviews with staff and residents, spoke with families and notified the physician. The Operations Manager stated she asked LVN A what happened regarding Resident #1. She stated LVN A told her she had put a cream on the resident back prior 20 minutes before a CNA notified LVN A Resident #1 was found on the floor. The Operations Manager stated the ADON had been communicating with the hospital when she found out Resident #1 had been transferred to another hospital for a higher acuity. She stated they had a conference that included the ADON, the Corporate RN, and the Administrator. She stated the DON was on leave during this time and was not available. The Operations Manager stated the facility followed PL , d+[DATE] (abuse provider letter) on when to report. She stated the PL indicated abuse should be reported to the State Survey Agency within a 2-hour window. She stated injuries of unknown origin should also be reported within 2 hours. She stated she did not consider this circumstance to be an injury of unknown origin because LVN A had been in Resident #1's room [ROOM NUMBER] minutes prior to the incident and no one else had been in the room. She stated no one else had been in the room because LVN A had been working on the hallway and had see anyone else in the hallway. She stated she felt like the facility knew what had happened, that Resident #1 fell which resulted in a broken neck. She stated after reviewing PL ,d+[DATE] for reporting requirements of injuries of unknown origin that Resident #1's incident did meet the category of injury of unknown origin. She stated she had not previously reviewed the decision tree for reporting in the provider letter, but after reviewing she agreed it should have been reported. She stated she had communicated with the Administrator about the incident and he said since they knew it was a fall in her room they made the decision not to report. During an interview on [DATE] at 3:19 p.m. the Administrator stated her with the company COO and interim facility Administrator. had delegated the responsibility of abuse coordinator to the Operations Manager. He stated the Operations Manager was an AIT. The Administrator stated there are no decisions that are made without his knowledge. He stated he talks to staff multiple times a day. The Administrator stated he was first notified of Resident #1's injury on [DATE] via phone call. He stated he was told she had a fracture to her neck. He stated based on information in her notes, Resident #1 had been in her room; a nurse saw her 20 minutes before the incident and her doll was next to her which she reached for and fell . The Administrator stated he did not think her injury was suspicious because she had a history of reaching for things. He stated the location of her injury (neck) was vulnerable to trauma. He stated Resident #1's incident was not witnessed by staff and Resident #1 was not able to tell him what happened. He stated based on PL , d+[DATE] which the facility utilizes for guidance on reporting, the 3rd part of the requirement for reporting included suspicion and this injury did not meet the criteria. The Administrator stated a fractures neck was a significant injury but was not suspicious because of the way she fell . He stated he came to that conclusion because Resident #1 had a hematoma on her forehead, was nauseated and was spitting out blood although the facility was unable to determine where the blood was found (coming from). He stated after completing the investigation of the incident, the Operations Manager and himself came to the conclusion it was not reportable. (continued on next page)

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	676114	A. Building B. Wing	09/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Hills Health and Rehabilitation Center	2091 Bandera Hwy Kerrville, TX 78028

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident #2's face sheet dated [DATE] revealed an admitted [DATE] with readmitted [DATE] with diagnoses which included: unspecified dementia, depression and unsteadiness on feet. Record review of Resident #2's quarterly MDS dated [DATE] revealed a BIMS of 7 which indicated a severe cognitive impairment. Record review of Resident #2's annual MDS dated [DATE] revealed a BIMS of 12 which indicated a moderate cognitive impairment. Record review of Resident #2's of Care Plan revealed on [DATE] revealed Resident #2 had behaviors which included: self-transferring from chair to bed and toilet causing bruising and risk for falls, causes self to hit head on wall during self-transfers with interventions which included anticipate and meet Resident #2's needs, intervene as needed. The care plan revealed Resident #2 had dementia and impaired cognitive function with interventions to monitor and report any changes in cognitive function. Record review of a typed statement by PTA D dated [DATE] revealed: Patient (unknown name) was approached for physical therapy and reported that her shoulder was hurting her because of a transfer she was assisted with early this morning. The patient states She slapped me on the chest and on my face with my pillow. She just throws me around and then I hit my head on the wall in the bathroom. During an attempted interview on [DATE] at 2:05 p.m. Resident #2 was confused and unable to provide any information. During an interview on [DATE] at 2:20 p.m. CNA B stated on Monday, [DATE] she went into Resident #2's room to get her ready for lunch and Resident #2 was very upset. CNA B stated Resident #2 stated a night time staff member who used to work in a jail and who treated women likes men grabbed her arms and was shaking her during the night. CNA B stated Resident #2 was able to describe the staff member as a CNA that was pretty, tall, slim with long dark hair. CNA B stated that description fit CNA C. CNA B stated she wrote a statement detailing the same information. CNA B stated she reported the incident to the Unit Manager, but the ADON came to talk to her about it. CNA B stated she did not report to the Abuse Coordinator because she could not find her in the building and thought she might not be in the facility for the day, so she reported it to her supervisor. CNA B stated no other residents had complained about CNA C. (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 1:39 p.m. the ADON stated she received a written statement from a contract worker who worked in physical therapy indicating Resident #2 was hit against the wall during a transfer by an unknown staff member. The ADON stated she interviewed Resident #2 who described the staff member as pretty and healthy. The ADON stated CNA C was the aide who had been assigned to work with Resident #2 for the past few nights. The ADON stated Resident #2 was upset and her speech and explanation was all over the place. The ADON stated Resident #2 said she put her hands up there and the staff just put her up there. She stated she and the SW were trying to figure out what she meant. The ADON stated Resident #2 was shaking her fists and was very angry. She stated they tried to calm her down to get more information. The ADON stated Resident #2 was very independent but did need assistance. She stated Resident #2 wants to put her hands on the bar in the bathroom and then wants to pull herself up and wants staff to assist only. The ADON stated what they finally got was that a staff member did not wait for her to do it by herself which upset her. The ADON stated Resident #2 was also talking about her sister having died the day before which was not accurate information. The ADON stated Resident #2 did not use CNA C's name. She stated Resident #2 stated she had never worked with this staff before and indicated she liked working with CNA C and was excited when she was assigned to work with her . The ADON stated CNA C was interviewed and stated there were no incidents that had occurred only that Resident #2 was excited to see her. The ADON stated the written statement was given to the Operations Manager and Administrator and abuse was implied in the statement. The ADON stated she also interviewed LVN B. She stated she gave all the information to the Operations Manager and then had a conference call about the interviews with staff and residents , residents' statements, BIMS assessment which was low. She stated they had the SW do a bedside BIMS the same day to assesses cognition and the assessment was 4 (which indicated a severe cognitive impairment). The ADON stated Resident #2 was normally alert and oriented x 2. She knew who she was and where she was but could not state date or time of day and had some confusion at baseline. The ADON stated as a team they discussed the findings and unsubstantiated the allegations. During an interview on [DATE] at 2:52 p.m., the Operations Manager stated Resident #2 reported that on night shift a really pretty CNA came in to toilet her and she did not like that the CNA moved too quickly and when she stood up with her grab bar, the CNA moved too quickly and she bumped her head on the wall. The Operations Manager stated Resident #2 had a specific way she wanted to be transferred which was really just standby by assistance as she had her own specific routine. She stated as part of the routine of transfer, when she comes up she had contact with the wall with her hair. The Operations Manager stated when speaking with Resident #2 she could not identify the staff. She stated they interviewed CNA C who had been scheduled to work with her. The Operations Manager stated CNA C stated they had a good night and nothing usual had happened. She stated CNA C was familiar with the resident. The Operations Manager stated during the investigation it was noted Resident #2 had a lower-than-normal BIMS score and they completed a change of condition for the resident and followed up with her physician. She stated they got orders for a UA because Resident #2 was saying weird staff that was out of character and there was obviously something going on. The Operations manager stated she talked to the Administrator about Resident #2's change of condition and UA. She stated the Administrator did not feel like the incident needed to be reported. The Operations Manager stated after reviewing PL ,d+[DATE] (abuse provider letter) that the abuse with or without serious bodily injury should be reported. She stated she did not make the decision whether to report. During an interview on [DATE] at 3:44 p.m. the Administrator stated the facility follows HHSC guidelines for reporting. He stated he did not agree that the incident #2 needed to be reported because the investigation revealed the resident had a change of condition that was addressed by the facility. (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 a facility policy, titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program last revised [DATE] revealed the policy did not address reporting of incidents. Record review of PL ,d+[DATE] titled Abuse, neglect, Exploitation, Misappropriation of Resident Property and Other Incidents that a Nursing Facility Must Report to the Health and Human Services Commission (HHSC) dated [DATE] revealed: 2.1 Incidents that a NF Must Report to HHSC; abuse, neglect, suspicious injuries of unknown source .immediately, but not later than two hours after the incident occurs or is suspected. Attachment #1: Injuries of unknown source: note: 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. Attachment 2 (Decision Tree) Does it involve resident to resident sexual activity-no-Did the event that caused the allegation involve suspected abuse or serious bodily injury? Yes- report the incident within two hours.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38511 Based on observation, interview, and record review the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 3 residents (Resident #3) reviewed for pharmacy services. The facility failed to administer Resident #3's morning medications which included 7 medications within the facilities policy window for administration of medications. This failure could place residents at risk of not receiving the therapeutic effects of their prescribed medications. The findings included: Record review of Resident #3's face sheet dated [DATE] revealed an admitted [DATE] and readmitted [DATE] which included: systemic lupus erythematosus with organ or system involvement (systemic autoimmune disease with multisystemic involvement), pain in left hip and long term (current) use of systemic steroids. Record review of Resident #3's Care Plan last revised on [DATE] revealed she had lupus pain medication for chronic pain with interventions which included administer analgesic medications as ordered by physician. Record review of Resident #3's quarterly MDS assessment dated [DATE] revealed a BIMS score of 13 which indicated the resident was cognitively intact. Record review of Resident #3's September MAR and medication Administration Audit report revealed: 1. Amlodipine Besylate tablet 5 mg, give 1 tablet by mouth one time a day for hypertension was scheduled for 8:00 am and was not administered until 12:09 pm by MA F on [DATE]. 2. Esomeprazole Magnesium Capsule delayed release 40 mg, give 1 capsule by mouth two times a day for peptic ulcer disease scheduled for 8:00 am was not administered until 12:09 pm by MA F on [DATE]. 3. Cholecalciferol tablet 1000 unit, give 2 tablets by mouth one time a day for vitamin d deficiency was scheduled at 8:00 am was administered at 12:10 pm by MA F on [DATE]. 4. Prednisone tablet 2.5 mg, give 1 tablet by mouth one time a day was scheduled at 8:00 am was not administered until 12:09 am by MA F on [DATE]. 5. Tylenol tablet, give 650 mg by mouth, two times a day related to system lupus was scheduled at 8:00 am and was not administered until 12:09 pm by MA F on [DATE]. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. Tramadol 50 mg, give 1 tablet by mouth three times a day for pain was scheduled for 9:00 am was not administered until 12:10 pm by MA F on [DATE]. 7. Hydrocodone-Acetaminophen oral tablet ,d+[DATE], give one tablet by mouth two times a day for pain was scheduled for 9:00 am and was not administered until 12:10 pm by MA F on [DATE]. During an interview on [DATE] at 11:19 a.m., Resident #3 stated she was aggravated because she had yet to receive her morning medications as of this interview. She stated she had lupus and needed her medication. She stated her Lupus, and her pain control was dependent of receiving her medication on time to prevent a flare up. She stated when she had a flare up, she would get pain. Resident #3 stated normally her medications arrived on time. She stated this was the first time her medications had been so late. During an observation/interview of MA F on [DATE] at 11:30 am revealed while the MA was passing medication, the computer screen highlighted as red several residents for late medication administration, including Resident #3. During an interview, MA F stated the red lights indicated the medication was late. She stated she had not yet given morning medications to 13 of 36 residents including Resident #3. MA F stated she was late getting to work today. She stated she was supposed to be at work by 6:00 am but did not arrive at work until 8:30 am. She stated she called her supervisor (unknown name) and informed them she was running late. She stated the nurse she was working with (unknown name) knew she was late. She stated she did not specifically tell anyone she was late once she already got to work and did not specifically ask for assistance to ensure medication was given timely because they already knew she was late. She stated she was supposed to administer medications 1 hour before to 1 after schedule time . During an interview on [DATE] at 12:15 p.m., LVN G stated she was the charge nurse over MA F. She stated she herself arrived for work at 5:45 a.m. but was not certain what time medication aides were supposed to arrive for work. LVN G stated at 7:44 am she contacted the ADON/on call staff and notified them MA F had not arrived for work. She stated the on-call person (unknown name) responded that MA F was approximately 20 minutes away. LVN G stated MA F had a pattern of late arrival, and it had something to do with children. She stated it was her normal pattern. LVN G stated MA F did not tell her she was late administering meds. She stated she was not sure what she would have done because she had her own assignment and her own medications to administer. LVN G stated medication should be administered within 1 hour before to 1 hour after the scheduled time. LVN G stated it was important to administer medications on time because labs could be altered if not on time. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 3:56 p.m., the DON stated most staff work from 6 am to 6 pm with some staff working from 6 am -2 pm. She stated her expectation was for staff to be at the facility at 6:00 am but she was not sure what the company policy indicated. She stated she was new to the facility and still in the process of making her expectations of timeliness know to staff. She stated as of this interview she had not yet communicated that expectation to staff. The DON stated she was made aware MA F was coming in late today. She stated she was notified at 8:45 am. The DON stated it was important for staff to arrive at the facility on time for patient safety. She stated staff from the previous shift should stay until someone from the current shift had arrived, however they did not utilize night shift MA's so there was no one to cover that position to her knowledge. The DON stated she was not aware medications were late. The DON stated it was important for staff to administer meds timely 1 hour before or 1 hour after the schedule time expired. She stated it was important for medication half-life, meds needed to be given timely to be effective and/or sometimes meds are given multiple times a day. The DON stated some disease processes were dependent on timely administration. She stated her expectation would be for the medication aide to notify the charge nurse before the medication administration window expired. Record review of the facility policy titled Medication Administration schedule last revised [DATE] revealed: Medications are administered according to established schedules. 3. Scheduled medications are administered within one hour of their prescribed time, unless otherwise specified. 4. Scheduled medications designated as time-critical (medications that may cause harm or sub-therapeutic effect if administered before or after the scheduled time) are administered at the scheduled time or within 30 minutes of scheduled time. 5. Time critical medications are designated by the pharmacy and include b. scheduled opioids used for chronic pain or palliative care.

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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ staff that are licensed, certified, or registered in accordance with state laws. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38511 Based on observation, interview, and record review the facility failed to ensure professional staff were licensed, certified, or registered in accordance with applicable State laws for 1 of 8 staff (LVN A) reviewed for staff qualifications. The facility failed to ensure LVN A transferred her nursing license to Texas from Colorado within 60 days of establishing residency in Texas. This failure could place residents at risk of not receiving care and services from staff who were properly licensed. The findings included: Record review of LVN A's personnel file revealed a Texas Driver's license issues [DATE] with a local Texas address. Record review of Texas Board of Nursing license verification revealed LVN A's Texas nursing license was listed as inactive and had expired on [DATE]. Record review of LVN A's personnel file revealed a Colorado multistate license which expired [DATE]. During an observation/interview on [DATE] at 11:38 a.m., LVN A was observed working in the facility while passing medication. LVN A stated she originally had a Texas nursing license until she moved to Colorado 6 years ago. She stated she had a current Colorado license. LVN A stated she moved back to Texas a couple of years ago and stated she had established permanent residency in Texas. She stated she had notified the Texas BON that she had established residency in Texas and was not aware she needed a Texas license. LVN A stated Texas was her permanent home state. She stated the DON and facility management were aware she did not have a Texas nursing license. She stated they told her it was okay until she renewed her license, and she did not need a Texas license. During an interview on [DATE] at 5:50 p.m. the HR Director along with the Operations Manager and Administrator from a sister facility, the HR Director stated they were aware LVN A Texas nursing license was expired. She stated on [DATE] they had a discussion on residency establishment. The HR Director stated the former DON and former Administrator were informed of LVN A's license situation. The HR Director stated their response was they were aware but since LVN A's Colorado License was still active she could continue to work. The HR Director stated she was not sure if the former DON and former Administrator were aware LVN A had established residency in Texas. The HR Director stated after the discussion on [DATE] with current management it was decided she would be allowed to continue to work. During an interview on [DATE] at 5:50 p.m. the Operations Manager stated she did participate in the meeting on [DATE] about LVN A license and it was decided LVN A would be allowed to continue to work with her Colorado license. (continued on next page)

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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Occupations Code, Title 3 Health Professions, Subtitle E: Regulation of Nursing, Chapter 304: Nurse Licensure Compact, Section 304.0015 Nurse Licensure Compact: revealed: Article IV: Application for Licensure in a Party State: b. a nurse may hold a multistate license, issued by the home state, in only one party state at a time c. If a nurse changes primary state of residence by moving between two party states, the nurse must apply for licensure in the new home state, and the multistate license issued by the prior home state will be deactivated in accordance with applicable rules adopted by the commission. Record review of the Interstate Commission of Nurse Licensure Compact Administrator Final Rules effective [DATE] revealed: page 7 402. Multistate Applicate Responsibilities: 1. On all application forms for multistate licensure in a party state, an applicant shall declare a primary state of residence 2. A multistate licensee who changes primary state of residence to another party state shall apply for a multistate license in the new party state within 60 days. Record review of a facility document (untitled and undated) which the Administrator indicated was from the employee handbook revealed Licensure, Registration, and Certifications: If you are in a position that requires being professionally licensed, registered or certified, it is your responsibility at the employees' expense to maintain current, active credentials while employed by this facility. Failure to do so could result in suspension, or termination of your employment.