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	12/21/2024

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39251 Based on interviews and record review, the facility failed to develop and implement a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality of care for 2 of 4 residents (Resident #1 and Resident #4) reviewed for baseline care plan. The facility failed to initiate a baseline care plan within 48 hours of the admitted for Resident #1 and Resident #4. This failure could affect newly admitted residents and place them at risk of not receiving continuity of care and communication among nursing home staff to ensure their immediate care needs were met. Findings included: Record review of Resident #1's Admission Record, dated 11/14/24, revealed Resident #1 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses which included: malignant melanoma of skin (skin cancer), osteoporosis (weak/brittle bones), muscle weakness, gait/mobility abnormality, lack of coordination, cognitive communication deficit (difficulty with thinking and language), type 2 diabetes (chronic condition that affects the way the body processes blood sugar), memory deficit, frontal lobe and executive function deficit (damage to the frontal lobe of the brain causing impairment in executive function), hypertension (high blood pressure), cerebral infarction (stroke - disrupted blood flow to the brain), and syncope (fainting/passing out) and collapse. Record review of Resident #1's Baseline Care Plan, revealed it was completed on and dated 11/18/24, by LVN H. Record review of Resident #4's Admission Record, dated 12/20/24, revealed Resident #4 was admitted to the facility on [DATE], with diagnoses which included: myocardial infarction (heart attack), hypertension (high blood pressure), dementia (group of thinking and social symptoms that interferes with daily functioning), and anxiety disorder (feeling of dread, fear, or uneasiness). Record review of Resident #4's Baseline Care Plan, revealed it was completed on and dated 11/24/24, by LVN H. (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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/21/24 at 6:32 pm, LVN H (MDS Nurse) said she did not know why the baseline care plans were not completed within 48 hours of admission. LVN H further stated it was technically the admitting nurse's responsibility to complete the baseline care plans. During an interview on 12/21/24 at 7:12 pm, LVN M (ADON) said the floor nurses were responsible for completing the assessment part of the baseline care plans. LVN M further stated the IDT reviewed the baseline care plans during the morning meeting and ensured they were complete. LVN M said the ADONs were responsible for ensuring the baseline care plans were completed within 48 hours of the residents' admission. The facility did not have a DON during the investigation. Record review of the facility's policy titled, Care Plans - Baseline, dated 2001 and revised 2022, revealed: .A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission .

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39251 Based on interviews and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident's rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 2 of 4 residents (Resident #1 and Resident #4) reviewed for care plans. The facility failed to develop a person-centered care plan with interventions that addressed: 1. Resident #1's ADL needs; risk for falls; cognitive deficits, dietary needs, therapy; and discharge planning. 2. Resident #4's ADL needs, cognitive deficits, dietary needs, hospice, medication side effects, treatments, and medications. This deficient practice could affect residents and place them at risk for not having their needs and preferences met. Findings included: 1. Record review of Resident #1's Admission Record, dated 11/14/24, revealed Resident #1 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses which included: malignant melanoma of skin (skin cancer), osteoporosis (weak/brittle bones), muscle weakness, gait/mobility abnormality, lack of coordination, cognitive communication deficit (difficulty with thinking and language), type 2 diabetes (chronic condition that affects the way the body processes blood sugar), memory deficit, frontal lobe and executive function deficit (damage to the frontal lobe of the brain causing impairment in executive function), hypertension (high blood pressure), cerebral infarction (stroke - disrupted blood flow to the brain), and syncope (fainting/passing out) and collapse. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's comprehensive MDS assessment, dated 11/18/24, revealed the resident had a BIMS score of 11, indicating moderately impaired cognition. Further review of the MDS revealed: Resident #1 felt down, depressed, or hopeless on several days; had an impairment to a lower extremity; required partial/moderate assistance with toileting hygiene, shower/bathe self, dressing lower body, and substantial assistance with putting on/taking off footwear; moderate assistance with mobility and transfers; occasionally incontinent of bladder; active diagnoses included: Cancer, DVT/PE, hypertension, diabetes mellitus, hyperlipidemia (high cholesterol), osteoporosis (brittle bones), depression, memory deficit, frontal lobe and executive function deficit, muscle weakness, abnormalities of gait and mobility, lack of coordination, cognitive communication deficit, and restless legs syndrome; received pain medication in the last 5 days; was at risk of developing pressure ulcers/injuries, had a surgical wound; received insulin injections; received antidepressant, anticoagulant, opioid, antiplatelet, and hypoglycemic medications; ST to start 11/15/24, OT to start 11/15/24, and PT to start 11/15/24; resident preferred to discharge to the community. The MDS assessment revealed related care area (CAA) triggers included: Cognitive loss/dementia, ADL function/rehabilitation potential, urinary incontinence/indwelling catheter, psychosocial well-being, activities, falls, dehydration/fluid maintenance, pressure ulcer, and psychotropic drug use. Record review of Resident #1's Care Plan, dated 12/15/24, revealed the following focus areas: allergies, activities, diabetes, actual falls, anticoagulant therapy, and antidepressant medication. Record review of Resident #1s' Order Summary Report, dated 12/15/24, revealed orders for the following: Regular diet (fortified meal plan), monitoring for side effects of anticoagulant and antidepressant medications, wound care, code status, pain monitoring/assessment, and weekly skin assessments. 2. Record review of Resident #4's Admission Record, dated 12/20/24, revealed Resident #4 was admitted to the facility on [DATE], with diagnoses which included: Myocardial infarction (heart attack), hypertension (high blood pressure), dementia (group of thinking and social symptoms that interferes with daily functioning), and anxiety disorder (feeling of dread, fear, or uneasiness). Record review of Resident #4's comprehensive MDS assessment, dated 11/26/24, revealed the resident had a BIMS score of 6, indicating severely impaired cognition. Further review of the MDS revealed: Resident #4 required partial/moderate assistance with eating, oral hygiene, upper body dressing, and personal hygiene, required substantial assistance with toileting hygiene, dressing lower body, and putting on/taking off footwear; substantial assistance with mobility and transfers; always incontinent of bladder and occasionally incontinent of bowel; active diagnoses included: CAD, hypertension, Non-Alzheimer's Dementia, anxiety disorder, and myocardial infarction; received pain medication in the last 5 days; had a fall; was at risk of developing pressure ulcers/injuries; received antipsychotic, antianxiety, and antidepressant medications; received hospice care; resident preferred to remain in the facility. The MDS assessment revealed related care area (CAA) triggers included: Cognitive loss/dementia, communication, ADL function/rehabilitation potential, urinary incontinence/indwelling catheter, behavioral symptoms, falls, nutritional states, pressure ulcer, and psychotropic drug use. Record review of Resident #4's Care Plan, dated 12/20/24, revealed the following focus areas: Code status, activities, risk for skin shearing, actual falls, and risk for falls (added on 12/20/24). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #4's Order Summary Report, dated 12/20/24, revealed orders for the following: Regular diet (fortified meal plan), monitoring for side effects of antianxiety, antipsychotic, and antidepressant medications, hospice, wound care, code status, pain monitoring/assessment, and weekly skin assessments. During an interview on 12/21/24 at 6:32 pm, LVN H said the comprehensive care plans were completed using the information from the MDS assessment, because the MDS assessment addressed medications, level of care, ADL assistance, incontinent care, the BIMS score, behaviors, activities, pain, and nutrition. LVN H said all this information from the MDS assessment was then carried over to the care plan. LVN H said the facility used a resource MDS nurse, who completed certain sections of the MDS. LVN H said she did not pull Resident #1's MDS assessments sections completed by the resource MDS nurse onto Resident #1's care plan. For Resident #4's care plan, LVN H said, that was on me, I need to catch up on care plans. LVN H further stated she assumed when someone else completed an MDS section that person also completed the care plan. LVN H said as the MDS Coordinator it was her responsibility to ensure care plans were complete and accurate. LVN H said the facility policy regarding care plans was that they had to be completed within 7 days of the admission MDS assessment, reviewed quarterly and annually, and updated if necessary. The facility did not have a DON during the investigation. During an interview on 12/21/24 at 8:03 pm, the Administrator said the MDS nurse was responsible for ensuring care plans were complete and accurate. Record review of facility's policy, titled Care Plans, Comprehensive Person-Centered dated 2001, revealed: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . 3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment . 7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: (1) services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; (2) any specialized services to be provided as a result of PASARR recommendations; and (3) which professional services are responsible for each element of care . c. includes the resident's stated goals upon admission and desired outcomes; d. builds on the resident's strengths; and (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. reflects currently recognized standards of practice for problem areas and conditions. 8. Services provided for or arranged by the facility and outlined in the comprehensive care plan are: a. provided by qualified persons; b. culturally competent; and c. trauma-informed . 10. When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers. 11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39251 Based on observations, interviews, and record review, the facility failed to review and revise resident care plans after each assessment for 1 of 4 residents (Resident #1) reviewed for care plan revision/timing. The facility failed to ensure Resident #1's care plan was revised to reflect falls on (4) occasions. This deficient practice could affect residents the care/services and may cause a delay in treatment and/or decline in health. Findings included: Record review of Resident #1's Admission Record, dated 11/14/24, revealed Resident #1 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses which included: malignant melanoma of skin (skin cancer), osteoporosis (weak/brittle bones), muscle weakness, gait/mobility abnormality, lack of coordination, cognitive communication deficit (difficulty with thinking and language), type 2 diabetes (chronic condition that affects the way the body processes blood sugar), memory deficit, frontal lobe and executive function deficit (damage to the frontal lobe of the brain causing impairment in executive function), hypertension (high blood pressure), cerebral infarction (stroke - disrupted blood flow to the brain), and syncope (fainting/passing out) and collapse. Record review of Resident #1's comprehensive MDS assessment, dated 11/18/24, revealed the resident had a BIMS score of 11, indicating moderately impaired. Record review of the facility's incident log, dated 12/15/24, revealed Resident #1 had falls on 11/19/24, 11/25/24, two falls on 11/27/24, 12/11/24, and 12/13/24. Record review of Resident #1's Care Plan, dated 12/15/24, revealed: [Resident #1] has had an actual fall with no injury r/t Poor Balance and Unsteady gait 11/27/24 11/28/24, initiated on 11/28/24 and revised on 12/6/24. Goal: [Resident #1] will resume usual activities without further incident through the review date., initiated on 11/28/24 and target date 12/8/24. Interventions/Tasks for the focus included: Call don't fall signs in room initiated 12/6/24, Continue interventions on the at-risk plan, initiated 11/28/24, fall mat at bedside, initiated 12/6/24, Fall mat beside residents [sic] bed to help prevent injury due to falls out of bed, initiated 11/28/24, and PT consult for strength and mobility, initiated 11/28/24. During an interview on 12/18/24 at 2:31 pm, LVN L said LVN H was responsible for the resident care plans. During a telephone interview on 12/19/24 at 12:27 pm, the CVP said from her understanding Resident #1's care plan had been updated after each fall with additional interventions discussed in the IDT meetings. The CVP further stated care plans were updated during the meeting as interventions were discussed. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and observation on 12/19/24 at 3:20 pm, Resident #1 was sitting in a recliner in her hospital room, green/purple discoloration was noted to the left temple, area surrounding the left eye and the left hand. Resident #1 said she thought she had fallen at the facility four times. During a telephone interview on 12/21/24 at 5:56 pm, LVN D said the floor nurses did not review or update care plans, they just informed each other of changes during shift report. During an interview on 12/21/24 at 6:32 pm, LVN H said other interventions should have been put in place for Resident #1 if she continued to fall. LVN H further stated each fall should have been reviewed but she was not in the facility during some the days Resident #1 sustained falls. LVN H said incidents and related documentation were reviewed during the morning meetings as well as what the residents were doing prior to the incident. LVN H said interventions were then put in place depending on the action that caused the incident. LVN H said she did not know why this was not done after each of Resident #1's falls. LVN H said the facility policy regarding care plans was that they be reviewed quarterly, annually, and updated if necessary. LVN H said as the MDS coordinator, she was responsible for ensuring care plans were updated. The facility did not have a DON during the investigation. During an interview on 12/21/24 at 8:03 pm, the Administrator said the MDS nurse was responsible for ensuring care plans were complete and accurate. Record review of facility's policy, titled Care Plans, Comprehensive Person-Centered dated 2001, revealed: . 12. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition; b. when the desired outcome is not met .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39251 Based on observations, interviews, and record review the facility failed to ensure that each resident received adequate supervision and assistance devices to prevent accidents for 1 of 4 residents (Resident #1) reviewed for accidents and supervision. The facility failed to ensure Resident #1 had adequate interventions and supervision in place to prevent accidents for Resident #1. Resident #1 had seven falls in 1 month (11/19/24, 11/25/24, 11/27/24 x2, 12/11/24 x2, and 12/13/24), the last of which resulted in injuries and hospitalization . An IJ was identified on 12/19/24. The IJ template was provided to the facility on [DATE] at 7:15 pm. While the IJ was removed on 12/21/24, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm because the facility needed to monitor the implementation of the plan of removal. These failures placed the resident at risk for accidents and serious injuries. Findings included: Record review of Resident #1's Admission Record, dated 11/14/24, revealed Resident #1 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses which included: malignant melanoma of skin (skin cancer), osteoporosis (weak/brittle bones), muscle weakness, gait/mobility abnormality, lack of coordination, cognitive communication deficit (difficulty with thinking and language), type 2 diabetes (chronic condition that affects the way the body processes blood sugar), memory deficit, frontal lobe and executive function deficit (damage to the frontal lobe of the brain causing impairment in executive function), hypertension (high blood pressure), cerebral infarction (stroke - disrupted blood flow to the brain), and syncope (fainting/passing out) and collapse. Record review of Resident #1's Comprehensive MDS assessment, dated 11/18/24, revealed Resident #1 had a BIMS score of 11, suggesting moderate cognitive impairment. Further review revealed Resident #1 had an impairment to a lower extremity, required partial/moderate assistance (Helper does less than half the effort. Helper lifts, holds. Or supports trunk or limbs) toileting hygiene, sit to stand, chair/bed-to-chair transfer, and toilet transfer; and was dependent (Helper does all the effort) to walk ten feet and picking up objects; required supervision/touch assistance to wheel 50 feet with two turns. Record review of Resident #1's Baseline Care Plan, dated 11/18/24, revealed Resident #1 had a history of falls. Record review of Resident #1's Order Summary, dated 12/15/24, revealed: Duloxetine 60 Mg once a day (used to treat Depression), Losartan Potassium 100 Mg once a day (used to treat high blood pressure), Metoprolol 100 Mg once a day (used to treat high blood pressure), and Tramadol 50 Mg as PRN (used to treat pain). (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's Care Plan, dated 12/15/24, revealed: [Resident #1] has had an actual fall with no injury r/t Poor Balance and Unsteady gait 11/27/24 11/28/24, initiated on 11/28/24 and revised on 12/6/24. Interventions/Tasks for the focus included: Call don't fall signs in room initiated 12/6/24, Continue interventions on the at-risk plan, initiated 11/28/24, fall mat at bedside, initiated 12/6/24, Fall mat beside residents [sic] bed to help prevent injury due to falls out of bed, initiated 11/28/24, and PT consult for strength and mobility, initiated 11/28/24. Record review of the facility's incident log, dated 12/15/24, revealed Resident #1 had falls on 11/19/24, 11/25/24, two falls on 11/27/24, 12/11/24, and 12/13/24. Record review of Resident #1's Fall Risk Evaluation, dated 11/14/24, revealed a score of 2. Further review of the evaluation revealed it was incomplete. Further review of the evaluations revealed .If the total score is ten or greater, the resident should be considered at HIGH RISK for potential falls. Prevention protocol should be initiated immediately and documented on the care plan . Record review of Resident #1's Fall Risk Evaluation, dated 11/14/24 and completed on 12/15/24, revealed a score of 19. Fall Risk Evaluation, dated 11/19/24, revealed a score of 13; 11/25/24, revealed a score of 20; 11/28/24, revealed a score of 22; 12/11/24, revealed a score of 20; and 12/13/24, revealed a score of 17. Further review of the evaluations revealed .If the total score is ten or greater, the resident should be considered at HIGH RISK for potential falls. Prevention protocol should be initiated immediately and documented on the care plan . Record review of Resident #1's Therapy Screen, dated 11/25/24, revealed: fall screen; patient educated on calling nursing staff for assistance with obtaining clothing as pt reports she fell out of her chair trying to get clothes. She reports she slid out of her char [sic]. Per nursing pt found sitting on floor in front of her closet and in front of w/c .will continue to educate and monitor for any falls. Record review of Resident #1's Therapy Screen, dated 11/29/24, revealed: Fall screen .reported to have multiple falls recently. Pt educated on transfer training from w/c-toilet-w/c and w/c-bed-w/c with use of .grab bar. Pt given constant reminders to always call for assistance with all transfers. Record review of Resident #1's Therapy Screen, dated 12/11/24, revealed: Fall screen-Pt had 2 falls today, one in the morning when attempting to pick up a small piece of paper from the floor and Pt fell later in day when attempting to gather items from bedside with falling out of w/c. Nursing, therapy, and aides in room educating and reminding pt to use call light prior to standing or reaching for items. Pt is very unsafe and does not recall safety techniques .We will continue to educate pt on safety and precautions. Record review of Resident #1's Therapy Screen, dated 11/21/24, revealed: Patient sustained a fall from attempting to stand up from WC using the end of the bed rail for assistance and walk into the bathroom, patient ending up falling to the floor landing on her buttocks .educated on importance of asking for assistance and using call light. Record review of Resident #1's Progress Notes revealed: 11/19/24 - No progress notes regarding Resident #1's fall. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	11/25/24 at 2:18 pm - This nurse called to room by CNA after resident was found on the floor. Upon entering room resident found in sitting position with legs out in front of her, non-skid socks in place. Resident in front of closet. Wheelchair with seat cushion upright, brakesunlocked [sic], positioned behind resident .Author: [LVN E] . 11/27/24 at 7:00 pm - Resident had unwitnessed fall in the bathroom. Resident stated she was trying to get up to wipe after using the bathroom. Resident stated that her surgical shoe, is what made her fall. Resident was found in the shower on her left side/back .Educated resident on using call light system for help and to not get up on her own .Author: [LVN D] . 11/27/24 at 11:35 pm - .SBAR .RESIDENT NOTED LYING ON RT SIDE ON FLOOR, NEXT TO BED, STATED I WAS TRYING TO ANSWER MY PHONE IT WAS RINGING, RESIDENT ASSESSED, VS TAKEN, NEURO CHECKS INITIATED PER FACILITY PROTOCOL, SKIN ASSESSMENT HEAD TO TOE DONE .FALL PRECAUTIONS INITIATED FLOOR MATTS [sic] IN PLACE, WILL CONTINUE TO MONITOR . 12/11/24 at 5:11 am - RESIDENT CONTINUES MONITORING UNWITNESSED FALL DAY 1/3 /C NEURO CHECKS, NO S/S ACUTE DISTRESS, NO C/O PAIN OR DISCOMFORT VOICED .WILL CONTINUE TO MONITOR. Author: [LVN F] . 12/13/24 at 1:53 pm - S/P Fall day 3/3 Resident continues to try and self-transfer. Resident needs constant monitoring and reorientation. Resident utilizes call light but does not wait for assistance. Resident educated on importance of waiting for staff assistance with transfers. Neuros assessed per protocol. Author: [LVN E] . 12/13/24 at 6:20 pm - .head to Toe assessment performed. resident unconscious, and resident breathing. Unable to arouse resident and assess pain. Awaiting EMS arrival. Author: [LVN D] . 12/13/24 at 6:25 pm - Awaiting EMS arrival. This nurse by residents [sic] side, reassuring resident that staff is with her. Resident still unconscious. Resident is still breathing. Author: [LVN D] . 12/13/24 at 6:33 pm - .at approximately [6:15 pm] [MA A] the medication aide alerted this nurse that our resident [Resident #1] was on the floor from an unwitnessed fall. resident was found on the floor face down, left arm underneath her body. Resident was unconscious. Blood evident on the [sic] floor. Residents nose was bleeding, Unsure from the way resident was laying if head laceration occured [sic]. Resident unable to respond to questions. Vitals 98.6 T, 159/95 BP, 80 Heart rate. EMS immediately called. resident finally able to respond to pain. Resident unable to tell us what hurt. EMS arrived on scene and assessed resident. Resident put in C-collar by Ems and taken out to hospital. ADON [LVN L] notified once resident was taken by EMS. MD notified as well. Residents' [sic] roommate said resident got upeven [sic] though she told her to call but resident did not listen to her. Roommate was the one who initiated and called for help. Author: [LVN D] . Record review of the facility's incident reports revealed: 11/19/24 at 10:51 pm - .Per CNA [CNA O], resident had witnessed fall. CNA [CNA O] stated that the resident was in her wheelchair and tried holding onto the edge of the bed to stand up to go to the bathroom. Upon trying to stand, [CNA O] stated she witness [sic] the resident slide down onto the ground from wheelchair. Per [CNA O] CNA, and resident, resident did not hit her head and landed strictly on bottom. No skin tears or bruising or pain present . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	11/25/24 at 1:28 pm - .This nurse called to room by CNA after resident was found on the floor. Upon entering room resident found in sitting position with legs out in front of her, non-skid socks in place. Resident in front of closet. Wheelchair with seat cushion upright, brakes unlocked, positioned behind resident. Resident alert and oriented x3, respirations even and unlabored, denies pain. I was sitting on the edge of my wheelchair trying to reach in the closet when I jut plopped down straight on my but [sic] . 11/27/24 at 11:15 pm - .Resident was found lying on the bathroom floor in shower. Resident stated she tried to stand up and wipe herself. Resident stated that her surgical shoe is what caused her to fall. Resident was found lying on her left side/back. Resident denied pain at initial assessment. Neurological asssessment [sic], and pain assessment completed at this time .Resident stated she did not hit her head . 11/27/24 at 11:35 pm - .RESIDENT NOTED LYING ON RT SIDE ON FLOOR, NEXT TO BED, STATED I WAS TRYING TO ANSWER MY PHONE IT WAS RINGING, RESIDENT ASSESSED, VS TAKEN, NEURO CHECKS INITIATED PER FACILITY PROTOCOL, SKIN ASSESSMENT HEAD TO TOE DONE, HEAD NORMOCEPHALIC, NO S/S ACUTE DISTRESS, RESIDENT ABLE TO MOVE ALL EXTREMITITES, NO C/O PAIN OR DISCOMFORT, NON-SKID SOCKS ON AT TIME OF INCIDENT, RESIDENT NON COMPLIANT CONTINUES TO ATTEMPT TRANSFERS WITHOUT ASSITANCE, POOR SAFETY AWARENESS, BED AT LOWEST POSITION. CALL LIGHT WITHIN REACH, REITERATED IMPORTANCE OF USING CALL LIGHT FOR ASSISTANCE, RESIDENT ACKNOWLEGES UNDERSTANDING STATING I KNOW ,I KNOW I SHOULD CALL, YOU ALL WILL BE HAPPY WHEN I LEAVE THIS PLACE, BLAME MY FALL TO THE PERSON CALLING MY PHONE AT THIS TIME . 12/11/24 at 4:35 am - .RESIDENT UNWITNESSED FALL , NOTED SITTING ON BUTTOCKS IN FRONT OF RECLINER, RESIDENT ASSESSED, HEAD TO TOE DONE, NO VISIBLE INJURIES NOTED, VS TAKEN, NEURO CHECKS INITITATED PER FACILITY PROTOCOL, NON-SKID SOCKS ON AT TIME OF INICIDENT, RESIDENT STATED I WAS TRYING TO PICK UP MY REMOTE TO WATCH TV, IT fell RESIDENT REITERATED THE IMPORTANCE OF USING CALL LIGHT FOR ASSISTANCE, STATED YES , I KNOW, I DID NOT FALL I JUST SLID OFF MY CHAIR, NO NOTHING HURTS AND NO I DID NOT HIT MY HEAD, IM SORRY RESIDENT ASSISTED ONTO W/C AND IS NOW IN COMMON AREA WATCHING TV, WILL CONTINUE TO MONITOR, MD, AND ADON NOTIFIED, RESIDENT SELF RP. RESIDENT STATED I WAS TRYING TO PICK UP MY REMOTE TO WATCH TV, IT fell STATED YES, I KNOW, YOU DONT HAVE TO TELL ANYONE I JUST SLID OF MY CHAIR, NO NOTHING HURTS AND NO I DID NOT HIT MY HEAD, IM SORRY . 12/11/24 at 2:55 pm - .CNA came to grab this nurse to let her know resident had un-witnessed fall. Resident observed on her left hip in front of wheelchair. Resident stated no pain, and that she knows she is supposed to call for help transferring but just didn't call. Neuro assessment done and resident at neurological baseline. Resident able to move bilateral upper and lower extremities. Re educated resident on call light use . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	12/13/24 at 6:15 pm - .At approximately 18:15 [6:15 pm] the medication aide alerted this nurse that our resident [Resident #1] was observed on the floor from an un witnessed fall by the CNA on the hall, however fall witnessed by resident's roommate. Resident was observed with her face down on the floor, and left arm underneath her body. Resident was unconscious, respiration noted, but unable to respond or answer any of my questions that were asked. Blood was evident on the floor underneath resident's face, nose noted to be bleeding at this time. Unable to move resident due to a possible neck or back Injury. Unsure from the way resident was laying if head laceration occurred. EMS immediately notified. This nurse continued to reassure resident that there was staff with her. this nurse stayed with resident until EMS arrived on scene. EMS then arrived on scene, where they also performed a head to toe assessment, at this time resident still unconscious. EMS then put resident into a C-Collar and resident began to respond and answer questions from EMS regarding her pain level and stated she hurt all over her body EMS immediately transported her out. ADON notified at 18:25 [6:25 pm] once resident was safe with EMS. [MD] notified at 18:40 [6:40 pm]. Resident Unable to give Description . Record review of Resident #1's Hospital B documentation, dated 12/17/24, revealed Dementia and diagnostic report on a CT scan of Resident #1's brain/head without contrast. The report, dated 12/13/24, revealed IMPRESSION: .subarachnoid hemorrhage .Left frontal scalp hematoma . During a telephone interview on 12/15/24 at 2:45 pm, LVN D said Resident #1 had fallen on 12/13/24 and was found on the floor in her room face down with her left arm under her body, there was blood on the floor, and blood was coming from her nose. LVN D said she was unsure if Resident #1 had a head laceration and was not moved because they were unsure if she had a neck injury. LVN D said Resident #1 was breathing but snoring and her vitals were normal. EMS was called, LVN D said Resident #1 did not wake up at all. LVN D said Resident #1 did not respond to questions from EMS but did open her eyes when EMS turned her over. LVN D further stated Resident #1 said she hurt all over. LVN D said the fall was unwitnessed by staff but Resident #1's roommate said Resident #1 was getting up out of her wheelchair and her roommate told her not to get up and to use the call light. LVN D said Resident #1 did not like to use her call light. LVN D further stated Resident #1 had been educated about using the call light. LVN D said Resident #1 would apologize for not using the call light to ask for assistance. LVN D said Resident #1 had sustained other falls with no injuries. LVN D said there were signs in each resident's room, reminding them to use the call light, especially if they have fallen, but could not recall if Resident #1 had or not. LVN D said she did not remember if the fall mat was next to Resident #1's bed. During a telephone interview on 12/15/25 at 2:53 pm, CMA A said on 12/23/24 she was preparing medications when she heard someone yelling for help. CMA A saw Resident #1 on the floor, checked to see if she was okay, and told the nurse. CMA A further stated Resident #1 was fast asleep that hit knocked her out, staff called EMS. CMA A said she had walked by earlier and Resident #1 was sitting in her wheelchair by her bed, facing the door. CMA A said Resident #1 was able to use the call light and was coherent to use it. CMA A said she had caught Resident #1 transferring from the bed to the chair and told her to use the light when she wanted to transfer. CMA A further stated she would remind Resident #1 to use the call light when she saw her. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 12/15/24 at 3:05 pm, CNA B said on 12/13/24 Resident #1 fell within 20 minutes after the start of her shift. CNA B said she and the CNA from the previous shift just completed a hall walk to ensure her residents were safe. CNA B said she was assisting another resident across the hall in the restroom when she heard someone start to yell so she asked CMA A to see what was going. CNA B said she was told by CMA A that Resident #1 was on the floor. CNA B said Resident #1 had knocked herself out and she was snoring. CNA B said Resident #1 had to be in a state of unconsciousness when she landed because the position she was in was not natural. CNA B said during her round Resident #1 was sitting in her wheelchair. CNA B said this was only the second shift she worked on the skilled hall but had heard Resident #1 was a huge fall risk. CNA B said she saw Resident #1 trying to get up a few times on the shift prior and staff went in to redirect her, made sure the call light was in reach, and asked her to use it. CNA B said Resident #1 tried to get out of bed or her wheelchair without assistance. CNA B further stated she was not sure if Resident #1 had dementia, but staff had to reiterate. Interview on 12/15/24 at 2:15 pm, Resident #1's roommate said she was sitting in the room when she saw Resident #1 standing on12/13/24 but was unsure why she got up. Resident #1's roommate said she did not actually see her fall because it was dark. The state investigator did not observe a Call don't fall or fall mat in Resident #1's room. During an interview and observation on 12/16/24 at 4:45 pm, LVN D said Resident #1 was unsteady and had a surgical shoe that made her more unsteady. LVN D further stated Resident #1 could bare weight with assistance and was not able to walk on her own. LVN D said the fall mat in Resident #1's room might have contributed to the fall on 12/13/24 because of the surgical shoe. LVN D said Resident #1 was not on a toileting schedule and was able to tell staff when she needed to use the restroom. LVN D said she did not know how often Resident #1 was checked on the other shifts but on her shift the aides went up and down the hall about every thirty minutes and so did she. Resident #1's room was observed to be in the middle of the hallway with a table and two empty chairs outside the door. During an interview on 12/16/24 at 5:02 pm, CNA C said Resident #1 was asked her every 2 hours if she needed to use the restroom or she would let the staff know when she needed to use the restroom. CNA C said she tried to get to know her residents as much as possible or would find out from the therapy department the level of care residents required. CNA C said she did not know how to access the Kardex (document used to view the residents' level of need/care) and did think CNAs could have access to them. CNA C said Resident #1 was able to use the call light to call for assistance. CNA C further stated Resident #1 had started getting up more without help but was not sure when this started. CNA C said Resident #1 did not have a fall mat. CNA C said the staff told Resident #1 not to get up alone and Resident #1 would say yeah I know but she still got up without calling for help. CNA C said she had seen Resident #1 trying to stand at times and went in her room to assist her. CNA C said Resident #1 did not have special supervision and did not know how often the nurses went into her room. CNA C said she did not know what the facility's At risk plan or Fall protocol were. CNA C said if a resident fell staff were required to notify the nurse immediately and the nurses followed up with interventions. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 12/18/24 at 12:27 pm, LVN E said she did not think Resident #1 fell on [DATE] but remembered LVN F said Resident #1 had fallen on her shift. LVN E said Resident #1 did fall on 11/25/24 while looking for clothes in her closet. LVN E said she told Resident #1 not to get up and to use her call light. LVN E further stated she did not think Resident #1 had new interventions after 11/28/24. LVN E said Resident #1 never had a fall mat in her room and thought the fall mat would have put Resident #1 at a higher risk for falls. She stated she was never really in bed during the day, she was usually in the wheelchair or recliner, and she would self-transfer so she thought the mat would have tripped her. LVN E said the facility's fall protocol was to initiate neuro checks and make sure the residents' call light was within reach. LVN E said she did not think Resident #1 refused to use the call light but just forgot. LVN E further stated Resident #1 was forgetful and was confused at times, adding she thought Resident #1 had dementia. LVN E said she did not review resident care plans, did not know where to find them, and had not heard of any expectations regarding reviewing care plans. LVN E said she learned about the residents' level of care through the hospital paperwork, what the CNAs saw, shift report, and if the residents needed a higher level of care, therapy would usually let the staff know. LVN E said Resident #1's room was in the middle of the hallway where the CNAs sat to complete their documentation. LVN E further stated the CNAs sat at the table outside Resident #1's room from time to time. During an interview on 12/18/24 at 1:42 pm, the PTA said Resident #1 had had multiple falls during self-attempted transfers since her admission despite repeated education reminding her not to self-transfer. The PTA said she educated Resident #1 every day and she demonstrated no carry over between sessions, there was poor cognitive insight to her own deficits. The PTA said Resident #1's poor cognition was communicated to the nursing staff and documented in the daily notes that Resident #1 was a very high fall risk. The PTA said Resident #1 did not have a floor mat because she was not falling off the bed but fell during self-transfers, during functional tasks. The PTA said a fall mat would have probably put Resident #1 at a higher risk for falls and if staff had added a fall mat to Resident #1's care plan it was not communicated to her. The PTA said Resident #1's cognitive status was very poor since her admission, she had significant safety awareness deficits, and needed constant reminders. During an interview on 12/18/24 at 1:55 pm COTA K said Resident #1 was working on cognitive things during therapy, she was very forgetful, easily distracted, her problem solving and sequencing were bad. COTA K said she focused on the call light with Resident #1, because she had a lot of falls and just was not safe. COTA K said she thought Resident #1's cognition had gotten worse. COTA K said their main goal was to keep Resident #1 safe because her balance was poor. COTA K said Resident #1's condition had been communicated to the nursing staff. COTA K said the staff reminded Resident #1 to use the call light but it was about her remembering to use it. COTA K said Resident #1 did not have increased supervision other than her room door was kept open. COTA K said she had to repeat instructions to Resident #1 during therapy sessions because she forgot the task they were working on during the same session. During a telephone interview on 12/18/24 at 2:14 pm, Resident #1's family member said Resident #1's medical/surgical history had taken a toll on her cognitively. Resident #1's family member said Resident #1 had been feeling dizzy. Resident #1's family member further stated Resident #1's cognitive decline had been more than normal in the last couple of months and she got confused. Resident #1's family member said she did not know if Resident #1 remembered to use the call light and wait for assistance. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 12/18/24 at 2:31 pm, LVN L said she did not know if Resident #1 was falling due to lack of memory, but she kept trying to get up and would fall, and she had a surgical shoe and she would try to walk with that shoe. LVN L further stated Resident #1 was forgetful. LVN L said she did not think Resident #1 was not purposefully non-complaint. LVN L said Resident #1 had call don't fall sign, a fall mat, and verbal redirection on her care plan. LVN L said she could not say how long Resident #1 retained information regarding using the call light. LVN L said Resident #1's room was located by the CNAs table and there was a CNA at the table a lot of times. LVN L said Resident #1 was off balance because of the surgical shoe and did not start falling until after she got the surgical shoe. LVN L said she did not know why Resident #1 had not been moved closer to the nurses' station yet but thought it was because her room was close to the CNAs documentation station and there was always someone sitting there. LVN L said the MDS nurse was responsible for updating care plans and the care plans were reviewed during the morning meetings. LVN L further stated since she was assigned to the skilled hall, she also met with the therapy department on Tuesdays and Thursdays to review the residents' needs and goals. LVN L said nurses were expected to review resident care plans but did not know when or how often they were required to review them. LVN L said her expectation as a ADON was for nurses to review care plans if they notice a change in condition. Attempted interview on 12/19/24 at 9:45 am with the Physician was unsuccessful. During an interview on 12/19/24 at 10:54 am, LVN H said the facility's at-risk plan meant residents were at risk for falls and standard interventions were added to the care plans. LVN H further stated interventions included: monitoring the residents for falls and if they had an actual fall it was added to the care plan along with interventions. LVN H said according to therapy Resident #1 was impulsive and tried to be independent. LVN H further stated therapy worked on reminding Resident #1 to use the call light, adding Resident #1 did well for a while, but then returned to not using it. LVN H said a sign was put in Resident #1's room because visual reminders were more effective. LVN H said reminders to use the call light was added to Resident #1's care plan but no other interventions had been added. LVN H said moving Resident #1 closer to the nurses' station had not been discussed prior to the 12/13/24 fall. LVN H said she did not know if Resident #1's surgical boot had been discussed because she did not always work at the facility. LVN H said other interventions should have been put in place for Resident #1 if she continued to fall. LVN H further stated each fall should have been reviewed but she was not in the facility during some the days Resident #1 sustained falls. LVN H said incidents and related documentation were reviewed during the morning meetings as well as what the residents were doing prior to the incident. LVN H said interventions were then put in place depending on the action that caused the incident. LVN H said she did not know why this was not done after each of Resident #1's falls. LVN H said the facility policy regarding care plans was that they be reviewed quarterly and annually and updated if necessary. LVN H said as the MDS coordinator, she was responsible for ensuring care plans were updated. LVN H said she was not aware that the interventions on Resident #1's care plan had not been implemented and management was responsible for ensuring interventions were implemented. LVN H further stated she could not say whether additional interventions would have prevented additional falls for Resident #1. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview and observation on 12/19/24 at 3:20 pm, Resident #1 was sitting in the chair in her hospital room, green/purple discoloration was noted to the left temple, area around her left eye, and left hand. Resident#1 said she had gotten in an accident but did not remember how. Resident #1 said she fell at home on 12/13/24 on the floor, hit her head and put a hole in the paneling in the kitchen. Resident #1 said she was trying to cook. Resident #1 said she fell like four times while at the facility. Resident #1 said she understood that not calling for help was a safety issue and she needed to pay attention to that. Resident #1 said she had been feeling light-headed a lot lately and thought she had mentioned this to the doctor. Resident #1 said she mentioned feeling dizzy to the facility staff and was told to sit down if she felt like she was falling. Resident #1 said she did not remember what she was doing or where she was going when she fell on [DATE]. Resident #1 further stated she told them I would get there when I get there. Resident #1 said she was sure the surgical shoe caused her to fall because it slipped, and she told them that it was slipping and making her fall. Resident #1 said she ended up falling and was unable to get up. Resident #1 said at times when she put her feet down, she got confused about them moving or not. Resident #1 further stated she did not know how she got to the hospital. During an interview on 12/19/24 at 3:50 pm, the Hospital B LVN said Resident #1's memory was good in the morning but started getting confused around 2 pm. The Hospital B LVN said Resident #1 had a hemorrhage which was now stable and a rib fracture. The Hospital B LVN said Resident #1 had not fallen at the hospital, she was checked every hour, and asked if she needed anything during that time. Interview attempts with LVN F on 12/19/24 at 5:30 pm and 12/21/24 at 6:28 pm were unsuccessful. During an interview on 12/21/24 at 5:43 pm, CMA A said she did not remember seeing a call don't fall sign on Resident #1's wall or a fall mat. CMA A further stated she never saw anything in front of Resident #1's bed, never. CMA A said she had overheard Resident #1 had several falls. CMA A further stated Resident #1's interventions had not been communicated to her. CMA A said before Resident #1 fell on [DATE] she had not heard about a Kardex (document used to view the residents' level of need/care) or how to access it. CMA A further stated that Resident #1 did not have any additional interventions in place prior to 12/13/24. CMA A said Resident #1 always had her call light and was reminded to use it, but she did not use it. CMA A said she thought Resident #1 forgot to use the call light sometimes. During a telephone interview on 12/21/24 at 5:56 pm, LVN D said she did not remember if Resident #1 had a fall on 11/19/24 during her shift. LVN D said if Resident #1 had fallen on her shift, she would have documented it. When we give report, we say whether they have fallen, and what interventions were in place and document it in the report book. She stated, We did not deal with the care plans, us nurses on the floor. I am new, I have only been there for two months, so I would not even know, we just informed each other during report. She remembered to use the call light, she says I know, I know. I have to use the red button when I need something. During an interview on 12/21/24 at 7:12 pm, LVN M said she worked on the long-term side but if Resident #1's interventions were not preventing her falls then they were not working. LVN M said the ADONs were responsible for ensuring care plan interventions were implemented and LVN L was responsible for the skilled hall were Resident #1 resided. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 12/19/24 at 12:27 pm, the CVP (Interim DON) said based on interviews with Resident #1 she either did not think to use the call light for assistance or forgot. The CVP said if Resident #1 was forgetting to use the call light for assistance, then the reminders to use the call light were not effective. The CVP said the facility's goal was to keep re-educating Resident #1 and she would use the call light after the reminders. The CVP said Resident #1'a surgical shoe was di [TRUNCATED]

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	12/21/2024

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 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. 39251 Based on interviews and record review, the facility failed to utilize the services of a registered nurse for at least eight consecutive hours per day, seven days per week for 4 days out of 5 days (11/19/24, 11/25/24, 11/27/24, and 12/11/24) reviewed for nursing services. The facility failed to ensure a registered nurse was scheduled for eight consecutive hours per day, seven days per week on the following dates: 11/19/24, 11/25/24, 11/27/24, and 12/11/24. This deficient practice could place residents at risk of not receiving adequate care. Findings included: Record review of the facility's Staffing Disclosure Sheets revealed the following: 11/19/24: Census - 111 o 1 RN for the day shift, 6 hours; 0 RN for the night shift 11/25/24: Census - 114 o 1 RN for the day shift, 6 hours; 0 RN for the night shift 11/27/24: Census - 111 o 1 RN for the day shift, 6 hours; 0 RN for the night shift 12/11/24: Census - 114 o 1 RN for the day shift, 6 hours; 0 RN for the night shift Record review of the facility's employee timesheets revealed RN G did not punch in on 11/19/24, 11/25/24, 11/27/24, or 12/11/24. During a joint interview on 12/20/24 at 9:30 am, the Administrator said the facility did not have an RN during the weekdays, other than the DON, until the DON left approximately three weeks prior to the investigation. LVN E said the facility had one RN (RN G) who worked Fridays, Saturdays, and Sundays 10:00 pm - 6:00 am. LVN E, the Administrator, and the CVP said they were not aware the facility was required to utilize the services of a registered nurse, other than the DON, for at least eight consecutive hours per day, seven days per week. LVN E said she was responsible for completing the Staffing Disclosure Sheet with the help of the Administrator . During an interview on 12/20/24 at 2:24 pm, LVN E clarified the RN staffing according to the time punch was correct. (continued on next page)

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 12/20/24 at 2:49 pm, the Administrator said the facility did not have a waiver of the requirement to provide services of a registered nurse for more than 40 hours a week. During a telephone interview on 12/21/24 at 7:55 pm, RN G said she worked at the facility on Fridays, Saturdays, and Sundays from 10:00 pm - 6:00 am. Record review of the facility's policy, titled Staffing, Sufficient and Competent Nursing, dated 2001, revealed: . The director of nursing services (DNS) may serve as the charge nurse only when the average daily occupancy of the facility is 60 or fewer residents. 3. A registered nurse provides services at least eight (8) consecutive hours every 24 hours, seven (7) days a week .