

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/08/2025
NAME OF PROVIDER OR SUPPLIER River Hills Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50531</p> <p>Based on interview, and record review, the facility failed to ensure that based on the comprehensive assessment of a residents, the residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, for 1 of 10 residents (Resident #1) reviewed for quality of care, in that:</p> <p>The facility failed to transcribe Resident #1's hospital order for insulin glargine on admission according to discharge instructions, and failed to administer the medication for 6 days from 1/31/25-2/5/25.</p> <p>An IJ was identified on 2/7/25. The IJ template was provided to the facility on [DATE] at 5:01 PM. While the IJ was removed on 2/8/25, the facility remained out of compliance at a scope of isolated and severity level of no actual harm with potential for more than minimal harm that is not IJ, due to the need for the facility to evaluate the effectiveness of the corrective action.</p> <p>This failure could place residents at risk for hyperglycemia related to missing medication doses.</p> <p>Findings include:</p> <p>Record review of Resident #1's face sheet printed 02/06/2025 revealed a [AGE] year-old female admitted on [DATE] after recent hospitalization with a diagnosis of UTI and new on-set CHF exacerbation with co-morbidity of DMII (a long-term condition in which the body does not make enough insulin).</p> <p>Record review of Resident #1's Baseline Care Plan, dated 01/30/2025, revealed resident was a Type II Diabetic and was receiving insulin.</p> <p>Record review of Resident #1's Admission MDS, dated [DATE], reflected it was pending completion and submission.</p> <p>Record review of Resident #1's hospital discharge instructions, dated 01/30/2025, revealed Resident #1 had an order for 17u Insulin Glargine 1x daily. Discharge instructions did not indicate blood glucose level checks.</p> <p>Record review of Resident #1 February 2025 MAR revealed the facility did not transcribe an order for 17u Insulin Glargine until 02/06/2025.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's blood glucose levels revealed the following results: 2/5/25 @ 6:21 PM 233 mg/dL, 2/6/25 @ 9:28 AM 446 mg/dL, 2/6/25 @ 4:52 PM 274 md/dL, and 2/6/25 @ 5:13 PM 274 mg/dL. Blood glucose levels were not checked prior to 2/5/25.</p> <p>Record review of Resident #1 blood sugar levels after receiving 17units of insulin glargine revealed 2/7/25 at 10:30 AM blood sugar level of 219 mg/dL.</p> <p>An interview and observation of Resident #1 on 2/6/25 at 3:24 PM revealed Resident #1 sitting up at edge of bed with bedside table in place going thru her mail. The resident was wearing personal clothing items, presented clean, well-groomed, odor free, and wearing prescription glasses in place, that were clean and serviceable. The resident was hard of hearing, but was amiable and accepting of surveyor interaction. Resident #1 stated she told her family member yesterday [02/05/205] that she had not received her insulin like she did at home but did not mention it to facility staff. Resident #1 stated she notified her family member. Resident #1 stated she administers her own insulin at home. Resident #1 verbalized she felt fine today and was pleased that correct orders were now in place. Resident #1 stated she had lived with diabetes for years, did not feel any different.</p> <p>In an interview on 02/05/25 at 4:30 PM with ADON LVN G, the DON, the Regional Nurse, and the Administrator, the DON stated LVN G was notified by Resident#1's family member that the resident was supposed to received daily insulin administration. LVN G confirmed an order for insulin glargine 17u daily was listed on Resident #1's discharge instructions from the hospital, dated 01/30/2025, and contacted physician for insulin orders and administered 17u insulin glargine at 4:27 PM. The Administrator stated this event would be called in to the state as a medication error.</p> <p>In an interview with the DON on 02/06/2025 at 4:45 PM, the DON confirmed that Resident #1 had not received insulin for 6 days from 01/31/25-02/5/25, putting the resident at risk for hyperglycemia (elevated blood sugar levels) with both short-term (hyperglycemia, diabetic ketoacidosis) and long-term (damage to kidneys, eyes and nerves) effects. The DON stated she expected all nursing staff to confirm discharge instructions and transcribe them to the EMR to ensure administration of medications.</p> <p>In an interview with Administrator on 02/06/25 at 5:00 PM, the Administrator stated the facility failed to provide necessary medication to Resident #1 per physicians' order. The Administrator stated she expected nursing staff to follow physicians' orders.</p> <p>In an interview with MD #1 on 2/6/255 at 5:45 PM, MD #1 (current physician as of 2/6/25) revealed that when he was notified of Resident #1's BS 446, he advised them to give 4u fast acting and re-check the resident's BS. MD #1 stated he did not like aggressive s/s for geriatric patients and would figure out where she was normally and adjust as needed. MD #1 stated he did not feel more adverse effects as the resident's levels were similar to the hospital levels. MD #1 stated his expectations were, of course are that they follow his orders and is is pleased with the fast action they took with termination of the nurse he spoke to personally regarding the 4u of Lantus administration.</p> <p>In an interview with MD #2 on 2/6/25 at 5:55 PM, MD #2 (admitting physician) stated he did not recall exactly what Resident #1's admitting orders were but recalled he did ask the facility to continue hospital orders and he evaluated the resident in person on 1/31/25. MD #2 stated he was not concerned when they told him about the missed Lantus dose of 17u because it is long acting and stays 36-40 hours, so not that damaging. MD #2 stated he had protocols in place for Glucagon and that a s/s for Lantus were not recommended anyway.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of the facility policy named, Reconciliation of medications on Admission, revised July 2017, revealed, admitting nurse should reconcile the discharge medications to include dose, route and frequency for all medications, notify physician to verify admitting orders and transcribe them accordingly to the EMR.</p> <p>Record review of the facility policy named, Administering Medications, revised April 2019, revealed, medications are administered in accordance with prescriber orders.</p> <p>This was determined to be an Immediate Jeopardy (IJ) on 2/7/25 at 5:01 PM. The Administrator and the DON were notified and provided the IJ Template on 2/7/25, and a Plan of Removal was requested.</p> <p>[Facility Name]</p> <p>Tag Cited: F684</p> <p>Alleged Issues:</p> <p>The facility failed to enter and obtain the appropriate prescribed medication for resident upon admission and notify the physician when medication was 'unavailable' or not administered.</p> <p>Plan of Removal</p> <p>1. Immediate Actions</p> <p>The Medical Director was notified by the Administrator on 2/07/2025 of the Immediate Jeopardy.</p> <p>The DON completed an Admission Drug Regimen review and reconciliation on all new admissions along with the Medical Director date range of 1/30/2025 to current. An Admission drug regimen review and reconciliation tracker was created and put in place by the DON on 2/07/2025, review as completed 2/07/2025.</p> <p>A resident medication administration audit report was conducted by DON and MDS coordinator on 2/08/2025 to ensure medication availability for each resident.</p> <p>Change of condition assessment audit was reviewed on 2/07/2025 for date range of 1/30/2025 to current. Change of condition assessment audit was conducted by the DON on 2/07/2025.</p> <p>Change of condition assessment audit will be monitored in daily clinical meeting Monday through Friday with IDT team conducted by the DON or designee. Saturday and Sunday the change of condition review audit will be performed by the DON or designee.</p> <p>2. Education</p> <p>DON and ADON in serviced on notifying MD when medications are not transcribed accurately or not available and documenting MD recommendations on 2/07/2025 by VP of Clinical. DON and ADONs were educated on change of condition. When a resident has a change of condition or before sending the resident out, DON must be notified, MD must be notified, and a change of condition must be opened and completed. In service provided by the VP of clinical on 2/07/2025.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>One on one education provided to nursing staff regarding the Charge Nurse calling the Medical Director and review the hospital discharge medication list, once reconciled enter all orders at the time of admission, complete admission note, ensure that drug regimen review is completed, and all assessments completed. Education completed by DON and ADON's on 2/07/2025.</p> <p>One on one education provided to nursing staff in regard to notifying MD when medications are not available and to provide a progress note with MD recommendations when medications are not available. Education provided by DON and ADONs on 2/07/2025.</p> <p>Staff that were not physically present in the facility were contacted via phone and education reviewed with them by the DON and ADONs on 2/07/2025.</p> <p>3. Monitoring</p> <p>The Admission Drug Regimen Review and Reconciliation tracker on new admissions will be reviewed daily in morning clinical meeting by the IDT Team Monday through Friday. Saturday and Sunday, the Admission Drug Regimen Review and Reconciliation will be completed by the DON or designee. An audit of every MAR will be conducted Monday through Friday in the clinical meeting by the DON or designee to ensure medication availability for all residents. Saturday and Sunday, the medication administration audit will be completed by the DON or designee.</p> <p>The Admission Drug Regiment Review and Reconciliation tracker will be presented at the monthly Quality Assurance Performance Improvement (QAPI) meeting for a minimum of three months.</p> <p>4. QAPI Committee Review:</p> <p>An Ad Hoc QAPI committee meeting was completed 2/07/2025.</p> <p>5. Plan of Removal date: 2/07/2025</p> <p>The Plan of Removal was accepted on 02/08/2025 at 5:29 p.m., and the verification of the POR included the following:</p> <p>1. Interview with Medical Director on 2/07/2025 at 4:45 PM verified he was notified of IJ. Interview with DON and Administrator on 2/08/2025 verified the Admissions Drug Regimen Review and Reconciliation was completed for all residents admitted since 1/20/2025. This surveyor completed 7 of 7 admissions reviews from 1/30/2025-2/7/2025 with no errors noted. Record review on 2/08/2025 verified medication administration audit report was conducted by MDS Coordinator and DON. Verified Change of Condition assessment audit was completed by DON 2/8/2025 and verified Change of Condition assessment audit in place with Administrator.</p> <p>2. Interviews on 2/08/2025 between hours of 7:30 AM - 7:00 PM with 17 of 27 FT/PRN Nurses:</p> <p>LVN H stated aware of how to complete a change of condition and understands importance of accurate medication reconciliation for new admissions.</p> <p>RN I stated understanding of how to input orders into EMR, identify and report change of condition and need to clarify admitting orders with MD.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Inservice Training and Training log for 27 of 27 FT/PRN Staff reviewed and 8 of 8 Agency Nurses for completion. [6 FT 6a-6p, 5 FT 6p-6a, 12 PRN with varying shifts, 3 Administrative Nurses to include DON/ADON/ADON].</p> <p>Interview on 2/08/2025 with 11 of 27 FT/PRN Nurses and 4 of 4 Agency Nurses on duty 2/08/2025 verified they received in-service from DON or ADON regarding medication reconciliation process for admissions.</p> <p>Inservice Training and Training log for 27 of 27 FT/PRN Staff review and 8 of 8 Agency Nurses for completion. [6 FT 6a-6p, 5 FT 6p-6a, 12 PRN with varying shifts, 3 Administrative Nurses to include DON/ADON/ADON].</p> <p>Interviews on 2/8/2025 with 11 of 27 FT/PRN Nurses and 4 of 4 Agency Nurses on duty 2/08/2025 verified they received in-service from DON or ADON regarding medication availability, who to contact and how to access Emergency medication system.</p> <p>Inservice Training & Training log for 27 of 27 FT/PRN Staff reviewed and 8 of 8 Agency Nurses for completion. [6 FT 6a-6p, 5 FT 6p-6a, 12 PRN nurses with varying shifts, 3 Administrative Nurses to include DON/ADON/ADON].</p> <p>Record review on 2/08/2025 of In-service log and training provided reviewed. All nurses interviewed were able to identify how to complete a Change of Condition assessment, how to verify orders for new admissions according to discharge instructions by transcribing and verbalizing to physician (or designee) to include how to input information in EMR including parameters and sliding scale needs for insulin orders. Through interview and observation, staff members were able to demonstrate they received identified inservices and demonstrated knowledge of subject matter through surveyor questions.</p> <p>3. Record review on 2/08/2025 of Admission Drug Regimen and Reconciliation Tracker that will be kept by the Administrator and/or DON during clinical meeting. DON verbalized she will review MAR in clinical meetings to ensure medication availability. On 2/08/2025, Administrator confirmed Admission Drug Regimen Review and Reconciliation tracker will be reviewed at least quarterly in QAPI meeting.</p> <p>4. On 2/08/2025, Administrator confirmed QAPI meeting was completed 2/07/2025.</p> <p>The Administrator was informed the Immediate Jeopardy was removed on 2/08/2025 at 7:37 PM. The facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.</p>		

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<p>F 0755</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50531</p> <p>Based on interview and record review, the facility failed to provide pharmacological 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 10 residents (Resident #1) reviewed for pharmacy services.</p> <p>The facility failed to acquire, receive, dispense, and administer Resident #1's scheduled insulin 17u Insulin Glargine daily as ordered for 6 days from 1/31/25-2/5/25.</p> <p>An IJ was identified on 2/07/2025. The IJ Template was provided to the facility on [DATE] at 5:01 PM. While the IJ was removed on 2/08/2025, the facility remained out of compliance at a scope of isolated and severity level of no actual harm with potential for more than minimal harm that is not IJ, due to the need for the facility to evaluate the effectiveness of the corrective action.</p> <p>This deficient practice could place resident at risk for adverse side effects of hyperglycemia.</p> <p>Findings include:</p> <p>Record review of Resident #1's face sheet printed 02/06/2025 revealed a [AGE] year-old female admitted on [DATE] after recent hospitalization with a diagnosis of UTI and new on-set CHF exacerbation with co-morbidity of DMII (a long-term condition in which the body does not make enough insulin).</p> <p>Record review of Resident #1's Baseline Care Plan, dated 01/30/2025, revealed resident was a Type II Diabetic and was receiving insulin.</p> <p>Record review of Resident #1's hospital discharge instructions dated 01/30/2025 revealed Resident #1 had an order for 17units Insulin Glargine 1 x daily. Hospital discharge instructions dated 01/30/2025 did not include orders to check blood glucose levels.</p> <p>Record review of Resident #1's February 2025 MAR dated 02/06/2025 revealed the facility failed to transcribe orders for daily insulin until 02/05/2025.</p> <p>Record review of Resident #1's blood glucose levels revealed the following results: 2/5/25 @ 6:21 PM 233 mg/dL, 2/6/25 @ 9:28 AM 446 mg/dL, 2/6/25 @ 4:52 PM 274 md/dL, and 2/6/25 @ 5:13 PM 274 mg/dL. Blood glucose levels were not checked prior to 2/5/25.</p> <p>Record review of Resident #1 blood sugar levels after receiving 17units of insulin glargine revealed 2/7/25 at 10:30 AM blood sugar level of 219 mg/dL.</p> <p>In an interview with LVN G on 2/5/25 at 4:30: PM, LVN G stated she was notified by Resident #1's family member that Resident #1 received daily insulin. LVN G stated she confirmed the hospital discharge medication listing and that the admitting nurse had failed to transcribe the order for 17units Insulin Glargine daily.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>An interview and observation of Resident #1 on 2/6/25 at 3:24 PM revealed Resident #1 sitting up at edge of bed with bedside table in place going thru her mail. The resident was wearing personal clothing items, presented clean, well-groomed, odor free, and wearing prescription glasses in place, that were clean and serviceable. The resident was hard of hearing, but was amiable and accepting of surveyor interaction. Resident #1 stated she told her family member yesterday [02/05/2025] that she had not received her insulin like she did at home but did not mention it to facility staff. Resident #1 stated she notified her family member. Resident #1 stated she administers her own insulin at home. Resident #1 verbalized she felt fine today and was pleased that correct orders were now in place. Resident #1 stated she had lived with diabetes for years, did not feel any different.</p> <p>In an interview with DON on 02/06/25 at 4:45 PM, the DON stated she was informed by LVN G of the missed order for daily insulin Glargine on Resident #1's admission 01/30/2025. The DON confirmed LVN G notified the resident's physician on 2/025/2025 at 4:30 PM and obtained orders for 17units Insulin glargine daily. The DON confirmed the resident had not received insulin for 6 days from 01/31//25-02/5/25, putting her at risk for hyperglycemia (elevated blood sugar levels) with both short-term and long-term effects. The DON stated she expected all nursing staff to confirm discharge instructions and transcribe them to the EMR to ensure administration of medications.</p> <p>In an interview with Administrator on 02/06/25 at 5:00 PM, the Administrator stated the facility failed to provide necessary medication to Resident #1 per physicians' order. The Administrator stated she expected nursing staff to follow physicians' orders.</p> <p>In an interview with MD #1 on 2/6/255 at 5:45 PM, MD #1 (current physician as of 2/6/25) revealed that when he was notified of Resident #1's BS 446, he advised them to give 4u fast acting and re-check the resident's BS. MD #1 stated he did not like aggressive s/s for geriatric patients and would figure out where she was normally and adjust as needed. MD #1 stated he did not feel more adverse effects as the resident's levels were similar to the hospital levels. MD #1 stated his expectations were, of course are that they follow his orders and is is pleased with the fast action they took with termination of the nurse he spoke to personally regarding the 4u of Lantus administration.</p> <p>In an interview with MD #2 on 2/6/25 at 5:55 PM, MD #2 (admitting physician) stated he did not recall exactly what Resident #1's admitting orders were but recalled he did ask the facility to continue hospital orders and he evaluated the resident in person on 1/31/25. MD #2 stated he was not concerned when they told him about the missed Lantus dose of 17u because it is long acting and stays 36-40 hours, so not that damaging. MD #2 stated he had protocols in place for Glucagon and that a s/s for Lantus were not recommended anyway.</p> <p>Record review of the facility policy named, Reconciliation of medications on Admission, revised July 2017, revealed, admitting nurse should reconcile the discharge medications to include dose, route and frequency for all medications, notify physician to verify admitting orders and transcribe them accordingly to the EMR.</p> <p>Record review of the facility policy named, Administering Medications, revised April 2019, revealed, medications are administered in accordance with prescriber orders.</p> <p>This was determined to be an Immediate Jeopardy (IJ) on 2/7/25 at 5:01 PM. The Administrator and the DON were notified and provided the IJ Template on 2/7/25, and a Plan of Removal was requested.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>[facility]</p> <p>Tag Cited: F755</p> <p>Alleged issues:</p> <p>The facility failed to provide pharmacological services to meet the needs of Resident #1 when admitting nurse did not reconcile Insulin Glargine to Resident #1's medication record as per hospital discharge instructions.</p> <p>Plan of Removal</p> <p>1. Immediate Actions</p> <p>The Medical Director was notified by the Administrator on 2/07/2025 of the Immediate Jeopardy. The DON completed a chart audit on all residents receiving insulin on 2/07/2025 with audit date beginning 1/30/2025. An insulin tracker reconciliation process was put in place for an audit to be completed daily by DON or designee to ensure insulin is administered correctly and in a timely manner. Insulin Tracker will be monitored by DON or ADON daily in clinical meeting with the IDT Team Monday thru Friday. On weekends, Insulin Tracker will be monitored by DON or designee. The DON completed an Admission Drug Regimen review and reconciliation on all new admissions with the Medical Director with a date range of 1/20/2025-current. An Admission Drug Regimen Review and Reconciliation tracker was created and put in place by the DON on 2/07/2025 and review was completed 2/07/2025.</p> <p>2. Education</p> <p>An inservice was conducted for the DON and ADONs by the VP of Clinical on 2/07/2025 on reconciliation of medications for all admissions. One on one education provided to clinical staff that upon admission, discharge medication list will be reconciled with MD via phone (verbal), or in person with charge nurse. Once the charge nurse has completed the medication reconciliation, the DON or designee will review the reconciliation to confirm accuracy. The DON or designee will track the reconciliation on the admission drug regimen/reconciliation log. Tracking began on 1/30/2025, conducted by the DON. DON and designee will educate nursing staff before the next shift and newly hired nurses. IDT Team were educated on the importance of timely insulin administration provided by DON on 2/07/2025. Staff that were not physically present in the facility were contacted via phone and education provided to them by the DON and/or ADONs on 2/07/2025. DON and ADONs will educate nursing staff before the next shift.</p> <p>3. Monitoring</p> <p>The reconciliation of medications with MD will be monitored by the DON or ADONs by using the Admission Drug Regimen Review and Reconciliation tracker. The tracker log consists of signing off on the MD reconciliation review of discharge medications list and reviewing the order listing in daily clinical meeting Monday-Friday by the DON or designee and IDT Team. Saturday and Sunday, tracker will be monitored by the DON or designee. Reconciliation tracking log was initiated for new admissions beginning 1/30/2025 to current by the DON. The insulin monitoring tracker will be presented at the monthly Quality Assurance Performance meeting.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER River Hills Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2091 Bandera Hwy Kerrville, TX 78028	
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<p>F 0755</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>4. QAPI Committee Review: Ad Ad Hoc QAPI committee meeting was completed on 2/07/2025.</p> <p>The Plan of Removal was accepted on 02/08/2025 at 5:29 p.m., and the verification of the POR included the following:</p> <p>1. Interview with Medical Director on 2/07/2025 at 4:45 PM verified he was notified of IJ.</p> <p>Record review on 2/8/25 for 12 of 12 residents with insulin orders (chart audit), insulin tracker and drug regimen review completed. Verified available insulin medication matched order for 3 of 3 residents [Resident #1, Resident #3, Resident 4] on 2/8/25 at 11:30 a.m</p> <p>Record review on 2/08/2025 verified in-service and education was completed for 28 of 28 FT / PRN staff [6 FT 6a-6p, 5 FT 6p-6a, 12 PRN with varying shifts, 3 Administrative Nurses to include DON/ADON/ADON] and 8 of 8 Agency staff on 2/07/2025.</p> <p>2. Interviews on 2/08/2025 between hours of 7:30 AM - 7:00 PM with 17 of 27 FT/PRN Nurses:</p> <p>LVN H stated aware of how to complete a change of condition and understands importance of accurate medication reconciliation for new admissions.</p> <p>RN I stated understanding of how to input orders into EMR, identify and report change of condition and need to clarify admitting orders with MD.</p> <p>LVN J stated understanding of importance of verifying admitting orders and confirming with MD as well as date input in EMR.</p> <p>LVN C stated inservices received for change of condition, medication reconciliation and understands importance.</p> <p>LVN K stated understands process of medication reconciliation for admissions and need to take time in reviewing discharge instructions, verbalized understanding of change of condition notifications.</p> <p>LVN L stated understanding of change of condition and understands need to clarify all discharge instructions for admissions and verify with MD.</p> <p>LVN M stated received inservices for change of condition and clarification of medication reconciliation for discharge instructions on new admissions.</p> <p>LVN N stated understanding of importance of completing new admissions and discharge instructions / medication reconciliation on all new admissions and notifying MD for change of conditions.</p> <p>LVN AE stated received inservices on identify and reporting change of condition and importance of completing accurate medication reconciliation on all admissions.</p> <p>LVN O stated received inservices for change of condition and new admissions. Stated understands how to complete medication reconciliations and date input in EMR.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>LVN Q stated understands how to complete new admission assessments, change of condition assessments and medication reconciliation according to discharge instructions.</p> <p>LVN S stated understanding of need for clarification and accuracy for new admissions and following discharge instructions, notifying MD and completed change of condition assessments.</p> <p>LVN T stated received inservices for change of condition and understands importance of notifying MD and verify new admission orders.</p> <p>LVN U stated understanding of process for new admissions and need to ensure accurate transcription and notification of MD to verify orders.</p> <p>LVN V stated received inservices for change of condition, medication reconciliation for new admissions and understands how to input into EMR.</p> <p>LVN X stated understands need to accuracy when completing new admission medication reconciliation and notifying MD of change of condition.</p> <p>4 of 4 Agency Nurses on duty 2/08/2025 (LVN Z, LVN Y, LVN AI, LVN B) verified they received in-services and training from DON or ADON (RN DON AG, LVN ADON G, LVN ADON R, Admin LVN P) regarding completing a Change of Condition assessment, completing new and re-admission medication reconciliation and admission assessments according to Admission Checklist to include verifying orders (all orders, but specifically insulin orders) and transcribing orders in EMR.</p> <p>Inservice Training and Training log for 27 of 27 FT/PRN Staff reviewed and 8 of 8 Agency Nurses for completion. [6 FT 6a-6p, 5 FT 6p-6a, 12 PRN with varying shifts, 3 Administrative Nurses to include DON/ADON/ADON].</p> <p>Interview on 2/08/2025 with 11 of 27 FT/PRN Nurses and 4 of 4 Agency Nurses on duty 2/08/2025 verified they received in-service from DON or ADON regarding medication reconciliation process for admissions.</p> <p>Inservice Training and Training log for 27 of 27 FT/PRN Staff review and 8 of 8 Agency Nurses for completion. [6 FT 6a-6p, 5 FT 6p-6a, 12 PRN with varying shifts, 3 Administrative Nurses to include DON/ADON/ADON].</p> <p>Interviews on 2/8/2025 with 11 of 27 FT/PRN Nurses and 4 of 4 Agency Nurses on duty 2/08/2025 verified they received in-service from DON or ADON regarding medication availability, who to contact and how to access Emergency medication system.</p> <p>Inservice Training & Training log for 27 of 27 FT/PRN Staff reviewed and 8 of 8 Agency Nurses for completion. [6 FT 6a-6p, 5 FT 6p-6a, 12 PRN nurses with varying shifts, 3 Administrative Nurses to include DON/ADON/ADON].</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review on 2/08/2025 of In-service log and training provided reviewed. All nurses interviewed were able to identify how to complete a Change of Condition assessment, how to verify orders for new admissions according to discharge instructions by transcribing and verbalizing to physician (or designee) to include how to input information in EMR including parameters and sliding scale needs for insulin orders. Through interview and observation, staff members were able to demonstrate they received identified inservices and demonstrated knowledge of subject matter through surveyor questions.</p> <p>3. Record review on 2/08/2025 of facility initiated tracker that will be reviewed in clinical meetings. Confirmed monitoring process by Administrator and DON.</p> <p>Completed record review on 2/08/2025 of facility tracking form.</p> <p>Observation on 2/08/2025 at 11:45 AM of insulin administration for 1 of 1 residents (Resident #3) completed with no errors.</p> <p>Confirmed with 11 of 21 FT/PRN Nurses that they received competency training for insulin administration and order implementation. 1 PRN nurse LVN Q had not received competency training and has not worked since November 2025. LVN Q is aware that he will need to complete competency training prior to start of next scheduled shift (no shift identified at this time). [6 FT 6a-6p, 5 FT 6p-6a, 12 PRN with varying shifts, 3 Administrative Nurses to include DON/ADON/ADON].</p> <p>4. Interview with Administrator on 2/08/2025 confirmed that tracking system will be reviewed at least quarterly during QAPI meeting.</p> <p>The Administrator was informed the Immediate Jeopardy was removed on 2/08/2025 at 7:37 PM. The facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50531</p> <p>Based on observation, interview and record review the facility failed to ensure residents were free from significant medication errors for 1 of 12 residents (Resident #1) reviewed for significant medication errors, in that:</p> <p>The facility failed to ensure Resident #1 was administered Insulin Glargine 17units daily for 6 days from 1/31/25-2/5/25.</p> <p>An IJ was identified on 2/07/2025. The IJ Template was provided to the facility on [DATE] at 5:01 PM. The IJ was removed on 2/08/2025. The facility remained out of compliance at a scope of isolated and severity level of no actual harm with potential for more than minimal harm that is not IJ, due to the need for the facility to evaluate the effectiveness of the corrective actions.</p> <p>This failure placed resident at risk for adverse side effects to include increase in blood glucose levels and life-threatening complication of Diabetic ketoacidosis.</p> <p>Findings include:</p> <p>Record review of Resident #1's face sheet, dated 02/06/2025, revealed a [AGE] year-old female admitted [DATE] with diagnoses of UTI and new on-set CHF with co-morbidity of DMII (a long-term condition in which the body does not make enough insulin).</p> <p>Record review of Resident #1's hospital discharge instructions, dated 01/30/2025, revealed an order for 17u Insulin Glargine 1x daily. Hospital discharge instructions did not include monitoring of blood glucose levels.</p> <p>Record review of Resident #1's blood glucose levels revealed the following results: 2/5/25 @ 6:21 PM 233 mg/dL, 2/6/25 @ 9:28 AM 446 mg/dL, 2/6/25 @ 4:52 PM 274 md/dL, and 2/6/25 @ 5:13 PM 274 mg/dL. Blood glucose levels were not checked prior to 2/5/25.</p> <p>Record review of Resident #1's Baseline Care Plan, dated 01/30/2025, revealed resident was a Type II Diabetic and was receiving insulin.</p> <p>Record review of Resident #1's Admission MDS, dated [DATE], revealed the MDS was pending completion and submission.</p> <p>Record review of Resident #1's February 2025 MAR revealed the facility did not transcribe an order for 17u Insulin Glargine until 02/06/2025.</p> <p>In an interview with LVN G on 2/5/25 at 4:30: PM, LVN G stated she was notified by Resident #1's family member that Resident #1 received daily insulin. LVN G stated she confirmed the hospital discharge medication listing and that the admitting nurse had failed to transcribe the order for 17units Insulin Glargine daily.</p> <p>(continued on next page)</p>

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>An interview and observation of Resident #1 on 2/6/25 at 3:24 PM revealed Resident #1 sitting up at edge of bed with bedside table in place going thru her mail. The resident was wearing personal clothing items, presented clean, well-groomed, odor free, and wearing prescription glasses in place, that were clean and serviceable. The resident was hard of hearing, but was amiable and accepting of surveyor interaction. Resident #1 stated she told her family member yesterday [02/05/2025] that she had not received her insulin like she did at home but did not mention it to facility staff. Resident #1 stated she notified her family member. Resident #1 stated she administers her own insulin at home. Resident #1 verbalized she felt fine today and was pleased that correct orders were now in place. Resident #1 stated she had lived with diabetes for years, did not feel any different.</p> <p>In an interview with DON on 02/06/25 at 4:45 PM, the DON stated she was informed by LVN G of the missed order for daily insulin Glargine on Resident #1's admission 01/30/2025. The DON confirmed LVN G notified the resident's physician on 2/025/2025 at 4:30 PM and obtained orders for 17units Insulin glargine daily. The DON confirmed the resident had not received insulin for 6 days from 01/31//25-02/5/25, putting her at risk for hyperglycemia (elevated blood sugar levels) with both short-term and long-term effects. The DON stated she expected all nursing staff to confirm discharge instructions and transcribe them to the EMR to ensure administration of medications.</p> <p>In an interview with Administrator on 02/06/25 at 5:00 PM, the Administrator stated the facility failed to provide necessary medication to Resident #1 per physicians' order. The Administrator stated she expected nursing staff to follow physicians' orders.</p> <p>In an interview with MD #1 on 2/6/255 at 5:45 PM, MD #1 (current physician as of 2/6/25) revealed that when he was notified of Resident #1's BS 446, he advised them to give 4u fast acting and re-check the resident's BS. MD #1 stated he did not like aggressive s/s for geriatric patients and would figure out where she was normally and adjust as needed. MD #1 stated he did not feel more adverse effects as the resident's levels were similar to the hospital levels. MD #1 stated his expectations were, of course are that they follow his orders and is is pleased with the fast action they took with termination of the nurse he spoke to personally regarding the 4u of Lantus administration.</p> <p>In an interview with MD #2 on 2/6/25 at 5:55 PM, MD #2 (admitting physician) stated he did not recall exactly what Resident #1's admitting orders were but recalled he did ask the facility to continue hospital orders and he evaluated the resident in person on 1/31/25. MD #2 stated he was not concerned when they told him about the missed Lantus dose of 17u because it is long acting and stays 36-40 hours, so not that damaging. MD #2 stated he had protocols in place for Glucagon and that a s/s for Lantus were not recommended anyway.</p> <p>Record review of the facility policy named, Reconciliation of medications on Admission, revised July 2017, revealed, admitting nurse should reconcile the discharge medications to include dose, route and frequency for all medications, notify physician to verify admitting orders and transcribe them accordingly to the EMR.</p> <p>Record review of the facility policy named, Administering Medications, revised April 2019, revealed, medications are administered in accordance with prescriber orders.</p> <p>This was determined to be an Immediate Jeopardy (IJ) on 2/7/25 at 5:01 PM. The Administrator and the DON were notified and provided the IJ Template on 2/7/25, and a Plan of Removal was requested.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The following Plan of Removal submitted by the facility was accepted on 2/8/2025 at 5:29 PM.</p> <p>[facility Name]</p> <p>Tag Cited: F760</p> <p>Alleged Issues:</p> <p>The facility failed to ensure Resident #1 was free from significant medication errors when the facility failed to administer Insulin Glargine medication according to hospital discharge instructions and fast acting insulin as ordered by the physician.</p> <p>Plan of Removal</p> <p>1. Immediate Actions</p> <p>The Medical Director was notified by the Administrator on 2/07/2025 of the Immediate Jeopardy.</p> <p>The DON completed a chart audit on all residents receiving insulin on 2/07/2025. An insulin tracker was implemented for an audit to be completed daily to assure insulin is administered correctly and in a timely manner. Audit completed by DON on 2/07/2025. Insulin Tracker will be monitored by DON or ADON daily in clinical meeting with IDT Team Monday thru Friday. On Saturday and Sunday Insulin tracker will be monitored by the DON or designee.</p> <p>The DON completed an insulin audit on 2/07/2025 to confirm insulin orders were in place and transcribed correctly.</p> <p>2. Education</p> <p>An in-service was conducted with DON and ADONs by the VP of Clinical on 2/07/2025 in regard to the insulin order audit and educating staff on administration competency and glucometer use check off. One on one education to clinical staff regarding physician's orders for insulin administration are to be followed accurately and on time. Blood glucose monitoring orders are to be followed accurately an on time. Date will be documents in the residents' chart at time of administration. Completed by DON and ADON's on 2/07/2025.</p> <p>DON will educate nursing staff before their next shift and new hire nurses before they begin working. IDT Team members were educated on the importance of timely insulin administration. DON or designee will verify daily insulin tracker in clinical meeting (Monday through Friday, DON or designee Saturday and Sunday) on new admissions an insulin dependent residents by reviewing the MAR daily.</p> <p>Staff that were not physically present in the facility were contacted via phone and education reviewed with them by the DON and ADON's on 2/07/2025. DON and ADONs will have nursing staff educated before their next shift.</p> <p>3. Monitoring</p> <p>(continued on next page)</p>

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The order listing will be reviewed daily in the morning clinical meeting by the IDT Team Monday through Friday. Saturday and Sunday, the order listing will be reviewed by the DON or designee and tracked on the insulin log.</p> <p>Interventions will be implemented with the insulin tracker log Monday through Friday in the clinical meeting with the IDT Members and monitored by the DON or designee on Saturday and Sunday. Insulin tracker will be monitored by the DON and Administrator for completion.</p> <p>The insulin monitoring tracker will be presented at the monthly QAPI meeting for a minimum of three months.</p> <p>Insulin / glucose administration competencies was observed and conducted by the DON and ADONs on 2/08/2025. Insulin / glucose competencies will be completed for new hire nurses during on boarding with DON or designee.</p> <p>4. QAPI Committee</p> <p>An Ad Hoc QAPI committee meeting was completed 2/07/2025.</p> <p>The Plan of Removal was accepted on 02/08/2025, and the verification of the POR included the following:</p> <p>1. Interview with Medical Director on 2/07/2025 at 4:45 PM verified he was notified of IJ. Record review of facility created tracker audit of all residents receiving insulin on 2/08/2025. Reviewed process of on-going monitoring with DON. Review for 12 of 12 residents with insulin orders to verify orders are in EMR system was completed on 2/0/2025 with no errors. Verification of administration of 3 of 3 residents insulin per MAR and observation of 1 of 1 residents (Resident #3) insulin administration was completed on 2/08/2025 with no errors.</p> <p>2. Interview on 2/08/2025 with 11 of 27 FT/PRN Nursing Staff and 4 of 4 Agency staff on duty 2/08/2025 to confirm that they received in-service on administration of insulin.</p> <p>Observation completed on 2/08/2025 at 12:00 PM for 1 of 1 residents (Resident #3) insulin administration for accuracy of order and medication available. Verified with each nurse interview that they understood how to input orders into the EMR system, understood the process for following insulin orders and recording data accurately and timely. [6 FT 6a-6p, 5 FT 6p-6a, 12 PRN with varying shifts, 3 Administrative Nurses to include DON/ADON/ADON].</p> <p>Interviews on 2/08/2025 between hours of 7:30 AM - 7:00 PM with 17 of 27 FT/PRN Nurses:</p> <p>LVN H stated understands how to input insulin orders in EMR and complete change of condition assessments.</p> <p>RN I stated understand insulin parameters, how to input into EMR and notify MD for change of condition.</p> <p>LVN J stated understands how to input insulin parameters in EMR and how to complete change of condition assessments.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>LVN C stated understands how to complete orders for insulin with accurate parameters and need to notify physician of change of condition.</p> <p>LVN K stated understands change of condition assessments, need to notify MD and how to data input insulin parameters in EMR.</p> <p>LVN L stated understands how to complete insulin orders and change of condition assessment.</p> <p>LVN M stated understands how to put insulin orders in EMR per physicians orders and to notify MD of change of condition.</p> <p>LVN N stated understands how to input insulin orders in EMR and how to complete change of condition assessments.</p> <p>LVN AE stated understands how to recognize and report change of condition assessments and need to notify MD and understands how to input insulin orders and parameters in EMR.</p> <p>LVN O stated understands how to input insulin orders in EMR and understands what assessments / notifications are needed for change of conditions.</p> <p>LVN Q stated receives inservices on insulin orders and change of conditions.</p> <p>LVN S stated understands training on insulin orders administration and data input and change of condition notifications.</p> <p>LVN T stated understands need to notify MD for change of condition and understands how to input insulin orders in EMR, LVN U stated received inservices on insulin orders and identifying / reporting change of condition.</p> <p>LVN V stated understands how to complete insulin administration orders and input parameters in EMR and understands how to complete change of condition assessments.</p> <p>LVN X stated received inservices on insulin orders administration and date input in EMR and inservice on completing and recognizing change of condition</p> <p>4 of 4 Agency Nurses on duty 2/08/2025 (LVN Z, LVN Y, LVN AI, LVN B) verified they received in-services and training from DON or ADON (RN DON AG, LVN ADON G, LVN ADON R, Admin LVN P) on competency for insulin administration, how to enter insulin parameters in EMR, insulin documentation and change of condition notifications.</p> <p>Reviewed / copied facility created insulin tracker that will be reviewed in clinical meeting. [6 Ft 6a-6p, 5 FT 6p-6a, 12 PRN with varying shifts, 3 Administrative Nurses to include DON/ADON/ADON]. All nurses interviewed were able to verbalize how to transcribe and date input insulin orders including blood sugar monitoring parameters in the EMR. All nurses interviewed verbalized understanding of need to notify physician of change of condition related to blood sugar levels.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Verification of administration of 3 of 3 residents insulin per MAR on 2/8/25 at 11:30 AM [Resident #1, Resident #3, Resident #4] and observation of 1 of 1 residents (Resident #3) insulin administration was completed on 2/08/2025 at 11:45 AM with no errors.</p> <p>3. Record review on 2/08/2025 of facility initiated tracker that will be reviewed in clinical meetings. Confirmed monitoring process by Administrator and DON.</p> <p>Completed record review on 2/08/2025 of facility tracking form.</p> <p>Observation on 2/08/2025 at 11:45 AM of insulin administration for 1 of 1 residents (Resident #3) completed with no errors.</p> <p>Confirmed with 11 of 21 FT/PRN Nurses that they received competency training for insulin administration and order implementation. 1 PRN nurse LVN Q had not received competency training and has not worked since November 2025. LVN Q is aware that he will need to complete competency training prior to start of next scheduled shift (no shift identified at this time). [6 FT 6a-6p, 5 FT 6p-6a, 12 PRN with varying shifts, 3 Administrative Nurses to include DON/ADON/ADON].</p> <p>4. Administrator verified QAPI meeting was completed with PIP in place in conjunction with this Plan of Removal.</p> <p>The Administrator was informed the Immediate Jeopardy was removed on 2/08/2025 at 7:37 PM. The facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/08/2025
NAME OF PROVIDER OR SUPPLIER River Hills Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, quality laboratory services/tests to meet the needs of residents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36232</p> <p>Based on interview and record review, the facility failed to provide or obtain laboratory services to meet the needs of its residents for 1 of 2 residents (Resident #2) reviewed for laboratory services, in that:</p> <p>The facility did not obtain a UA C&S (a medical test that combines a urinalysis with a culture and sensitivity test to diagnose and treat urinary tract infections) for Resident #2 as ordered by a physician.</p> <p>This deficient practice could place residents at risk for a delay in identifying or diagnosing a problem, adjusting medications, and ensuring treatment needs were identified and addressed.</p> <p>Findings included:</p> <p>Record review of Resident #2's face sheet, dated 02/04/2025, revealed an admitted [DATE] and a readmitted [DATE], with diagnoses that included: Raynaud's syndrome without gangrene (a condition that causes decreased blood flow to the extremities but doesn't always lead to dead tissue), essential primary hypertension (persistently elevated high blood pressure), depression (a common mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest in activities once enjoyed) and cognitive communication deficit (a communication difficulty caused by a cognitive impairment).</p> <p>Record review of Resident #2's quarterly MDS, dated [DATE], revealed a BIMS of 11, indicating moderately impaired cognition.</p> <p>Record review of Resident #2's comprehensive care plan, updated 11/13/2024, revealed the focus areas ADL self-care performance deficit with a goal of will maintain current level of function through the review date and intervention Toilet use: Requires (extensive assistance) by (1) staff for toileting, and Incontinence of bowel and bladder with the goal will be clean, dry and odor free and the intervention report to physician any s/s of burning on urination, febrile (having of showing the symptoms of a fever), pyuria (urine containing white blood cells or pus), hematuria (blood in the urine) or malodorous urine. Both focus areas were initiated 08/11/2024.</p> <p>Record review of Resident #2's EHR revealed a progress note from RN F dated 08/30/2024 at 10:23 AM indicating Resident #2 was confused, agitated and confabulating, she had not slept well the night before, and had baseline confusion exacerbated by limited sleep. The resident's physician and RP were notified and a new order for a UA with C&S was received.</p> <p>Record review of the resident's EHR revealed there was no order for a UA C&S (Culture & Sensitivity) ordered by the physician.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/08/2025
NAME OF PROVIDER OR SUPPLIER River Hills Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2091 Bandera Hwy Kerrville, TX 78028	
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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 02/05/2025 at 1:30 PM, ADON G stated she was instructed to complete a skin assessment on Resident #2 on 08/30/2024 by the facility's former DON. She was not aware the UA order had not been put in the system and monitored. RN F seemed a little scattered and overwhelmed. She did not recall him ever mentioning that he or the aide failed to get a urine sample or had difficulty getting it. It was not brought to the leadership's attention it was not obtained at that time. The resident was admitted to the hospital for a different reason on 09/08/2024, at which time a UA was done. She was diagnosed with a UTI and treated with antibiotics.</p> <p>During an interview on 02/05/2025 at 1:55 PM, the administrator and DON stated RN F received a telephone order from Resident #2's physician for the UA C&S but never put it in the system and as a result of this failure, the resident's urine was never assessed by the laboratory to see if she had a UTI. There was no follow-up. The facility now has a process in place to review order summaries every day to ensure nothing is dropped. ADONs are responsible for monitoring lab orders. RN F was no longer employed by the facility; he was on staff for approximately one month and terminated by mutual agreement due to his difficulty keeping up with the workload on 09/13/2024.</p> <p>During a telephone interview on 02/05/2025 at 3:15 PM, RN F stated when he received the verbal order from Resident #2's physician he told the floor CNA working the floor to collect the urine specimen but she had difficulty obtaining it as the resident was uncooperative. She was confused and resistant to following directions. He passed the information along to the incoming charge nurse.</p> <p>Record review of facility policy Lab and Diagnostic Test Results - Clinical Protocol dated November 2018 revealed, Assessment and Recognition: 1. The physician will identify and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs. 2. The staff will process test requisitions and arrange for tests. 3. The laboratory. Diagnostic radiology provider, or other testing source will report test results to the facility.</p> <p>Record review of facility policy Telephone Orders dated February 2014 revealed, Verbal telephone orders may be accepted from each resident's attending physician. 1. Verbal telephone orders may only be received by licensed personnel (e.g., RN, LPN/LVN, pharmacist, physician, etc.). Orders must be reduced to writing, by the person receiving the order and recorded in the resident's medical record. 2. The entry must contain the instructions from the physician, date, time, and the signature and title of the person transcribing the information. 3. Telephone orders must be countersigned by the physician during his or her next visit.</p>		