

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  05/13/2025
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48753</b></p> <p>Based on observation, interview, and record review the facility failed to ensure residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for 3 of 8 residents (Resident #6, #7 and #8) reviewed for reasonable accommodation of resident needs, in that..</p> <ol style="list-style-type: none"> <li>1. The facility failed to ensure Resident #6 had access to his call light which was wrapped up in a basket on his nightstand outside of the resident's reach.</li> <li>2. The facility failed to ensure Resident #7 had access to his call light which was attached to his bed outside of the resident's reach.</li> <li>3. The facility failed to ensure Resident #8 had access to his call light which was tucked inside of his closed nightstand drawer out of the resident's reach.</li> </ol> <p>These deficient practices could place residents at risk of not maintaining and/or achieving independent functioning, dignity, and well-being.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Record review of Resident #6's undated face sheet revealed Resident #6 was a [AGE] year-old male who admitted to the facility on [DATE] with a diagnosis of Parkinsonism (brain condition that causes slow movements, stiffness and tremors).</li> </ol> <p>Record review of Resident #6's fall risk evaluation, dated 03/25/2025, revealed Resident #6 had a score of 21 indicating Resident #6 was a high risk for potential falls.</p> <p>Record review of Resident #6's admission MDS assessment, dated 02/28/2025, revealed a BIMS score of 10, indicating moderately impaired cognition. Section GG - Functional Abilities revealed Resident #6 required substantial assistance from staff with dressing, bed mobility and transfers. Section J revealed Resident #6 had a fall prior to admission/entry of the facility and Resident #6 had 2 or more falls without injury since admission to the facility.</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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #6's comprehensive care plan, revealed Resident #6 had a care plan stating Resident #6 was at risk for falls, dated initiated 02/21/2025 and revised 02/24/2025. The intervention for the fall risk care plan included be sure [Resident #6] call light is within reach and encourage [Resident #6] to use it for assistance as needed. [Resident #6] needs prompt response to all requests for assistance.</p> <p>During an observation, 05/08/2025 at 9:00 a.m., Resident #6 was observed sitting in the middle of his bed that was placed in the low position with a fall mat beside the bed on the floor. Resident #6's call light was observed in a basket on the nightstand approximately 4 feet away from Resident #6.</p> <p>During an interview with Resident #6 on 05/08/2025 at 9:00 a.m., Resident #6 stated he could not reach his call light but was able to point to where the call light was located on the nightstand. Resident #6 stated he used his call light to call for assistance when needed and stated staff usually kept his light within reach. Resident #6 stated he had not had any falls recently and stated he had never fallen due to his call light being out of reach.</p> <p>During an interview with MA A on 05/08/2025 at 9:10 a.m., MA A entered Resident #6's room and stated Resident #6's call light was not within Resident #6's reach. MA A placed the call light within reach of Resident #6. MA A stated anyone who walks into a resident room is responsible for ensuring resident call lights are in place. MA said call lights should be within hands reach of a resident and stated she had received training on call light placement. MA A stated it was important to keep resident call lights within reach, so a resident does not fall, and they can call when they need help.</p> <p>2. Record review of Resident #7's undated face sheet revealed Resident #7 was a [AGE] year old male who admitted to the facility on [DATE] with diagnoses that included Dementia (loss of cognitive functioning), Parkinsonism (brain condition that causes slow movements, stiffness and tremors), Cerebral Infarction (also known as a stroke, blockage in a blood vessel in the brain) and Hemiplegia (partial or total paralysis on one side of the body).</p> <p>Record review of Resident #7's quarterly MDS assessment, dated 02/13/2025, revealed a BIMS score of 9, indicating moderately impaired cognition. Section GG - Functional Abilities revealed Resident #7 was dependent on staff for chair to bed transfers and required substantial assistance from staff with bed mobility and ADL's. Section J revealed Resident #7 had no falls in the facility since the previous MDS assessment.</p> <p>Record review of Resident #7's fall risk evaluation, dated 03/20/2025, revealed a score of 14, indicating Resident #7 was a high risk for potential falls.</p> <p>Record review of Resident #7 comprehensive care plan revealed a care plan, date initiated 11/03/2022, notifying staff of needs/wants/help and the listed interventions included, [Resident #7] education on ringing bell for assistance or needs, [Resident #7] education with call system and proper use and [Resident #7] will be provided with a call light and observe within reach. Resident #7 had a care plan, date initiated 12/20/2024, that revealed Resident #7 was at risk for falls related to confusion, gait and balance problems, paralysis and unaware of safety needs and the interventions included, be sure [Resident #7] call light is within reach and encourage [Resident #7] to use it for assistance as needed. [Resident #7] needs prompt response to all requests for assistance.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 05/08/2025 at 9:05 a.m., Resident #7 was observed sitting in his wheelchair positioned in front of his bed with the back of the wheelchair next to the bed. Resident #7's call light was observed attached to the bed behind the resident.</p> <p>During an interview with Resident #7, 05/08/2025 at 9:05 a.m., Resident #7 stated he did not know where his call light was located and stated he could not reach it. Resident #7 stated he used his call light to call for assistance from the staff and stated the staff answer his call light and assist him with care. Resident #7 stated he had not had any falls and stated staff usually kept his call light within reach.</p> <p>During an interview with MA A, 05/08/2025 at 9:12 a.m., MA A stated Resident #7 could not reach his call light and placed Resident #7's call light within reach.</p> <p>During an observation on 05/08/2025 at 1:52 p.m., Resident #7 was observed sitting in his wheelchair beside his bed. Resident #7's call light was observed draped over his roommate's nightstand on opposite side of room and another call light was lying on the floor approximately 3 feet away from Resident #7.</p> <p>During an interview with the Administrator, 05/08/2025 at 1:55 p.m., the Administrator stated Resident #7's call light was located on his roommate's nightstand and the call light on the floor belonged to his roommate who was not in the room at the time of the observation. The Administrator stated Resident #7's call light should have been within his reach.</p> <p>3. Record review of Resident #8's undated face sheet revealed Resident #8 was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses that included a Traumatic Brain Injury (injury to the brain from an external mechanical force which may lead to permanent or temporary impairment of cognitive, physical and psychosocial functions).</p> <p>Record review of Resident #8's quarterly MDS assessment, dated 04/27/2025, revealed Resident #8 had short term and long-term memory deficits and severely impaired cognitive decision-making skills. Section B- Hearing, Speech, Vision, revealed Resident #8 was rarely understood and rarely understood others. Section GG- Functional Abilities, revealed Resident #8 was dependent on staff for ADL's transfers and bed mobility. Section J revealed Resident #8 had not had any falls since his prior MDS assessment.</p> <p>Record review of Resident #8's Fall Risk Evaluation, dated 03/20/2025, revealed a score of 12, indicating Resident #8 was a high risk for potential falls.</p> <p>Record review of Resident #8 comprehensive care plan revealed a care plan, date initiated 11/03/2022, notifying staff of needs/wants/help and the listed interventions included, [Resident #8] will have education on ringing bell for assistance or needs, [Resident #8] education with call system and proper use and [Resident #8] will be provided with a call light and observe within reach. Resident #8 had a care plan, date initiated 12/19/2024, that revealed Resident #8 had an actual fall with poor balance and unsteady gait on 11/21/2024.</p> <p>During an observation, 05/08/2025 at 9:15 a.m., Resident #8 was observed sitting in his wheelchair with the back of his wheelchair facing his nightstand. Resident #8's call light was observed tucked inside the closed nightstand drawer, out of reach of Resident #8.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation, 05/08/2025 at 1:57 p.m., Resident #8 was observed sitting in his wheelchair with the back of his wheelchair facing his nightstand. Resident #8's call light was observed tucked inside the closed nightstand drawer, out of each of Resident #8.</p> <p>During an interview with MA A, 05/08/2025 at 1:58 p.m., MA A stated Resident #8's call light was in his nightstand drawer and out of reach of Resident #8. MA A placed Resident #8's call light within reach.</p> <p>During an interview with CNA E, 05/08/2025 at 2:42 p.m., CNA E stated she was the CNA assigned to work with Resident #6, #7 and #8. CNA E stated call lights should be within a residents reach in their room and stated if they were in a wheelchair it should be clipped to their shirt or blanket. CNA E stated everyone was responsible for ensuring call lights were in reach and stated she had received training on keeping call lights within reach for residents. CNA E stated it was important for call lights to be in reach of a resident in case they fall or need to get up to go to the bathroom or things like that. CNA E stated Resident #6 had his call light in reach when she went in to get him up around 6 a.m. and CNA E stated, maybe the call light got moved out of the way when I trying to get him up, but he refused to get up. CNA E stated she had placed Resident #7's call light around his waist and stated, it did not have a clip on it, so I guess it fell to the floor. CNA E stated Residents #6 and #7 were able to use their call lights to call for assistance when needed. CNA E stated she thought she placed Resident #8's call light in reach but stated, I should not make excuses, lots of people go in and out of there but I think I put it on him. CNA E stated Resident #8 did not use his call light to call for assistance.</p> <p>During an interview with the ADON, 05/13/2025 at 12:16 p.m., the ADON stated everyone was responsible for ensuring resident call lights were within reach of the resident and stated facility staff had received training on call light placement and the most recent training occurred 05/08/2025. The ADON stated it was important for call lights to be within reach so that a resident can call for assistance when they need assistance and prevent them from trying to do something on their own. The ADON said a resident could be harmed by having a fall if a call light was not in reach.</p> <p>During an interview with the Administrator, 05/13/2025 at 12:25 p.m., the Administrator stated call light placement was a team effort and a task that was everyone's responsibility. The Administrator stated resident call lights should be in reach of the resident and said staff had received training on keeping resident calls lights in reach of the resident. The Administrator said it was important for a call light to be in reach so a resident has access to it if they need assistance and stated and resident could go without assistance when he or she needs it if the call light was not in reach.</p> <p>Record review of a facility policy titled Answering the Call Light, Copyright 2001 [company name] Revision Date September 2022, revealed the purpose of the policy was to ensure timely responses to the resident's requests and needs. Under a section titled, General Guidelines, the policy read, 5. Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor.</p> <p>Record review of a facility in-service training report, dated 05/08/2025, revealed the topic was call lights and the summary of the training stated, please ensure call lights are within reach of the resident. Either clipped or placed next to them. If call light not working please notify maintenance immediately. If resident unable to use traditional call light and needs pancake/flat button let ADON/MDS. The in-service contained 51 names, including CNA E.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48753</b></p> <p>Based on interviews and record review the facility failed to ensure that the MDS assessment accurately reflected the resident's status for 1 of 12 (Resident #3) whose MDS assessments were reviewed in that:</p> <p>Resident #3 had 1 of 2 falls inaccurately coded on the MDS assessment.</p> <p>This deficient practice could place residents at risk for inadequate care and services to meet their needs based on inaccurate MDS assessments.</p> <p>The findings were:</p> <p>Record review of Resident #3's undated face sheet revealed Resident #3 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses that included Dementia (loss of cognitive functioning) and Osteoporosis (bone disease characterized by decreased bone density and mass). Resident #3 had a date of discharge listed on the face sheet of 04/23/2025.</p> <p>Record review of Resident #3's discharge MDS assessment, dated 02/17/2025, revealed Resident #3 had short term and long-term memory deficits and a BIMS test was not completed. Section J revealed Resident #3 had 1 fall with major injury during the MDS assessment look back period.</p> <p>Record review of Resident #3's undated comprehensive care plan revealed a care plan, date initiated 02/24/2025, date revised 04/24/2025 and date cancelled 04/24/2025, for an actual fall related to poor balance, poor communication and comprehension and an unsteady gait. The care plan included actual fall dates of 02/03/2025 and 02/17/2025.</p> <p>Record review of a facility document titled, Incident by Incident Type revealed a section labeled Fall Incidents. Resident #3 name was on the report with a fall date of 02/03/2025 at 8:34 a.m. and a fall date of 02/17/2025 at 4:00 a.m.</p> <p>Record review of Resident #3's incident report, dated 02/03/2025 at 8:34 a.m., revealed Resident #3 had a fall from her wheelchair and did not sustain any injuries.</p> <p>Record review of Resident #3's incident report, dated 02/17/2025 at 4:00 a.m., revealed Resident #3 was observed sitting on the floor in her room in front of her walker. Resident complained of right hip pain and was sent to the hospital for evaluation and treatment after an x-ray revealed a hip fracture.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with MDS Coordinator L, on 05/12/2025 at 11:00 a.m., MDS Coordinator L stated the MDS Coordinators were responsible for completing a resident MDS assessment. MDS Coordinator L stated Section J of the MDS assessment was where a resident's fall history was coded and included if the resident had any falls, the number of falls and the level of injuries and this information time frame was from the time of the previous assessment or admission/entry or reentry. MDS Coordinator L stated the information gathered to complete Section J is compiled from reviewing the risk management fall system in the EMR that listed the names of residents who had fallen and types of injuries, review of progress notes, radiology imaging and hospital paperwork. MDS Coordinator L stated it was important for the MDS assessment to be accurate because it is capturing the most accurate part of the resident chart, and we are communicating through the MDS the level of care the patient is needing and what is going on with the resident. MDS Coordinator L stated the MDS Coordinators had received training on MDS accuracy and stated MDS Coordinators had to go through each section of the MDS and take a test to make sure the MDS Coordinators were coding the MDS's correctly. MDS Coordinator L stated she did not complete the MDS assessment on Resident #3 on 02/17/2025 and stated it was completed by MDS Coordinator M who no longer worked at the facility. MDS Coordinator L stated Resident #3's fall on 02/03/2025 should have been captured on Section J of the MDS and the MDS should have reflected that Resident #3 had 2 falls on the MDS assessment, 1 with no injury and 1 with major injury.</p> <p>During an interview with the Administrator, 05/13/2025 at 12:55 p.m., the Administrator stated the MDS Coordinators were responsible for completing the MDS assessments and the purpose of the MDS was to have accurate care listed that the resident is receiving at the facility. The Administrator stated the MDS Coordinators had received training on completing the MDS assessments and stated the information on the assessment was compiled from information gathered in morning meetings, therapy and Social Work and stated, it is a team effort to get accurate information. The Administrator stated it was important for the MDS to be accurate, to make sure we a correct and accurate plan for the residents care in the facility.</p> <p>Record review of a facility policy titled, Comprehensive Assessments copyright 2001 [company name] (revised March 2020, revealed comprehensive assessments are conducted to assist in developing person-centered care plans. Under section titled, Policy Interpretation and Implementation, the policy stated, 11. Completed assessments are maintained in the resident's active record for a minimum of 15 months. These assessments are used to develop, review and revise the resident's comprehensive care plan.</p>		