STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676114	A. Building B. Wing	09/16/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure each resident receives adequate supervision and assistance devices to prevent accidents for 2 of 3 residents (Residents #1 and #2) reviewed for accidents/hazards. The facility failed to ensure fall mats were in place while Residents #1 and #2 were in bed on 9/16/2025. These failures could result in injury to residents. Findings included:Resident #1:Record review of Resident #1's face sheet, dated 9/16/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included displaced intertrochanteric fracture of the right femur (a break in the large, upper bone of the right leg), fracture of the superior rim of right pubis (a break of a bone in the pelvis), vascular dementia (a progressive disorder causing cognitive decline), and repeated falls. Record review of Resident #1's quarterly MDS, submitted 8/26/2025, reflected a BIMS score of 05, indicating severely impaired cognition. Section J1900 of the MDS reflected Resident #1 had experienced 1 fall without injury during the assessment period.Record review of a documented Fall Risk Evaluation of Resident #1 dated 9/11/2025 reflected a score of 19.0 and categorized the resident as at risk. Record review of Resident #1's comprehensive care plan, accessed and printed on 9/16/2025, reflected care planning for fall prevention, actual falls, and behavior problems related to poor safety awareness. Interventions for actual falls included a fall mat (initiated 8/08/2025) and relocation to a room closer to the nurse's station (initiated 6/17/2025). Record review of the facility's incident and accidents report dated 9/16/2025 reflected the most recent fall by Resident #1 was on 9/11/2025.In an observation and interview on 9/16/2025 at 1:45 PM, Resident #1 was observed awake and resting in bed. The fall mat was folded up and leaning against furniture in the room. HCNA C was exiting Resident #1's room and stated she had just completed routine hygiene tasks for Resident #1 and was finished providing care. After exiting the room, HCNA C did not return to implement the fall mat. Resident #1 was unable to participate in the attempted interview due to cognitive decline. A subsequent observation of Resident #1 on 9/16/2025 at 1:55 PM revealed the fall mat had not been implemented and remained leaned against the furniture. In an interview with HCNA C on 9/16/2025 at 1:57 PM, she reported she was not aware Resident #1 required a fall mat for fall prevention as the fall mat was not in place when she entered his room to provide care. She stated she saw the fall mat leaning against the furniture but was unsure if the fall mat belonged to Resident #1 or his roommate. HCNA C stated she was provided the information about fall prevention measures for residents from the facility nursing staff or through the medical chart. She reported potential harm to residents from not having a care planned fall mat implemented was serious injury or death. Resident #2: Record review of Resident #2's face sheet, dated 9/16/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included Parkinsonism (a progressive, degenerative neurological disorder causing tremors and muscular weakness) and repeated falls. Record review of Resident #2's quarterly MDS, submitted 8/13/2025, reflected a BIMS score of 12, indicating moderately impaired cognition. Section J1900 of the MDS reflected Resident #2 had experienced 2 falls without injury during the assessment period. Record review of a documented Fall Risk Evaluation of Resident #2 dated 7/29/2025 reflected a score of 16.0 and categorized the resident as at risk. Record review of Resident #2's comprehensive care plan, accessed and printed on 9/16/2025, reflected care planning for physical/verbal aggression, actual falls related to poor balance/poor communication and comprehensive/ poor safety awareness/ unsteady gait, and risk for falls. Interventions for actual falls included a fall mat (initiated 3/26/2026) and a scoop mattress (a modified bed mattress with defined edges to prevent someone from rolling out of bed) (initiated 5/08/2025). Record review of the facility's incident and accidents report dated 9/16/2025 reflected the most recent fall by Resident #2 was on 7/29/2025. In an observation and interview on 9/16/2025 at 1:44 PM, Resident #2 was observed awake and resting in bed. Resident #2's fall mat was folded up and leaning against furniture in the room. Resident #2 was unable to participate in the attempted interview due to cognitive decline. A subsequent observation on 9/16/2025 at 2:10 PM revealed the fall mat had not been implemented and remained leaned against the furniture. In an interview with CNA B on 9/16/2025 at 1:46 PM, she stated Resident #1 and #2 care plan interventions included lowering the bed and implementing a fall mat whenever they were in bed. She was unaware Resident #2's fall mat was not implemented at that time, and she stated Resident #2 had recently returned from physical therapy. She theorized the physical therapy staff likely did not replace the fall mat after assisting Resident #2 into bed. She stated Resident #1 had the fall mat in place earlier in the day and had probably been moved by HCNA C.