

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 11/26/2025
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 0882</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the person designated as the infection preventionist completed specialized training in infection prevention and control for the facility. The facility failed to ensure the DON, who was designated as the facility's Infection Preventionist had completed specialized training in infection prevention and control. This failure could place residents at risk for cross contamination and infection and ineffective infection surveillance. The findings included:Record review of the facility assessment, dated [DATE] revealed the DON was listed as the facility Infection Preventionist. During an interview on [DATE] at 2:29 p.m., LVN A stated she was the facility Infection Preventionist in training. She stated she was in charge of the facility infection prevention program including tracking and surveillance. She stated she was currently in training by the DON. She stated she had not started any specialized training in infection prevention. She stated she was just in the phase where she identified the training program and had not yet registered and had not completed any portion of the training. During an interview on [DATE] at 2:49 p. m., the Administrator stated the DON was the Infection Control Preventionist and was responsible for the oversight of the program. During an interview on [DATE] at 3:06 p.m., the DON stated LVN A was the designated Infection Preventionist. The DON stated LVN just now told her she did not have her training certification complete. The DON stated she was under the assumption that the training was already completed. The DON stated at one time she had her certification in 2023. The DON stated she was no longer certified and her training certificate had expired. She was unable to provide any proof of training prior to exit. The DON stated she was aware of the requirement to have an IP on staff. She stated it was important to have someone with the training in infection control because the knowledge and courses required were lengthy and it was important to have someone who understood the processes. Record review of the facility policy, titled Infection Preventionist (IP) (undated) revealed: The facility must designate one or more individual(s) as the infection preventionist(s)(IP) who are responsible for the facility's IPCP. The IP must: Have professional training in nursing, medical technology, microbiology, epidemiology or another related field. A professionally trained nurse must have earned a certificate/diploma or degree in nursing. 2. The IP must be qualified by education, training, experience or certification. The IP must have the knowledge to perform the role; Recommended specialized training .3. The IP should remain current with infection prevention and control issues and be aware of national organizations guidelines as well as those from national/state/local public health authorities (e.g. emerging pathogens). 6. the IP must physically work onsite in the facility. That individual cannot be an off-site consultant or perform the IP work at a separate location such as a corporate office or affiliated short term acute care facility.</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