

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  02/04/2026
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 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to notify the resident and the resident's representative(s) of discharge and the reasons for the move in writing and in a language and manner they understand, as soon as practicable for 1 of 4 residents (Resident #1) reviewed for discharges. The facility failed to ensure Resident #1 received written notice of discharge after he was emergently discharged on 1/10/2026. This failure could result in a violation of residents' rights and improper discharge. Findings included: Record review of Resident #1's admission Record dated 2/04/2026 reflected an [AGE] year-old male admitted to the facility on [DATE] and discharged on 1/10/2026 to an acute care hospital. Relevant diagnoses included unspecified dementia (a cognitive disorder that impacts memory) and anxiety (a mental health disorder characterized by excessive worrying). Record review of Resident #1's admission MDS submitted 12/28/2025 reflected a BIMS score of 06, which indicated severely impaired cognition. Section Q0310 of the MDS reflected the resident's overall goal was 1. Discharge to the community. Section Q0400 reflected the discharge planning was not actively occurring at the time of submission. Record review of Resident #1's Discharge- Return Not Anticipated MDS submitted 1/10/2026 reflected a BIMS score was not assessed. Section E of the MDS reflected the following:E0200 Behavioral Symptom- Presence and FrequencyA. Physical behavioral symptoms directed toward others (1) Behavior of this type occurred 1 to 3 daysB. Verbal behavioral symptoms directed toward others (0) Behavior not exhibitedE0600 not included in assessmentE0800 Rejection of care- Presence and FrequencyDid the resident reject evaluation or care that is necessary to achieve the resident's goals for health and well-being? (1) Behavior of this type occurred 1 to 3 daysE0900 Wandering Presence and FrequencyHas the resident wandered? (2) Behavior of this type occurred 4 to 6 days, but less than daily Record review of Resident #1's Progress Notes dated 2/04/2026 reflected the following entries:Effective date 1/10/2026 7:01 PM: Verbal aggression Initiated, Resident's room, Nursing Description: 100 Hall Nurse witnessed: @1:47 RESIDENT BECAME AGITATED STAFF ATTEMPTING TO REDIRECT AND REASSURE [family member] WOULD BE COMING TO VISITWHEN HE WAKES UP IN THE MORNING TO NO AVAIL. RESIDENT CONTINUES TO BECOME MORE AGITATED PUNCHED CAREGIVER IN FACE. PROVIDER AND DON AWARE AND BOTH RECOMMEND RESIDENT GO BACK TO THE HOSPITAL FOR HIGHERLEVEL OF CARE FOR EVAL FOR GERI PSYCH RELATED TO BEHAVIORS. RESIDENT MEDICATED WITH CLONAZEPAM ANDDEPAKOTE IN ICE CREAM WITH NO AFFECT. RESIDENT FOUND IN BED WITH ROOMMATE WITH PILLLOW AND LYING ON TOPOFROOMMATE. RESIDENT REMOVED FROM HIS ROOM TO COMMON AREA WHERE RESIDENT FLIPPED OVER COFFEE TABLE,ATTEMPTED TO THROW LAMP THROUGH WINDOW AND BEGAN BANGING ON WINDOW AS WELL RESIDENT SENT TO [Local Hospital Emergency Department] VIAAMBULANCE AND POLICE. PROVIDER CALLED REPORT TO THE ER AS WELL AS NURSE.Effective date 1/10/2026 5:26 PM Physician Progress Notel was called last evening because [sic] [Resident #1] was severely agitated. He was refusing his medications. He was trying to leave facility. He was aggressive with hitting, biting and kicking staff. He tried to head-butt staff as well. He reportedly attempted to [sic] throw his wheelchair.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  676114	Facility ID:  676114  If continuation sheet Page 1 of 5

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F 0628  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	<p>For the safety of staff and other patients I ordered him to be sent to the ER. He was reportedly fine with no behaviors at the ER and was sent back. No interventions or medications were required. Upon return I spoke with nursing to monitor carefully. I received a call that he was continued to be agitated [sic] but was a bit more directable. He was given dose of clonazepam and depakote. I called the ER to let them know that we might need to send him back if he continued to be a danger to our staff and other patients. Early this morning I received a call from nursing that he had attempted to smother his roommate with a pillow. I then ordered that he be sent back to the hospital. We are unable to accept him back until he has undergone thorough psychiatric evaluation and has been stable for a couple of days. He has represented a clear risk to the safety of our staff and other residents. In an interview on 2/04/2026 at 3:30 PM, the DON stated Resident #1's behavior was a significant safety risk to himself, other residents, and the facility staff. She said Resident #1 required a level of care that could not be provided by the facility, and the status of his cognition and behaviors was not accurately conveyed to the facility prior to admission. She said the facility was attempting to find alternative placement for Resident #1, and his family member was aware, but he had not yet been accepted for transfer. Due to the nature of the behaviors of 1/10/2026, she said she instructed facility staff to transfer Resident #1 to the local emergency department and to provide the explicit information to the receiving hospital that Resident #1 could not return to the facility for safety reasons. She said Resident #1 had likely not been given a written notice of discharge after the unplanned discharge as the LSW was out of town and it was an unusual circumstance. She said the failure to provide this written notice could be a violation of a resident's rights. In an interview with the LSW on 2/04/2026 at 3:38 PM, she said Resident #1 had not been given a written notice of discharge after the unplanned discharge on [DATE] as she was out of town during Resident #1's entire admission. She said all residents receive written notice of discharge and room changes as required by law, but she was unaware Resident #1 had been admitted and discharged in her absence. Record review of the facility policy titled Transfer and Discharge (Involuntary; initiated by the facility, not the resident) undated, received 2/04/2026; reflected the following: The notice must be provided at least 30 days prior to the transfer or discharge of the resident. Exceptions to the 30-day requirement apply when the transfer or discharge is affected because: Health and/or safety of individuals would be endangered due to the clinical or behavioral status of the resident. In these exceptional cases, the notice must be provided to the resident, resident's representative if appropriate and the LTC Ombudsman as soon as practicable before the transfer or discharge.</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**</b> Based on interview and record review, the facility to ensure the assessment accurately reflected the resident's status for 1 of 4 residents (Resident #1) reviewed for resident assessments. The facility failed to ensure Resident #1's discharge MDS accurately reflected the frequency of the resident's physically aggressive and wandering behaviors at the time of discharge. This failure could lead to improper oversight and care of residents. Findings included: Record review of Resident #1's admission Record dated 2/04/2026 reflected an [AGE] year-old male admitted to the facility on [DATE] and discharged on 1/10/2026 to an acute care hospital. Relevant diagnoses included unspecified dementia (a cognitive disorder that impacts memory) and anxiety (a mental health disorder characterized by excessive worrying). Record review of Resident #1's Discharge- Return Not Anticipated MDS submitted 1/10/2026 reflected a BIMS score was not assessed. Section E of the MDS reflected the following:E0200 Behavioral Symptom- Presence and FrequencyA. Physical behavioral symptoms directed toward others (1) Behavior of this type occurred 1 to 3 daysB. Verbal behavioral symptoms directed toward others (0) Behavior not exhibitedE0600 not included in assessmentE0800 Rejection of care- Presence and FrequencyDid the resident reject evaluation or care that is necessary to achieve the resident's goals for health and well-being? (1) Behavior of this type occurred 1 to 3 daysE0900 Wandering Presence and FrequencyHas the resident wandered? (2) Behavior of this type occurred 4 to 6 days, but less than daily Record review of Resident #1's Progress Notes dated 2/04/2026 reflected the following entries:Effective date 1/10/2026 7:01 PM: Verbal aggression Initiated, Resident's room, Nursing Description: 100 Hall Nurse witnessed: @1:47 RESIDENT BECAME AGITATED STAFF ATTEMPTING TO REDIRECT AND REASSURE WIFE WOULD BE COMING TO VISITWHEN HE WAKES UP IN THE MORNING TO NO AVAIL. RESIDENT CONTINUES TO BECOME MORE AGITATED PUNCHED CAREGIVER IN FACE. PROVIDER AND DON AWARE AND BOTH RECOMMEND RESIDENT GO BACK TO THE HOSPITAL FOR HIGHERLEVEL OF CARE FOR EVAL FOR GERI PSYCH RELATED TO BEHAVIORS. RESIDENT MEDICATED WITH CLONAZEPAM ANDDEPAKOTE IN ICE CREAM WITH NO AFFECT. RESIDENT FOUND IN BED WITH ROOMMATE WITH PILLLOW AND LYING ON TOPOFROOMMATE. RESIDENT REMOVED FROM HIS ROOM TO COMMON AREA WHERE RESIDENT FLIPPED OVER COFFEE TABLE,ATTEMPTED TO THROW LAMP THROUGH WINDOW AND BEGAN BANGING ON WINDOW AS WELL RESIDENT SENT TO [Local Hospital Emergency Department] VIA AMBULANCE AND POLICE. PROVIDER CALLED REPORT TO THE ER AS WELL AS NURSE.Effective date 1/10/2026 5:26 PM Physician Progress Note was called last evening because [sic] [Resident #1] was severely agitated. He was refusing his medications. He was trying to leave facility. He was aggressive with hitting, biting and kicking staff. He tried to head-butt staff as well. He reportedly attempted to throw his wheelchair. For the safety of staff and other patients I ordered him to be sent to the ER. He was reportedly fine with no behaviors at the ER and was sent back. No interventions or medications were required. Upon return I spoke with nursing to monitor carefully. I received a call that he was continued to be agitated [sic] but was a bit more directable. He was given dose of clonazepam and depakote. I called the ER to let them know that we might need to send him back if he continued to be a danger to our staff and other patients. Early this morning I received a call from nursing that he had attempted to smother his roommate with a pillow. I then ordered that he be sent back to the hospital. We are unable to accept him back until he has undergone thorough psychiatric evaluation and has been stable for a couple of days. He has represented a clear risk to the safety of our staff and other residents.Effective date 1/09/2026 7:00 PM Health Status NoteResident continues to attempt to elope facility, staff redirecting resident away from the doors and attempting to engage in alternative activities to distract resident. Wife just left facility as resident had previously been napping when she arrived. @ 1920 [7:20 PM] resident awake and attempting to ambulate without assistance, redirected to his</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>the progress notes when completing the assessment. Record review of the facility policy titled Comprehensive Assessments (dated 2001, revised March 2022), reflected the following: 8. A significant error is an error in as assessment where:a. the resident's overall clinical status is not accurately represented (i.e., miscoded) on the erroneous assessment and/or results in an appropriate plan of care; andb. the error has not been corrected via submission of a more recent assessment.</p>