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	05/07/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, or mistreatment, including misappropriation were reported immediately, but not later than 2 hours after allegation is made, if the events that cause the allegation involve abuse or results in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 2 or 4 residents (Resident #1, Resident #3) reviewed for reporting missing funds. The facility failed to ensure Resident #1's, on 03/13/2026, and Resident #3's, on 12/12/2025, allegation of misappropriation of funds was reported to the SSA .This failure could place all residents at risk for misappropriation and neglect by not immediately reporting allegations of misappropriation to the proper authorities at the facility, other officials, and State Survey Agency.Findings include:Record review of Resident #1's admission Record, dated 05/05/2026, revealed a [AGE] year-old female admitting to the facility on [DATE] with diagnoses including Major Depressive Disorder (serious, common mental health condition characterized by persistent, severe low mood, loss of interest, and low energy, lasting at least two weeks); General Anxiety Disorder (persistent, excessive, and uncontrollable worry about everyday things - such as health, finances, or family - that lasts for at least six months); Type 2 Diabetes(chronic condition where high blood sugar levels result from body's inability to use insulin properly or produce enough of it); and Muscle Weakness (reduced ability to exert force with muscles, often feeling like effort is needed to move arms, legs, or other body parts). Record review of Resident #1's Quarterly MDS, dated [DATE], revealed a BIMS score of 15 indicating an intact cognitive response.Record review of Resident #1's Care Plan, revised 04/25/2026, revealed a risk of falls, ADL self-care deficits, psychosocial wellbeing concerns, and impaired mobility.Record review of Resident #1's Progress Notes, dated 05/05/2026, revealed no mention of complaint or grievance related to money missing from resident room.Record review of Resident #1's grievance form, dated 03/13/2026, revealed that the grievance was received on 03/13/2026 and generated by Resident #1. Per grievance form Resident #1 described the concern as she had $52 come missing from her room. Follow-up section of Resident #1's grievance form revealed action taken by ADMIN on 03/14/2026 was that $52 was provided to Resident #1. Response section of grievance form revealed that Resident #1 would be placing her money in a Trust Fund to prevent loss. Record review of Resident#1's financial statements, dated 03/14/2026, revealed that $52 was received in resolution of grievance concerning lost funds.During an interview on 05/06/2026 at 10:56 am with ADMIN surveyor was told by ADMIN that he was unsure if there was a report done regarding Resident #1's missing funds to the SSA. ADMIN would need to check his records.During an interview on 05/06/2026 at 11:29 am, ADMIN stated that there was no self-report submitted to the SSA regarding Resident #1's grievance. During an interview on 05/05/2026 at 2:41 pm, MDS LVN stated that Resident #1 shared with her that $52 was missing from room. Resident #1 inquired about the plan to replace the money. (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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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MDS LVN informed Resident #1 that she had completed a grievance form and stated that the ADMIN is going to replace.During an interview and record review on 05/07/2026 at 9:17 am, BOM provided documentation relating to Resident #1's reimbursement of $52 and stated that the reimbursement was pulled from petty cash and that this was approved by ADMIN. BOM stated that $50 was moved into the Trust Fund that Resident #1 opened with them and $2 was kept by Resident #1 for the vending machine. BOM confirmed that the reimbursement happened on 03/14/2026 with print out of Resident #1's Cash Receipt for $52, signed by Resident #1 and ADMIN.Record review of Resident #3's admission Record, dated 05/05/2026, revealed a [AGE] year-old female admitting to the facility on [DATE] with diagnoses including Muscle Weakness (reduced ability to exert force with muscles, often feeling like effort is needed to move arms, legs, or other body parts); Presence of Cardiac Pacemaker (small implantable device placed under skin of the chest to manage irregular or slow heart rhythms, generally due to conditions [NAME] sinus node dysfunction or heart block); Paroxysmal Atrial Fibrillation (type of irregular, rapid heart rhythm that starts and stops suddenly on its own, typically lasting less than seven days); and Hypertension (chronic condition where the force of blood against artery walls is consistently too high).Record review of Resident#3's Quarterly MDS, dated [DATE], revealed a BIMS score of 14 indicating an intact cognitive response.Record review of Resident #3's Care Plan, revised 05/01/2026, revealed a pacemaker in place, fall risk, and a self-care performance deficit. Record review of Resident #3's Progress Notes, dated 05/05/2026, revealed no mention of complaint or grievance related to money missing from resident room.Record review of Resident #3's grievance form, dated 02/23/2026, revealed that the family member placed grievance regarding multiple concerns, including billing and finances.Record review of facility grievance forms, dated 05/06/2026, revealed no grievance listed for Resident #3 in December 2025 or January 2026.During an interview and record review on 05/07/2026 at 9:17 am, BOM stated that Resident #3 has a Trust Fund account with the facility and outside bank usage as well. BOM printed copy of Trust Fund Transaction History for January 1, 20260 - January 21, 2026 that revealed a cash deposit of $145 to Resident #3's Trust Fund account dated 01/21/2026. Petty Cash Box receipt was provided to surveyor dated 01/19/2026 for $145 for Resident #3. BOM stated that ADMIN instructed her to reimburse the $145 to Resident #3 and provided email corroborating statement. During an interview and record review with Resident #3's family member on 05/07/2026 at 9:20am, family member stated that they emailed ADMIN on 02/23/2026 about multiple issues as well as requesting verification of receipt of Trust Fund reimbursement. Resident family member stated the missing money was reported to ADMIN in December. On or around the 12th.During an interview on 05/07/2026 at 10:05 am, ADMIN stated that the normal process to rule out ANE is that they investigate and they report it to SSA if facility suspects funds were stolen. If resident does not state my money was stolen we do not investigate it. We treat it as misplaced funds. ADMIN also stated that there is no way to 100% absolutely ascertain funds were misplaced versus stolen. ADMIN also stated that if facility reports funds as stolen to SSA then it would mean that the facility is admitting to exploitation and that the facility had no grounds to deem that is what happened. ADMIN stated that for Resident #1, Resident #1 never used verbiage of stolen to refer to missing money so it was never reported to SSA. ADMIN also stated that Resident #1 never utilized verbiage of stolen before February email dated 02/23/2026 so it was not reported to SSA till that point.Record review of facility policy for Abuse: Prevention of and Prohibition Against, dated 04/2025, revealed that misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. Policy also revealed that Allegations of abuse, neglect, misappropriation of resident property, or exploitation will be reported outside the Facility and to the appropriate State or Federal agencies in the applicable timeframes, as per this policy and applicable regulations.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administration of all drugs and biologicals) for 1 of 1 resident (Resident #2) to meet the needs of the resident, in that: Resident #2's narcotic count log indicated Oxycodone 5mg medication was administered two times on 04/13/2026 without documentation in the MAR.This deficient practice could place residents at risk for injuries by not having an accurate record of medication administration available in the medical record. The findings included:A record review of resident #2's face sheet dated 05/05/2026 revealed an admission date of 04/11/2026 with diagnoses which included dislocation of internal left hip prosthesis (the ball of the hip implant comes out of the socket) and polyneuropathy (nerve damage that may cause weakness, numbness, and burning pain). A record review of resident #2's MDS dated [DATE] revealed a BIMS score of 15 indicating intact cognition.A record review of resident #2's care plan initiated 04/13/2026, revealed: Resident #2 has analteration in musculoskeletal status r/t left hip prothesis dislocation, intervention, Give analgesics as ordered by the physician. Monitor and document for side effects and effectiveness, and resident #2 is on pain medication therapy (tylenol, gabapentin, hydrocodone, oxycodone) r/t left hip dislocation, neuropathy, intervention, Administer ANALGESIC medications as ordered by physician. Monitor/document side effects and effectiveness Q-SHIFT. A record review of resident #2's physician order summary dated 05/05/2026 revealed to administer the following medications: oxyCODONE HCl Oral Tablet 5 MG (Oxycodone HCl)Give 2 tablet by mouth every 4 hours as needed for severe pain (7-10), with a start date of 04/11/2026. Interview with M Chest pharmacy on 05/07/2026 at 8:21 am confirmed that 108 Oxycodone 5mg tablets were delivered to facility on 04/12/2026 for resident #2. A record review of resident #2's narcotic count sheet for: OXYCODONE TAB 5mg, give 2 tablets (10MG) by mouth every 4 hours as needed, indicated the following doses of medication were administered: 04/13/2026 at 11:30am 2 tablets given, with a remaining count of 106 tabs, and 04/13/2026, no time recorded, 2 tabs given, with a remaining count of 104 tabs. A record review of resident #2's MAR in the electronic medical record revealed no documentation for administration of oxycodone 5mg on 04/13/2026.During an interview with resident #2 on 05/05/2026 at 9:59 am, the resident stated a dose of oxycodone was received on 04/13/2026 at 4:30pm.During an interview on 05/07/2026 at 9:37am with ADON B, she stated confirmation that the oxycodone 5mg was not documented on resident #2's MAR as being administered on 04/13/2026. ADON stated the staff should be documenting all medications on the MAR as they are administered to avoid discrepancies. ADON stated missed documentation was an identified issue that was being addressed through education and pulling the missed documentation report. During an interview on 05/07/2026 at 10:45 am with DON, she stated her expectation is that nursing staff document medication administration in the MAR at the time the medication is given to remain in compliance and avoid medication errors. DON stated she is working on educating staff and the nursing leadership is reviewing documentation daily.A record review of the facility's policy titled, Medication Administration, dated 06/2022, revealed, 3. All current drugs and dosages must be recorded on the resident's medication administration record (MAR). 6. When PRN medications are administered, the nurse must record: B. The date and time administered. The seven rights of medication administration are as follows in order to ensure safety and accuracy of administration. #6. Right Documentation-Document administration or refusal of the medication after the administration or attempt and note any concerns.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility failed to ensure all drugs and biologicals were stored in accordance with professional standards for 2 of 8 medication carts (100 Hall nurses medication cart and 100 Hall medication aide cart) reviewed for storage of drugs.The facility failed to ensure the carts for 100 Hall, for both the nurse medication cart and the medication aide cart, were locked and secured on 05/05/2026609 .This failure could place residents at risk of medication misuse, medication errors, drug diversion or harm due to accidental ingestion of unprescribed medications.Findings included:During an observation on 05/06/2026 at 10:03 am, the nurses medication cart on 100 Hall by nurses station was unlocked, the nurse sitting 10 to 15 feet away behind the nurses station. Several unknown residents were ambulating on and around the hall. LVN A stood and exited from nurses station and approached this surveyor when surveyor opened top drawer of nurses medication cart and began rummaging around the drawer while asking whose cart was open.During an interview on 05/06/2026 at 10:03 am, LVN A stated that she never leaves her cart unlocked and she apologized. LVN proceeded to lock medication cart when stating that she knows the cart should be locked at all times. LVN A stated that the negative impact to residents when the cart is left unlocked and unattended is that they could get into medications and take something that they are not supposed to. During an observation on 05/06/2026 at 2:46 pm, the medication aide cart was found unlocked on 100 Hall. Surveyor stood beside cart while looking directly at LVN A. LVN A left nurses station, 10-15 feet away, and jogged to nurses medication cart next to the medication aide cart and reached out to push on the lock. After a second LVN A noticed the medication aide cart next to surveyor was unlocked. LVN A reached over to lock the medication aides medication cart.During an interview on 05/06/2026 at 2:46 pm, LVN A stated that CMA A was on lunch break and she was unsure what time she went to lunch.During an interview on 05/06/2026 at 3:15 pm, CMA A stated that she went to lunch and thought she had locked the cart. CMA A stated that she left the keys to the medication cart with LVN A. CMA A stated that leaving a medication cart unlocked and unattended could negatively impact residents by giving them the opportunity to take medications that are not theirs.During an interview on 05/07/2026 at 10:08 am, ADON A stated that the expectation for all medication carts is that they are locked when unattended. ADON A stated that the negative impact to residents for an open medication cart is that they can be hurt taking things that are not theirs.During an interview on 05/07/2026 at 10:36 am, DON stated that medication carts should be locked when staff steps away from them. Record review of CMA A's time punches on 05/06/2026 revealed CMA A clocked out for lunch at 2:00 pm and clocked back in from lunch at 3:08 pm.Record review of facility's Medication Access and Storage policy, dated 06/2025, revealed that all drugs and biologicals should be stored in locked compartments.