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	06/13/2025

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents had the right to personal privacy and confidentiality of his or her personal and medical records for 1 of 5 residents (Resident #13) reviewed for privacy, in that: The facility failed to ensure that MA (E) locked the computer after she walked away and left it unattended, which exposed Resident #13's morning medication list. This failure could place residents at risk of having their medical information exposed to others and cause residents to feel uncomfortable and disrespected. The findings include: Record review of Resident #13's face sheet dated, 6/12/25 reflected an [AGE] year-old female resident who was admitted to the facility on [DATE] with diagnoses which included: Anxiety disorder (a group of mental health conditions characterized by excessive, persistent, and uncontrollable feelings of worry and fear), Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), and dysphagia (difficulty swallowing foods or liquids). Record review of Resident #13's Quarterly MDS assessment, dated 5/05/25, reflected a BIMS score of 04, which indicated severe cognitive impairment. Observation on 6/11/25 at 9:45 AM revealed MA (E) prepared Resident #13's morning medication and walked away from the computer, leaving the screen facing the wall. MA (A) did not lock the computer screen and was away from the computer for 10 minutes. During an interview on 6/11/25 at 9:58 AM, MA (E) stated she was not aware of the option to lock the computer screen and believed minimizing the screen was sufficient. MA (E) noted Resident #13's private medical information might have been exposed when she stepped away from the computer. (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/12/25 at 9:39 AM, the DON stated she was unaware that Resident #13's records had been left open and unattended by MA (E). The DON stated her expectation was for the facility nursing staff to uphold HIPAA regulations and lock computer screens when they were away from them. The DON emphasized that all staff members should protect residents' information. The DON expressed concern that leaving residents' charts open and unattended could lead to unauthorized access. The DON also stated she would be responsible for overseeing compliance with this task, and she would monitor it by conducting random computer screen checks. Record review of the facility's policy dated 2001, titled policy statement, reflected: The facility is required to abide by the terms of its current effective privacy notice.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure. the resident has a right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safely for 1 of 4 community showers, 1 of 20 resident rooms, in that: 1. A community shower chair had brown substance at the bottom of seat. 2. 400 hall shower room was missing 1 tile. 3. room [ROOM NUMBER] door frame to bathroom was missing the frame on 1 side of the door frame. This failure could place residents at risk of lack of facility cleanliness and a homelike environment. The Findings were: 1. Observation on 6/11/2025 at 3:50 PM with CNA I and J in the 400-shower room revealed the shower chair had brown substance on the bottom of seat. CNA G and H stated the shower chair was to be cleaned after each use. Interview on 6/11/2025 at 3:51 PM with CNA's I and J stated the shower chair had brown substance and should be cleaned after each use. The CNA's stated the hospice CNA last used the shower room. Interview on 6/11/2025 at 4:25 PM with LVN K in the 400-hall shower room confirmed the CNA's discussed with her the shower chair had brown substance . LVN K stated the aides should be cleaning and disinfecting the shower chairs after each use. Interview on 6/11/2025 at 4:46 PM with LVN K stated she would discuss shower concerns with housekeeping and maintenance director. LVN K stated she would follow up with the CNA's about the shower chair being cleaned after each use by CNA. LVN K stated the risk for residents was potential injury, and respiratory infection. Interview on 6/12/2025 at 6:30 PM the ADON stated the shower hall concerns could risk infection control and the expectation was to keep the shower rooms tidy and in good working condition. 2. Observation on 6/11/2025 at 3:50 PM with CNA I and J in the 400-shower room revealed a missing 1 tile. Interview on 6/11/2025 at 3:51 PM with CNA's I and J stated the shower tile would be reported to Maintenance Director. CNA I and J stated they had not noticed the tile missing. Interview on 6/11/2025 at 4:25 PM with LVN K in the 400-hall shower room confirmed the tile was missing and in resident room [ROOM NUMBER], bathroom door frame was missing on 1 side. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 6/11/2025 at 4:46 PM with Housekeeper Manager stated she did was not aware of the tile missing or the door frame in resident room [ROOM NUMBER]. The Housekeeping Director stated she would report the missing tile to the Maintenance Director. The Housekeeping Director stated the housekeeping aides clean in the resident showers daily. Interview on 6/11/2025 at 4:53 PM with Maintenance Director stated no staff had reported the missing tile in the shower room or the missing door frame in resident room [ROOM NUMBER]. The Maintenance Director stated the staff could input the item that needed to be fixed in the software maintenance program. No policy was provided. 3. Observation on 6/11/2025 at 5:00 PM with the Maintenance Director revealed room [ROOM NUMBER] was missing a door frame on one side. Maintenance stated no staff had reported this to him. Interview on 6/12/2025 at 6:30 PM with the ADON stated the missing tile and missing door frame could have a risk of infection and injury to resident skin. ADON stated the expectation was to keep the shower rooms tidy and in good working condition. Record review of policy, Homelike Environment dated February 2021, revealed Residents are provided with as safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings to the extent possible. 2. The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: 1. Clean, sanitary, and orderly environment.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the interview and record review, the facility failed to ensure that residents are free from chemical restraints related to PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483. 45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order, for 1 of 3 residents (Resident #62) reviewed for chemical restraint, in that: The facility failed to ensure Resident #62 was prescribed a psychotropic drug for anxiety, no longer than 14 days PRN (as needed). This deficient practice could place residents at risk of receiving unnecessary psychotropic medications. The findings were: Record review of Resident #62's face sheet, dated 6/13/25, revealed an [AGE] year-old female admitted to the facility on [DATE] with the diagnosis that included: anxiety (intense, excessive, and persistent worry and fear about everyday situations), depression (mood disorder characterized by persistent feelings of sadness) and hypertension (medical term used when the force of your blood against arterial walls is consistently too high). Record review of Resident #62's BIM's assessment completed 5/07/25, revealed a BIM's score of 12, which indicated moderate cognitive impairment. Record review of Resident #62's care plan, dated 4/09/25, revealed the resident uses antianxiety medication Xanax with interventions to administer medicines as ordered by a physician. Record review of Resident #62 order summary, dated June 2025, revealed an order for Xanax oral tablet 0. 5mg, give one tablet by mouth every 6 hours as needed for anxiety indefinite. Record review of the medication administration record for Resident # 62, dated 6/12/2025, revealed Resident # 62 had received Xanax 0.5 mg on 6/5/25, 6/6/25,6/7/25, 6/8/25, 6/8/25, and 6/11/25. During an Interview with the DON on 6/12/25 at 9:18 a.m., it was stated Resident # 62 had an order for Xanax 0.5 mg every 6 hours PRN indefinite, and the order should have only been for 14 days. She did not know why the order was written over 14 days, as overuse can place Resident # 62 at risk for respiratory depression. The nursing supervisor confirmed that she was responsible for overseeing this task daily and currently monitors it at random, which was why the deficient practice was an oversight. Record review of the facility's policy titled, Medication Therapy, dated 2001, revealed, . all decisions related to medications shall include appropriate elements of the care process, such as principles of prescribing for the elderly.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that included measurable objectives and time frames to meet a resident's medical, nursing, mental, and psychosocial needs that were identified in the comprehensive assessment for 4 (Residents #37, #63, #76, and #86) of 21 residents reviewed for care plans. 1. The facility failed to develop care plan interventions for Resident #37's hearing loss. 2. Resident #63's care plan had the wrong code status. 3. Resident #76's care plan had her oxygen liters wrong. 4. Resident #86's care plan had the wrong tube feeding formula. These failures could place residents at risk of not receiving care and services related to their identified needs to maintain or reach their highest practicable physical, mental, and psychosocial wellbeing. The findings included: 1. Record review of Resident #37's face sheet, dated [DATE], reflected an [AGE] year-old resident initially admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe) and pneumonia (infection that inflames air sacs in one or both lungs, which may fill with fluid). Record review of Resident #37's Quarterly MDS Assessment, dated [DATE], reflected that Resident #37 had a BIMS of 13, indicating the resident was able to hear with Moderate difficulty, indicating that the speaker has to increase volume and speak distinctly. Record review of Resident #37's Comprehensive Person-Centered Care Plan, dated last review completed [DATE], did not reflect that Resident #37 was hard of hearing. Record review of Resident #37's Provider Progress Note, dated [DATE], reflected, [Resident #37] is severely hard of hearing . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and Interview on [DATE] at 12:30 PM, Resident #37 stated he could not hear the Surveyor. Resident #37 stated he had hearing aides at one point but they became lost and he is uncertain if anyone will get him a new one. 2. Record review of Resident #63's admission Record dated [DATE] was documented she was admitted on [DATE], re-admitted on [DATE] with diagnoses of Acute Kidney Failure, cognitive communications deficit, and schizophrenia. Record review of Resident #63's Advanced Directive was a DNR (do not resuscitate). Record review of Resident #63's OODNR was signed and dated [DATE]. Record review of Resident #63's consolidated orders for [DATE] was documented an order for DNR. Record review of Resident #63's care plan dated [DATE] was documented Resident #63 request code status of Full Code. Interview on [DATE] at 2:51 PM with SW stated Resident #63 should be a DNR, not sure why the care plan had Resident #63 as a Full Code. The SW stated she completed the residents code status and the care plans. Interview on [DATE] atb11:00 AM with MDS stated they were responsible for the resident's care plans, and the code status was the responsibility of the SW. Interview on [DATE] at 11:28 AM with ADON stated the code status being wrong on care plans could lead to staff providing CPR, if they had an OODNR. The ADON stated the expectation would be that staff follow the correct orders and have them corrected in the care plan. 3. Record Review of Resident #76's admission Record dated [DATE] and she was admitted on [DATE] with diagnoses of Heart Failure, Acute Kidney Failure, cognitive communication deficit, lack of coordination, and her code status was Full Code. Record Review of Resident #76's consolidated orders for [DATE] revealed an order to Decrease oxygen to 2L NC. Maintain oxygenof >94%. Record Review of Resident #76's MDS dated [DATE] in Section O: Special Treatments, Procedures and Programs was checked for oxygen. Record Review of Resident #76's care plan dated [DATE] revealed she had oxygen therapy, will have no signs and symptoms of poor oxygen absorption through the review date., Change residents position every 2 hours to facilitate lung secretion movement and drainage, Monitor for signs and symptoms of respiratory distress and report to MD as needed: Respirations, Pulse oximetry, Increased heart rate (Tachycardia), Restlessness, Diaphoresis, Headaches, Lethargy, Confusion, Atelectasis, Hemoptysis, Cough, Pleuritic pain, Accessory muscle usage, Skin color, and OXYGEN SETTINGS: Oxygen via nasal canula at 3 LPM (as needed). Humidified. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on [DATE] at 10:52 AM in Resident #76's room revealed her oxygen concentrator was on and she had the tubing in her nasal cavity. Observation of the oxygen concentrator was at 2 LPM. Interview on [DATE] at 4:31 PM with LVN K confirmed Resident # 76's oxygen level was at 2 LPM on her oxygen concentrator. Interview on [DATE] at 5:54 PM with DON stated Resident #76 Oxygen concentrator risk could be residents not getting the correct order and expectation of nursing would be to make sure the orders match the residents care plans. Interview on [DATE] at 10:48 AM with MDS stated Resident #76's oxygen concentrator stated she was on 3 liters and now she was decreased to 2 liters. MDS stated this change was on [DATE]. MDS stated the nurses should let the MDS staff know of any resident order changes. MDS stated the risk would be resident not getting the correct oxygen concentration and expectation to make sure the care plan and orders match for residents. Interview on [DATE] at 11:20 AM with ADON talk about new orders on morning meetings., but not responsible for care plans for correct Oxygen. ADON stated the MDS staff and individual departments are responsible for resident care plans. 4. Record Review of Resident #86's admission Record dated [DATE] was admitted on [DATE], re-admitted on [DATE] with diagnoses of seizures, muscle weakness, cognitive communication deficit, and memory deficit following cerebral infarctions. Record Review of Resident #86's consolidated orders for [DATE] was documented give Jevity 1.5 or equivalent 240ml bolus 4 times a day if eats less than 75% four times a day for nutrition. Record Review of Resident #86's Quarterly MDS dated [DATE] was documented in Section K Swallowing/Nutritional Status for A. tube feeding. Record Review of Resident #86's Care Plan dated [DATE] was documented Glucerna 1.2 bolus PRN. Record review of Facility Policy titled, Care Plans, Comprehensive Person-Centered dated revised [DATE], reflected, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Further review reflected, The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes services that are to be furnished to attain or maintain the residents highest practicable well-being . c. includes the resident's stated goals upon admission and desired outcomes

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 of 6 residents (Resident #9) reviewed for personal hygiene. The facility failed to provide Resident #9 with 7 of 9 scheduled showers between 05/21/2025 and 06/11/2025. This failure could place residents who require assistance from staff for personal hygiene at risk of not receiving care and services contributing to overall poor hygiene, risk of experiencing a diminished quality of life, and possible skin infections. The findings included: Record review of Resident #9's Face Sheet, dated 06/12/2025, reflected an [AGE] year-old resident with an initial admission date of 12/05/2024. Resident #9 had diagnoses that included other acute osteomyelitis, left ankle and foot (inflammation of bone caused by infection); chronic kidney disease (longstanding disease of the kidneys leading to renal failure); and acute diastolic (congestive) heart failure. Record review of Resident #9's Quarterly MDS Assessment, signed and completed on 05/29/2025, reflected Resident #9 had a BIMS score of 11, indicating the resident was moderately cognitively impaired. Resident #9's MDS assessment indicated that Resident #9 was Dependent (helper does ALL of the effort) for showering/bathing. Record review of Resident #9's Comprehensive Person-Centered Care Plan, undated, reflected, [Resident #9] has an ADL self-care performance deficit with interventions, [Resident #9] requires (extensive assistance) by (1-2) staff with (bathing/showering) (3x/week) and as necessary. Record review of Resident #9's tasks in his electronic health record did not reflect the residents assigned shower days. Further review revealed Resident #9 did not receive 7 of the 9 showers scheduled. Between 05/21/2025 and 06/11/2025, Resident #9 received showers on the following dates: 05/21/2025 and 05/30/2025. There were no other showers documented on the resident's electronic health record. During an observation and attempted interview on 06/10/2025 at 11:00 AM, Resident #9's room was observed with a sign from family stating, No showers in a month??? Resident #9 was unable to answer any questions relating to his showers. Interview on 06/12/2025 at 11:30 am, CNA D stated that they were assigned to Resident #9's hallway generally, and Resident #9's shower days were Tuesday, Thursday, and Saturday . CNA D stated they use shower sheets but was unsure of where they were located. Shower sheets requested from CNA D and the DON on 06/12/2025 at 11:30 AM and were never provided to the surveyor. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/12/2025 at 5:38 PM, the DON stated her expectation is for residents to be on a rotating shower schedule upon admission, with showers either Monday, Wednesday, and Friday or Tuesday, Thursday, and Saturday. The DON stated her expectation was for showers to occur on the scheduled days, and the risk to residents for not receiving showers could include skin breakdown. Record review of facility policy, dated reviewed 03/2018, titled, Activities of Daily Living (ADL), Supporting, reflected, Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received proper treatment and assistive devices to maintain hearing abilities for 1 of 8 residents (Resident #37) reviewed for hearing. The facility failed to ensure Resident #37 received appropriate services to assess for maintaining or improving hearing abilities. This failure could place residents at risk for unmet needs and diminished quality of life related to communication. The findings included: Record review of Resident #37's face sheet, dated 06/13/2025, reflected an [AGE] year-old resident initially admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe) and pneumonia (infection that inflames air sacs in one or both lungs, which may fill with fluid). Record review of Resident #37's Quarterly MDS Assessment, dated 06/06/2025, reflected that Resident #37 had a BIMS of 13, indicating the resident was able to hear with Moderate difficulty, indicating that the speaker has to increase volume and speak distinctly. Record review of Resident #37's Comprehensive Person-Centered Care Plan, dated last review completed 05/14/2025, did not reflect that Resident #37 was hard of hearing. Record review of Resident #37's Provider Progress Note, dated 06/09/2025, reflected, [Resident #37] is severely hard of hearing . Observation and Interview on 06/11/2025 at 12:30 PM, Resident #37 stated he could not hear the Surveyor. Resident #37 stated he had hearing aides at one point but they became lost and he is uncertain if anyone will get him a new one. Interview on 06/13/2025 at 11:30 AM, the SW stated she knew Resident #37 had an appointment next month, but was not aware of when his last appointment was. The SW stated the VA would have that information and she could try to get it from the social worker at the VA. Record review of facility policy titled, Hearing Impaired Resident, Care of, dated revised February 2018, reflected, Staff will assist the resident (or representative) with locating available resources, scheduling appointments and arranging transportation to obtain needed services. And, Staff will help residents who have lost or damaged hearing devices in obtaining services to replace the devices.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review failed to ensure the resident environment remains as free of accident hazards as is possible for 1 of 8 (#33) residents in the 400 halls, in that: Resident #33's fall matt was not in place. This failure could place residents at risk for injuries. The Findings were: Record review of Resident #33's admission Record dated 6/13/2025 revealed she was admitted on [DATE], re-admitted on [DATE] with diagnoses of hemiplegia and hemiparesis following cerebral infraction affecting right dominate side (a person is experiencing weakness or paralysis (hemiplegia) or weakness alone (hemiparesis) on the left side of their body due to a stroke affecting the right side of their brain, which typically controls the left side of the body.), acute kidney failure, cognitive communication deficit, Alzheimer's, and seizures. admission record was documented she was on hospice services. Record review of Resident #33's Quarterly MDS was dated 5/ 28/2025, was documented BIMS score was 3/15 (severely impaired) and had history of falls. Record review of Resident #33's Care Plan dated 6/5/2025 was documented Resident #33 had an actual fall related to poor balance, poor communications/comprehension, unsteady gait. The intervention was a fall mat at bedside. Observation on 6/10/2025 at 10:30 AM in Resident #33's room revealed she as sleeping in bed, and the fall mat was in place. Observation of COTA coming into Resident #33's room and moved the fall mat to take a closer look at residen t. Observed COTA leaving the room but did not move the fall mat back in place. COTA left the room and went into another resident room. Observation on 6/10/2025 at 11 AM in Resdinet #33's room with COTA revealed she did not have the fall matt near her bed. Interview on 6/10/2025 at 11:01 AM with COTA came by and surveyor asked her, about Resident 33's fall mat, she stated she forgot to place the fall mat back close to the residents bed. Interview on 6/10/2025 at 11:03 AM CNA M stated Resident #33 should have the floor mat near her bed for falls. CNA M stated Resident #33 had a history of falls. CNA M stated it was important to have a fall mat in case resident falls and she does not get hurt. Interview on 6/12/2025 at 5:54 PM the DON stated if resident did not have fall preventions in place, fall matt. The DON stated the risk for Resident # 33 would be injury to the resident and she expected the staff to follow the interventions for falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 6/13/25 at 11:03 AM with both MDS A and B nurses confirmed Resident #33's care plan dated 5/4/2025 had documented intervention for falls, a fall mat. Interview on 6/13/2025 at 11:25 AM with ADON B stated not having the fall mat in place for Resident #33s could be at risk for further injury and the expectation was that any staff member should replace the fall mat prior to leaving the room. Record review of Resident #33's incident report dated 5/4/2025 at 6L45 AM was documented she was found on the floor by staff with laceration to left brow. Resident #33 stated she was trying to go to bathroom and was taken to the emergency room. Record review of policy, Safety and Supervision of Residents dated 2001 was documented Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervisor and assistance to prevent accidents are facility-wide priorities. Individualized, Resident-Centered Approach to Safety, 4. Implementing interventions to reduce accident risks and hazards shall include the following: d. ensuring that interventions are implemented.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to ensure that a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible, for 1 of 8 residents (Resident #18) reviewed for urinary catheters. The facility failed, for 10 consecutive days, to follow the physicians' order to flush Resident #18's urinary catheter twice a day. These failures could place residents at risk for a decline in their health status. The findings included: A record review of Resident #18's admission record dated 6/13/2025 revealed an admission date of 4/8/2025 with diagnoses which included neuromuscular dysfunction of bladder (no bladder control because of brain, spinal cord, or nerve problems), urinary tract infection, and Parkinson's disease (an illness that affects the part of the brain that controls movement, walk, talk, sleep, and thought). A record review of Resident #18's quarterly MDS assessment, dated 5/17/2025, revealed she was an [AGE] year-old female admitted for long term care related to a neurogenic bladder (a malfunction of the urine bladder complicated by the disruption of nerve signals to the nervous system). Further review revealed Resident #18 was assessed with a BIMS score of 5 out of a possible 15 which indicated severe cognitive impairment. Resident #18 was assessed with the need for an indwelling urinary catheter. * * A record review of Resident #18's nursing progress notes revealed ADON B documented on 5/31/2025 a Situation, Background, Assessment, Recommendation (SBAR) report where she reported to the physician, this nurse was notified by the aide that the resident had blood tinged urine in her (brand name, sic[urinary collection]) bag. There was some blood and blood clots in the tubing and on the brief. Further review revealed ADON B documented the physician prescribed nursing staff to remove and replace Resident #18's indwelling urinary collection bag. A record review of Resident #18's physicians orders revealed LVN N documented on 6/2/2025 a new order from the physician to flush Resident #18 indwelling urinary catheter twice a day. Further review of the order revealed the order type: drop down list was selected as other orders (no documentation required). * (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident #18's medical record reviewed for the period of 6/2/2025 to 6/12/2025 revealed no evidence that Resident #18 had received her prescribed flush treatment for her indwelling catheter. During an observation on 6/10/2025 at 10:40 AM revealed Resident #18 was seated in her wheelchair and had an indwelling urinary catheter evidence by the observation of her urinary catheter collection bag secured to her wheelchair below her bladder level and was concealed in an opaque privacy cover. During an interview on 6/12/2025 at 3:45 PM LVN O stated she was the nurse for Resident #18 for 6/12/2025 and was the nurse for Resident #18 on 6/11/2025 from 6:00 AM to 6:00 PM. LVN O stated Resident #18 had an indwelling urinary catheter and she had not flushed Resident #18's catheter. LVN O reviewed Resident #18's physicians orders and recognized an error in Resident #18's order. LVN O stated LVN P had documented an order for flushing Resident #18's indwelling urinary catheter twice a day beginning on 6/2/2025, however, she had not chosen for documentation to be completed on the section of the electronic order titled order type. LVN O stated the choice documented on the order was other orders (no documentation required) and thus the order did not transcribe to the treatment administration record; the order was not visible to floor nurses who utilize the treatment administration record as a guide for providing treatment and care throughout the day. LVN O reviewed the record and could not find evidence Resident #18 had received her flush for her indwelling urinary catheter. LVN O stated the record revealed Resident #18 was producing clear, yellow, sediment free urine with vital signs which were within normal limits. LVN O stated she would assess Resident #18 for harm and report to the physician and her supervisor ADON B. During an interview on 6/12/2025 at 4:45 PM ADON B stated she was the ADON for Resident #18 and LVN O. ADON B stated she had received a report from LVN O regarding Resident #18 failed indwelling urinary catheter flush treatment. ADON B stated the physician had received an SBAR from LVN O and had discontinued the flush order because Resident #18 was producing unremarkable urine and had no need for a flush of her indwelling catheter. ADON B stated she had reviewed the medical record for Resident #18 and had recognized LVN P had not documented the order to reflect the order onto Resident #18's treatment administration record and thus other nurses were unaware of the order. ADON B stated all new orders were reviewed daily in the morning Interdisciplinary Team (IDT) meeting and had reviewed the order on 6/3/2025, however the order was not reviewed for accuracy for transcription to the treatment administration record. ADON B stated she was supervised by the DON. ADON B stated the IDT included herself, the DON, and the administrator as well as other department heads. During an interview on 6/12/25 at 5:45 PM the DON stated she had received a report from ADON B regarding the failed flush for Resident #18's indwelling catheter and had ensured Resident #18 had no adverse effects from the failure. The DON stated due to Resident #18's improved urine production the physician discontinued the flush order on 6/12/2025. The DON stated a review of the order revealed LVN P had not documented the order correctly and thus the order was not transcribed to the treatment administration record and other nurses were unaware of the order. The DON stated she and the Administrator as well as other department heads were members of the IDT. The DON stated the IDT team met on 6/3/2025 and had reviewed all new orders from the previous day however the review failed to recognize the improperly documented order and thus Resident #18 had not received her prescribed indwelling urinary catheter flush. The DON stated the risk to residents was they may not receive the therapeutic effects of the physicians' prescribed treatments. A policy regarding the failure was requested and the facility provided the Charting and Documentation policy. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of the facility's Charting and Documentation dated July 2016, revealed, Policy Statement: All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Policy Interpretation and Implementation: . 7. Documentation of procedures and treatments will include care-specific details, including: a. The date and time the procedure/treatment was provided. b. The name and title of the individual(s) who provided the care. c. The assessment data and/or any unusual findings obtained during the procedure/treatment. d. How the resident tolerated the procedure/treatment. e. Whether the resident refused the procedure/treatment. f. Notification of family, physician, or other staff, if indicated; and g. The signature and title of the individual documenting.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on record reviews and interviews the facility failed to ensure the services of a Registered Nurse (RN) for at least 8 consecutive hours a day, 7 days a week, for 1 of 1 facility's reviewed for nursing staffing. The facility failed to have the services of an RN on 5/31/2025 and on 6/1/2025. These failures could have placed residents at risk of not having the critical skills of a RN. The findings included: A record review of the facility's census reports for the dates of 5/31/2025 and 6/1/2025 revealed a census of 101 residents daily. A record review of the facility's RN staff payroll hours for the period from 3/1/2025 through 6/10/2025 revealed no evidence for the services of an RN for 8 consecutive hours on 5/31/2025 through 6/1/2025. During an interview on 6/13/2025 at 10:00 AM ADON A stated she was not aware of the federal and state requirement to have at a minimum the services of an RN for 8 consecutive hours a day. ADON A stated she was aware to attempt to have the services of an RN daily but not the rationale for the attempt. ADON A stated she was responsible for the facility's nursing schedule. ADON A stated she recognized during the week prior to the weekend, Saturday 5/31/2025 through Sunday 6/1/2025, she had no available regular staff RN to work the weekend and attempted to utilize the nursing staff agency to staff the weekend. ADON A stated she posted the available RN shift on the contracted nursing staff agency's website and prior to the scheduled 6:00 AM to 6:00 PM shift beginning Saturday 5/31/2025 she recognized no one had accepted the shift. ADON A stated she then posted the shift availability for an LVN and the shift was filled by an agency LVN. ADON A stated the agency LVN worked the facility's 100-hall. ADON A stated the schedule change from an RN to and LVN for the weekend was not reported the to her supervisors, the DON and or the Administrator. ADON A stated she had reported the schedule change on 6/2/2025 to the interdisciplinary team (IDT) during the morning meeting. ADON A stated the IDT included the DON and the Administrator. During an interview on 6/13/2025 at 10:51AM the DON and the Administrator stated the facility census for 5/31/2025 and 6/1/2025 was 101 residents. The DON and the Administrator stated they were in attendance in the IDT morning meeting on Monday 6/2/2025 and discussed the previous weekend staffing of an LVN instead of an RN. The DON stated she had not known of the lack of a scheduled RN prior to the weekend. The DON stated had she been informed she could have intervened to attempt to staff the facility with an RN to include herself to staff the weekend as an RN supervisor. The DON stated the risks to residents was the lack of an RN skill set for the weekend. A record review of the facility's Staffing, Sufficient and Competent Nursing policy dated august 2022, revealed, Our facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment. (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Policy Interpretation and Implementation Sufficient Staff: . A registered nurse provides services at least eight (8) consecutive hours every 24 hours, seven (7) days a week. RNs may be scheduled more than eight (8) hours depending on the acuity needs of the Resident

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to ensure residents were free from any significant medication errors, for 1 of 6 residents (Resident #9) reviewed for medication errors, in that: LVN C administered Resident #9's meropenem (an intravenous antibiotic used to treat a variety of bacterial infections) antibiotic intravenously at the wrong infusion rate and effectively administered the medication in half of the intended time, over 30 minutes instead of 1 hour. This failure could place residents at risk of not administering medications as prescribed and increasing adverse effects. The finding included: A record review of Resident #9's admission record dated 6/12/2025 revealed an admission date of 5/20/2025 with diagnoses which included osteomyelitis (a serious bone infection that can occur due to bacteria) left ankle and foot; chronic kidney disease stage 4 severe (severe, irreversible damage to the kidneys. At this stage, the kidneys are functioning at only 15-29% of their normal capacity, leading to the accumulation of waste products in the blood). A record review of Resident #9's quarterly MDS assessment dated [DATE] revealed Resident #9 was an [AGE] year-old male admitted for long term care related to a bone infection to his left ankle complicated by diabetes mellitus (common form of diabetes, characterized by insulin resistance, where the body's cells do not respond effectively to insulin). Resident #9 was assessed with a BIMS score of 11 out of a possible 15 which indicated mild cognitive impairment. further review revealed Resident #9 had a PICC line intravenous access port (peripherally inserted central catheter (PICC), also called a PICC line, is a long, thin tube that's inserted through a vein in your arm and passed through to the larger veins near your heart.) * A record review of Resident #9's physicians orders revealed a physician's order on 5/20/2025; the physician prescribed Resident #9 to be administered 1 gram of meropenem intravenously every 12 hours, at 9:00 AM and again at 9:00 PM, for a month. Further review revealed no evidence for a flow rate to infuse the medication. During an observation and interview on 6/12/2025 at 5:50 PM Resident #9 presented in his room in bed. Resident #9 stated he had an infection to his left ankle and had received medications via his PICC line on his right arm. Resident #9 demonstrated his right arm PICC line. Resident #9 stated he received medication from the nurse in the mornings and evenings. During an observation on 6/12/2025 at 8:42 PM revealed LVN C prepared Resident #9s meropenem antibiotic. LVN C reviewed the antibiotic bag and pharmacy label. The pharmacy label revealed, meropenem 1000mg / NS sic[normal saline] 100ml . infuse 100ml (1GM) intravenously over 60 minutes, every 12 hours for a month. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 6/12/2025 at 8:42 PM revealed LVN C administered Resident #9's meropenem 1-gram 100ml via residents PICC line on his right arm and used a intravenous flow regulator (a small white plastic device about 1.25 x 1.33, barrel shaped, designed with marking which included off, open, 5ml, 10ml, 15ml, . up to 250ml. by twisting the barrel from different ends and setting to any flow rate up to 250ml an hour.) LVN C set the flow meter to 200ml an hour and began Resident #9's intravenous antibiotic medication administration. LVN C stated she reviewed the order and there was no specification for a flow rate, and she has administered the medication previously and has set the flow rate at 200ml an hour and sets an alarm to return in 45 minutes and the infusion will be completed. During an interview on 6/13/2025 at 10:01 AM the DON stated nursing staff should follow physicians' orders and follow the medication administration rights which included a review to ensure the right medication, the right dose, and right route of administration. The DON stated the review of the medication would include the medications pharmacy label and the administration recommendations. The DON stated the flow regulator should have been set to the pharmacy's recommendations 100ml an hour. The DON stated the flow rate of 200ml an hour would have administered the dose in half the intended time and could have potentially increased adverse reactions to the medication administration. The DON stated Resident #9 was assessed without adverse reactions and the physician was given a report with no new orders. A record review of the facility's Intravenous Medication Administration dated October 2024, revealed, Purpose: The purpose of this procedure is to provide guidelines for the safe and aseptic administration of medications intravenously. Preparation: . Assessment: . 2. Review physician's order (resident name, medication, dose, concentration, route, rate, frequency and special instructions). Compare with medication dispensed by the pharmacy. 3. If no rate is ordered, calculate rate according to dose, volume and time ordered. 7. Administer medication according to prescribed rate. If using via gravity, set dial to prescribed rate. If infusing via pump, set pump to prescribed rate. A record review of the United States of America's National Library Of Medicine website https://www.ncbi.nlm.nih.gov/books/NBK596734/ accessed 6/13/2025, titled Chapter 23 IV Therapy Management revealed, Steps; Disclaimer: Always review and follow agency policy regarding this specific skill. Verify the provider order with the medication administration record (eMAR/MAR). Perform the first check of the six rights of medication administration while withdrawing the IV fluids from the medication dispensing unit. Check expiration date and verify patient allergies. Perform the second check of the six rights of medication administration. Perform safety steps: . Perform the third medication check of the six rights of medication administration at the patient's bedside. Remove the primary IV tubing from the packaging. If administering IV fluid by gravity, note the drip factor on the package and calculate drops/min. Perform the necessary calculations for the infusion rate. Set the infusion rate based on the provider order: For infusion pump: Set volume to be infused and rate (mL/hr) to be administered. For gravity: Calculate drop per minute.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observations, interviews, and record reviews the facility failed to store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys for 1 of 2 medication storerooms and 3 of 10 medication carts reviewed for security and control, in that: 1. LVN L left the 100-hall medication cart unattended, unsupervised, and unlocked. 2. LVN Q left the 100-hall medication cart unattended, unsupervised, and unlocked. 3. LVN C left the medication room on the 100-200-hall unattended, unsupervised, and unlocked. These failures could place residents at risk of misappropriation of property, not receiving the therapeutic effects of medications, and or adverse effects of medications. The findings included: During an observation and interview on 6/10/2025 at 9:10 AM revealed the 100-hall cart located on the 100-hall unattended, unsupervised, and unlocked. Continued observations revealed residents and staff ambulating on the hall without observation of a nurse assigned to the medication cart. At 9:14 AM LVN G came out of a resident's room adjacent from the medication cart and locked the cart. LVN G stated she was in a resident's room providing care, the residents room door was closed, she could not see the medication cart, recognized the cart had been left unattended and unlocked, and she locked the medication cart. LVN G stated she was the nurse for the 100-hall and was assigned the control of the medication cart. LVN G stated the cart should be locked when not attended. During an observation and interview on 6/12/2025 at 8:04 PM revealed the 100-hall medication cart parked at the 100-200-hall nurse station unsupervised, unattended, and unlocked. Further observation revealed Resident #29 nearby stated the nurses were down the 100 and 200-halls and no nurses were at the nurse stations. During an observation on 6/12/2025 at 8:05 PM revealed the 100-200-hall medication room located at the 100-200-hall nurse's station was unsupervised, unattended, and unlocked. Continued observation revealed the door to the medication room was propped opened by a cardboard box. Observations of the interior of the medication room revealed drugs which included but not limited to, drugs stored on shelves, drugs stored in refrigerators, and narcotics stored in a single locked compartment, as well as alcoholic liquors and wines. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/12/2025 at 8:11 PM revealed CNA H stated the medication cart for the 100-hall was stationed at the 100-200-hall nurse station unattended and unlocked. CNA H stated the cart was assigned to LVN Q and was unaware of her whereabouts. CNA H stated the 100-200-hall medication room was unlocked with the door propped open by a cardboard box. CNA H stated the nurse could be down the halls providing care to residents. During an interview on 6/12/2025 at 8:18 PM LVN Q stated the 100-hall medication cart was assigned to her and she had the keys and had left the cart unlocked while she was down the 100-hall providing care to residents. LVN Q stated she could not see her cart from the areas where she was providing care and stated she mistakenly left the cart unlocked. LVN Q recognized the 100-200-hall medication room was unlocked with the door propped open by a cardboard box. LVN Q removed the box and thus locked the door to the medication room. LVN Q stated she had not left the medication room unlocked and LVN C also had keys to the medication room. During an interview on 6/12/2025 at 8:21 PM LVN C stated she was the charge nurse for the 200-hall and had keys to the 100-200-hall medication room. LVN C stated she could not recall but it could be possible she left the medication room unlocked. During an interview on 6/13/2025 at 10:01 AM the DON stated she received a report that LVN's C and Q had left their medication carts and the door to the 100-200-hall medication room unlocked. The DON stated all medications should be secured and locked when not in direct attendance. The DON stated the practice could place residents at risk for harm by misappropriation of property and by not receiving the therapeutic effects of medications and or adverse effects of medications. A record review of the facility's Medication Storage policy dated 7/2022, revealed, Policy: It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. Policy Explanation and Compliance Guidelines 1. General Guidelines: a. All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls. b. Only authorized personnel will have access to the keys to locked compartments. c. (continued on next page)

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart. 2. Narcotics and Controlled Substances: a. Schedule II drugs and back-up stock of Schedule III, IV and V medications are stored under double-lock and key. b. Schedule II controlled medications are to be stored within a separately locked permanently affixed compartment when other medications are stored in the same area, such as in refrigerator

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for 1 of 1 facility reviewed for food service safety, in that: 1. A fridge used to hold snacks and other food and drink items for residents was observed to contain an unlabeled and undated sandwich and a past best-by date gallon of milk. 2. A food storage bin had a scoop that was left in the bin. These failures could place residents who receive food and/or snacks from the facility at risk for food borne illness. The findings included: 1. Observation and interview on 06/12/2025 at 11:05 AM revealed a refrigerator with resident snacks revealed the following: *an unlabeled and undated item, appearing to be a sandwich. * a gallon of liquid, appearing and labeled as milk, with the best by date of Jun 10. MA E stated she regularly went through this refrigerator and threw anything away 2 days after its labeled date. MA E stated she was not sure why the sandwich was not labeled and that the milk should have been thrown away on the date or the date after it was best by. 2. Observation on 6/10/2025 at 9:20 AM in kitchen with FSM and Dietician revealed in dry storage a large bin container of breading contained a scoop in it. Interview on 6/10/2025 at 9:22 AM with the FSM and the Dietician took the scoop out of the container/bin and said this was not supposed to be left in the containers. Interview on 6/13/2025 at 9:50 AM with Dietician stated the risk for a scoop left in a food container could risk bacteria growth and should be stored separately. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record of the policy Food Receiving and Storage foods shall be received and stored in a manner that complies with safe food handling practices. Dry Storage, 3. Dry foods and goods are handled and stored in a manner that maintains the integrity of the packaging until they are ready to use. 4. Dry Food that are stored in bins are removed from the original packaging Record review of the Facility Policy titled, Refrigerators and Freezers, undated, reflected, All food is appropriately dated to ensure proper rotation by expiration dates.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The personal refrigerators in residents' Room # 203 A contained food items which were unlabeled and undated. This deficient practice could place residents at risk of foodborne illness due to consuming foods which are spoiled. The findings were: Observation on 06/10/2025 at 9:20 a.m. revealed the personal refrigerator in resident room [ROOM NUMBER]A contained a container of mole and fideo, which was unlabeled and undated. Observation in room [ROOM NUMBER] A on 06/11/2025 at 10:45 a.m. revealed a container with mole and fideo was still present. During an interview with LVN L on 06/11/2024 at 12:55 a.m., LVN L confirmed the personal refrigerator in resident Room # 203 A contained a container with mole and fidelo which was unlabeled and undated. During an interview with the DON on 06/12/2025 at 10:27 a.m., the DON confirmed perishable food and drinks in residents' personal refrigerators should be labeled and dated to prevent residents from consuming spoiled foods. The DON stated the night shift nursing assistants were responsible for overseeing this task and this was not being monitored. Record review of the facility's policy titled, refrigerators and freezers, dated 2001 revealed, .All food is appropriately dated to ensure proper rotations by expiration date.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections, for 1 of 6 residents reviewed for infection prevention protocols, in that: LVN KR administered Resident #9's antibiotic intravenously while placing the entire medication cart into Resident #9's room and then removing the cart, without sanitization, with intentions of continuing medication administration with peer residents. This failure could place residents at risk for harm by infections by cross contamination. The finding included: A record review of Resident #9's admission record dated 6/12/2025 revealed an admission date of 5/20/2025 with diagnoses which included osteomyelitis (a serious bone infection that can occur due to bacteria) left ankle and foot; chronic kidney disease stage 4 severe (severe, irreversible damage to the kidneys. At this stage, the kidneys are functioning at only 15-29% of their normal capacity, leading to the accumulation of waste products in the blood). A record review of Resident #9's quarterly MDS assessment dated [DATE] revealed Resident #9 was an [AGE] year-old male admitted for long term care related to a bone infection to his left ankle complicated by diabetes mellitus (common form of diabetes, characterized by insulin resistance, where the body's cells do not respond effectively to insulin). Resident #9 was assessed with a BIMS score of 11 out of a possible 15 which indicated mild cognitive impairment. further review revealed Resident #9 had a PICC line intravenous access port (peripherally inserted central catheter (PICC), also called a PICC line, is a long, thin tube that's inserted through a vein in your arm and passed through to the larger veins near your heart.) During an observation and interview on 6/12/2025 at 5:50 PM Resident #9's room entry presented with signage which read, Stop: enhanced barrier precautions everyone must: clean their hands including before entering and leaving the room. The providers and staff must also: wear gloves and a gown for the following high contact Resident care activities. Device care or use: central line . wound care: any skin opening requiring a dressing. Do not wear the same gown and gloves for the care of more than one person. Further observation revealed Resident #9 presented in his room in bed. Resident #9 stated he had an infection to his left ankle and had received medications via his PICC line on his right arm. Resident #9 stated he received medication from the nurse in the mornings and evenings. Resident #9 stated the staff wear PPE while caring for him. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 6/12/2025 at 8:42 PM revealed LVN C prepared Resident #9's meropenem antibiotic. LVN C stated Resident #9 was under Enhanced Barrier Precautions related to Resident #9's left foot wound and an indwelling PICC line. LVN C performed hand hygiene, donned a gown, and gloves and then placed the entire medication cart into Resident #9's room and administered Resident #9's intravenous medication via Resident #9's PICC line. LVN C completed the intravenous medication administration removed the medication cart from the room and parked the cart in the 100-hall way. LVN C doffed the PPE performed hand hygiene and stated she intended to continue to use the medication cart to administer medications to peer residents on 100-hall. LVN C stated she was the charge nurse for 100-hall and was assigned to work from 2:00 PM to 10:00 PM. LVN C stated she usually took the cart into residents' rooms if she needs to and with Resident #9 the need was to have the intravenous equipment nearby. During an interview on 6/13/2025 at 10:01 AM the DON stated the facility policy was to comply with the Centers for Disease prevention and Control's (CDC) Enhanced Barrier Precautions recommendations (EBP) which included Resident #9, related to Resident #9's left foot wound and his PICC line. The DON stated EBP's included not to take any equipment into EBP rooms without sanitizing the materials after exiting the rooms. The DON stated LVN KR should not have taken the entire medication cart into any EBP rooms. The DON stated the risk to residents was cross contamination infections. A record review of the CDC's website: https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/faqs.html Accessed 6/13/2025, revealed, Stop: enhanced barrier precautions everyone must: clean their hands including before entering and leaving the room. The providers and staff must also: wear gloves and a gown for the following high contact Resident care activities. Device care or use: central line . wound care: any skin opening requiring a dressing. Do not wear the same gown and gloves for the care of more than one person. A record review of the facility's Infection Prevention and Control Program dated 3/2022, revealed, Policy: This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Policy Explanation and Compliance Guidelines: . 9. Equipment Protocol: a. All reusable items and equipment requiring special cleaning, disinfection, or sterilization shall be cleaned in accordance with our current procedures governing the cleaning and sterilization of soiled or contaminated equipment. b. Single-use disposable equipment is an alternative to sterilizing reusable medical instruments. Single-use devices must be discarded after use and are never used for more than one resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. Reusable items potentially contaminated with infectious materials shall be placed in a impervious clear plastic bag. Label bag as CONTAMINATED and place in the soiled utility room for pickup and processing. d. The central supply clerk will decontaminate equipment with a germicidal detergent prior to storing for reuse