

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676193	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2025
NAME OF PROVIDER OR SUPPLIER The Waterton Healthcare & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2875 Shiloh Road Tyler, TX 75703	
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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27140 Based on interview and record review the facility failed to ensure accurate assessments were completed for 7 of 15 residents (Residents #9, #15, #20, #24, #25, #38, and #112) reviewed for accuracy of assessments. The facility failed to ensure (Residents #9, #15, #20, #24, #25, #38, and #112's MDS assessment was accurately coded for Preadmission Screening and Resident Review (PASRR). These failures could place residents at risk for not receiving the appropriate care and services to maintain the highest level of well-being. Findings included: 1. Record review of Resident #9's face sheet for March 2025 indicated she was an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included schizoaffective disorder (a mental health condition including schizophrenia and mood disorder symptoms), bipolar type and anxiety. Record review of Resident #9's PASRR Level 1 screening done 05/01/2024 indicated she did not have a primary diagnosis of dementia and was positive for mental illness. Record review of Resident #9's PASRR Evaluation done 05/17/2024 indicated she was positive for mental illness but did not meet the PASRR definition for mental illness for specialized services. Record review of Resident #9's admission MDS dated [DATE] Section A1500. Preadmission Screening and Resident Review (PASRR) indicated No if resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Section I Active Diagnoses under Psychiatric/Mood Disorder indicated the resident had anxiety, bipolar disorder, and schizophrenia. 2. Record review of Resident #15's face sheet for March 2025 indicated she was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included schizoaffective disorder (a mental health condition including schizophrenia and mood disorder symptoms), bipolar type, insomnia, and schizophrenia. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 676193	Facility ID: 676193 If continuation sheet Page 1 of 8

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #15's PASRR Level 1 screening done 08/17/2018 indicated she was positive for MI. Record review of Resident #15's PASRR Evaluation done 09/20/2022 indicated she was positive for MI. The resident was positive for mental illness but did not meet the PASRR definition for mental illness for specialized services. Record review of Resident #15's annual MDS dated [DATE] Section A1500. Preadmission Screening and Resident Review (PASRR) indicated No if resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Section I Active Diagnoses under Psychiatric/Mood Disorder indicated the resident had depression, bipolar disorder, and schizophrenia. 3. Record review of Resident #20's face sheet for March 2025 indicated he was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses which included schizoaffective disorder (a mental health condition including schizophrenia and mood disorder symptoms), bipolar type, mood disorder, anxiety, and post-traumatic stress disorder (a mental health condition that can develop after experiencing or witnessing a traumatic event). Record review of Resident #20's PASRR Level 1 screening done 11/20/2020 indicated he was positive for MI. Record review of Resident #20's significant change MDS dated [DATE] Section A1500. Preadmission Screening and Resident Review (PASRR) indicated No if resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Section I Active Diagnoses under Psychiatric/Mood Disorder indicated the resident had anxiety, depression, schizophrenia, and post-traumatic stress disorder. 4. Record review of Resident #24's face sheet for March 2025 indicated she was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included anxiety, depression and bipolar disorder. Record review of Resident #24's PASRR Level 1 screening done 09/02/2024 indicated she did not have a primary diagnosis of dementia and was positive for mental illness. Record review of Resident #24's PASRR Evaluation done 09/19/2024 indicated she was positive for mental illness but did not meet the PASRR definition for mental illness for specialized services. Record review of Resident #24's admission MDS dated [DATE] Section A1500. Preadmission Screening and Resident Review (PASRR) indicated No if resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Section I Active Diagnoses under Psychiatric/Mood Disorder indicated the resident had anxiety, bipolar disorder, and depression. (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Record review of Resident #25's face sheet for March 2025 indicated she was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included schizoaffective disorder (a mental health condition including schizophrenia and mood disorder symptoms), depressive type, delusional disorder (a serious mental illness that causes people to have unshakable false beliefs for at least a month), anxiety, hoarding, and mild intellectual disabilities. Record review of Resident #25's PASRR Level 1 screening done 05/30/2019 indicated she did not have a primary diagnosis of dementia and was positive for mental illness and intellectual disabilities and developmental disabilities. Record review of Resident #25's PASRR Evaluation done 09/20/2024 indicated she was positive for intellectual and developmental disabilities and did qualify for specialized services and positive for mental illness but did not meet the PASRR definition for mental illness for specialized services. Record review of Resident #25's annual MDS dated [DATE] Section A1500. Preadmission Screening and Resident Review (PASRR) indicated No if resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Section I Active Diagnoses under Psychiatric/Mood Disorder indicated the resident had anxiety, depression, psychotic delusions, and schizophrenia; under Other the resident had autistic disorder and mild intellectual disability. 6. Record review of Resident #38's face sheet for March 2025 indicated she was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included major depression, anxiety, insomnia, and post-traumatic stress disorder (a mental health condition that can develop after experiencing or witnessing a traumatic event). Record review of Resident #38's PASRR Level 1 screening done 01/26/2023 indicated she did not have a primary diagnosis of dementia and was positive for mental illness and intellectual disabilities and developmental disabilities. Record review of Resident #38's PASRR Evaluation done 01/27/2023 indicated she was positive for mental illness but did not meet the PASRR definition for mental illness for specialized services. Record review of Resident #38's annual MDS dated [DATE] Section A1500. Preadmission Screening and Resident Review (PASRR) indicated No if resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Section I Active Diagnoses under Psychiatric/Mood Disorder indicated the resident had anxiety, depression, and post-traumatic distress disorder. 7. Record review of Resident #112's face sheet for March 2025 indicated he was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses which included major depression and anxiety. Record review of Resident #112's PASRR Level 1 screening done 04/05/2016 indicated he was positive for mental illness. Record review of Resident #112's PASRR Evaluation done 09/20/2022 indicated he was positive for mental illness but did not meet the PASRR definition for mental illness for specialized services. (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #112's annual MDS dated [DATE] Section A1500. Preadmission Screening and Resident Review (PASRR) indicated No if resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Section I Active Diagnoses under Psychiatric/Mood Disorder indicated the resident had anxiety and depression. During an interview on 03/25/2025 at 3:45 PM, the MDS Coordinator said the facility used the RAI Version 3.0 Manual as the policy for completing MDS assessments. She said she also had a corporate resource person. She said Section A 1500 indicated if the resident was positive for mental illness, intellectual disability or developmental disability. She said she did not realize the Section I Active Diagnoses was related to Section A PASRR screening documentation. She said she thought if the local authority had found residents that did not qualify for PASRR services because they did not meet the PASRR definition for mental illness for specialized services and she was told to answer no because they were negative. She said she did not know Section A had to be coded as positive for mental illness, intellectual disability or developmental disability even though they did not qualify for PASRR services. 37495 42902 47723		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37495 Based on observation, interview and record review, the facility failed to maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance and offered a therapeutic diet when there is a nutritional problem, and the health care provider orders a therapeutic diet for 1 of 4 residents (Resident #21) reviewed for nutrition. The facility failed to ensure Resident #21 received a health shake (nutritional supplement) on 03/24/25, 03/25/25, 03/26/25 and 2 desserts on 03/24/25, 03/25/25 with her meals as prescribed by the physician. These failures placed the resident at risk for weight loss, malnutrition, loss of energy, and decreased quality of life. Findings included: Record review of a face sheet dated 3/26/2025 indicated Resident #21 was a [AGE] year-old female who admitted on [DATE] with diagnoses which included dementia (decline in cognitive function that affects memory, thinking, and social abilities), major depressive disorder (mood disorder that causes persistent feelings of sadness and loss of interest), iron deficiency (lack of iron in the body), vitamin D deficiency (lack of vitamin D in the body), muscle weakness, and abnormal weight loss. Record review of Resident #21's physician orders dated 03/26/2025 indicated she had an order, dated 02/24/2022, for a regular mechanical soft diet and to receive a health shake (nutritional supplement) with her meals and 2 desserts for lunch and dinner. Resident #21 had an order, dated 02/17/2025, for 4 ounces of house supplement four times a day. Record review of the comprehensive care plan dated 03/26/2025 for Resident #21 indicated she had a nutritional problem related to protein calorie malnutrition, history of abnormal weight loss, and vitamin deficiency initiated on 03/02/2022 and revised on 10/17/2023. Interventions included diet as ordered by the physician and RD to evaluate and make diet change recommendations as needed. Record review of a quarterly MDS dated [DATE] indicated Resident #21 made herself understood and usually understood others. Resident #21 had a BIMS score of 6 indicating she had severe cognitive impairment. The MDS indicated Resident #21 had significant weight loss of 5% or more in a month or loss of 10% in the last 6 months. The MDS indicated Resident #21's height was 62 inches and her weight was 98 pounds. Record review of the Resident #21's recorded weights indicated she weighed: 109.2 lbs. on 10/02/2024 103.6 lbs. on 11/15/2024 102.4 lbs. on 12/04/2024 (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	98.2 lbs. on 02/12/2025 96.2 lbs. on 03/12/2025 Record review of a Quarterly Nutrition Progress Note dated 01/29/2025 indicated Resident #21 had no significant weight changes the past 3 months. Resident #21 received a regular mechanical soft diet, health shakes with meals and 2 desserts at lunch and dinner. Resident #21 received 4 ounces of house supplements three times a day. Resident #21 remained on supplements to maximize her nutrient intake. Record review of a Nutrition Progress Note dated 02/17/2025 indicated Resident #21 had significant weight loss of 10.1% in 4 months. Resident #21 received a regular mechanical soft diet, health shakes with meals and 2 desserts at lunch and dinner. Resident #21 remained on supplements to maximize her nutrient intake. RD recommendations indicated to increase house supplements to 4 ounces four times a day. Record review of Resident #21's noon meal ticket dated 03/24/2025 indicated, under tray instructions, health shake with all meals and no gravy. Resident #21's noon meal ticket did not indicate she was to receive 2 desserts at lunch and dinner. During an observation and interview on 03/24/2025 at 12:22 PM, there was a full case of Magic Cups in the kitchen freezer. The DM said she was responsible for ordering health shakes, Magic Cups, and other nutritional supplements from the food supplier. The DM said the supplier notified her a few weeks ago they did not have health shakes because the company who made them recalled them. The DM said Magic Cups are being substituted in place of health shakes until they are available again. During an observation of lunch service on 03/24/2025 at 12:55 p.m., Resident #21 was in the dining room eating lunch. There was an egg roll, orange chicken, broccoli, fried rice, and a cup of fruit cocktail for dessert on Resident #21's meal tray. Resident #21 did not receive a Magic Cup or a second dessert with her meal. During an observation on 03/25/2025 at 12:25 p.m., Resident #21 was eating lunch in the dining room. There was a roll, meatloaf, scallop potatoes, carrots, and a piece of white cake with icing for dessert on Resident #21's tray. Resident #21 did not receive a Magic Cup or a second dessert with her meal. During an observation and interview on 03/26/2025 at 7:35 a.m., Resident #21 was in her room eating breakfast. There was a piece of toast, scrambled eggs, ground sausage, and a bowl of oatmeal on Resident #21's tray. Resident #21 did not receive a Magic Cup with her meal. Resident #21 said breakfast was good, but her favorite thing was the toast. Resident #21 said there was no health shake or magic cup on her breakfast tray this morning. Resident #21 said she would drink a shake or eat an ice cream if it was on her meal tray. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/26/2025 at 1:41 p.m., CNA B said she had been employed at the facility for 2 months and worked the 6 a.m.-2 p.m. shift on the hall where Resident #21 resided. CNA B said Resident #21 usually ate breakfast in her room and lunch and dinner in the dining room. CNA B said Resident #21 has had weight loss and was supposed to get a health shakes with her meals. CNA B said she did pass out breakfast trays this morning but not to Resident #21. CNA B said she was not aware Resident #21 did not receive a health shake on her breakfast tray this morning. CNA B said the dietary staff were responsible for placing the health shakes on the meal trays and the nurses were supposed to check the diet orders and tray cards to ensure the residents were getting what was ordered. During an interview on 03/26/2025 at 1:41 p.m., CNA C said he had been employed at the facility for several years and worked the 6 a.m.-2 p.m. shift on the hall where Resident #21 resided. CNA C said Resident #21 usually ate breakfast in her room but ate lunch and dinner in the dining room. CNA C said Resident #21 received health shake with her meals due to weight loss. CNA B said he did not know if Resident #21 received a health shake this morning because he did not take her breakfast to her. CNA B said the dietary staff were responsible for placing the health shakes on the meal trays and the nurses were supposed to check the diet orders and tray cards to ensure the residents were getting what was ordered. During an interview on 03/26/2025 at 1:57 p.m., LVN A said she had been employed at the facility for 1 month and worked the 6 a.m.-2 p.m. shift on the hall where Resident #21 resided. LVN A said Resident #21 usually ate breakfast in her room but ate lunch and dinner in the dining room. LVN A said Resident #21 had an order to give health shakes with her meals due to weight loss. LVN A said if resident eats in the dining room the dietary staff are responsible for placing the health shakes on the meal trays and the nurses are supposed to check the diet orders and tray cards to ensure the residents were getting what was ordered. LVN A said the dietary staff do not usually put health shakes on the trays if a resident ate in their room and when that happens the nursing staff are then responsible for providing health shakes for the residents. LVN A said she did not know if Resident #21 received a health shake with her meal this morning because she did not pass out her tray or check on her until after she ate. LVN A said she was responsible for ensuring Resident #21 had received her health shakes with her meals. LVN A said a resident is at risk for weight loss if they do not receive health shakes or nutritional supplements as ordered. During an interview on 03/26/2025 at 2:22 p.m., the DON said the RD comes to the facility on ce a month and as needed and meets with her during that time to discuss residents with weight loss concerns. The DON said Resident #21's weight loss started when she was sick last month, and her appetite decreased. The DON said Resident #21 had an order for health shakes with meals to help stabilize her weight loss. The DON said if resident eats in the dining room the dietary staff are responsible for placing the health shakes on the meal trays and the nurses are supposed to check the diet orders and tray cards to ensure the residents were getting what was ordered. The DON said was not aware Resident #21 did not receive a health shake or 2 desserts for lunch on 03/24/25 and 03/25/25 or a health shake this morning. The DON said she expect residents to receive all nutritional supplements and diets as ordered by the physician. The DON said a resident is at risk for weight loss if they do not receive health shakes or nutritional supplements as ordered. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy on Nutrition Status Management revised on 12/2023 indicated, .2. Dietary Evaluation: .b. If there is a significant change in the resident's condition related to weight or nutrition, the RD will make recommendation to offer additional nutrition to those residents including all high-risk residents. Options include, but are not limited to, fortified cereal, large portions, between meal snacks, and commercial nutritional supplements.		