

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  745050	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/01/2024
NAME OF PROVIDER OR SUPPLIER  Riverside Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1555 Bandera Hwy Kerrville, TX 78028	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0642</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a qualified health professional conducts resident assessments.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38511</p> <p>Based on interviews and record review, the facility failed to ensure a registered nurse signed and certified that the MDS assessment was completed for 2 of 4 residents (Resident #1 and #3) reviewed for MDS completion, in that;</p> <ol style="list-style-type: none"> <li>1. The facility failed to ensure Resident #1's admission MDS assessment was completed.</li> <li>2. The facility failed to ensure Resident #3's entry admission MDS assessment was completed.</li> </ol> <p>These failures could place residents at risk for incomplete or inaccurate documentation that does not completely reflect the resident's current status.</p> <p>The findings included:</p> <p>1. Record review of Resident #1's face sheet, dated 6/25/2024 revealed an admitted [DATE] with diagnoses which included: unspecified fracture of fifth lumbar vertebra sequela (6/04/2024 - a fracture that occurred after initial encounter), parkinsonism (movement disorder from deterioration of the brain which typically involves slowed movements, rigidity or stiffness and tremors), progressive supranuclear ophthalmoplegia [Steele-[NAME]-[NAME] syndrome] (Also known as PSP: a rare progressive brain disease which affects walking, balance, eye movements and swallowing. Damage of cells in the areas of brain that control body movement, coordination and thinking), abnormalities with gait and mobility, generalized muscle weakness (decrease in strength), glaucoma (damage to the optic nerve which provides information to the brain either with or without raised pressure in the eye and leads to vision loss) and insomnia (trouble falling or staying asleep).</p> <p>Record review of Resident #1's Admission MDS assessment dated [DATE] revealed the facility licensure designation was coded as neither Medicare nor Medicaid certified and MDS data not required by the state. The SW signed as having completed on 6/12/2024, and the Corporate MDS LVN signed as having completed on 6/22/2024. There was no RN signature of completion and the CAAs were left blank</p> <p>Record review of Resident #1's electronic medical record for MDS revealed the full ARD (admission assessment) was 7 days overdue as viewed on 6/25/2024 and was listed as in progress.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0642</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Record review of Resident #3's face sheet dated 6/25/2024 revealed an admitted [DATE] with diagnoses that included: Sequelae of cerebrovascular disease (neurologic deficits), depression, anxiety disorder, insomnia, glaucoma (eye disease that can affect vision), tremor, morbid obesity and hypertension (high blood pressure).</p> <p>Record review of Resident #3's admission MDS assessment dated [DATE] revealed the facility licensure designation was coded as neither Medicare nor Medicaid certified and MDS data not required by the state. The SW signed as having completed on 6/12/2024, and the Corporate MDS LVN signed as having completed on 6/19/2024 and 6/22/2024. There was no RN signature of completion and the CAAs were left blank.</p> <p>Record review of Resident #3's medical record for MDS revealed the admission ARD was due on 6/13/2024 and was 12 days overdue.</p> <p>During an interview on 6/25/2024 at 3:29 p.m., the Administrator stated the DON was not in the facility because she had been working night shift for a staff member who quit. She stated the facility did not have an ADON because the facility was new and they had a low census (28). She stated the facility did not have an MDS Coordinator. The Administrator stated MDS assessments were completed offsite by Corporate.</p> <p>During an interview on 6/25/2024 at 3:30 p.m., Corporate HR and BOM stated the facility did not have an MDS Coordinator on staff and the DON was not in the facility and they did not have an ADON. She stated MDS assessments were completed by Corporate MDS nurse who was the reimbursement specialist, but she was not available. The BOM stated a Clinical Reimbursement Specialist (contract) who worked in corporate was handling MDS assessments while the Corporate MDS nurse was unavailable.</p> <p>During an interview on 6/25/2024 at 5:20 p.m., the Corporate MDS nurse stated she could not answer specific questions about specific residents or MDS assessments. She stated the facility did not have their own MDS nurse but they needed one. The Corporate MDS nurse stated she was assigned to complete facility MDS assessments. She stated she opened MDS assessments and then via communication with the DON and DOR completed the assessments. She stated she was not on-site at the facility and worked remotely. She stated since she worked with the corporation, she had two other facilities in addition to this facility to manage and she could not keep up with this facility.</p> <p>During an interview on 6/25/2024 at 4:37 p.m., the Corporate Clinical Reimbursement Specialist stated she was not an employee of the facility or corporation, and she did not have a contract with the facility. She stated she was not completing MDS assessments but was opening some for staff to enter data but had no other contribution to the MDS assessments.</p> <p>During an interview on 6/25/2024 at 6:00 p.m., the DON stated the facility was licensed since 5/31/2024 and was a brand-new facility. She stated she was having to work as a floor nurse due to staffing. She stated she had no ADON to assist and the facility did not have an MDS Coordinator. She stated MDS assessments were being completed by Corporate MDS nurse. She stated she had no time to look at MDS assessments since working night shift as a charge nurse. She stated she had not been able to do a majority of her DON duties. She stated the Corporation was aware she was not performing DON audits or duties. The DON stated the Corporate MDS nurse had not communicated to her that she was not completing assessments and she had no direct contact with the Corporate MDS nurse but it was a known issue at the facility at the corporate level.</p> <p>(continued on next page)</p>		

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<p>F 0642</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/26/2024 at 2:08 p.m., the Corporate RN stated MDS assessments were the responsibility of the Corporate MDS nurse who was an LVN because the facility did not have an MDS Coordinator on staff.</p> <p>During an interview on 6/27/2024 at 3:20 p.m., the DON stated the Corporate MDS nurse was the person responsible for reviewing MDS assessments for completion. She stated a Corporate RN should be signing the assessments. The DON stated she was unsure if the Corporate MDS nurse was an LVN or RN. The DON stated she was not providing MDS oversight as it was handled at the corporate level right now. The DON stated the VP of Clinical Operations was in charge of Corporate MDS nurse.</p> <p>During an interview on 6/27/2024 at 11:22 p.m., the VP of Clinical Operations (Corporate) identified herself as Director of Clinical Operations and stated the MDS assessments should be completed and signed by an RN. The Director of Clinical Operations stated the DON was not RUG certified and was not qualified for MDS assessments. She stated she had never specifically reached out to the DON but had communicated with the Corporate MDS nurse who would communicate to her when an MDS assessment needed an RN signature. The Director of Clinical Operations stated she would sign the assessments as the RN. The Director of Clinical Operations stated she was not aware any MDS assessments needing an RN signature.</p> <p>Record review of a facility policy, titled MDS 3.0 Completion dated 7/2022 revealed: ARD or assessment reference date, refers to the specific endpoint in the MDS assessment process (last day of MDS observation period). 1. According to federal regulation, the facility conducts initially and periodically a comprehensive, accurate and standardized assessment of each resident's functional capacity, using the RAI specified by State. 2. Types of OBRA Assessments: b. Admission Assessment-completed within 14 days of admission counting the day of admission 4. Care Plan Team Responsibility for Assessment Completion: a. i. The responsibility of all sections of the MDS will be clearly signed .iii. The RN coordinator signs, dates, and attests (in section Z0500A) to timely completion of the RAI, once all other disciplines have completed their sections. v. The CAAs are completed no later than 14 days after admission and each time a comprehensive MDS is completed. vi. The RN overseeing the completion of the CAAs will sign the CAA Summary section at the Signature of the RN Coordinator for CAA process and Date Signed section. The date the process was completed will be entered beside the signature.</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38511</b></p> <p>Based on interviews and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objective and timeframe's to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 3 residents (Resident #1, #3, #4) of 4 residents reviewed for care plans.</p> <p>1. Facility failed to develop a person-centered care plan that addressed Resident #1's risk for fall to with interventions to prevent further injury when he was admitted to the facility on [DATE] with a broken neck from a fall at home and when he had a fall at the facility on 6/05/2024 (date of admission), 6/09/2024, two falls on 6/12/2024 and a fall on 6/24/2024 which resulted in a subdural hemorrhage (a pool of blood between the brain and its outermost covering) which required hospitalization in the ICU.</p> <p>An IJ was identified on 06/26/2024 at 3:50 PM. The IJ template was provided to the facility on [DATE] at 3:50 PM. While the IJ was removed on 06/28/2024 at 7:58 PM, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm because of the facility's need to monitor the implementation of the plan of removal.</p> <p>2. The facility failed to develop a person-centered care plan with interventions that addressed Resident #4's assessment which indicated a high fall risk or when the resident had an actual fall on 6/17/2024</p> <p>3. The facility failed to develop a person centered care plan that addressed Resident #3's moderate risk for falls or any of his admitting diagnoses.</p> <p>These deficient practices could affect all residents and place them at risk for accidents and falls with injury and missed care.</p> <p>The findings included:</p> <p>1. Record review of Resident #1's face sheet, dated 6/25/2024 revealed an admitted [DATE] with diagnoses which included: unspecified fracture of fifth lumbar vertebra sequela (6/04/2024 - a fracture that occurred after initial encounter), parkinsonism (movement disorder from deterioration of the brain which typically involves slowed movements, rigidity or stiffness and tremors), progressive supranuclear ophthalmoplegia [Steele-[NAME]-[NAME] syndrome] (Also known as PSP: a rare progressive brain disease which affects walking, balance, eye movements and swallowing. Damage of cells in the areas of brain that control body movement, coordination and thinking), abnormalities with gait and mobility, generalized muscle weakness (decrease in strength), glaucoma (damage to the optic nerve which provides information to the brain either with or without raised pressure in the eye and leads to vision loss) and insomnia (trouble falling or staying asleep).</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #1's hospital discharge summary dated 6/04/2024 before admission to the facility on [DATE] revealed the resident had a fall on 5/11/2024 with fracture of spinous process of cervical vertebrae (break in the bones of the neck) (5/11/2024) with fusion of cervical spine on 5/17/2024 (surgical repair of the fracture). The hospital discharge stated Resident #1 had multiple falls in the past year.</p> <p>Record review of Resident #1's 5-day admission MDS assessment revealed a BIMS of 13 which indicated the resident was cognitively intact. The fall history on admission listed no fall history. Resident #1's functional status was listed as unable to ambulate with maximum assistance needed for ADL care including coming from sit to stand position. The MDS was in-complete and not signed therefore no CAA's areas were triggered.</p> <p>Record review of Resident #1's admission fall risk assessment dated [DATE] revealed the resident was at high risk for falls with a history of 3 or more falls in the past 3 months.</p> <p>Record review of Resident #1's baseline care plan dated 6/05/2024 revealed the resident required supervision or touch assistance to stand and transfer and walking was not attempted. The baseline care plan indicated Resident #1 had a history of falls in the last month prior to admission with no additional input on interventions to prevent falls. The baseline care plan was signed by the DOR.</p> <p>Record review of Resident #1's care plan conference dated 6/12/2024 revealed the resident had limited assist for ADL care and stood up unassisted. The notes stated he had a couple of falls, tended to be impulsive and was more active at night. It also noted his impaired vision related to glaucoma, diagnoses of fracture of vertebra sequela, and PSP. The Document was signed by the SW.</p> <p>Record review of physician orders revealed an order for fall mat to side of bed while in bed for safety with a start date of 6/05/2024.</p> <p>Record review of Resident #1's Fall Incident Report dated 6/5/2024 (date of admission) revealed a nurse (unknown) heard a banging sound coming from the resident room and observed Resident #1 lying on floor beside bed partially on the fall mat and partially on floor. No injuries noted. The report indicated Resident #1 was confused and listed predisposing situation factors as: admitted within last 72 hours and ambulating without assistance. No interventions to prevent future falls were documented. Report documented by LVN L.</p> <p>Record review of Resident #1's Physical Therapy Evaluation and Treatment Plan dated 6/07/2024 revealed Resident #1 was a fall risk and had a cervical collar (neck brace that prevents movement of the neck) in place 24/7 (24 hours a day, 7 days a week). The evaluation indicated Resident #1 had impairment of strength to his lower extremities (legs and hips). Fall predictors: inadequate postural control, discontinuity of steps and weak trunk and hip extensors. (Inability to control posture, unequal steps while walking and weakness).</p> <p>Record review of Resident #1's Fall Incident Report dated 6/09/2024 revealed Resident #1 was heard making a loud grunt when LVN P saw Resident #1 sitting on the floor with his back against the door. He stated he was sitting down and needed to use the restroom. He was noted with low blood pressure of 86/48 upon assessment and the MD was notified. No injuries noted. Predisposing factors were documented as confusion, gait imbalance, impaired memory and ambulating without assistance. No interventions to prevent future falls were documented. Report documented by the DON.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #1's Fall Incident Report dated 6/12/2024 at 3:20 p.m., revealed Resident #1 was reaching for his phone on the floor when he lost balance and sat on the floor. No injuries were noted. The report indicated Resident #1 was cognitively intact with predisposing factors which included: gait imbalance, ambulating without assist, transfer, using wheeled walker. The report stated Resident #1 transfers and ambulates without assistance. Nursing staff had educated the resident multiple times on how to use call light for assistance. There were no interventions to prevent future falls documented. The document was signed by LVN G.</p> <p>Record review of Resident #1's Fall Incident Report dated 6/12/2024 at 3:31 p.m. revealed Resident #1 stated he fell and hit his head on his walker but did not tell anyone. An abrasion was observed to the top of his scalp. Predisposing factors included poor lighting and using walker. No interventions were documented to prevent future falls.</p> <p>Record review of Resident #1's Fall Incident Report dated 6/24/2024 at 3:45 am revealed LVN P documented that around 3:45 am she heard Resident #1 yelling help from his room and found him seated on his bottom scooting towards the door. Resident #1 stated he was going forward in his wheelchair and fell . Later he stated he was standing up with his walker and fell back but does not recall what happened or why he fell . Upon assessment Resident #1's left pupil was larger than the right pupil and bleeding was noted from the back of his head. Resident #1 stated Where am I, where am I? Pressure was applied to his head and 911 was called. Resident #1 was sent to the hospital. Predisposing factors were listed as other without further explanation. No interventions were documented to prevent future falls.</p> <p>Record review of hospital ER records dated 6/24/2024 for Resident #1 revealed Resident #1 was brought into the ER via EMS after a fall at the nursing facility. Nursing home staff stated he fell backwards, hitting his head on the ground. He had an Aspen c-collar (stiff neck brace that prevents movement of the head) in place as he is currently recovering from a recent fracture of C5 (break to the bones in neck). Resident #1 reported pain to the back of his head. Upon exam Resident #1 had an abrasion to the back of his head and his left pupil was larger than the right. A brain CT revealed he had a small subdural hemorrhage (a pool of blood between the brain and its outermost covering) and posterior scalp (back of the head) soft tissue swelling. Resident #1 was transferred from the local hospital to a trauma center at larger hospital in a nearby city.</p> <p>Record review of hospital records dated 6/25/2024 from the trauma hospital revealed Resident #1 had a diagnosis of fall with subdural hemorrhage on aspirin use (anticoagulant medication). The resident was monitored in ICU for changes in neuro status. Repeated brain CT showed no worsening of the subdural hemorrhage and he was discharged back to the facility.</p> <p>Record review of a handwritten document of a witness statement dated 6/26/2024 for CNA Z revealed at 3:30 ish (am) patient (Resident #1) in living room- he walked back to his room with us observing him, heard yelling from room. Patient told staff he fell face first but head bleeding from back, then patient stated he was standing with walker and fell backwards, did not know what happened. Clarification written on 6/28/2024 added additional information which included: patient did have walker in TV room and used that to walk back to his room prior to hearing resident yell for help. Both walker and wheelchair were present close to resident when he was found. The document was signed by the Administrator.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #1's medical record revealed the comprehensive care plan was blank and no plan of care had been initiated.</p> <p>During an interview on 6/25/2024 at 12:02 p.m., Resident #1's family member stated Resident #1 does not sleep during the night very well. She stated he was strong in his legs but unsteady on his legs. She stated when he needed to go to the bathroom he will go and if he cannot sleep, he will get up and go sit in a chair. She stated his disease made it so he was oblivious to a lot of things. She stated he does not know pain or hunger but was able to make his needs known. She stated she was currently with Resident #1 at the hospital after his fall at the facility. She stated he had a bleed in his brain. She stated he had a history of many falls.</p> <p>2. Record review of Resident #4's face sheet dated 6/25/2024 revealed an admitted [DATE] with diagnoses which included: insomnia, metabolic encephalopathy (brain dysfunction with symptoms which could include confusion), and muscle weakness (generalized).</p> <p>Record review of Resident #4's baseline care plan dated 6/12/2024 revealed she had a history of falls in the month prior to admission with no interventions to prevent falls listed. The document was not signed.</p> <p>Record review of Resident #4's Fall Risk assessment dated [DATE] revealed she was at high risk for falls, signed by the DON.</p> <p>Record review of Resident #4's Incident report dated 6/17/2024 revealed upon entering the resident's room to administer medications the nurse noticed the bathroom door was closed. Upon entrance the nurse found Resident #4 lying on the floor in front of the bathroom sink with her head facing the door. The light was off and the water was running in the sink. Her wheelchair was next to the toilet near her feet with the brakes not locked. The assessment revealed no injuries. The document was signed by the DON.</p> <p>Record review of Resident #4's medical record revealed a comprehensive care plan had not been started or initiated.</p> <p>Record review of Resident #4's Multidisciplinary Care Conference dated 6/19/2024 revealed the resident had a fall on Monday (date not specified) in the bathroom and required limited to extensive assistance for ADL care. The document indicated Resident #4's medication was reviewed. The evaluation/goals were listed as decrease fall risk. The document was signed by the SW.</p> <p>Record review of Resident #4's 5-day admission MDS assessment dated [DATE] revealed a BIMS score of 9 which indicated a moderate cognitive impairment. Resident #4's functional status upon admission was listed as requiring moderate assistance to go from sitting to standing, transferring from chair and toilet and she did not ambulate (walk). The MDS assessment was incomplete and not signed by an RN therefore no CAA's were triggered.</p> <p>3. Record review of Resident #3's face sheet dated 6/25/2024 revealed an admitted [DATE] with diagnoses including: Sequelae of cerebrovascular disease (neurological deficits), depression, anxiety disorder, insomnia, glaucoma (eye disease that can affect vision), tremor, morbid obesity and hypertension (high blood pressure).</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #3's Fall Risk assessment dated [DATE] revealed a score of 9 which indicated a moderate risk for falls. The assessment revealed Resident #3 had a history of 3 or more falls in the past 3 months.</p> <p>Record review of Resident #3's 5-day admission MDS assessment dated [DATE] revealed a BIMS score of 14 which indicated the resident was cognitively intact. Resident #3's functional status was listed as set up assistance for sit to stand and transfers and touch assistance needed to walk 10 feet. The MDS assessment was incomplete and not signed by an RN therefore no CAAs were triggered.</p> <p>Record review of the facility incident/accident log revealed Resident #3 had no documented falls since admission.</p> <p>Record review of Resident #3's medical record revealed there was no comprehensive care plan, and the document was blank.</p> <p>During an interview on 6/25/2024 at 2:01 p.m., LVN B stated the CNAs were trained to identify residents at risk for falls by the POC and Kardex (a document that lists interventions for care). LVN B demonstrated how the Kardex was pulled up in PCC (Point Click Care - the facility's electronic charting system) which resulted in showing a blank Kardex. LVN B stated she had not seen any care plans for residents including Resident #1, #3, and #4. She stated if there were no care plans then the Kardex were not loading because they were generated from the care plan. LVN B stated without care plans they had no way of identifying interventions for falls. LVN B stated she was not sure who was responsible for completing the care plans but she knew no one in-house (in the facility) was completing them. She stated it was not a charge nurse duty. She stated she had not seen any completed for any residents in the facility. She stated the facility did not have an MDS Coordinator. She stated there was a Corporate MDS person, but she did not know the details.</p> <p>During an interview on 6/25/2024 at 3:30 pm with the Corporate HR Specialist and the BOM revealed the DON was not in the facility and the facility did not employ an ADON or MDS Coordinator. They stated the Corporate MDS specialist had been handling MDS assessments but was unavailable. They stated another Corporate Reimbursement Specialist was filling in for the Corporate MDS person.</p> <p>During an interview on 6/25/2024 at 3:37 p.m., the DOR (Director of Rehabilitation) stated the facility held Care Plan meetings at 48 hours after admission which was an introduction for the resident and family to facility staff and then a week later an interdisciplinary care plan meeting was held, where the plan of care for residents was discussed. She stated she typically participated in those meetings along with the DON when she could attend, SW, and BOM. The DOR stated for Resident #1 she was aware he had repeated falls. She stated she was not aware of any other resident in the facility with fall concerns. She stated they discuss how the resident(s) were doing at the facility. She stated during the meeting they had discussed contributing factors to the falls. She stated the notes were documented by whom ever was assigned to transcribe for the meeting. She stated the therapy department did not touch care plans. She stated the facility did not have an MDS Coordinator who typically completes care plans. She stated they had a Corporate MDS person who was overseeing care plans, but the DON was the one who was doing them to her knowledge.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/25/2024 at 4:32 p.m., Corporate MDS nurse stated she was unable to answer specific questions regarding the residents at the facility. She stated the facility did not have an MDS Coordinator nurse. She stated they needed one. The Corporate MDS nurse stated she would talk to the DON and the DOR about the residents, and she would open the MDS assessments but was not closing them. The Corporate MDS nurse stated the facility care plans were an assigned task to her. She stated she had done some care plans (residents unknown) but it was the facility who was supposed to do care plans. She stated the comprehensive care plans should be completed within 7 days of the MDS assessment. The Corporate MDS nurse stated she was a regional employee with two other facilities she was responsible for and was unable to complete them all. She stated she had not communicated her inability to complete her assignment with the facility Administrator personally but knows there was some sort of email that was circulated letting the Administrator know she needed to handle it. The Corporate MDS nurse stated the facility had a lot of admissions and it was really hard for her to manage 12 admissions a week. She stated care plans were important because it informed staff on how to take care of the residents, what their needs were, what their desires were and everything about the resident. The Corporate MDS nurse stated she was not familiar with Resident #1, and she was not able to answer questions about specific residents.</p> <p>During an interview on 6/25/2024 at 4:37 p.m., the Corporate Reimbursement Specialist stated she had not had contact with anyone at the facility and was not providing any oversight to patient care. She stated she did not work for the facility or Corporate and was an independent contractor. She stated she had spoken to Corporate but did not have a current contract and was not able to answer any question.</p> <p>During an interview on 6/25/2024 at 5:43 p.m., the SW stated he attended care plan meetings. He stated there was an informal meeting within 48 hours of admission and then a week later a comprehensive care plan meeting. The SW stated he facilitated the meetings and documented the care plan notes and assessment. The SW stated he facilitated the discussion for the care plans but did not document or create care plans for the residents. The SW stated the DON and DOR had been completing resident care plans. The SW stated during Resident #1's comprehensive care plan meeting they discussed the resident's PSP disease which was related to Parkinson's disease because the diagnoses made people fall backwards. The SW stated this had happened several times before admission requiring Resident #1 to wear a neck collar. The SW stated Resident #1 was walking and therapy was encouraging him to be safe. The SW stated he was aware Resident #1 had several falls since admission to the facility. He stated he could not recall the specifics that were discussed about interventions. He stated Resident #1 was impulsive and would do things outside the realm of recommendations such as get on the floor by himself. The SW stated staff set verbal boundaries and they all know he was a fall risk and why he was here. He stated that was why he was getting therapy. He stated he did not note in his documentation or notes any specific interventions to prevent falls and was not responsible for the care plan.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/25/2024 at 6:00 p.m., the DON stated she was aware residents at the facility did not have comprehensive care plans and their initial baseline care plans were not signed. She stated as the only RN working at the facility, she was opening the care plans on admission but was not able to follow up. She stated it was a good question as to who was in charge of resident care plans. The DON stated the Corporate MDS nurse did not come to the facility and she had never met her. The DON stated she had reached out to the Corporate MDS nurse who stated she was too busy to complete the care plans. The DON stated the Corporate MDS nurse told her it was on her plate to do it. The DON stated she told the Corporate MDS nurse she (DON) did not have time to do it. The DON stated the facility did not have their own MDS Coordinator. The DON stated right now, to her knowledge, no one was assigned to complete resident care plans. The DON stated the facility was brand new and just got their license as of 5/31/2024. She stated since the opening she was having to work as a floor nurse, mostly at night because they did not have enough licensed staff. She stated she had worked as a charge nurse for the past 30 days which absolutely limited what she could do as a DON. She stated she was not able to attend morning meetings, IDT or care plan meetings. She stated her primary focus had been patient care and communication with floor staff. The DON stated the Administrator and Clinical Support Specialist (Corporate RN) were both aware of her limitations. She stated the response from the Administrator was nothing was being done to help the situation. The DON stated acknowledgement that Resident #1 did not have a care plan to address his falls. She stated they did have an order (physician order) for a fall mat. She stated the DOR was working specifically with Resident #1. The DON stated during his care plan meeting the family member of Resident #1 stated he did not sleep at night and that was his normal routine. The DON stated as Resident #1 had gotten stronger with therapy he was now more mobile and was coming out of his room. The DON stated she was aware of his fall history early in his admission process. The DON stated the family member typically sat with Resident #1 during the day and left in the early evening. The DON stated they were not updating the care plan after each fall because there was no care plan. She stated the incident/accident list was the most accurate documentation of his falls. She stated to her knowledge Resident #1 had 5 falls since admission. She stated the latest one was the only one in which he sustained an injury. The DON stated the causative factor in Resident #1's falls was his impulsivity. She stated fall interventions consisted of low bed, fall mat, keep an eye on him and therapy. She stated the Kardex was not updated for use by the CNAs because there was no care plan. The DON stated the CNAs were told verbally about fall risk and interventions since the Kardex was not accurate. She stated they were also rounding (checking on him) every 2-3 hours. The DON stated Resident #1 was on increased rounding of 1-hour intervals but his supervision was not spelled out. She stated they did not put any new interventions in place after each fall. The DON stated it was important to prevent falls to prevent injury. She stated she considered a brain bleed a serious injury. She stated all staff were responsible for ensuring resident safety.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/26/2024 at 9:05 a.m., the Administrator stated she was aware the residents did not have comprehensive care plans. She stated she was also aware Resident #1 had multiple falls while in the facility with no comprehensive care plan in place and a baseline care plan which had not been updated. The Administrator stated the facility was new and had opened at the end of March 2024 but had received their license more recently (date unknown). The Administrator stated she ensured staff knew how to care for Resident #1 by giving verbal report to each other. She stated they did not have specific interventions in place to prevent Resident #1 from falling. She stated they did talk about falls during morning meetings including the use of fall mats, keeping him in eyesight and reminding him to use the call-light but these were not written down. The Administrator stated the DON had communicated she was not able to fulfill her DON duties and the corporate leaders knew the DON was struggling. The Administrator stated the DON was working the floor, doing staffing and schedules and was on-call for clinical but was unable to do the care plans. The Administrator stated the DON did attend care plans meeting when she could. The Administrator stated she had tried to remedy the situation by continuing to hire more staff as the facility census rose. She stated the current census was 29 residents. The Administrator stated she had communicated with the medical director resident falls and the need for additional staff but not specifically about the lack of care plans at the facility. The Administrator stated she was responsible for facility management but was not always able to make decisions independently of Corporate.</p> <p>During an interview on 6/26/2024 at 12:12 p.m., the Corporate Clinical Operations Specialist stated he provided oversight to the Administrator. He stated the Administrator had been given full [NAME] to hire whatever staff was needed but was unsure of the date she was given this information. He stated, as of now, the corporate staff was helping to manage the building so that the Administrator did not need to hire for the positions. He stated this included the MDS Coordinator. The Corporate Clinical Operations Specialist stated the Corporate MDS coordinator was not located in the facility, but communicated with staff that was in the building including the DON and DOR.</p> <p>During an interview on 6/26/2024 at 2:08 p.m., the Corporate Clinical RN stated she split her time between three facilities. She stated she came to this facility approximately 1 time a week. The Corporate Clinical RN stated the Corporate MDS nurse and DON were responsible for care plans. The Corporate Clinical RN stated she was not aware the residents did not have comprehensive care plans until surveyor intervention but was aware there were residents with falls including Resident #1 whom had multiple falls. The Corporate Clinical RN stated she puts in orders for new admissions and audits the system but did not audit care plans. She stated she should have looked at it more closely. The Corporate Clinical RN stated approximately one week to a week and a half ago the Administrator was given the go ahead to hire the staff she needed, including an MDS Coordinator. She stated the facility's census was preventing the full go ahead prior to that point.</p> <p>Record review of a facility policy, titled Comprehensive Care Plans dated 10/2022 revealed: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident., consistent with resident rights, that includes measurable objectives and timeframe's to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the resident's comprehensive assessment. 2. The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment. All Care Assessment Areas (CAAs) triggered by the MDS will be considered in developing the plan of care. Other factors identified by the interdisciplinary team, or in accordance with the resident's preferences will also be addressed in the plan of care. 4. The comprehensive care plan will be prepared by an interdisciplinary team .</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The Administrator was notified of an IJ on 06/26/2024 at 3:50 p.m. and was given a copy of the IJ template and a Plan of Removal (POR) was requested.</p> <p>The Plan of Removal was accepted on 06/27/2024 at 6:55 PM and included the following:</p> <p>1. Immediate actions</p> <p>The Medical Director was notified by the Administrator on 6/26/25 of the Immediate Jeopardy</p> <p>The DON reassessed all residents using the Fall Risk Assessment Tool on 6/26/24.</p> <p>The DON ensured all residents identified as at risk for falls had safety measures, as well as resident specific interventions, added to their care plans.</p> <p>The DON ensured the safety measures and resident specific interventions that were added to the care plans were also reflected on the Kardex so that the CNAs had access to this information.</p> <p>Clinical support specialist has completed all comprehensive care plans for all current residents as of 6/27/24.</p> <p>2. Education</p> <p>Inservice education to clinical staff regarding the comprehensive care plans of residents was completed with clinical staff by Clinical Care Specialist on 6/26/24. This includes how to identify a high fall risk resident, where to find information specific to each resident on the Kardex. The DON will make sure that all staff is educated before the start of their next shift.</p> <p>The Clinical Support Specialist instructed all the clinical staff including nurses and CNAs to review the updated Kardex prior to their next shift on 6/26/24.</p> <p>Inservice education on Kardex was completed by Clinical Care Specialist on 6/26/24. DON will make sure all remaining staff is educated before the start of their next shift.</p> <p>3. Monitoring</p> <p>Incidents will be reviewed daily in morning clinical meeting by the IDT team. Interventions will be put in place on the care plan at this time by the DON and Kardex will be updated. Interventions will be reviewed weekly in the SOC meeting by the IDT to ensure proper interventions have been put in place.</p> <p>The monitoring will be presented at the monthly Quality Assurance Performance Improvement meetings for a minimum of three months.</p> <p>IDT team will schedule the comprehensive care plans to make sure they are completed within twenty one days after a resident admits. As of 6/27/24 and going forward the Clinical Support Specialist will monitor to make sure care plans are completed and going forward the DON will be responsible for completing the comprehensive care plan.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38511</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure that each resident received adequate supervision and assistance devices to prevent accidents for 1 (Resident #1) of 4 residents reviewed for accidents and supervision, in that;</p> <p>The facility failed to ensure Resident #1 was supervised while ambulating and had interventions in place to prevent falls. Resident #1 who was admitted with a significant history of falls, had 5 documented falls at the facility from admission to discharge, 6/05/2024 date of admission, 6/09/2024, 6/12/2024 x 2 and 6/24/2024 when he fell during the night and suffered a subdural hematoma (a pool of blood between the brain and its outermost covering) and required a hospital stay in ICU.</p> <p>This failure resulted in the identification of an Immediate Jeopardy (IJ) on 6/26/2024 at 3:50 PM. The IJ template was provided to the facility on [DATE] at 3:50 PM. While the immediacy was removed on 6/28/2024 at 7:58 p.m., the facility remained out of compliance at a scope of isolated and a severity level of no actual harm due to the facility's need to monitor the implementation of the plan of removal.</p> <p>This deficient practice could affect all residents and place them at risk for accidents and falls resulting in injury, disability, or death.</p> <p>The findings included:</p> <p>Record review of Form 3613-A Provider Investigation Report dated 6/24/2024 revealed the facility self-reported to the state agency a fall with major injury for Resident #1. The report indicated Resident #1 had a history of falls prior to admission, a history of falls in the facility, was independently ambulatory and required no special supervision. The report indicated Resident #1 had an unwitnessed fall with a laceration to the back of the head. The facility investigation findings of fall with injury were confirmed by the Administrator on 6/28/2024.</p> <p>Record review of Resident #1's face sheet, dated 6/25/2024 revealed an admitted [DATE] with diagnoses which included: unspecified fracture of fifth lumbar vertebra sequela (6/04/2024 - a fracture that occurred after initial encounter), parkinsonism (movement disorder from deterioration of the brain which typically involves slowed movements, rigidity or stiffness and tremors), progressive supranuclear ophthalmoplegia [Steele-[NAME]-[NAME] syndrome] (Also known as PSP: a rare progressive brain disease which affects walking, balance, eye movements and swallowing. Damage of cells in the areas of brain that control body movement, coordination and thinking), abnormalities with gait and mobility, generalized muscle weakness (decrease in strength), glaucoma (damage to the optic nerve which provides information to the brain either with or without raised pressure in the eye and leads to vision loss) and insomnia (trouble falling or staying asleep).</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's hospital discharge summary dated 6/04/2024 before admission to the facility on [DATE] revealed the resident had a fall on 5/11/2024 with fracture of spinous process of cervical vertebrae (break in the bones of the neck) (5/11/2024) with fusion of cervical spine on 5/17/2024 (surgical repair of the fracture). The hospital discharge stated Resident #1 had multiple falls in the past year.</p> <p>Record review of Resident #1's 5-day admission MDS assessment revealed a BIMS of 13 which indicated the resident was cognitively intact. The fall history on admission listed no fall history. Resident #1's functional status was listed as unable to ambulate with maximum assistance needed for ADL care including coming from sit to stand position.</p> <p>Record review of Resident #1's admission fall risk assessment dated [DATE] revealed the resident was at high risk for falls with a history of 3 or more falls in the past 3 months.</p> <p>Record review of Resident #1's baseline care plan dated 6/05/2024 revealed the resident required supervision or touch assistance to stand and transfer and walking was not attempted. The baseline care plan indicated Resident #1 had a history of falls in the last month prior to admission with no additional input on interventions to prevent falls. The baseline care plan was signed by the DOR.</p> <p>Record review of Resident #1's care plan conference dated 6/12/2024 revealed the resident had limited assist for ADL care and stood up unassisted. The notes stated he had a couple of falls, tended to be impulsive and was more active at night. It also noted his impaired vision related to glaucoma, diagnoses of fracture of vertebra sequela, and PSP. The Document was signed by the SW.</p> <p>Record review of physician orders revealed an order for fall mat to side of bed while in bed for safety with a start date of 6/05/2024.</p> <p>Record review of Resident #1's Fall Incident Report dated 6/5/2024 (date of admission) revealed a nurse (unknown) heard a banging sound coming from the resident room and observed Resident #1 lying on floor beside bed partially on the fall mat and partially on floor. No injuries noted. The report indicated Resident #1 was confused and listed predisposing situation factors as: admitted within last 72 hours and ambulating without assistance. No interventions to prevent future falls were documented. Report documented by LVN L.</p> <p>Record review of Resident #1's Physical Therapy Evaluation and Treatment Plan dated 6/07/2024 revealed Resident #1 was a fall risk and had a cervical collar (neck brace that prevents movement of the neck) in place 24/7 (24 hours a day, 7 days a week). The evaluation indicated Resident #1 had impairment of strength to his lower extremities (legs and hips). Fall predictors: inadequate postural control, discontinuity of steps and weak trunk and hip extensors. (Inability to control posture, unequal steps while walking and weakness).</p> <p>Record review of Resident #1's Fall Incident Report dated 6/09/2024 revealed Resident #1 was heard making a loud grunt when LVN P saw Resident #1 sitting on the floor with his back against the door. He stated he was sitting down and needed to use the restroom. He was noted with low blood pressure of 86/48 upon assessment and the MD was notified. No injuries noted. Predisposing factors were documented as confusion, gait imbalance, impaired memory and ambulating without assistance. No interventions to prevent future falls were documented. Report documented by the DON.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's Fall Incident Report dated 6/12/2024 at 3:20 p.m., revealed Resident #1 was reaching for his phone on the floor when he lost balance and sat on the floor. No injuries were noted. The report indicated Resident #1 was cognitively intact with predisposing factors which included: gait imbalance, ambulating without assist, transfer, using wheeled walker. The report stated Resident #1 transfers and ambulates without assistance. Nursing staff had educated the resident multiple times on how to use call light for assistance. There were no interventions to prevent future falls documented. The document was signed by LVN G.</p> <p>Record review of Resident #1's Fall Incident Report dated 6/12/2024 at 3:31 p.m. revealed Resident #1 stated he fell and hit his head on his walker but did not tell anyone. An abrasion was observed to the top of his scalp. Predisposing factors included poor lighting and using walker. No interventions were documented to prevent future falls. The document was signed by LVN P.</p> <p>Record review of Resident #1's Fall Incident Report dated 6/24/2024 at 3:45 am revealed LVN P documented that around 3:45 am she heard Resident #1 yelling help from his room and found him seated on his bottom scooting towards the door. Resident #1 stated he was going forward in his wheelchair and fell . Later he stated he was standing up with his walker and fell back but does not recall what happened or why he fell . Upon assessment Resident #1's left pupil was larger than the right pupil and bleeding was noted from the back of his head. Resident #1 stated Where am I, where am I? Pressure was applied to his head and 911 was called. Resident #1 was sent to the hospital. Predisposing factors were listed as other without further explanation. No interventions were documented to prevent future falls.</p> <p>Record review of hospital ER records dated 6/24/2024 for Resident #1 revealed Resident #1 was brought into the ER via EMS after a fall at the nursing facility. Nursing home staff stated he fell backwards, hitting his head on the ground. He had an Aspen c-collar (stiff neck brace that prevents movement of the head) in place as he is currently recovering from a recent fracture of C5 (break to the bones in neck). Resident #1 reported pain to the back of his head. Upon exam Resident #1 had an abrasion to the back of his head and his left pupil was larger than the right. A brain CT revealed he had a small subdural hemorrhage (a pool of blood between the brain and its outermost covering) and posterior scalp (back of the head) soft tissue swelling. Resident #1 was transferred from the local hospital to a trauma center at larger hospital in a nearby city.</p> <p>Record review of hospital records dated 6/25/2024 from the trauma hospital revealed Resident #1 had a diagnosis of fall with subdural hemorrhage on aspirin use (anticoagulated medication). The resident was monitored in ICU for changes in neuro status. Repeated brain CT showed no worsening of the subdural hemorrhage and he was discharged back to the facility.</p> <p>Record review of a handwritten document of a witness statement dated 6/26/2024 for CNA Z revealed at 3:30 ish (am) patient (Resident #1) in living room- he walked back to his room with us observing him, heard yelling from room. Patient told staff he fell face first but head bleeding from back, then patient stated he was standing with walker and fell backwards, did not know what happened. Clarification written on 6/28/2024 added additional information which included: patient did have walker in TV room and used that to walk back to his room prior to hearing resident yell for help. Both walker and wheelchair were present close to resident when he was found. The document was signed by the Administrator.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's medical record revealed the comprehensive care plan was blank and no comprehensive plan of care had been initiated.</p> <p>During an interview on 6/25/2024 at 12:02 p.m., Resident #1's family member stated Resident #1 does not sleep during the night very well. She stated he was strong in his legs but unsteady on his legs. She stated when he needed to go to the bathroom he will go and if he cannot sleep, he will get up and go sit in a chair. She stated his disease made it so he was oblivious to a lot of things. She stated he does not know pain or hunger but was able to make his needs known. She stated she was currently with Resident #1 at the hospital after his fall at the facility. She stated he had a bleed in his brain. She stated he had a history of many falls.</p> <p>During an interview on 6/25/2024 at 1:46 p.m., CNA A stated she identifies residents who are at risk for falls from report. She stated she just learned today that the POC (point of care, computer access for CNA's) also would indicate a risk for falls. She stated she had not looked at Resident #1's POC and was not aware of any interventions for fall risk for Resident #1. She stated, at times, Resident #1 did not call for assistance and was refusing ADL care. CNA A stated she was not certain if she had training on fall prevention.</p> <p>During an interview on 6/25/2024 at 2:01 p.m., LVN B stated the CNAs were trained to identify residents at risk for falls by the POC and Kardex (a document that list interventions for care). LVN B demonstrated how the Kardex was pulled up in PCC (Point Click Care - the facility's electronic record system) which resulted in showing a blank Kardex. LVN B stated she had not seen any care plans for residents including Resident #1. She stated if there were no care plans then the Kardex were not loading because they were generated from the care plan. LVN B stated without care plans they had no way of identifying interventions for falls. She stated most residents with fall risk had low beds and fall mats ordered by a physician. She stated another way was during CNA-to-CNA report. LVN B stated if there was anything specific going on she would tell the CNA. LVN B stated the facility did not have any visual identification for fall risk. LVN B stated Resident #1 had one side of his bed against the wall, a low bed and a fall mat. She stated at night, he got up to go to the bathroom and sometimes was unable to urinate. LVN B stated Resident #1 got up all the time, he was never in bed and only slept in small spurts. She stated this did not happen during the daytime, only at night. She stated during the day he used his call light. LVN B stated the DON had been working nights because a nurse had walked out and the Corporate DON was not on site for issues. LVN B stated she did not have access to the facility fall prevention policy and had no training for falls.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Riverside Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1555 Bandera Hwy Kerrville, TX 78028	
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/25/2024 at 3:37 p.m., the DOR stated Resident #1 was making progress in therapy. She stated he had worked on strengthening, endurance and safety. She described Resident #1 as impulsive. The DOR stated therapy had him not walking by himself and walking with the assistance of staff. She stated when he used his walker on his own, he should be redirected. The DOR stated either the resident's family member or staff should walk with him with the walker, and he needed assistance with ADLs such as dressing. The DOR stated Resident #1 wore a cervical collar from a fall with injury prior to coming to the facility. She stated he wore the collar at all times, and it hindered his vision and view because his neck was not mobile. The DOR stated Resident #1's progress had fluctuated during therapy. She stated he was starting to need less assistance. For instance, he could now push up to standing with just stand by assistance. The DOR stated she was aware of 3 falls he had since admission. The fall on 6/24/2024 and two priors on unknown dates. She stated he had a fall mat in place and staff had expressed concerns for him using the walker by himself. She stated they tried to keep him in the TV room so they could visually see him, but he was pretty impulsive and would get up by himself and go back to his room on his own. The DOR stated on 6/12/2024 they had a care plan meeting in which the family member, DON, SW, BOM, and herself attended. She stated they discussed that Resident #1 stood up unassisted with a couple of falls and tended to be impulsive and that he was more active at night. She stated this should be documented in his care plan, but she was not responsible for it. She stated the notes from the meeting indicated Resident #1 was on a fall prevention program, but the facility did not have a fall prevention program in place. She stated she had spoken to the DON about starting a program with colored signs of red, yellow and green stop signs that would alert both the resident and staff to their fall risk, but nothing currently was in place, and it was on her to-do list. The DOR stated as of today, there was nothing used to identify residents at high risk for falls. She stated verbal reports were given to CNAs and nursing staff that a resident was at risk for falls. The DOR stated she had reviewed a lot of documents and could not say whether or not she had reviewed the facility fall prevention policy.</p> <p>During an interview on 6/25/2024 at 4:19 p.m., LVN L stated Resident #1 wore a neck brace due to a fall prior to admission. She stated on an unknown date (documented as 6/05/2024 which was date of admission), she heard a noise coming from Resident #1's room. She stated he had a fall mat beside his bed and she found him half-way on the fall mat. She stated he had no injuries. She stated to her knowledge he had no other falls. LVN L stated for fall interventions they had fall mat and low bed. She stated Resident #1 kept trying to get up on his own and needed assistance getting up. She stated he was able to walk with his walker but need help to stabilize while he walked because he would get off balance. She stated she did not edit or update his care plan after his fall although as a charge nurse she was able to do so. She stated CNA staff were informed of fall risk by the Kardex or by staff verbally telling them. She stated she had been trained on fall prevention (date unknown).</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/25/2024 at 4:29 p.m., LVN D stated Resident #1 would stand up by himself and they had to keep a close eye on him, but she had other residents. She stated Resident #1 was able to walk with supervision, but that was not always the case. She stated the facility staff could not be there 24-hours a day and she had other residents to take care of. She stated she would sit him in his wheelchair and move him upfront. She stated she never witnessed a fall but did see him sit on the floor, crawl on the floor, and lean on the wall for support. She stated another nurse saw him stand and then watched him slide down the wall to the floor, but she never personally saw it. She stated she knows LVN P have found him on the floor in his room (date unknown) on night shift. She stated interventions she used to prevent falls were redirection, have him lay back down, have him sit in a chair and take him to watch TV. She stated he never stayed put and he took little naps during the night of approximately 30 minutes. She stated him attempting to get up was constant. She stated he did not use his call light. She stated even when she gave him the call light, he would not push it or if he pushed it he would not wait. LVN D stated she does not remember any safety devices for interventions. LVN D stated she just had basic fall training and could not remember the details or the date.</p> <p>During an interview on 6/25/2024 at 5:15 p.m., CNA C stated she was night shift. She stated Resident #1 was constantly up at night. She stated he did not stay in his room very often and did not sleep except for about 20 minutes at a time. She stated she usually helped him up to the bathroom and to his bed. She stated she was told she had to watch him for safety but did not know why. She stated she was not aware of his fall risk or history of falls. She stated she did not know what she was told about his fall risk. CNA C stated Resident #1 wore a neck brace, he was alert and he was able to answer questions. She stated he had a fall mat, walker and wheelchair for interventions and nothing else that she was aware of. CNA C stated she had been trained on fall prevention during orientation. She stated she knew she had to look at environmental things to make sure nothing was in the resident's path.</p> <p>During an interview on 6/25/2024 at 5:43 p.m., the SW stated Resident #1 had a comprehensive care plan meeting about one week after his admission. The SW stated he facilitated the meeting and documented the notes. He stated during Resident #1's meeting, his PSP disease which was related to Parkinson's disease was discussed because the diagnoses made people fall backwards. The SW stated this had happened several times before admission requiring Resident #1 to wear a neck collar. The SW stated Resident #1 was walking and therapy was encouraging him to be safe. The SW stated he was aware Resident #1 had several falls since admission to the facility. He stated he could not recall the specifics that were discussed about interventions. He stated Resident #1 was impulsive and would do things outside the realm of recommendations such as get on the floor by himself. The SW stated staff set verbal boundaries and they all know he was a fall risk and why he was here. He stated that was why he was getting therapy. He stated he did not note in his documentation or notes any specific interventions to prevent falls and was not responsible for the care plan.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/25/2024 at 6:00 p.m., The DON stated the facility was brand new and just got their license as of 5/31/2024. She stated since the opening she was having to work a floor nurse, mostly at night because they did not have enough licensed staff. She stated she had worked as a charge nurse for the past 30 days which absolutely limited what she could do as a DON. She stated she was not able to attend morning meetings, IDT or care plan meetings. She stated her primary focus had been patient care and communication with floor staff. The DON stated the Administrator and Clinical Support Specialist (Corporate RN) were both aware of her limitations. She stated the response from the Administrator was nothing was being done to help the situation. The DON stated she was available 24/7 by phone and staff was instructed to call her for any change of condition and they had clear direction on what to do. The DON stated the facility did not have an ADON and she was the only RN working at the facility. The DON stated acknowledgement that Resident #1 did not have a care plan to address his falls. She stated they did have an order (physician order) for a fall mat. She stated the DOR was working specifically with Resident #1. The DON stated during his care plan meeting the family member of Resident #1 stated he did not sleep at night and that was his normal routine. The DON stated as Resident #1 had gotten stronger with therapy, he was now more mobile and was coming out of his room. She stated they were all trying to keep an eye on him, but it was usually just her and 1-2 CNAs during night shift. She stated Resident #1 would move around and they were unaware he was up. She stated the facility was a big empty building with a lot of vacant real estate in which he could move around unsupervised before they realized he was up. The DON stated she was aware of his fall history early in his admission process. The DON stated the family member typically sat with Resident #1 during the day and left in the early evening. The DON stated they were not updating the care plan after each fall because there was no care plan. She stated the incident/accident list was the most accurate documentation of his falls. She stated to her knowledge Resident #1 had 5 falls since admission. She stated the latest one was the only one in which he sustained an injury. The DON stated the causative factor in Resident #1's falls was his impulsivity. She stated fall interventions consisted of low bed, fall mat, keep an eye on him and therapy. She stated the Kardex was not updated for use by the CNAs because there was no care plan. The DON stated the CNAs were told verbally about fall risk and interventions since the Kardex was not accurate. She stated they were also rounding (checking on him) every 2-3 hours. The DON stated since the facility was new the DOR had not had a chance to implement her fall prevention program and she was not aware of the yellow sticker identification mentioned in the facility's fall prevention policy. The DON stated Resident #1 was on increased rounding of 1-hour intervals but his supervision was not spelled out, meaning that the level of supervision needed wasn't made clear. She stated they did not put any new interventions in place after each fall. The DON stated it was important to prevent falls to prevent injury. She stated she considered a brain bleed a serious injury. She stated all staff were responsible for ensuring resident safety. The DON stated she monitored staff by working on the floor with them as she was and having direct contact with them. She stated she was not doing medical record audits because she did not have time. The DON stated she does not think Resident #1's fall could have been prevented due to the resident's impulsivity unless he had 1:1 supervision. The DON stated she did feel Resident #1 was appropriately placed and they had not discussed discharging him although they had discussed his need for supervision with the family member during the care plan meeting which was why the family member spent so much time at the facility.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an observation/interview on 6/26/2024 at 8:22 a.m., Resident #1 was observed in bed with a cervical collar in place. He was laying on his right side in a fetal position with an eye mask covering his eyes. Although he was sleeping with his eyes closed, his right hand was fiddling with the light cord constantly. His call light was under the covers. A fall mat was on the floor beside the bed with the bed in low position. There was no yellow sticker beside his name on the door name plate to indicate he was at risk for falls.</p> <p>During an interview on 6/26/2024 at 9:05 a.m., the Administrator stated the facility was new and had opened at the end of March 2024 but had received their license more recently (date unknown). She stated she was aware Resident #1 had repeated falls and had no comprehensive care plan and that his baseline care plan had not been updated. The Administrator stated she ensured staff knew how to care for Resident #1 by giving verbal report to each other. She stated they did not have specific interventions in place to prevent Resident #1 from falling. She stated they did talk about falls during morning meetings including the use of fall mats, keeping him in eyesight and reminding him to use the call-light but these were not written down. The Administrator stated it was important to write the interventions down so staff will know how to take care of patients and for communicating. The Administrator stated she was ensuring the safety of the residents by doing visual checks of staff answering call lights and going into rooms and by verbal communication with staff, management, and therapy. The Administrator stated management was assisting with call lights and that leadership staff would monitor call lights/answer them as needed. She stated she did not have an ADON on staff and would not until the census reached approximately 40 residents. She stated the current census was 28. She stated she was hiring staff as they build their census. The Administrator stated she had briefly reviewed the facility fall prevention policy. She stated she was not aware certain aspects were not implemented. She stated the DON was responsible for the implementation. The Administrator stated the consequences of the fall prevention policy not being implemented were potential resident harm. The Administrator stated the DON had communicated she was not able to fulfill her DON duties and the corporate leaders knew the DON was struggling. The Administrator stated she had tried to remedy the situation by continuing to hire more staff. The Administrator stated she was responsible for facility management but was not always able to make decisions independently of Corporate.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a interview on 6/26/2024 at 9:47 p.m., LVN P stated she worked night shift. She stated Resident #1 came to the facility to recover from a C4-5 fracture (from a fall). She stated they knew he was a fall risk. She stated the first week in the facility she would take him everywhere with her, including when she was passing medications to other residents because he was constantly getting up. She stated she would also round on him every 30 minutes to 1 hour. LVN P stated Resident #1's family member stated at home he would sleep on the couch and got a max of 2 hours of sleep and would wander at night. LVN P stated she would tell him to use the call light and she would let him watch movies on the TV because he was alert and oriented. LVN P stated he knows how to use the call light and will use it when he has to go to the bathroom. She stated Resident #1 had a low bed. LVN P stated Resident #1 was able to walk on his own. She stated at first, they had him in the wheelchair, then he had therapy and now used the walker. LVN P stated she does supervise Resident #1 while he was using the walker but did not know what everyone else does. She stated she had not seen anything on his chart and no one had told her he needed supervision while walking. She stated she supervised him because she knows he is a fall risk and she tried to tend to him the best she could. LVN P stated she told the CNAs verbally what the residents needs were and she will explain if there is a fall risk and remind the CNAs to make rounds. LVN P stated she had not looked for Resident #1's care plan because the DON told her about Resident #1's needs. She stated she went off what she was verbally told. LVN P stated on 6/24/2024 she put Resident #1 to bed and then had to deal with an emergency with another patient. She stated she finally had a chance to sit down and chart when she heard Resident #1 yell for help. She stated she went into his room and he was seated on his butt while scooting to the door. She stated Resident #1 stated he was scooting in his wheelchair and fell forward. She stated she assessed him and noted a cut on the back of his head. She stated while she was applying pressure to his head, she asked him again what happened, and he repeated it but it did not make sense since the cut was on the back of his head. LVN P stated he then stated he stood up with his walker and fell back. LVN P stated she was assessing his pupils when she noted one was getting larger than the other. She stated she called the DON but already knew she needed to send him out and called 911. LVN P stated Resident #1's character began to change. He started saying Where am I and started to get confused. She stated his pupils were also not equal. LVN P stated she did not notice anything that could have contributed to his fall. She stated Resident #1 must have gotten up and walked to his walker. She stated she assumed he fell back and hit his head because the wound was on the back of his head and he did not remember how he fell . LVN P stated prior to the fall the last time she checked on him was when she was walking down the hall a few minutes before. LVN P did not answer direct questions about whether or not she had addressed Resident #1's insomnia with the physician. She stated he was on Seroquel (an antipsychotic medication) for delirium which also helps with sleep, but the family member had requested it be discontinued (date unknown). She stated the family member did not want him on any sleep medications because she said his wakefulness at night was his normal pattern. LVN P stated Resident #1 needed 1:1 supervision at night. She stated everyone in administration was aware he needed lots of attention. She stated they had all talked about how frequently he got up. LVN P stated she was not aware of the fall policy. She stated staff needed a visual indicator of fall risk.</p> <p>During an observation on 6/26/2024 at 11:22 a.m., Resident #1 was observed sleeping with low bed and fall mat in place. Resident #1 responded to his name when called but put up his hand and declined an interview.</p> <p>During an interview on 6/26/2024 at 11:36 a.m., LVN G stated she could not recall any falls or specific care for Resident #1.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an observation/interview on 6/27/2024 at 10:17 a.m. Resident #1 was observed sleeping in bed. His family member was at bedside. The family member refused entrance to the resident's room and stated Resident #1 did not want to talk to the surveyor. The family member stated Resident #1 had PSP which caused him to fall. She stated since his last fall she had purchased a soft helmet to protect his head from falls.</p> <p>During an interview on 6/28/2024 at 3:39 p.m. CNA Z stated on 6/24/2024 at approximately 3:40 am Resident #1 was seated in the living room watching TV. She stated she observed him get up and use his walker heading back to his room. She stated he was using his walking and was walking perfectly fine. CNA Z stated she knew he needed assistance with walking but LVN P told her he was fine and that he was okay without the assistance. CNA Z stated when she was watching him walk, he was doing just fine. She stated he was a fast mover and he would sneak past them, but she did watch him walk and he seemed okay. She stated a short while later she heard help help help coming from his room. She stated Resident #1 was on the floor in his room with bleeding from his head. CNA Z stated he demonstrated leaning forward from his wheelchair, but he had a cut on the back on his head. CNA Z stated LVN P was the nurse who also responded. CNA Z stated later Resident #1 [TRUNCATED]</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38511</p> <p>Based on observation, interview, and record review the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 4 residents (Resident #2) reviewed for pharmacy services.</p> <p>The facility failed to acquire and administer Resident #2's scheduled dose of oxycodone prior to rehabilitation services on 6/25/2024.</p> <p>This failure could place residents at risk of increased pain and poor quality of life.</p> <p>The Findings were:</p> <p>Record review of Resident #2's face sheet, dated 6/25/2024 revealed an admitted [DATE] with diagnoses which included hypertension and type 2 diabetes mellitus.</p> <p>Record review of Resident #2's baseline care plan, dated 6/12/2024 revealed the resident was cognitively intact and did not have the presence of pain and would be receiving physical and occupational therapy to improve functional status.</p> <p>Record review of Resident #2's Pain Evaluation dated 6/12/2024 revealed the resident had a right knee replacement with reports of occasional pain within the last 5 days located in the joint of the post op surgical incision. Interventions for pain were documented as relaxation techniques and medication.</p> <p>Record review of Resident #2's 5-day admission MDS assessment dated [DATE] revealed a BIMs score of 15 which indicated the resident was cognitively intact. The pain assessment was left blank.</p> <p>Record review of Resident #2's physician orders for June 2024 revealed a physician order for oxycodone/acetaminophen 5/325 mg oral tablet, give one tablet by mouth one time a day for pain at 10:00 a. m. The order start date was 6/21/2024.</p> <p>Record review of Resident #2's June 2024 MAR revealed oxycodone/acetaminophen 5/325 mg oral tablet, give one tablet by mouth one time a day for pain at 10:00 am was documented was not given as documented by LVN I on 06/25/2024.</p> <p>Record review of Resident #2's progress notes dated 6/25/2024 at 10:25 a.m. revealed LVN I documented: no medication oxycodone/acetaminophen 5/325 mg oral tablets) on hand .</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation/interview on 6/25/2024 at 10:34 a.m., Resident #2 was observed seated on the edge of her bed with an obvious dressing to her left knee and significant bruising in the tissue surrounding the knee. Resident #2 did not have any facial grimacing or body expressions of pain and was conversational. She stated she had a total knee replacement to her left knee and had come to the facility for rehabilitative services. She stated the recovery, healing had been more extensive than she had hoped and was second guessing her decision to have the surgery in the first place. Resident #2 stated she was currently experiencing anxiety because she was scheduled for rehabilitation at 11:00 a.m. She stated the nurses at the facility were great and had really worked with her to minimize her pain and anxiety. She stated she now took anxiety medication that was helping. Resident #2 stated currently she was experiencing some anxiety because the facility ran out of her oxycodone and was not able to give her the scheduled 10:00 am dosage. Resident #2 stated the facility ran out of oxycodone the day before on 6/24/2024. She stated she was able to get her dosage yesterday at 10:00 am as expected but had not had it today. She stated currently she had no pain. She stated her pain was only when she first started moving in the morning and eased as she moved her joint. She stated she was just worried she would not be able to participate in therapy without her oxycodone. Resident #2 stated regular Tylenol was sufficient to treat her pain when she was not in therapy. Resident #2 stated a family member was going to bring some oxycodone from home but would not arrive at the facility until after her therapy.</p> <p>During an observation/interview on 6/25/2024 at 10:52 a.m., LVN I's medication cart had an empty bottle of oxycodone 5/325 mg labeled with Resident #2's name. No other oxycodone for Resident #2 was observed in the medication cart. LVN I stated today (6/25/2024) was her first day working at the facility. She stated Resident #2 did not get her scheduled 10:00 a.m. dosage of oxycodone as prescribed by a physician because there was no oxycodone at the facility for the resident. She stated she was unsure why Resident #2 did not have any medication. LVN I stated Resident #2 was waiting on a family member to bring the medication from home. LVN I stated the nurses should re-order medication from the pharmacy when they were running low but she was unsure how far in advance it should be ordered. LVN I stated she had given Resident #2 an ice pack for her knee approximately 30 minutes ago and had not thought of getting the medication out of the e-kit (emergency medications). LVN I stated she was still learning the facility procedures.</p> <p>During an interview on 6/25/2024 at 11:00 a.m., LVN B stated Resident #2's oxycodone was scheduled to ensure she had it approximately 1-2 hours prior to therapy. She stated the nurses should send an order to pharmacy with a face sheet and then call the pharmacy to verify they got the order. LVN B stated for Resident #2 her orthopedic physician orders the oxycodone. She stated the facility put in for a refill yesterday (6/24/2024) but it would not be ready for 1-2 days. LVN B stated if a resident uses their own pharmacy rather than the facility pharmacy, they can get it quicker. LVN B stated Resident #2's family member went to get the prescription from their own pharmacy, but the medication was not ready when he arrived. LVN B stated refills should be ordered 5 days in advance but because the facility was new their computer system was not yet coordinated with the pharmacy computer system. LVN B stated she does not know why Resident #2's oxycodone was not ordered in advance. LVN B stated the facility did have an e-kit that contained oxycodone. She stated the charge nurse would have to call the physician for a one-time request in order to get a code from pharmacy to open the e-kit and pull the medication from it. LVN B stated it was important to give pain medication as ordered by a physician so pain did not get out of hand or affect the residents activities of daily living.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Riverside Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1555 Bandera Hwy Kerrville, TX 78028	

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation/interview on 6/25/2024 at 11:10 a.m., Resident #2 was observed in the therapy gym riding the stationary bike at a slow pace. Resident #2 stated she still had not received her oxycodone. She stated her leg was stiff which was normal. She stated she was using an ice pack on it and was not in much pain right now.</p> <p>During an observation/interview on 6/25/2024 at 3:20 p.m., Resident #2 was observed ambulating slowly in the hallway with her walker. She stated she had received her oxycodone at an unknown time following therapy and her pain was under control and she felt good.</p> <p>During an interview on 6/25/2024 at 3:23 p.m. Physical Therapy Assistant BB stated she was informed by staff that Resident #2 did not get her scheduled pain medications at 10:00 am for her 11:00 am therapy session and was in a little pain. She stated she was told there was a problem with her medication, but she was not sure what. She stated she told Resident #2 she was going to reschedule her therapy session for later in the day but Resident #2 refused and stated she wanted to go ahead with therapy as scheduled. PTA BB stated Resident #2 normally has a lot of anxiety and anticipates pain but denied pain during therapy. PTA BB stated she gave Resident #2 ice packs and gave her options to reduce her level of intensity. She stated Resident #2 worked at her normal level of intensity by her own choice and she was even introduced to a new exercise in which she actively participated and tolerated well without pain.</p> <p>During an interview on 6/26/2024 at 7:44 a.m., the DON stated the facility should maintain 7 days of medication in the facility. She stated staff should monitor medications and medication carts to ensure medications could be re-ordered as needed. The DON stated oxycodone was a common medication at the facility and was available for staff to pull from the e-kit. The DON stated the facility was new and was working with a new pharmacy and they had some technical difficulties. She stated she had been working with a pharmacy representative to ensure there were no delays on medications. The DON stated it was important to communicate delays in medication administration with the physician and the resident.</p> <p>Record review of a facility policy titled Pharmacy Services dated 7/2022 revealed. 1. The facility will provide pharmaceutical services to include procedures that assure the accurate acquiring, receiving, dispensing, and administering of all routine and emergency drugs and biologicals to meet the need of each resident, are consistent with state and federal requirements and reflect current standards of practice.</p>

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p>38511</p> <p>Based on interview and record review, the facility failed to employ staff with the appropriate competencies and skill sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care, and the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required for 1 of 1 kitchen in that:</p> <p>The facility failed to have a certified Dietary Manager or Registered Dietician to serve as the Director of Food and Nutrition Services.</p> <p>This deficient practice could place the residents who consume food prepared from the kitchen at risk of food borne illness and not receiving adequate nutrition.</p> <p>The findings included:</p> <p>Record review of a staff roster (undated) obtained on date of entrance (6/25/2024) revealed the facility had three dietary staff members and no Dietary Manager or Registered Dietician was listed on the staff roster.</p> <p>During an interview on 6/26/2024 at 7:44 a.m., the DON stated the facility did not have Dietary Manager.</p> <p>During an interview on 6/26/2024 at 9:05 a.m., the Administrator stated the facility did not have a Dietary Manager to serve as Director of Food and Nutrition Services and had not had once since the facility opened around March 2024. The Administrator stated she did not have anyone covering in lieu of a Dietary Manager although one of the facility's dietary staff, [NAME] F, was considering the position. She stated she would send [NAME] F to school. The Administrator stated at the time of the interview [NAME] F had not accepted the job position and was not enrolled in classes. The Administrator stated [NAME] F had been attending care plan meetings, completed ordering and was coming to morning meetings but was not yet trained or licensed.</p> <p>During an interview on 6/26/2024 at 11:55 a.m. Dietary Staff AA stated the kitchen did not have a dietary manager. He stated if there were any questions staff asked [NAME] F for assistance. Dietary Staff AA stated they had all the supplies they needed, which were ordered by [NAME] F.</p> <p>During an Interview on 6/28/2024 at 11:07 a.m., [NAME] F stated she was the cook for morning and midday meal services. She stated the kitchen had a total of 3 cooks and one newly hired dietary aide. She stated the kitchen did not have a Dietary Manager. She stated the Administrator had spoken to her she had been offered the position of Dietary Manager, but she had not made a decision and it was still up in the air. [NAME] F stated she was not currently enrolled in the classes to become dietary manager and did not have the training required. She stated she had been ordering supplies for the kitchen along with the Administrator. [NAME] F stated she was not performing dietary assessments and did not have access to the facility computer system and had no experience doing assessments.</p> <p>(continued on next page)</p>		

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/01/2024 at 11:34 a.m., the Registered Dietician stated she worked for a company that may have a contract for dietary services with the facility. She stated she did not have access to the contract. She stated she was not an employee of the facility. She stated she was located in another city (hundreds of miles away) and did not visit the facility for in-person visits. She stated she performed remote charting for new resident admissions to evaluate for nutrition needs on an as needed basis. She stated she was not providing oversite to the kitchen and had no plans on visiting the facility in person.</p> <p>Record review of a facility policy, titled, Dietary Services-Staffing dated 2024 revealed: 1. The facility will employ a qualified dietitian or other clinically qualified nutrition professional on a full time, part time, or consultant basis. 3. If the dietitian or other clinically qualified nutritional professional is not employed full time, the facility will designate a person to serve as the director of food and nutrition services who: i. a certified dietary manager ii. A certified food service manager iii. Has similar national certification for food service management and safety from a national certifying body or iv. Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning v. has 2 or more years' experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including but not limited, foodborne illness, sanitation procedures, and food purchasing/receiving.</p> <p>Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&amp;HS, revealed 1-201.10.10(B) Accredited Program. (1) Accredited program means a food protection manager certification program that has been evaluated and listed by an accrediting agency as conforming to national standards for organizations that certify individuals .</p> <p>Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&amp;HS, revealed 2-102.12 Certified Food Protection Manager. (A) The PERSON IN CHARGE shall be a certified FOOD protection manager who has shown proficiency of required information through passing a test that is part of an ACCREDITED PROGRAM. 2-102.20 Food Protection Manager Certification. (B) A FOOD ESTABLISHMENT that has a PERSON IN CHARGE that is certified by a FOOD protection manager certification program that is evaluated and listed by a Conference for FOOD Protection-recognized accrediting agency as conforming to the Conference for FOOD Protection Standard for Accreditation of FOOD Protection Manager Certification Programs is deemed to comply with S[section]2-102.12.</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38511</b></p> <p>Based on interview, and record review, the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to maintain the highest practicable well-being of each resident for 1 of 1 facility reviewed for Administration.</p> <p>The facility failed to hire an onsite MDS Coordinator to ensure resident MDS assessments were completed accurately and timely and transmitted and comprehensive care plans were developed.</p> <p>This deficient practice could affect all residents and place them at risk for inaccurate, incomplete and unverified MDS assessments and incomplete care plans which could result in incomplete and inaccurate care and services.</p> <p>The findings included:</p> <p>Record review of a staff roster (undated) obtained on date of entrance (6/25/2024) revealed the facility did not have an MDS Coordinator listed as a member of staff.</p> <p>During an interview on 6/25/2024 at 3:29 p.m., the Administrator stated the DON was not in the facility because she had been working night shift for a staff member who quit. She stated the facility did not have an ADON because the facility was new, and they had a low census (28). She stated the facility did not have an MDS Coordinator. The Administrator stated MDS assessments were completed offsite by Corporate.</p> <p>During an interview on 6/25/2024 at 3:30 p.m., Corporate HR and BOM stated the facility did not have an MDS Coordinator on staff and the DON was not in the facility and they did not have an ADON. She stated MDS assessments were completed by Corporate MDS nurse who was the reimbursement specialist but she was unavailable. The BOM stated a Clinical Reimbursement Specialist (contract) who worked in corporate was handling MDS assessments while the Corporate MDS nurse was unavailable.</p> <p>During an interview on 6/25/2024 at 5:20 p.m., the Corporate MDS nurse stated could not answer specific questions about specific residents or MDS assessments. She stated the facility did not have their own MDS nurse but they needed one. The Corporate MDS nurse stated she was assigned to complete facility MDS assessments and care plans. She stated she opened MDS assessments and then via communication with the DON and DOR completed the assessments. She stated she was not on-site at the facility and worked remotely. She stated she had not transmitted any MDS assessments for any residents in the facility because they did not have an NPI number, therefore they could not transmit. She stated she had not completed any care plans for residents at the facility because although the task was assigned to her it should be completed by the DON. She stated since she worked with the corporation, she had two other facilities in addition to this facility to manage and she could not keep up with this facility because they were admitting approximately 12 residents a week.</p> <p>(continued on next page)</p>

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/25/2024 at 4:37 p.m., the Corporate Clinical Reimbursement Specialist stated she was not an employee of the facility or corporation, and she did not have a contract with the facility. She stated she was not completing MDS assessments but was opening some for staff to enter data but had no other contribution to the MDS assessments.</p> <p>During an interview on 6/25/2024 at 6:00 p.m., the DON stated the facility was licensed since 5/31/2024 and was a brand-new facility. She stated she was having to work as a floor nurse due to staffing. She stated she had no ADON to assist and the facility did not have an MDS Coordinator. She stated MDS assessments were being completed by Corporate MDS nurse because the facility did not have an MDS Coordinator on staff. She stated she had no time to look at MDS assessments since working night shift as a charge nurse. She stated she had not been able to do a majority of her DON duties. She stated the Corporation was aware she was not performing DON audits or duties. The DON stated the Corporate MDS nurse had not communicated to her that she was not transmitting assessments and she had no direct contact with the Corporate MDS nurse, but it was a known issue at the facility at the corporate level. The DON stated she was aware that comprehensive care plans were not being completed for the residents at the facility because they did not have an MDS Coordinator.</p> <p>During an interview on 6/26/2024 at 9:05 a.m., the Administrator stated the facility was new and had just opened for its first resident at the end of March 2024. She said they became licensed as of 5/31/2024. The Administrator stated the facility had multiple staff vacancies due to its new status. She stated they hired staff as census grew and corporate was filling in for positions not yet filled. She stated the facility did not have an MDS Coordinator. The Administrator stated she was aware MDS assessments were not being transmitted but that had to do with a NPI number that the facility did not yet have. She stated she was responsible for facility management and for hiring of needed staff. The Administrator became emotional during the interview and stated she was not able to make hiring decisions independently of corporate. She stated the Corporate LNFA was her direct supervisor, and he was aware of the facility struggles. The Administrator stated she was not given the go ahead to hire needed staff until they had an influx of admissions on 6/18/2024.</p> <p>During an interview on 6/26/2024 at 12:12 p.m., the Corporate LNFA stated he was the Administrators supervisor. He stated the facility had been given full [NAME] to hire whatever staff was needed. He stated he did not know when this conversation took place or when the decision was made. He stated the facility did not utilize agency staff and they did not have a contract with any agency to provide staff. He stated currently, the corporation was helping to manage the facility.</p> <p>During an interview on 6/26/2024 at 1:32 p.m., the Corporate HR Director stated she was assisting the facility with the hiring process of needed staff until the facility could hire their own HR Director. She stated right now the facility did not have their own HR director because of low census. The Corporate HR Director stated they had not hired for the MDS Coordinator position. She stated she placed an ad for the position on 6/25/2024 (after surveyor entrance). She stated they had held out hiring an MDS Coordinator because of low census.</p> <p>During an interview on 6/26/2024 at 2:08 p.m., the Corporate RN stated MDS assessments were the responsibility of the Corporate MDS nurse who was an LVN because the facility did not have an MDS Coordinator on staff. The Corporate RN stated she did not perform MDS assessments and did not complete care plans. She stated the responsibility for the care plans would fall on the DON and Corporate MDS nurse.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/26/2024 at 2:29 p.m., the Administrator stated she was aware MDS assessments were not being transmitted and was aware that none of the resident comprehensive care plans were completed. She stated the facility was newly licensed and not being able to transmit MDS assessments when first opening was something that came along with a new building. She stated that was a corporate level decision and task.</p> <p>During an interview on 6/27/2024 at 3:20 p.m., the DON stated the Corporate MDS nurse was the person responsible for reviewing MDS assessments for completion and transmitting the data. She stated a Corporate RN should be signing the assessments. The DON stated she was unsure if the Corporate MDS nurse was an LVN or RN. The DON stated she was not providing MDS oversight as it was handled at the corporate level right now. The DON stated timely transmission of MDS assessments was important for the facility to accurately reflect the patient (resident).</p> <p>Record review of a facility assessment dated [DATE] revealed the facility was licensed for 130 beds. At the time the assessment was completed the facility had 3 residents in the facility. Part 3 of the assessment listed facility resources needed to provide competent support and care to the resident population and did not include the title of MDS Coordinator. MDS Coordinator was listed as a member of management for review of facility assessment and was left blank. A Resident Care Management Coordinator was listed as a required position.</p> <p>During an interview on 7/01/2024 at 12:05 p.m., the Corporate LNFA stated he was not sure why the facility assessment did not list MDS Coordinator specifically. He stated the position Resident Care Management Coordinator was the same as MDS Coordinator. He stated MDS Coordination was essential to the function of the facility.</p> <p>During an interview on 7/01/2024 at 1:02 p.m., the Corporate Clinical RN stated the facility did not have a policy for MDS Coordination.</p>		