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Form Approved OMB
No. 0938-0391

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 11/26/2024
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)
F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46447 Based on observation, interview, and record review, the facility failed to conduct an initial comprehensive assessment of each resident's functional capacity including the resident's needs, strengths, goals, life history, and preferences for 4 (Resident #1, Resident #2, Resident #3, and Resident #6) of 6 reviewed for assessments. 1. The MDS Coordinator failed to complete Resident #1's admission comprehensive assessment within 14 days after admission, 11/15/2024. 2. The MDS Coordinator failed to complete Resident #2's admission comprehensive assessment within 14 days after admission, 11/21/2024. 3. The MDS Coordinator failed to complete Resident #3's admission comprehensive assessment within 14 days after admission, 11/21/2024. 4. The MDS Coordinator failed to complete Resident #6's admission comprehensive assessment within 14 days after admission, 11/14/2024. This failure could affect newly admitted residents and result in residents not receiving the care and services as needed. The findings included: 1. Record review of Resident #1's Admission Record, dated 11/25/2024, reflected Resident #1 was admitted on [DATE]. Resident #1 was noted to be [AGE] years old. Record review of Resident #1's Diagnosis Report, dated 11/25/2024, reflected Resident #1 was diagnosed with unspecified fracture of the lower end of left radius (a break in the lower end of one of the left forearm bones), acute and chronic respiratory failure (a condition where there is not enough oxygen or too much carbon dioxide in the body), and chronic kidney disease (a condition where the kidneys lose their ability to filter blood and remove wastes). Record review of Resident #1's EMR (electronic medical record) on 11/25/2024 reflected Resident #1 had two MDS Assessments, an Entry MDS dated [DATE] and noted as Accepted, and an Admission/Medicare- 5 Day MDS dated [DATE] and noted as Exported. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's MDS Admission/ Medicare- 5-day assessment, dated 11/06/2024, reflected it had been completed and signed by Consultant MDS Coordinator on 11/23/2024. Observation and attempted interview with Resident #1 on 11/26/2024 at 10:28 a.m. Resident #1 observed to be participating in therapy. 2. Record review of Resident #2's Admission Record, dated 11/25/2024, reflected Resident #2 was admitted on [DATE]. Resident #2 was noted to be [AGE] years old. Record review of Resident #2's Diagnosis Report, dated 11/25/2024, reflected Resident #2 was diagnosed with depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), polyneuropathy (a disorder that damages the peripheral nerves, which control the movement of the arms and legs), and wedge compression fracture of unspecified lumbar vertebra (small breaks in the a lower bone of the spine). Record review of Resident #2's EMR on 11/25/2024 reflected Resident #2 had three MDS Assessments, an Entry MDS dated [DATE] and noted as Accepted, an Admission/ Medicare- 5 Day MDS dated [DATE] and noted as In Progress, and a Discharge Return Anticipated MDS dated [DATE] and noted as In Progress. Record review of Resident #2's MDS Admission/ Medicare- 5 day assessment, dated 11/11/2024, on 11/25/2024 reflected only section F signed and noted as completed. The MDS assessment was not signed by a RN Assessment Coordinator Verifying Assessment Completion. Attempted observation and interview of Resident #2 on 11/26/2024 at 10:22 a.m. revealed resident was at a local hospital and unavailable. 3. Record review of Resident #3's Admission Record, dated 11/25/2024, reflected Resident #3 was admitted on [DATE]. Resident #3 was noted to be [AGE] years old. Record review of Resident #3's Diagnosis Report, dated 11/25/2024, reflected Resident #3 was diagnosed with fibromyalgia (a disorder that affects muscle and soft tissue characterized by chronic muscle pain, tenderness, fatigue and sleep disturbances), noninfective gastroenteritis and colitis (inflammatory disorders often attributed to viruses or bacterial infections that affect the gastrointestinal tract resulting in abdominal pain and diarrhea) and urinary tract infection (UTI; infection in any part of the urinary system including the kidneys, bladder, ureters, and urethra). Record review of Resident #3's EMR on 11/25/2024 reflected Resident #3 had two MDS Assessments, an Entry MDS dated [DATE] and noted as Accepted, and an Admission/ Medicare- 5 Day MDS dated [DATE] and noted as In Progress. Observation and interview with Resident #3 on 11/26/2024 at 10:07 a.m. Resident #3 observed and interviewed in the resident's room. 4. Record review of Resident #6's Admission Record, dated 11/25/2024, reflected Resident #6 was admitted on [DATE]. Resident #6 was noted to be [AGE] years old. (continued on next page)

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F 0636

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Record review of Resident #6's Diagnosis Report, dated 11/25/2024, reflected Resident #6 was diagnosed with benign prostatic hyperplasia (enlarged prostate), peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), and dementia (a general term for impaired ability to remember, think, or make decisions).

Record review of Resident #6's EMR on 11/25/2024 reflected Resident #6 had two MDS Assessments, an Entry MDS dated [DATE] and noted as Accepted, and an Admission/ Medicare- 5 Day MDS dated [DATE] and noted as Exported.

Record review of Resident #6's MDS Admission/ Medicare- 5 Day assessment, dated 11/04/2024, reflected it had been completed and signed by Consultant MDS Coordinator on 11/23/2024.

Observation and attempted interview with Resident #6 on 11/26/2024 at 10:00 a.m. Resident #6 observed self-propelling himself in a wheelchair down the hall. Resident #6 was not available for interview.

During an interview on 11/26/2024 at 01:55 p.m., the Regional MDS Coordinator stated she worked for the corporate company of the nursing facility. The Regional MDS Coordinator stated she had been assisting the nursing facility with their MDS assessments since the nursing facility opened and a consulting company had just been brought on to also assist. The Regional MDS Coordinator stated that she was an LVN (licensed vocational nurse) and the MDS assessments had to be signed by an RN (registered nurse). The RN Assessment Coordinator signatures on the completed MDS assessments (Resident #1 and Resident #6) were identified as an RN from the consulting company. The Regional MDS Coordinator stated that she would typically have a weekly meeting with the facility staff; however, she had been busy with her other duties and had not been in the nursing facility building for the last couple of weeks. The Regional MDS Coordinator stated she had not been in contact with the contracted consulting company and was not knowledgeable on what the Consultant MDS Coordinator had done. The Regional MDS Coordinator stated the admission MDS was the resident's comprehensive assessment, and it should be completed within 14 days of the resident's admission. She stated that this was per the RAI (MDS Resident Assessment Instrument) manual and that the facility was to follow the RAI manual. The Regional MDS Coordinator stated she would consider the date of completion for a MDS Assessment as the date of the signature of the nurse (RN). She stated Resident #1's Admission MDS was signed on 11/23/2024 and that it was late, past the 14 days. The Regional MDS Coordinator stated it was probably late due to her focusing on her other duties and her not being an RN, so she could not sign it. The Regional MDS Coordinator confirmed Resident #6's Admission MDS was signed late.

During an interview on 11/26/2024 at 02:42 p.m., the DON stated she did not complete the MDS assessments and did not sign the MDS assessments. The DON stated the nursing facility nursing staff were not currently inputting any information into the resident's MDS assessments. The DON stated the corporate company was entering all information into the facility resident's MDS assessments. The DON stated she did not know the process for the MDS assessments and could not identify who was responsible for monitoring the MDS assessment schedule.

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	745050	A. Building B. Wing	11/26/2024

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

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/26/2024 at 03:33 p.m., the ADMIN stated he had weekly calls with the Regional MDS Coordinator. The ADMIN stated the Regional MDS Coordinator was scheduling and opening all the MDS assessments. The ADMIN stated he was not 100% positive who was tracking to ensure that the MDS assessments were signed but believed it would be either the Regional MDS Coordinator, the Consultant MDS Coordinator, or the company's VP of Clinical Operations. The ADMIN stated that if a MDS assessment was signed late, it would not impact the resident's care. He stated it would only impact the timeliness of the MDS assessment being completed. It would not change the orders that the facility had for the resident. Record review of facility policy, MDS 3.0 Completion, dated copyright 2024, revealed Definitions: 'OBRA Assessment' refers to an assessment mandated by the Omnibus Budget Reconciliation Act of 1987, which specifies a Minimum Data Set (MDS) of core elements for use in assessing nursing home residents. Policy Explanation and Compliance Guidelines: 1. According to federal regulations, the facility conducts initially and periodically a comprehensive, accurate and standardized assessment of each resident's functional capacity, using the RAI specified by the State. 2. Types of OBRA Assessments . b. Admission Assessment - completed within 14 days of admission counting the day of admission as day #1 . 4. Care Plan Team Responsibility for Assessment Completion: a. Interdisciplinary Responsibility for Completion of MDS Sections: . iii. The R.N. Coordinator signs, dates, and attests (in section Z0500A) to timely completion of the RAI, once all other disciplines have completed their sections.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46447 Based on observation, interview, and record review the facility failed to ensure the initial comprehensive assessment accurately reflected the resident's status for 2 (Resident #4 and Resident #5) of 4 residents reviewed for accuracy of assessments. 1. The facility failed to accurately code Resident #4's bladder and bowel appliance status on her admission comprehensive assessment. 2. The facility failed to accurately code Resident #5's fall history with fracture on her admission comprehensive assessment. These failures could place residents at risk of improper or incorrect care and services necessary for their physical, mental, and psychosocial well-being. The findings included: 1. Record review of Resident #4's Admission Record, dated 11/25/2024, reflected Resident #4 was admitted on [DATE]. Resident #4 was noted to be [AGE] years old. Record review of Resident #4's Diagnosis Report, dated 11/25/2024, reflected Resident #4 was diagnosed with cerebral infarction (a disruption in the brain's blood flow), constipation (a problem with passing stool), and urinary tract infection (UTI; infection in any part of the urinary system including the kidneys, bladder, ureters, and urethra). Record review of Resident #4's EMR (electronic medical record) on 11/25/2024 reflected Resident #4 had two MDS Assessments, an Entry MDS dated [DATE] and noted as Accepted, and an Admission/ Medicare- 5 Day MDS dated [DATE] and noted as Accepted. Record review of Resident #4's MDS Admission/ Medicare- 5-day assessment, dated 10/31/2024 and signed as completed on 11/01/2024, reflected Resident #4 had a BIMS score of 11 indicating she was moderately cognitively impaired and required partial/moderate assistance with toileting hygiene, personal hygiene, and toilet transfers. Her bladder and bowel status was coded as Resident #4 having an indwelling catheter with her always continent for bowel and bladder. Record review of Resident #4's Indwelling Catheter Assessment, dated 10/27/2024, reflected Resident #4 was not admitted with an indwelling catheter. Observation of Resident #4 on 11/26/2024 at 10:03 a.m. Resident #4 observed to be participating in a speech therapy session. Attempted interview at 10:35 a.m., resident refused interview. 2. Record review of Resident #5's Admission Record, dated 11/25/2024, reflected Resident #5 was admitted on [DATE]. Resident #5 was noted to be [AGE] years old. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #5's Diagnosis Report, dated 11/25/2024, reflected Resident #5 was diagnosed with orthopedic aftercare (care provided after a corrective or preventative treatment on deformities, disorders, or injuries of the bones or muscles), displaced intertrochanteric fracture of right femur (a hip fracture), and wedge compression fracture of unspecified lumbar vertebra (small breaks in the lower bone of the spine). Record review of Resident #5's EMR on 11/25/2024 reflected Resident #5 had two MDS Assessments, an Entry MDS dated [DATE] and noted as Accepted, and an Admission/ Medicare- 5 Day MDS dated [DATE] and noted as Accepted. Record review of Resident #5's MDS Admission/ Medicare- 5 day assessment, dated 10/28/2024 and signed as completed on 11/01/2024, reflected Resident #5 had a BIMS score of 03 indicating she was severely cognitively impaired, needed some help (needed partial assistance from another person to complete any activities) with self-care and indoor mobility (ambulation), and used a walker and wheelchair. Her fall history on Admission/Entry or Reentry was noted as having had a fall in the last month prior to admission/entry or reentry, no falls in the last 2-6 months prior to admission/entry or reentry, and no fracture related to a fall in the 6 months prior to admission/entry or reentry. Record review of Resident #5's Physician Progress Note, dated 10/09/2024, reflected under Admission HPI [history or present illness]: admitted to SNF [skilled nursing facility] on OCT1 as she was treated at [local hospital] for rt [right] inertrochanteric [sic] fx [fracture] . Record review of Resident #5's local hospital Discharge Summary, dated as signed 10/01/2024, reflected Patient sustained a mechanical fall at home resulted in severe pain. Imaging in the ED [emergency department] revealed a slightly displaced right femoral intertrochanteric fracture. Attempted observation and interview of Resident #5 on 11/26/2024 at 09:57 a.m. revealed resident was not in present in room and unavailable for interview. During an interview on 11/26/2024 at 01:55 p.m., the Regional MDS Coordinator stated she worked for the corporate company of the nursing facility. The Regional MDS Coordinator stated she had been assisting the nursing facility with their MDS assessments since the nursing facility opened and a consulting company had just been brought on to also assist. The Regional MDS Coordinator stated she or the nurse completing or signing the MDS assessment would be responsible for the assessment's completion and accuracy. She stated that an inaccuracy in the MDS assessment may impact a resident's care but was not sure. She stated it may impact care if a diagnosis was missed but it would depend on what the inaccuracy was. The Regional MDS Coordinator stated that it did not look as if Resident #4 had an indwelling catheter after reviewing the resident's nursing notes. She stated she did not see an indwelling catheter as having been present per the resident's admission notes. She stated the MDS assessment noting an indwelling catheter was an error. The Regional MDS Coordinator stated this error would not have impacted Resident #4's care because staff could not provide care for a catheter that was not present. The Regional MDS Coordinator stated she did not see Resident #5's physician note, that it was missed. She stated Resident #5's Admission MDS should have been coded as Yes for having had a fracture related to a fall in the 6 months prior to admission/entry or reentry. She stated she did not believe Resident #5's care was impacted by this error because Resident #5 was very stable when she admitted to the facility and she would have had the same risks for falls regardless of the documented history of fall. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/26/2024 at 02:42 p.m., the DON stated she did not complete the MDS assessments and did not sign the MDS assessments. The DON stated the nursing facility nursing staff were not currently inputting any information into the resident's MDS assessments. The DON stated the corporate company was entering all information into the facility resident's MDS assessments. The DON stated Resident #4 did not have an indwelling catheter and that all of Resident #4's assessments, except for the MDS admission assessment, do not say she had an indwelling catheter. The DON stated she did not know why Resident #4's MDS assessment was coded as if she had an indwelling catheter but that the error would not have impacted Resident #4's care. The DON stated that if Resident #4 had a catheter at admission, Resident #4 would have had orders associated with catheter care. The DON stated Resident #5 was at risk for falls and had received therapy as part of her fall interventions. During an interview on 11/26/2024 at 03:33 p.m., the ADMIN revealed he was not sure who was responsible for the accuracy of the MDS assessments but that the Regional MDS Coordinator or the Consultant MDS Coordinator would be the ones to ensure that they are accurately documenting. The ADMIN stated that Resident #4 having been coded as having had an indwelling catheter on her MDS admission assessment would not have impacted the nursing care because the nurses do not necessarily look at the MDS assessments. He stated that he could not state the impact or if there would have been an impact on Resident #5's care for having not been coded as having had a fracture from a fall within the 6 months prior to her admission because he was not a clinician. Record review of facility policy, MDS 3.0 Completion, dated copyright 2024, revealed Policy Explanation and Compliance Guidelines: 1. According to federal regulations, the facility conducts initially and periodically a comprehensive, accurate and standardized assessment of each resident's functional capacity, using the RAI specified by the State . 4. Care Plan Team Responsibility for Assessment Completion: a. Interdisciplinary Responsibility for Completion of MDS Sections: . ii. Persons completing part of the assessment must attest to the accuracy of the section they completed by signature and indication of the relevant sections.

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F 0656

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 46447

Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental needs that are identified in the comprehensive assessment, and services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 4 (Resident #1, Resident #4, Resident #5, Resident #6) of 4 residents reviewed for comprehensive care plans.

1. The facility failed to ensure Resident #1, who was documented for full code status, assessed as requiring supervision or touching assistance for transfers, and had a history of falls; had a care plan regarding code status, specified how many staff members were required to transfer the resident from bed to chair, and specified her fall risk and to include interventions to prevent and/or mitigate injury from falls.

2. The facility failed to ensure Resident #4, who was documented for full code status and had a history of falls; had a care plan regarding code status and interventions to prevent and/or mitigate injury from falls.

3. The facility failed to ensure Resident #5, who was assessed as requiring partial or moderate assistance for transfers and had a history of falls; had a care plan specifying how to transfer the resident from bed to chair and specified her fall risk, fall history, and to include interventions to prevent and/or mitigate injury from falls.

4. The facility failed to ensure Resident #6, who was documented for full code status, assessed as requiring supervision or touching assistance for transfers, and had a history of falls; had a care plan regarding code status, how to transfer the resident from bed to chair, and interventions to prevent and/or mitigate injury from falls.

These failures could place residents at risk for not receiving proper care and services.

The findings included:

1. Record review of Resident #1's Admission Record, dated 11/25/2024, reflected Resident #1 was admitted on [DATE]. Resident #1 was noted to be [AGE] years old. Resident #1's code status was noted as Full Code.

Record review of Resident #1's Diagnosis Report, dated 11/25/2024, reflected Resident #1 was diagnosed with unspecified fracture of the lower end of left radius (a break in the lower end of one of the left forearm bones), acute and chronic respiratory failure (a condition where there is not enough oxygen or too much carbon dioxide in the body), and chronic kidney disease (a condition where the kidneys lose their ability to filter blood and remove wastes).

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's EMR (electronic medical record) on 11/25/2024 reflected Resident #1 had two MDS Assessments, an Entry MDS dated [DATE] and noted as Accepted, and an Admission/Medicare- 5 Day MDS dated [DATE] and noted as Exported. Record review of Resident #1's MDS Admission/ Medicare- 5-day assessment, dated 11/06/2024, reflected Resident #1 had a BIMS score of 15 indicating she was cognitively intact. She was assessed as requiring supervision or touching assistance for chair/bed-to-chair transfers. Her fall history on Admission/Entry or Reentry was noted as having a fall in the last month, no falls in the last 2-6 months, and having had a fracture related to a fall in the last 6 months. Record review of Resident #1's Fall Risk Assessment, dated 11/02/2024, reflected Resident #1 required the use of assistive devices such as a cane, wheelchair, walker, or furniture. Record review of Resident #1's Care Plan, undated, accessed 11/25/2024 reflected: - Her care plan did not reflect or address Resident #1's Advance Directive status as Full Code. - Her care plan reflected Resident #1 had an ADL self-care performance deficit r/t [related to] S/P [status post] Fracture of left radius (NWB [non-weight baring]) and Left Femur, initiated and revised 11/18/2024. The interventions included TRANSFER: I require assistance with transfer with ('X' number) of care team members for assistance with transfers ., initiated 11/18/2024. - Her care plan reflected The resident is (SPECIFY High, Moderate, Low) risk for falls r/t Gait/balance problems, initiated 11/13/2024. No interventions were included in the care plan for the focus. Observation and attempted interview with Resident #1 on 11/26/2024 at 10:28 a.m. Resident #1 observed to be participating in therapy. 2. Record review of Resident #4's Admission Record, dated 11/25/2024, reflected Resident #4 was admitted on [DATE]. Resident #4 was noted to be [AGE] years old. Resident #4's code status was noted as Full Code. Record review of Resident #4's Diagnosis Report, dated 11/25/2024, reflected Resident #4 was diagnosed with cerebral infarction (a disruption in the brain's blood flow), constipation (a problem with passing stool), and urinary tract infection (UTI; infection in any part of the urinary system including the kidneys, bladder, ureters, and urethra). Record review of Resident #4's EMR on 11/25/2024 reflected Resident #4 had two MDS Assessments, an Entry MDS dated [DATE] and noted as Accepted, and an Admission/ Medicare- 5 Day MDS dated [DATE] and noted as Accepted. Record review of Resident #4's MDS Admission/ Medicare- 5-day assessment, dated 10/31/2024, reflected Resident #4 had a BIMS score of 11 indicating she was moderately cognitively impaired. Her fall history on Admission/Entry or Reentry was noted as having a fall in the last month, a fall in the last 2-6 months, and a fracture related to a fall in the last 6 months. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #4's Fall Risk Assessment, dated 10/27/2024, reflected Resident #4 was chair bound and required the use of assistive devices such as a cane, wheelchair, walker, or furniture. Record review of Resident #4's Care Plan, undated, accessed 11/25/2024 reflected: - Her care plan did not reflect or address Resident #4's Advance Directive status as Full Code. - Her care plan did not reflect or address Resident #4's risk for falls. Observation of Resident #4 on 11/26/2024 at 10:03 a.m. Resident #4 observed to be participating in a speech therapy session. Attempted interview at 10:35 a.m., resident refused interview. 3. Record review of Resident #5's Admission Record, dated 11/25/2024, reflected Resident #5 was admitted on [DATE]. Resident #5 was noted to be [AGE] years old. Record review of Resident #5's Diagnosis Report, dated 11/25/2024, reflected Resident #5 was diagnosed with orthopedic aftercare (care provided after a corrective or preventative treatment on deformities, disorders, or injuries of the bones or muscles), displaced intertrochanteric fracture of right femur (a hip fracture), and wedge compression fracture of unspecified lumbar vertebra (small breaks in the lower bone of the spine). Record review of Resident #5's EMR on 11/25/2024 reflected Resident #5 had two MDS Assessments, an Entry MDS dated [DATE] and noted as Accepted, and an Admission/ Medicare- 5 Day MDS dated [DATE] and noted as Accepted. Record review of Resident #5's MDS Admission/ Medicare- 5 day assessment, dated 10/28/2024, reflected Resident #5 had a BIMS score of 03 indicating she was severely cognitively impaired. She was assessed as requiring partial/moderate assistance for chair/bed-to-chair transfers. Her fall history on Admission/Entry or Reentry was noted as having had a fall in the last month, no falls in the last 2-6 months, and no fracture related to a fall in the 6 months. Record review of Resident #5's Fall Risk Assessment, dated 10/23/2024, reflected Resident #5 was categorized as high risk. She had intermittent confusion, 1-2 falls in the past 3 months, and had a balance problem while walking. Record review of facility report Incidents By Incident Type, date range 08/21/2024 to 11/21/2024, reflected Resident #5 had a fall on 11/14/2024. Record review of Resident #5's Care Plan, undated, accessed 11/25/2024, reflected: - Her care plan reflected Resident #5 had an ADL self-care performance deficit r/t cognitive impairment, weakness, initiated 11/18/2024. The interventions included TRANSFER: I require assistance with transfer with ('X' number) of care team members for assistance with transfers ., initiated 11/18/2024. - Her care plan did not reflect or address Resident #5's risk for falls or her history of falls. (continued on next page)

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 11/26/2024
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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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Attempted observation and interview of Resident #5 on 11/26/2024 at 09:57 a.m. revealed resident was not in present in room and unavailable for interview. 4. Record review of Resident #6's Admission Record, dated 11/25/2024, reflected Resident #6 was admitted on [DATE]. Resident #6 was noted to be [AGE] years old. Resident #6's code status was noted as Full Code. Record review of Resident #6's Diagnosis Report, dated 11/25/2024, reflected Resident #6 was diagnosed with benign prostatic hyperplasia (enlarged prostate), peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), and dementia (a general term for impaired ability to remember, think, or make decisions). Record review of Resident #6's EMR on 11/25/2024 reflected Resident #6 had two MDS Assessments, an Entry MDS dated [DATE] and noted as Accepted, and an Admission/ Medicare- 5 Day MDS dated [DATE] and noted as Exported. Record review of Resident #6's MDS Admission/ Medicare- 5 Day assessment, dated 11/04/2024, reflected Resident #6 had a BIMS score of 09 indicating he was moderately cognitively impaired. He was assessed as requiring supervision or touching assistance for chair/bed-to-chair transfers. His fall history on Admission/Entry or Reentry was noted as having had a fall in the last month, no falls in the last 2-6 months, and no fracture related to a fall in the last 6 months. Record review of Resident #6's Fall Risk Assessment, dated 10/31/2024, reflected Resident #6 had 3 or more falls in the past 3 months and had a balance problem while walking. Record review of Resident #6's Care Plan, undated, accessed 11/25/2024, reflected: - His care plan did not reflect or address Resident #6's Advance Directive status as Full Code. - His care plan did not reflect or address Resident #6's ADL needs. - His care plan did not reflect or address Resident #6's risk for falls. Observation and attempted interview with Resident #6 on 11/26/2024 at 10:00 a.m. Resident #6 observed self-propelling himself in a wheelchair down the hall. Resident #6 was not available for interview. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/26/2024 at 12:09 p.m., the LCSW (Licensed Clinical Social Worker) stated the facility had a care plan meeting for Resident #1 on 11/13/2024. He stated that the attendants for that meeting included himself, the DON, the activities director, the therapy director, and the business office manager. He stated that they discussed Resident #1's advance directives, she wanted to be full code. He stated that he could not say why her code status was not on her care plan. He revealed Resident #4's care plan meeting was on 11/13/2024. He stated that during that meeting, the attending facility staff, who included himself, the DON, the director of rehab, the activity director, and the dietary supervisor, discussed Resident #4's fall history and Resident #4's advance directives, she wanted to remain full code. The LCSW stated he couldn't answer as to why Resident #4's code status was not in her care plan. He revealed Resident #5's care plan meeting was on 11/07/2024 and the attendants included himself, the dietary supervisor, the ADON, the activity director, director of rehab, and the business office manager. He did not state what was discussed during Resident #5's care plan meeting. The LCSW stated Resident #6's care plan meeting was on 11/13/2024 and attendants included himself, the activity director, the dietary supervisor, the director of rehab, and the DON. He stated that during that meeting, Resident #6's advance directives, he wanted to remain full code, was discussed. He stated he couldn't answer on why Resident #6's code status was not on his care plan. He stated that the code status was supposed to be in the care plan and that he strives to discuss the advance directives for all care plan meetings. He stated that each discipline (care team member's discipline, such as nursing, social work, therapy, etc.) would strive to ensure that their areas were covered. He stated that fall history and risk would be the clinical team and the code status would be a team effort, sometimes he would document on it and sometimes the DON or the ADON would. The LCSW stated he couldn't answer on if anyone did a final review of the care plan. The LCSW stated that even if the code status was not in the care plan, a resident's code status would be visible on their EMR chart, including on the resident's face sheet (Admission Record) and a copy of the advance directives would be in the documents tab. He stated in these residents' cases, the discussion of each resident's advance directives would be documented within the care conference meeting notes. The LCSW stated that once a resident signs a DNR, the signed document was uploaded into their EMR chart, and the nurse was notified to write the order for the change in status with the document available for verification. He stated that once the order was verified, the EMR will automatically update the resident's EMR home page and the banner, which was on top of the resident's chart with their current code status. During an interview on 11/26/2024 at 01:55 p.m., the Regional MDS Coordinator stated she was involved in the development of a resident's care plan following the resident's comprehensive MDS assessment. She stated that the facility had usually seven (7) days after the completion of the MDS to do the care plan. She stated that items that should be on the care plan would include diagnoses, risk for falls, incontinence, code status, skin breakdown, and ADLs. She stated that this list of items was her personal list and that not everyone care plans the same. She stated that the ADLs should be specified but that sometimes the ADL assistance may be different from the MDS assessment because it may have changed since the resident admitted . She stated that the care plans are an IDT (Interdisciplinary Team) effort, but that she assumed it was her responsibility for ensuring that the care plans were completed and done. The Regional MDS Coordinator stated the facility staff usually do the care planning regarding fall history since she felt that they were more efficient in that. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/26/2024 at 02:42 p.m., the DON stated that everyone worked on the comprehensive care plans and that she tries to include the acute stuff and the diagnoses. She stated that the facility had 21 days per regulatory requirements to build the comprehensive care plan and that the review was scheduled with IDT involved. She stated that she believed the Regional MDS Coordinator reviewed the care plans but was not sure who was responsible for reviewing them for completion. The DON stated that she wouldn't say that Resident #1 was a fall risk but that she would have needed to be care planned for falls by the comprehensive and coded as being at risk for falls. She stated that Resident #4 had a history of strokes with some deficits, but she was very high functioning and tried to do things independently. She stated Resident #4 could be a fall risk and had been educated to not do things independently, which she had been very good about using her call light and waiting for assistance. The DON stated Resident #4 was not a high fall risk but in a comprehensive care plan she would be at least documented as being at risk for falls with standardized interventions. The DON stated she would expect Resident #4 to have a fall risk in her care plan by the comprehensive. The DON stated Resident #5 was a fall risk and had had a fall, which she would assume would have impacted her status. The DON stated that there was an IDT meeting to discuss Resident #5's fall interventions after her fall. The DON stated she would have been responsible for updating her care plan and it should have been in there. The DON stated that she remembered entering the information into the care plan but that it was not there (reviewing care plan during interview). The DON stated she believed that she entered the interventions on 11/18/2024 and on that same day, went in and audited all her residents with falls to ensure that none of them were missed. The DON stated Resident #5's ADL needs should have been specified in her care plan. The DON stated Resident #6's fall risk would have been the same as Resident #1 and Resident #4, he should have been care planned for being at risk for falls. The DON stated that she would think a resident's code status would be care planned. She stated that if it was not, it would not affect the resident's care because the resident's code status was displayed on every page of the resident's chart and it was on the resident's admission record. The DON stated that she would expect the care plan to include everything related to care, diagnoses, medications related to diagnoses, function, mobility, and ADLs. She stated that care plans should be specific to be person-centered. She stated fall risk was most often a separate section of the care plan. Discharge planning was not something that she care planned, social services would be responsible for that. Code status would be expected on the care plan. She stated that she had standards for care meetings that was in place for ensuring that nursing interventions were in place. She stated that social services would review code status and discharge planning and all IDT disciplines reviewed their own sections, with each being responsible for putting their own information in. She stated nursing would be responsible for fall risk with initial assessment for fall risk being the nursing department's responsibility, but the risk would also be evaluated by the IDT, which included therapy staff. She stated that if there were specific nursing tasks for fall interventions, such as please ensure the resident wears non-skid socks when ambulating or fall mats, she would put those interventions on the resident's Kardex (a documentation system), but she did not include generalized nursing interventions on the Kardex, such as call light within reach. She stated that because the residents discussed had specific therapy fall interventions, which they were receiving versus specific nursing interventions, their fall risk not being care planned would not have impacted their care. During an interview on 11/26/2024 at 03:33 p.m., the ADMIN stated the LCSW was responsible for scheduling the care plan meetings. He stated he was not positive on who was responsible for reviewing the care plans for completion but would thing it would be the person that signed and closed them. He stated for care plans, an RN had to close them, so the DON or the VP of Clinical Operations would have to review them. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of facility policy, MDS 3.0 Completion, dated copyright 2024, revealed Policy Explanation and Compliance Guidelines: . 4. Care Plan Team Responsibility for Assessment Completion: . d. Care Area Assessments (CAA's): . viii. The care plan is completed no later than 7 days after the date in V0200C (CAA's completion date) as well as no later than 21 days from the date of admission in cases where the comprehensive assessment is the admission MDS. Record review of facility policy, Comprehensive Care Plans, dated copyright 2024, revealed It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident right, that include measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. Policy Explanation and Compliance Guidelines: . 3. The comprehensive care plan will describe, at minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. b. Any services that would otherwise be furnished, but are not provided due to the resident's exercise of his or her right to refuse treatment . d. The resident's goals for admission, desired outcomes, and preferences for future discharge . 5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. 8. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made.