STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	745050	A. Building B. Wing	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Nursing and Rehabilitation Center	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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34957 Based on observation, interview, and record review, the facility failed to ensure, based on the comprehensive assessment of a resident, the resident received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices for 1 of 5 residents (Resident #1) reviewed for quality of care. The facility failed to ensure Resident #1 received wound care on 2/22/25 as ordered by the physician for cellulitis. The noncompliance was identified as PNC. The noncompliance began on 2/22/25 and ended on 2/23/25. The facility had corrected the noncompliance before the investigation began. This failure could place residents at risk of a decline in health, worsening wounds, and psychosocial harm. The findings include: Record review of Resident #1's face sheet, dated 2/28/25, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included: leukemia and cellulitis (swollen skin). The RP was listed as: the resident. Record review of Resident #1's quarterly MDS, dated , 6/03/24 reflected the resident's BIMS score was 15, which indicated no impairments in cognition Record review of Resident #1's CP, dated 1/6/25, reflected the goal of wound care and interventions included: document healing of cellulitis, not to scratch, nail hygiene, antibiotics if prescribed and weekly wound care. Record review of Resident #1's MD orders, dated 2/2025, reflected: daily wound care with orders for cleaning, pat dry, apply silver alginate, cover, and wrapping. The order also reflected the antibiotic: Bactrim tablet 800-160 mg daily. Record review of Resident #1's eMAR, dated 2/2025, reflected: wound care was not given 2/22/25 [by LVN B]; and wound care given 2/23/25 [by DON]. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	745050	A. Building B. Wing	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Nursing and Rehabilitation Center	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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Wound Nurse weekly report for February 2025 reflected no openings in the skin and skin was intact. Record review of Resident #1's skin assessment, dated 2/24/25, reflected: right leg redness; no measurements. Observation and interview on 2/28/25 at 11:40 PM, revealed Resident #1 was in their room, sitting on her W/C. The resident had no injuries; skin tears or bruises present; but had a wrapping on her right foot area. The wrapping was dated 2/27/25. Her disposition was one of anxiety; and the resident was alert and oriented to person, place and time. The Resident stated, .they (nursing service) did not give me wound care on Saturday (2/22/25) and Sunday (2/23/25) of this week. The resident stated nursing staff did not give her an explanation for the lack of ordered wound care. Resident #1 stated she complained to a CNA [could not remember the name]. Resident #1 stated her wound [cellulitis] was treated with an antibiotic. Resident #1 stated her wound [cellulitis] was getting better and there was no present pain; and did not want to miss wound treatment. During a telephone interview on 2/28/25 at 2:00 PM, the NP stated wound care was ordered daily by the physician for Resident #1 and the facility needed to follow MD orders. The NP stated orders needed to be followed to improve on the healing process. During an interview on 2/28/25 at 3:45 PM, LVN A (wound nurse) stated Resident #1 missed the wound treatment for cellulitis on 2/22/25. LVN A stated the resident did not suffer any harm because: treatment was cleaning and wrapping the skin, and the skin had no pressure injuries. LVN A stated the skin was intact on the last weekly skin assessment. LVN A stated, wound care was ordered daily; and it should have been done. LVN A stated, nurses Need to follow MD orders. LVN A stated she had no explanation for the weekend nurse [LVN B] not performing wound care on 2/22/25. During an interview on 2/28/25 at 3:55 PM, the DON stated the resident missed wound care on Saturday, 2/22/24. The DON stated LVN B did not provide an explanation why Resident #1 missed wound care; except that she got busy and forgot. The DON stated she disciplined LVN B by the issuance of written counseling. As a preventative measure for nursing staff, an in-service on wound care was conducted on 2/23/25, on the need follow MD orders. The DON stated 100% of nurses were trained who worked the floors on 2/23/25. The DON stated as part of prevention, the DON would monitor and educate nurses on following MD orders. The DON stated the resident did not suffer any harm because the condition was cellulitis. During an interview on 2/28/25 at 5:13 PM, LVN E stated she attended training on wound care and MD orders. The highlight of the training was to make sure wound care was performed to prevent complications to the resident. During an interview on 2/28/25 at 5:22 PM, LVN C stated she attended training on MD orders and wound care. The main highlights were not to falsify records and to do wound care within the prescribed period ordered by the physician. During an interview on 2/28/25 at 5:15 PM, LVN D stated: she attended training on orders and treatments. The main highlights of the training were to ensure care was done as ordered by the MD. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	745050	A. Building B. Wing	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Nursing and Rehabilitation Center	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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's in-service, dated 2/23/25 to 2/28/25, reflected 13 or 16 nurses were in-serviced on following MD orders and treatments: pending in-service for 3 PRN Nurses. Record review of employee file for LVN B reflected written counseling on 2/23/25. LVN B was given a written warning for not following doctor's orders and not performing wound care on 2/22/25.