STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455724	A. Building B. Wing	09/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterside Nursing & Rehabilitation	1213 Water St 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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42402 Based on observation, interview, and record review, the facility failed to ensure that nursing staff had the specific competencies and skill sets necessary to care for residents needs for 1 of 5 (Resident #1) reviewed for CPR and Code Blue. Facility did not have a process in place to ensure staff were trained to initiate CPR and Code Blue(The term code blue is an emergency code used to describe the critical status of a patient. Staff may call a code blue if a patient goes into cardiac arrest,. LVN A failed to initiate CPR upon finding Resident #1 unresponsive with no pulse or respirations. This failure resulted in the identification of Immediate Jeopardy (IJ) on [DATE] at 5:38 p.m. While the IJ was removed on [DATE] the facility remained out of compliance at actual harm that was not immediate jeopardy with a scope of pattern due to the facility's need to complete in-service training and evaluate the effectiveness of its corrective systems. This failure could place residents who are a full code at risk of not receiving necessary life sustaining measures which could result in death. The findings included: Record review of Resident #1's face sheet, undated, revealed a [AGE] year-old female with an admitted [DATE], and diagnoses which included End stage renal disease (A condition where the kidney reaches advanced state of loss of function. This causes changes in urination, fatigue, swelling of feet, high blood pressure, and loss of appetite.), Acquired hemolytic anemia (Hemolytic anemia is a disorder in which red blood cells are destroyed faster than they can be made. The destruction of red blood cells is called hemolysis.), peripheral vascular disease (is a blood circulation disorder that causes the blood vessels outside of your heart and brain to narrow, block, or spasm.), Type 2 diabetes mellitus(A condition results from insufficient production of insulin, causing high blood sugar.), orthopedic aftercare following surgical amputation both lower limbs, dependence on renal dialysis(When your kidneys fail, dialysis keeps your body in balance by: removing waste, salt and extra water to prevent them from building up in the body), and depression, unspecified. Advanced Directive indicated Full Code (full code allows for all interventions needed to restore breathing or heart functioning, including chest compressions, CPR, a defibrillator, and a breathing tube.) on face sheet. (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
	455724	A. Building B. Wing	09/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterside Nursing & Rehabilitation	1213 Water St 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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1 initial MDS dated [DATE] revealed a BIMS score of 10, which indicated cognitively impaired. (Scores closer to 0 indicate severe cognitive impact whilst scores closer to 15 indicate an intact cognitive response: 08 - 12: moderately impaired.) Section GG: Mobility indicated able to turn self in bed, required mild assist of 1 with transfers to wheelchair. Record review of Resident #1 Care plan start date of [DATE] revealed problem: Resident /or family member has requested Full code status. Goal: Full code status will be honored through next review date. Approach: Notify MD/family of any change in condition. Observe for change of condition. Refer to hospice as needed or desired. Staff will be aware of where to locate Code status information. Staff will initiate CPR and notify EMS for transport to hospital. Record review of progress notes written by LVN A on [DATE] at 4:46 a.m. revealed, resident found unresponsive and called all available staff to room, CPR initiated, and call placed to EMS.5:10 a.m. EMS here this nurse (LVN A) writer assisted with CPR EMS transported resident to {local er} at this time. 6:00 a. m. Called report to local hospital ER and she reports that resident has passed. And that family notified daughter is on her way to hospital and spouse cannot come.] Record review of Resident #1's admission agreement signed by legal representative on [DATE] page 14, titled; Cardiopulmonary Resuscitation (CPR)Determinator revealed an x beside statement: YES, I do wish CPR efforts in the event of cardiac arrest. I agree to full 911 protocol and transportation to the nearest hospital. Record review of Resident #1's hospital medical record titled Emergency Department Report dated [DATE] revealed Resident #1 arrived at local emergency room at approximately 5:24 a.m. on [DATE] via EMS with CPR in progress. Her initial heart rhythm asystole, with CPR in progress and intubated. There were no obtainable vital signs. Resident #1 was pronounced deceased at 5:31 a.m. on [DATE] by emergency room physician. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455724	A. Building B. Wing	09/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterside Nursing & Rehabilitation	1213 Water St 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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 5:06 a.m. with LVN A revealed she received report from LVN D for the 10:00 p.m. to 6:00 a.m. shift beginning on [DATE] and there were no issues regarding Resident #1. She further revealed at around 1:30 a.m. on [DATE] Nurse aide B, told me that (resident #1) was gurgling. I (LVN A) went and checked on (Resident #1) at about 1:45 a.m. and she was sleeping, no distress, her respirations were unlabored and so I (LVN A) did not want to disturb her. I took her temperature, and it was normal. LVN A further revealed on the morning of [DATE] around 4:46 a.m., Resident #1 was found unresponsive by Nurse Aide B and Hospitality Aide C who informed LVN A of Resident #1 not breathing and having no pulse. LVN A stated she went to Resident #1's room immediately when she was informed of the concern about Resident #1. She said she checked Resident #1 and found no pulse or respirations. LVN A stated she told Nurse Aide B and Hospitality Aide C, I am going to go get the crash cart and call for extra staff in building to help us, and to see if she (Resident #1) is a full code or a DNR. LVN A revealed she then left the room leaving Nurse Aide B and Hospitality Aide C with Resident #1. 4:54 a.m. LVN A stated she did an overhead page on the facility intercom which she said: All staff come to hall 200 for assistance, all staff come to hall 200 for assistance. LVN A further revealed at approximately 4:55 a.m. LVN D and CNA E immediately responded to the nurse's station on hall 200, LVN A then directed both to Resident #1's room. LVN A stated about 4:56 a.m. LVN D and CNA E took crash cart to Resident #1's room and CNA E began CPR on Resident #1 after LVN D determined there was no pulse or respirations present for Resident #1. At 5:10 a.m. LVN A stated EMS arrived and took over CPR from LVN D and CNA E. Resident #1 was transported via ambulance to local hospital emergency room where she was declared deceased at 5:31 a.m. LVN A further revealed she did not stay with Resident #1 and perform CPR when she determined by assessment that Resident #1 had no pulse or respirations. She further revealed she should have stayed with Resident #1 and sent other staff to call for help and get the crash cart. When asked why she did not call a code blue over the intercom, instead of saying All staff come to hall 200 for assistance, she stated I do not know I just wanted to get help. When asked if it was required for staff to have an active CPR card and training, she stated she did not know but she was CPR certified since June of 2022. During an interview on [DATE] at 3:32 a.m. LVN D confirmed LVN A called on the overhead speaker, All staff come to hall 200 for assistance, all staff come to hall 200 for assistance. He further revealed LVN A did not call a Code Blue overhead. He stated he and CNA E performed CPR on Resident #1 until EMS arrived. When asked if it was a requirement at the facility to have an active CPR certification, he stated he was not sure. He stated at this time he did not have one, but he knew how to do CPR and call Code Blue. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455724	A. Building B. Wing	09/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterside Nursing & Rehabilitation	1213 Water St 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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 4:05 a.m. with Nurse Aide B she revealed first had gone into Resident #1's room to check on her for rounds about 1:30 a.m. on the morning of [DATE]. She stated when she found Resident #1, she was making a gurgling noise and was slumped over in her bed appearing to be sleeping. She stated she informed the nurse (LVN A) who later checked her. She stated no other issues on rounds occurred until about 4:45 a.m. when she went into Resident #1's room and found her not breathing. Nurse Aide B stated she told Hospitality Aide C to go and get the nurse (LVN A) quickly because she wasn't breathing, and she could not feel a pulse. Nurse Aide B stated she repositioned Resident #1's head and raised her head with a pillow to help her breath. She revealed LVN A and Hospitality Aide C arrived in room approximately a minute after sending Hospitality Aide C to get help. Nurse Aide B stated LVN A assessed Resident #1 and stated she is not breathing. Nurse Aide B stated she told Nurse Aide B and Hospitality Aide C, I am going to go get the crash cart and call for extra staff in building to help us, and to see if she (Resident #1) is a full code or a DNR. LVN A then left the room leaving Nurse Aide B and Hospitality Aide C with Resident #1. Nurse Aide B stated she heard an overhead page on the facility intercom which she said: All staff come to hall 200 for assistance, all staff come to hall 200 for assistance. Nurse Aide B further revealed at approximately 4:55 a.m. LVN D and CNA E responded to Resident #1's room with the crash cart and stated LVN D stated she was a full code. CNA E began CPR on Resident #1 after LVN D determined there was no pulse or respirations present for Resident #1. Nurse Aide B stated she and Hospitality Aide C left the room to go and take care of the other residents. When asked why she did not start CPR or call a Code Blue on Resident #1, Nurse Aide B stated, I am not CPR certified, and I do not know how to do that. She further revealed she felt that LVN A should have stayed with Resident #1 and sent her and Hospitality Aide to get the crash cart and find out if Resident #1 was a full code or DNR. During an interview on [DATE] at 5:37 a.m. a.m. with Hospitality Aide C she revealed about 4:45 a.m. when she went into Resident #1's room with Nurse Aide B and saw that Nurse Aide B had a startled look on her face. She stated she asked Nurse Aide B what was wrong, and she stated she (resident #1) is not breathing. Hospitality Aide C stated Nurse Aide B told her to go and get the nurse (LVN A) quickly because she (resident #1) wasn't breathing, and she could not feel a pulse. Hospitality Aide C revealed she and LVN A arrived in room approximately in a minute. Hospitality Aide C stated LVN A checked Resident #1 and stated she is not breathing. Hospitality Aide C stated she told Nurse Aide B and herself, I am going to go get the crash cart and call for extra staff in building to help us, and to see if she (Resident #1) is a full code or a DNR. LVN A then left the room leaving Nurse Aide B and Hospitality Aide C with Resident #1. Hospitality Aide C stated she heard an overhead page on the facility intercom which she said: All staff come to hall 200 for assistance, all staff come to hall 200 for assistance. Hospitality Aide C further revealed at approximately 4:55 a.m. LVN D and CNA E responded to Resident #1's room with the crash cart and she heard LVN D stated she was a full code. CNA E began CPR on Resident #1 after LVN D determined there was no pulse or respirations present for Resident #1. Hospitality Aide C stated she and Nurse Aide B left the room to go and take care of the other residents. When asked why she did not start CPR or call a Code Blue on Resident #1, Hospitality Aide C stated, I do not know how to do that. She stated, why didn't the LVN stay with the resident and send one of us to get the crash cart and find out if Resident #1 was a full code or DNR? (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455724	A. Building B. Wing	09/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterside Nursing & Rehabilitation	1213 Water St 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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 6:15 a.m. the facility DON revealed: a Code Blue should be called overhead when a resident is found unresponsive. She further revealed the primary nurse should stay with the resident if they are found unresponsive and perform the appropriate treatments. The DON further revealed she was investigating the death of Resident #1 which had occurred on [DATE]. She further revealed she had initiated an in-service on [DATE] regarding crash cart locations, AED devices, how to call a Code Blue and who should lead a Code Blue. She stated she had approximately 14 staff who had signed the in-service but could not locate it at time of investigation. She stated it was not a requirement for nursing staff to have a CPR certification to work at the facility. She stated staff have not been regularly trained or in-serviced on CPR, Code Blue, or crash carts. The DON further stated the failure to understand the appropriate code for the resident could cause residents to receive a delay in life sustaining measures and possibly die. During a phone interview on [DATE] at 10:59 a.m. CNA F she was working on the secure unit of 100 hall, and she heard someone on the overhead intercom but could not understand the sentence that was being said. She stated, I did not here Code Blue called. CNA F stated she went to see what was happening on the 200 hall where the resident (resident #1) was located but did not stay because there was another nurse and another aide there. When asked if she was CPR certified she stated no. During an interview on [DATE] at 11:35 a.m. with CNA E she revealed she was working on the 300 hall when around 4:50 a.m. she heard on the facility overhead intercom, something like come to the 200 hall. She stated she thought at first it was an in-service. She further revealed she went with LVN D to the 200 hall nurses' station and was told to go to Resident #1's room with the crash cart and that Resident #1 was a Full code and not breathing. She stated she was CPR certified and after the nurse (LVN D) and she determined there was no pulse or respirations, she started CPR while the LVN (D) pulled items off the crash cart. She stated that her and LVN D continued CPR until EMS arrived, and they took over. CNA E stated she never felt a pulse or respirations from Resident #1. She stated she then left the room. During an interview on [DATE] at 9:45 a.m. the COO stated per facility policy, it does not specify who initiates CPR. The DON was present during the interview and stated the strongest and most qualified person would begin CPR on a resident. During an interview on [DATE] at 12:01 p.m. the facility DON stated all Licensed staff will be certified on Wednesday [DATE] by having training for CPR certification provided at the facility and cna's are not required to have training but are encouraged to. During an interview on [DATE] at 3:00 p.m. with facility ADON she revealed there was no actual paper just a visual walk around and reference to where things are for Employee new hire training regarding crash carts and general information. During an interview on [DATE] at 3:15 p.m. with facility DON she revealed there was no actual paper for Employee new hire training regarding crash carts and general information. She stated I go and show new staff where the crash cart is, the disaster book and doctor phone numbers. During an interview on [DATE] at 2:40 p.m., when asked why the immediacy was identified, the DON stated, In our scope of practice of nursing, upon hire, CPR is not required. It's not like we failed to check a book because it's not mandated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455724	A. Building B. Wing	09/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterside Nursing & Rehabilitation	1213 Water St 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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of facility policy titled: Cardiopulmonary Resuscitation Code Blue, dated [DATE] revealed: Policy: Basic Life Support will be delivered to any resident in need of this service, who does not have a DNR order in place. All licensed staff will be trained in basic life support. The Nurse Supervisor at the time of the incident will determine the initiation of basic life support and direct staff to assist and to activate the emergency response system, by calling CODE BLUE. Procedure (For One Person Rescue) 1. The nurse will verify the physician order at the medical record to determine appropriate care. 2. Determine unresponsiveness by tapping or gently shaking the resident and shouting, Are you okay?.3. Call out for help: Alert the staff with a call for a CODE BLUE, room number and building location.4. Delegate a specific person to check the resident's chart for DNR or Full Code status. If the resident is a Full Code, the designee should overhead page and report a CODE BLUE and the location of the incident, three times in a succession overhead and through the phone system. Available CPR certified personnel, especially RNs should report to that location. The designated person should call the paramedics/ambulance, attending physician and administrative personnel if available. The designee should report back to you as soon as possible with an update. During an interview on [DATE] at 9:58 a.m., the DON and the COO stated prior to surveyor intervention the facility had not checked to see if staff had active CPR certification cards in their personnel files and in-services related to CPR/Code Blue were not completed. During an interview on [DATE] at 2:46 p.m., the Regional Nurse Consultant, informed Investigator #2, the facility utilized the Nurse Orientation Form, when on-boarding new staff. Record review of the facility's Nurse Orientation Form, undated did not address CPR competency, CPR certification, or Code Blue. Record review of LVN A's employee personnel file revealed no evidence of staff education or competency for CPR or Code Blue. LVN D and CNA E's employee personnel file revealed no record of staff education or competency regarding CPR or Code Blue. Record review of 3 LVN, 1 certified nurse aide, 1 hospitality aide and 1 aide employee personnel files revealed there was no facility training for staff related to CPR or Calling CODE BLUE and there was no system in place to ensure competency of staff. Record review of facility's policy, Cardiopulmonary Resuscitation Code Blue dated [DATE] revealed: Policy: Basic Life Support will be delivered to any resident in need of this service, who does not have a DNR order in place. All licensed staff will be trained in basic life support. Section titled Procedure: 3) Call out for help, Alert staff with a call for a CODE BLUE, room number and building location. The DON, the Regional Nurse Consultant, and the Regional Director of Operations were notified on [DATE] at 5:20 p.m. an Immediate Jeopardy was identified due to the above failures and the IJ template was provided. The facility's plan of removal (POR) was accepted on [DATE] at 10:00 A.M. and included: PLAN OF REMOVAL (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455724	A. Building B. Wing	09/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterside Nursing & Rehabilitation	1213 Water St 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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Name of facility: [Facility name] Date: [DATE] Immediate action: On [DATE] LVN A was re-educated by the director of nursing regarding calling a code blue and actions to take per the facility policy Code Blue from the facility Disaster and Emergency Preparedness manual. On [DATE] LVN A participated in a mock code blue return demonstration. On [DATE], the chief operations officer and the regional nurse consultant again, educated LVN A on the Code Blue policy and managing the process as the CPR certified personnel in the facility at the time of the Code Blue. On [DATE], the director of nurses and human resources audited all licensed nursing personnel files to validate CPR certification. A list was compiled based on audits for nurses needing CPR certification to ensure a CPR licensed personnel is available on every shift in a 24hr/period. On [DATE], the regional director of operations secured CPR training with a certified American Heart Association instructor. The training will be conducted on [DATE] at 11:00AM for charge nurses not having current CPR certification. This will validate that current charge nurses at the facility have CPR certification. On [DATE] the director of nursing began 1:1 training with the charge nurses on calling a Code Blue and their responsibility and actions to take per the facility policy Code Blue. All facility staff received an in-service on Code Blue. This training was completed by end of day [DATE]. Facility plans to ensure continued compliance: Upon hire, the facility will verify that newly hired nurses have CPR certification. If they do not have CPR certification, they will be required to work with a CPR certified nurse. The DON/ADON will identify which charge nurses are CPR certified on the schedule. The daily staffing schedule to identify which charge nurses are CPR certified will be available at the nurses' station. New employees hired will receive the Emergency Preparedness training, including Code Blue. and a minimum of annually. Code Blue policy states that a CPR certified person will initiate and direct the staff per their certification. Code Blue policy is in the Disaster and Emergency Preparedness Manual and is available at the nurses' station and is educated on hire and annually. Nurses receiving CPR certification are aware of how to perform CPR, this is their training, along with the facility policy from the Emergency Preparedness training manual. The facility policy will continue to be followed per protocol and will be updated as needed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455724	A. Building B. Wing	09/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterside Nursing & Rehabilitation	1213 Water St 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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	HR will solicit a copy of a licensed nurse CPR upon hire and place in their personnel file. HR will be responsible for tracking of CPR certifications and will bring any concerns to the administrator for guidance. Administrator will verify upon new hires that they either have or do not have a CPR certification as a second check. Annually the Administrator will conduct a Code Blue training which will be maintained in the in-service binder. The director of nursing/designee will review all Code Blue's that occur within twenty-four (24) hours for one (1) month and randomly thereafter, to identify any concerns. The administrator/director of nursing will validate that corrections are made for any concerns. The administrator/designee will bring any concerns or trends regarding CPR to the monthly Quality Assurance Performance Improvement (QAPI) meeting for tracking, trending, and further interdisciplinary team (IDT) recommendations. On [DATE] to [DATE] the surveyor confirmed the facility implemented their Plan of Removal sufficiently to remove the IJ by: Observation on [DATE] at 10:00 a.m. revealed the Code Blue policy was seen in the 300 Hall nurses station. Medication Aide G was able to locate the CPR policy. Observation on [DATE] at 10:38 a.m. revealed crash cart was at the 200 Hall nurses station. LVN H was able to locate the crash cart and the CPR policy. Observation on [DATE] at 10:42 a.m. revealed crash cart was at the 100 Hall nurses station. LVN I was able to locate the crash cart and the CPR policy. During an interview on [DATE] 11:55 a.m., the DON stated LVN A attended 4 mock codes. Record review on [DATE] of an Inservice titled, Mock Codes, revealed 11 LVN's ,10 CNA's, and 1 CMA had signed an inservice for Mock Codes. During an interview on [DATE] at 6:04 p.m., the Regional Nurse Consultant stated the facility will be utilizing their CPR Code Blue policy for the new hires. During an interview on [DATE] at 2:08 p.m. LVN A stated she received education on Code Blue, Code Blue Policy, and Crash Cart. During an interview on [DATE] at 2:40 p.m., the DON stated she and HR/ABOM performed the audit for CPR certification for the nurses. During an interview on [DATE] at 1:06 p.m., the ABOM stated she did an audit for CPR certification for the nurses. The ABOM stated she checked CPR certification during the new hire process and she kept a copy of the CPR Certifications in a binder which would be sectioned by months. The ABOM stated this binder will be evaluated daily in the morning meeting. During an interview on [DATE] at 1:25 p.m., the Administrator stated he verified CPR certifications of new hires through the CPR certification binder, which will be reviewed daily in the morning meeting. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455724	A. Building B. Wing	09/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterside Nursing & Rehabilitation	1213 Water St 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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 2:40 p.m., the DON stated she used the Code Blue audit log form to review Code Blues that occur in the facility and information will be passed onto the administrator, the regional clinical VP, and also the QAPI. Interviews conducted on [DATE] revealed all 5 staff members who attended the CPR class stated they attended the class and were able to state what was taught, who was teaching the class, and CPR procedure. Interviews conducted from [DATE] - [DATE] revealed 17 of 17 charge nurses were able to identify how to call a code blue overhead, where the crash carts were located(on the left side of each nurses station on 100 hall and 200 hall and left side of hall 300 midway closet.) Record review of facility's education from [DATE] to [DATE] revealed 15 of the facility's nurses received education. Record review of facility's in-service, 1:1 Return Demonstration of Code, dated [DATE], revealed LVN A's Signature of attendance dated: [DATE]. Record review of facility's in-service, Code Blue, dated [DATE], revealed an education in-service was performed by the DON and ADON with regarding Code Blue Policy. LVN A's signature was seen on the attendance sheet. Record review of LVN A's personnel file revealed LVN A had a CPR card issued [DATE] with an expiration date of ,d+[DATE]. Record review of an untitled facility document, dated [DATE], revealed LVN A was educated on [DATE] by the Regional Nurse Consultant and the COO. Signatures of all 3 personnel are on the bottom of the page. Record review of facility's list, CPR Audit, undated, revealed the facility performed an audit on all licensed nursing personnel. 5 nurses did not have a valid CPR certification. Record review of sign-in sheet, undated, revealed 5 staff members attended the CPR class. Record review of facility's policy, CARDIOPULMONARY RESUSCITATION CODE BLUE, dated [DATE] revealed the facility had a policy on the procedure for code blue. Record review of staffing schedule, dated [DATE], revealed the licensed staff scheduled work had CPR next to their names, indicating they were CPR certified. Record review of in-service binder revealed an Emergency Preparedness training was scheduled for July. Record review of facility's QAPI agenda, undated, revealed the following items are on the agenda: education on code blue . 1 on 1 in-service on code blue, mock code and Timely initiating of code blue/CPR . CPR class, 1 on 1 in-service, mock code CPR cert audit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455724	A. Building B. Wing	09/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterside Nursing & Rehabilitation	1213 Water St 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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] at 10:00 a.m., the Regional Nurse Consultant was notified the IJ was removed. However, the facility remained out of compliance at a level of potential harm with a scope identified as a pattern due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455724	A. Building B. Wing	09/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterside Nursing & Rehabilitation	1213 Water St 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42402 Based on interview and record review the facility failed to ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials including the State Survey Agency in accordance with the State law through established procedures for 1 of 5 Residents (Resident #1) reviewed for reportable incidents in that: The facility did not report to HHSC (State Agency) within 24 hours that LVN A failed to initiate CPR immediately upon finding Resident #1 unresponsive with no pulse or respirations, resulting in Resident #1 passing away at hospital. This failure placed residents at risk for neglect and incidents involving resident safety not being reported to the State Agency by the facility. The findings were: Record review of Resident #1's face sheet, undated, revealed a [AGE] year-old female with an admitted [DATE], and diagnoses which included End stage renal disease (A condition where the kidney reaches advanced state of loss of function. This causes changes in urination, fatigue, swelling of feet, high blood pressure, and loss of appetite.), Acquired hemolytic anemia (Hemolytic anemia is a disorder in which red blood cells are destroyed faster than they can be made. The destruction of red blood cells is called hemolysis.), peripheral vascular disease (is a blood circulation disorder that causes the blood vessels outside of your heart and brain to narrow, block, or spasm.), Type 2 diabetes mellitus(A condition results from insufficient production of insulin, causing high blood sugar.), orthopedic aftercare following surgical amputation both lower limbs, dependence on renal dialysis(When your kidneys fail, dialysis keeps your body in balance by: removing waste, salt and extra water to prevent them from building up in the body), and depression, unspecified. Advanced Directive indicated Full Code (full code allows for all interventions needed to restore breathing or heart functioning, including chest compressions, CPR, a defibrillator, and a breathing tube.) on face sheet. Record review of Resident #1 initial MDS dated [DATE] revealed a BIMS score of 10, which indicated cognitively impaired. (Scores closer to 0 indicate severe cognitive impact whilst scores closer to 15 indicate an intact cognitive response: 08 - 12: moderately impaired.) Section GG: Mobility indicated able to turn self in bed, required mild assist of 1 with transfers to wheelchair. Record review of Resident #1 Care plan start date of [DATE] revealed problem: Resident /or family member has requested Full code status. Goal: Full code status will be honored through next review date. Approach: Notify MD/family of any change in condition. Observe for change of condition. Refer to hospice as needed or desired. Staff will be aware of where to locate Code status information. Staff will initiate CPR and notify EMS for transport to hospital. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455724	A. Building B. Wing	09/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterside Nursing & Rehabilitation	1213 Water St 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's progress notes authored by LVN A on [DATE] at 4:46 a.m. revealed, [resident found unresponsive and called all available staff to room, CPR initiated, and call placed to EMS.5:10 a.m. EMS here this nurse (LVN A) writer assisted with CPR EMS transported resident to [local hospital] at this time. 6:00 a.m. Called report to local hospital ER and she reports that resident has passed. And that family notified daughter is on her way to hospital and spouse cannot come.] Record review of Resident #1's hospital medical record titled Emergency Department Report dated [DATE] revealed Resident #1 arrived at local emergency room at approximately 5:24 a.m. on [DATE] via EMS with CPR in progress. Her initial heart rhythm asystole, with CPR in progress and intubated. There were no obtainable vital signs. Resident #1 was pronounced deceased at 5:31 a.m. on [DATE] by emergency room physician. During an interview on [DATE] at 5:06 a.m. with LVN A revealed she received report from LVN D for the 10:00 p.m. to 6:00 a.m. shift beginning on [DATE] and there were no issues regarding Resident #1. She further revealed at around 1:30 a.m. on [DATE] Nurse aide B, told me that (resident #1) was gurgling. I (LVN A) went and checked on (Resident #1) at about 1:45 a.m. and she was sleeping, no distress, her respirations were unlabored and so I (LVN A) did not want to disturb her. I took her temperature, and it was normal. LVN A further revealed on the morning of [DATE] around 4:46 a.m., Resident #1 was found unresponsive by Nurse Aide B and Hospitality Aide C who informed LVN A of Resident #1 not breathing and having no pulse. LVN A stated she went to Resident #1's room immediately when she was informed of the concern about Resident #1. She said she checked Resident #1 and found no pulse or respirations. LVN A stated she told Nurse Aide B and Hospitality Aide C, I am going to go get the crash cart and call for extra staff in building to help us, and to see if she (Resident #1) is a full code or a DNR. LVN A revealed she then left the room leaving Nurse Aide B and Hospitality Aide C with Resident #1. 4:54 a.m. LVN A stated she did an overhead page on the facility intercom which she said: All staff come to hall 200 for assistance, all staff come to hall 200 for assistance. LVN A further revealed at approximately 4:55 a.m. LVN D and CNA E immediately responded to the nurse's station on hall 200, LVN A then directed both to Resident #1's room. LVN A stated about 4:56 a.m. LVN D and CNA E took crash cart to Resident #1's room and CNA E began CPR on Resident #1 after LVN D determined there was no pulse or respirations present for Resident #1. At 5:10 a.m. LVN A stated EMS arrived and took over CPR from LVN D and CNA E. Resident #1 was transported via ambulance to local hospital emergency room where she was declared deceased at 5:31 a.m. LVN A further revealed she did not stay with Resident #1 and perform CPR when she determined by assessment that Resident #1 had no pulse or respirations. She further revealed she should have stayed with Resident #1 and sent other staff to call for help and get the crash cart. When asked why she did not call a code blue over the intercom, instead of saying All staff come to hall 200 for assistance, she stated I do not know I just wanted to get help. When asked if it was required for staff to have an active CPR card and training, she stated she did not know but she was CPR certified since June of 2022. Record review of HHS computerized program for tracking facility self-reports revealed the Administrator or DON did not self-report that LVN A failed to initiate CPR immediately upon finding Resident #1 unresponsive with no pulse or respirations, resulting in Resident #1 passing away at hospital. Review of Tulip indicated on [DATE] HHS received an anonymous complaint which revealed Resident #1 did not receive CPR in a timely manner resulting in her death. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455724	A. Building B. Wing	09/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterside Nursing & Rehabilitation	1213 Water St 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE],[DATE], and [DATE] the DON was asked if the incident regarding Resident #1 CPR and expiring having been reported to HHS, she stated no. The DON stated she didn't not think it needed to be reported because the resident received CPR and was transferred to the local hospital. Review of the facility's policy , Reporting Abuse to State Agencies and other Entities/Individuals, dated 2001revised [DATE]indicated: Policy Statement, all suspected violations and all substantiated incidents of abuse will be immediately reported to appropriate state agencies and other entities, or individuals as may be required by law. Section titled: Policy Interpretation and Implementation. 1. Should a suspected violation or substantiated incident of mistreatment, neglect, injuries of an unknown source, or abuse (including resident to resident abuse) be reported, the facility Administrator, or his/her designee, will promptly notify the following persons or agencies (verbally and written) of such incident: a. The State licensing/certification agency responsible for surveying/licensing the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455724	A. Building B. Wing	09/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterside Nursing & Rehabilitation	1213 Water St 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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43889 Based on record review and interview the facility failed to develop and implement a baseline care plan which includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care for 1 of 5 residents (Resident #3) reviewed for baseline care plans in that The facility did not develop a baseline care plan for Resident #3. This deficient practice could affect all residents and place them at risk of a care or services not being provided as needed. The findings were: Record review of Resident #3's face sheet revealed Resident #3 2as admitted to the facility on [DATE] with diagnoses of Parkinson's Disease (a disorder of the nervous system that affects movement, often including tremors), insomnia, unspecified, secondary hypertension, unspecified, and Chronic Obstructive Pulmonary Disease (a group of lung diseases causing constriction of the airways and difficulty breathing.) Record review of Resident #3's BIMS Score, dated 8/25/22, revealed Resident #3 BIMS score was not assessed. Record review of Resident #3's electronic medical record revealed Resident #3 did not have a baseline care plan. During an interview on 8/31/22 at 2:46 p.m., the Regional Nurse Consultant stated the facility's policy stated the care plan should be completed within 24 hours, but the facility actually followed state guidelines, which detail the care plan should be completed within 48 hours. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455724	A. Building B. Wing	09/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterside Nursing & Rehabilitation	1213 Water St 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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review on 9/1/22 at 10:44 a.m., the MDS-LVN F stated she was mostly in charge of creating the care plans. MDS-LVN F stated code status, specialized services, behaviors, diagnosis, and things unique to that patient, should be on a resident's care plan. MDS-LVN F stated a baseline care plan should be done within 48 hours and should have pain, Braden scale [an assessment tool used to evaluate a person's potential for getting bed sores, skin, diet, how the resident communicates, vision and hearing. Resident #3's electronic medical record was reviewed at this time with MDS-LVN F and MDS-LVN F confirmed Resident #3 did not have a baseline care plan. MDS-LVN F confirmed Resident #3 should have a baseline care plan. When asked what she believed happened to Resident #3's baseline care plan, MDS-LVN F stated she was doing direct-patient care during the time Resident #3's baseline care plan would have been completed. When asked if the facility had a quality assurance process to ensure care plans are created on time, MDS-LVN F stated the facility has a quality of care meeting with their Interdisciplinary Team where they reviewed baseline care plans. MDS-LVN F stated it was important to create a baseline care plan because it's the basis for the basic crate that the residents need for their stay and to recognize any change from that baseline. When asked what sort of risks could happen to a resident who did not have a baseline care plan created, MDS-LVN F stated, just their diets, vision, their basic ADL needs could not be done. During an interview and record review on 9/1/22 at 2:40 p.m., the DON stated the MDS and the social worker are responsible for making care plans. The DON stated the care plan should have actual or potential problems, our goals, our interventions . things such as diet, code status, hospice services. Resident #3's electronic medical record was reviewed with the DON at this time and the DON confirmed Resident #3 did not have a baseline care plan. When asked what happened with Resident #3's care plan, the DON stated the baseline care plan wasn't completed because of the activity we've had in our facility since Saturday. When asked to clarify what activity meant, the DON stated she was referring to the facility's Immediate Jeopardy. When asked what sort of quality assurance processes this facility had to ensure care plans are created on time, the DON stated the facility had a checklist of items to be completed within 72 hours of a resident's admission and a baseline care plan was one of the items on the checklist. The DON stated it was important to create a baseline care plan to implement interventions for the actual or potential complications for the patient. Record review of facility policy titled, Care Plans - Preliminary, dated August 2006, revealed the following: a preliminary plan of care to meet the resident's immediate needs shall be developed for each resident within twenty-four (24) hours of admission.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455724	A. Building B. Wing	09/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterside Nursing & Rehabilitation	1213 Water St 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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42402 Based on interviews and record reviews, the facility failed to provide basic life support, including CPR (Cardiopulmonary Resuscitation), to a resident requiring such emergency care and subject to related physician orders and the resident's directive for 1 (Resident #1) of 5 residents reviewed for CPR. LVN A failed to immediately start and continuously provide CPR when she determined Resident #1 did not have a pulse or respirations on [DATE]. LVN A did not know the code status of Resident #1 and CPR was not performed immediately. Resident expired at the local hospital emergency roiagnom on [DATE]. The failure resulted in an identification of an Immediate Jeopardy (IJ) on [DATE]. While the IJ was removed on [DATE] at 10:00 a.m. , the facility remained out of compliance at harm with a scope identified as a due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. This failure placed residents who requested a full code status at risk of not receiving necessary life-saving measures, which could result in death. Findings included: Record review of Resident #1's face sheet, undated, revealed a [AGE] year-old female with an admitted [DATE], and diagnoses which included End stage renal disease (A condition where the kidney reaches advanced state of loss of function.), Acquired hemolytic anemia (Hemolytic anemia is a disorder in which red blood cells are destroyed faster than they can be made.), peripheral vascular disease (is a blood circulation disorder that causes the blood vessels outside of your heart and brain to narrow, block, or spasm.), Type 2 diabetes mellitus(A condition results from insufficient production of insulin, causing high blood sugar.), orthopedic aftercare following surgical amputation both lower limbs, dependence on renal dialysis(When your kidneys fail, dialysis keeps your body in balance), and depression, unspecified. The face sheet indicated the resident had a Full Code (full code allows for all interventions needed to restore breathing or heart functioning, including chest compressions, CPR, a defibrillator, and a breathing tube.) status. Record review of Resident #1 initial MDS dated [DATE] revealed a BIMS score of 10, which indicated cognitively impaired. Section GG: Mobility indicated able to turn self in bed, required mild assist of 1 with transfers to wheelchair. Record review of Resident #1 Care plan start date of [DATE] revealed problem: Resident /or family member has requested Full code status. Goal: Full code status will be honored through next review date. Approach: Notify MD/family of any change in condition. Observe for change of condition. Refer to hospice as needed or desired. Staff will be aware of where to locate Code status information. Staff will initiate CPR and notify EMS for transport to hospital. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455724	A. Building B. Wing	09/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterside Nursing & Rehabilitation	1213 Water St 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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's progress notes authored by LVN A on [DATE] at 4:46 a.m. revealed, resident found unresponsive and called all available staff to room, CPR initiated, and call placed to EMS.5:10 a.m. EMS here this nurse (LVN A) writer assisted with CPR EMS transported resident to [local hospital] at this time. 6:00 a.m. Called report to local hospital ER and she reports that resident has passed. And that family notified daughter is on her way to hospital and spouse cannot come. Record review of Resident #1's hospital medical record titled Emergency Department Report dated [DATE] revealed Resident #1 arrived at local emergency room at approximately 5:24 a.m. on [DATE] via EMS with CPR in progress. Her initial heart rhythm asystole, with CPR in progress and intubated. There were no obtainable vital signs. Resident #1 was pronounced deceased at 5:31 a.m. on [DATE] by emergency room physician. During an interview on [DATE] at 5:06 a.m. with LVN A revealed she received report from LVN D from the 10:00 p.m. to 6:00 a.m. shift beginning on [DATE] and there were no issues regarding Resident #1. She further revealed at around 1:30 a.m. on [DATE] Nurse aide B, told me that (resident #1) was gurgling. I (LVN A) went and checked on (Resident #1) at about 1:45 a.m. and she was sleeping, no distress, her respirations were unlabored and so I (LVN A) did not want to disturb her. I took her temperature, and it was normal. LVN A further revealed on the morning of [DATE] around 4:46 a.m., Resident #1 was found unresponsive by Nurse Aide B and Hospitality Aide C who informed LVN A of Resident #1 not breathing and having no pulse. LVN A stated she went to Resident #1's room immediately when she was informed of the concern about Resident #1. She said she checked Resident #1 and found no pulse or respirations. LVN A stated she told Nurse Aide B and Hospitality Aide C, I am going to go get the crash cart and call for extra staff in building to help us, and to see if she (Resident #1) is a full code or a DNR. LVN A revealed she then left the room leaving Nurse Aide B and Hospitality Aide C with Resident #1. LVN A stated at 4:54 a.m. she did an overhead page on the facility intercom which she said: All staff come to hall 200 for assistance, all staff come to hall 200 for assistance. LVN A further revealed at approximately 4:55 a.m. LVN D and CNA E immediately responded to the nurse's station on hall 200, LVN A then directed both to Resident #1's room. LVN A stated about 4:56 a.m. LVN D and CNA E took crash cart to Resident #1's room and CNA E began CPR on Resident #1 after LVN D determined there was no pulse or respirations present for Resident #1. At 5:10 a.m. LVN A stated EMS arrived and took over CPR from LVN D and CNA E. Resident #1 was transported via ambulance to local hospital emergency room where she was declared deceased at 5:31 a.m. LVN A further revealed she did not stay with Resident #1 and perform CPR when she determined by assessment that Resident #1 had no pulse or respirations. She further revealed she should have stayed with Resident #1 and sent other staff to call for help and get the crash cart. When asked why she did not call a code blue over the intercom, instead of saying All staff come to hall 200 for assistance, she stated I do not know I just wanted to get help. She stated she was CPR certified since June of 2022. LVN A further revealed she knew as a nurse CPR was important and if not done properly a person could die. During an interview on [DATE] at 3:32 a.m., LVN D stated LVN A called on the overhead speaker, All staff come to hall 200 for assistance, all staff come to hall 200 for assistance. He further revealed LVN A did not call a Code Blue overhead. He stated he and CNA E performed CPR on Resident #1 until EMS arrived. When asked if it was a requirement at the facility to have an active CPR certification, he stated he was not sure. He stated at this time he did not have one, but he knew how to do CPR and call Code Blue. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455724	A. Building B. Wing	09/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterside Nursing & Rehabilitation	1213 Water St 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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 11:35 a.m., CNA E stated she was working on the 300 hall on [DATE] around 4:50 a.m. when she heard on the facility overhead intercom, something like come to the 200 hall. She stated she thought at first it was an in-service. She further revealed she went with LVN D to the 200 hall nurses' station and was told to go to Resident #1's room with the crash cart and that Resident #1 was a Full code and not breathing. She stated she was CPR certified and after the LVN D and she determined there was no pulse or respirations, she started CPR while the LVN D pulled items off the crash cart. She stated her and LVN D continued CPR until EMS arrived, and they took over. CNA E stated she never felt a pulse or respirations from Resident #1. She stated she then left the room. During an interview on [DATE] at 4:05 a.m., Nurse Aide B she revealed first had gone into Resident #1's room to check on her for rounds about 1:30 a.m. on the morning of [DATE]. She stated when she found Resident #1, she was making a gurgling noise and was slumped over in her bed appearing to be sleeping. She stated she informed the nurse (LVN A) who later checked her. She stated no other issues on rounds occurred until about 4:45 a.m. when she went into Resident #1's room and found her not breathing. Nurse Aide B stated she told Hospitality Aide C to go and get the nurse (LVN A) quickly because she wasn't breathing, and she could not feel a pulse. Nurse Aide B stated she repositioned Resident #1's head and raised her head with a pillow to help her breath. She revealed LVN A and Hospitality Aide C arrived in room approximately a minute after sending Hospitality Aide C to get help. Nurse Aide B stated LVN A assessed Resident #1 and stated she was not breathing. Nurse Aide B stated she told Nurse Aide B and Hospitality Aide C, I am going to go get the crash cart and call for extra staff in building to help us, and to see if she (Resident #1) was a full code or a DNR. LVN A then left the room leaving Nurse Aide B and Hospitality Aide C with Resident #1. Nurse Aide B stated she heard an overhead page on the facility intercom which she said: All staff come to hall 200 for assistance, all staff come to hall 200 for assistance. Nurse Aide B further revealed at approximately 4:55 a.m. LVN D and CNA E responded to Resident #1's room with the crash cart and LVN D stated Resident #1 was a full code. CNA E began CPR on Resident #1 after LVN D determined there was no pulse or respirations present for Resident #1. Nurse Aide B stated she and Hospitality Aide C left the room to go and take care of the other residents. When asked why she did not start CPR or call a Code Blue on Resident #1, Nurse Aide B stated, I am not CPR certified, and I do not know how to do that. She further revealed she felt that LVN A should have stayed with Resident #1 and sent her and Hospitality Aide to get the crash cart and find out if Resident #1 was a full code or DNR. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455724	A. Building B. Wing	09/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterside Nursing & Rehabilitation	1213 Water St 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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 5:37 a.m. a.m., Hospitality Aide C revealed about 4:45 a.m. on [DATE] when she went into Resident #1's room with Nurse Aide B and saw Nurse Aide B had a startled look on her face. She stated she asked Nurse Aide B what was wrong, and she stated Resident #1 was not breathing. Hospitality Aide C stated Nurse Aide B told her to go and get the LVN A quickly because Resident #1 wasn't breathing, and she could not feel a pulse. Hospitality Aide C revealed she and LVN A arrived in room approximately in a minute. Hospitality Aide C stated LVN A checked Resident #1 and stated she was not breathing. Hospitality Aide C stated she told Nurse Aide B and herself, I am going to go get the crash cart and call for extra staff in building to help us, and to see if she (Resident #1) is a full code or a DNR. LVN A then left the room leaving Nurse Aide B and Hospitality Aide C with Resident #1. Hospitality Aide C stated she heard an overhead page on the facility intercom which she said: All staff come to hall 200 for assistance, all staff come to hall 200 for assistance. Hospitality Aide C further revealed at approximately 4:55 a.m. LVN D and CNA E responded to Resident #1's room with the crash cart and she heard LVN D stated she was a full code. CNA E began CPR on Resident #1 after LVN D determined there was no pulse or respirations present for Resident #1. Hospitality Aide C stated she and Nurse Aide B left the room to go and take care of the other residents. When asked why she did not start CPR or call a Code Blue on Resident #1, Hospitality Aide C stated, I do not know how to do that. She stated, why didn't the LVN stay with the resident and send one of us to get the crash cart and find out if Resident #1 was a full code or DNR? During an interview on [DATE] at 6:15 a.m., the DON stated a Code Blue should be called overhead when a resident was found unresponsive. She further revealed the primary nurse should stay with the resident if they are found unresponsive and perform the appropriate treatments. The DON further revealed she was investigating the death of Resident #1 which had occurred on [DATE]. She stated she had initiated an in-service on [DATE] regarding crash cart locations, AED devices, how to call a Code Blue and who should lead a Code Blue. She stated she had approximately 14 staff who had signed the in-service but could not locate it at time of investigation. She stated it was not a requirement for nursing staff to have a CPR certification to work at the facility. She stated staff have not been regularly trained or in-serviced on CPR, Code Blue, or crash carts. The DON further stated the failure to understand the appropriate code for the resident could cause residents to receive a delay in life sustaining measures and possibly die. Record review of LVN A's employee personnel file revealed no evidence of staff education or competency list of performing CPR or Code Blue. Record review of CPR card provided by DON revealed LVN A had received CPR certification [DATE]. Further record review of employee personnel files for LVN D and CNA E revealed neither had education for competency list of performing CPR and Code Blue. During an interview on [DATE] at 9:45 a.m., the COO stated per facility policy, it does not specify who initiates CPR. The DON who was present during the interview, stated the strongest and most qualified person would begin CPR on a resident. During an interview on [DATE] at 12:01 p.m., the DON stated all Licensed staff will be certified on Wednesday [DATE] by having training for CPR certification provided at the facility and CNAs are not required to have training but are encouraged to. During an interview on [DATE] at 3:00 p.m., the ADON stated there was no actual paper for general orientation, just a visual walk around and reference to where things are for Employee new hire training regarding crash carts and general information. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455724	A. Building B. Wing	09/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterside Nursing & Rehabilitation	1213 Water St 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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 3:15 p.m., the DON she stated there was no actual paper for Employee new hire training regarding crash carts and general information. She stated she showed new staff where the crash cart , the disaster book, and doctor phone numbers were located. During an interview on [DATE] at 2:40 p.m., the DON stated she believed an immediacy was identified due to a lack of communication and clarification of staff roles during Resident #1's code blue. Record review of facility's policy, Cardiopulmonary Resuscitation Code Blue, dated [DATE] revealed: Policy: Basic Life Support will be delivered to any resident in need of this service, who does not have a DNR order in place. All licensed staff will be trained in basic life support. The Nurse Supervisor at the time of the incident will determine the initiation of basic life support and direct staff to assist and to activate the emergency response system, by calling CODE BLUE. Procedure (For One Person Rescue) 1. The nurse will verify the physician order at the medical record to determine appropriate care. 2. Determine unresponsiveness by tapping or gently shaking the resident and shouting, Are you okay?.3. Call out for help: Alert the staff with a call for a CODE BLUE, room number and building location.4. Delegate a specific person to check the resident's chart for DNR or Full Code status. If the resident is a Full Code, the designee should overhead page and report a CODE BLUE and the location of the incident, three times in a succession overhead and through the phone system. Available CPR certified personnel, especially RNs should report to that location. The designated person should call the paramedics/ambulance, attending physician and administrative personnel if available. The designee should report back to you as soon as possible with an update. The DON, facility Regional Nurse Consultant, and the Regional Director of Operations were notified on [DATE] at 4:20 p.m. an Immediate Jeopardy situation was identified due to the above failures and the IJ template was provided. The facility's plan of removal (POR) was accepted on [DATE] at 10:00 a.m. and included: 1.On [DATE] LVN A was re-educated by the director of nursing regarding calling a code blue and actions to take per the facility policy Code Blue from the facility Disaster and Emergency Preparedness manual. (See attached policy). Included in this training was a mock code blue return demonstration. 2.On [DATE], the facility social worker completed a 100% house audit on resident code statuses to validate correctness and completeness. Any concerns were corrected immediately. 3. On [DATE] the director of nursing began 1:1 training with the charge nurses on calling a Code Blue and their responsibility and actions to take per the facility policy Code Blue. Facility nurses will receive this training to be completed at 100% by end of day [DATE]. 4. On [DATE], the director of nursing began educating nursing staff and the interdisciplinary team (IDT) via a mock code blue training scenario. Nursing staff will receive the training vs a mock training scenario to be completed at 100% by end of day [DATE]. Facility plan to ensure continued compliance New employees hired will receive the Code Blue training upon hire and a minimum of annually. The director of nursing/designee will conduct mock code blue drills to be completed all shifts, quarterly and as needed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455724	A. Building B. Wing	09/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterside Nursing & Rehabilitation	1213 Water St 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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The director of nursing/designee will review all Code Blue's that occur within twenty-four (24) hours for one (1) month and randomly thereafter, to identify any concerns. Any concerns will be corrected immediately. The administrator/designee will bring concerns or trends will to the monthly Quality Assurance Performance Improvement (QAPI) meeting for tracking, trending, and further interdisciplinary team (IDT) recommendations. On [DATE] the surveyor confirmed the facility implement their plan of removal sufficiently to the remove the IJ by: Record review of in-service titled 1:1 Return Demonstration of Code with LVN A's Signature of attendance dated: [DATE]. Record review of Staff Development in-service attendance Sheet dated [DATE] performed by the DON and ADON with subject Code Blue Policy. LVN A with Signature of attendance. Record review of in-service titled Code status/crash cart dated [DATE] with LVN A by the COO via telephone. Record review of LVN A's employee file revealed there is no copy of CPR card or in-service regarding facility codes. This was made available on [DATE] to Investigator #2. Record review of audit of Resident Roster for code status performed by Social Worker on [DATE] revealed 90 resident medical records checked and validated for correctness and completeness. Record review of 10 sampled charts were reviewed with not issues related to DNR/Full code status. Interview on [DATE] at 1:38 p.m., the SW sated she had done code status audits on all residents in the facility and validated complete accurate records. She stated Full code was Highlight green and DNR was Red on the paper chart face sheet. In process by SW. Record review of in-service record title 1:1 Return Demonstration of Code performed by DON from [DATE] through [DATE] revealed signatures of attendance by licensed staff for 15 of 17 licensed nurses from facility. Interviews on [DATE] from 1:00p.m. to 2:00 p.m. with 13 staff (11 LVN's and 2 RN's) on the 6AM-2PM shift indicated they were correctly able to identify how to call a Code Blue overhead and where crash carts are all located (on the left side of each nurse's station on 100 hall and 200 hall and left side of hall 300 midway closet.) Interviews and record reviews of LVN's, CNA's and RNs on duty during time of investigation revealed staff were able to describe change of condition of residents and that code status was found in residents electronic file on the face sheet. Staff were able to describe CPR and to immediately start CPR if they did not know a resident's code status. Interviews on [DATE] from 2:00 p.m. to 4:00 p.m. with all nursing staff(1 RN, 2 LVN's,1 CMA,5 CNA's) working 2:00 p.m-10:00 p.m. revealed staff were able to describe change of condition of residents and that code status was found in residents electronic file on the face sheet. Staff were able to describe CPR and to immediately start CPR if they did not know a resident's code status. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455724	A. Building B. Wing	09/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterside Nursing & Rehabilitation	1213 Water St 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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interviews on [DATE] from 10:00 p.m.- 6:00 a.m. with all nursing staff (2 LVN's and 4 CNA's) revealed staff were able to describe change of condition of residents and that code status was found in residents electronic file on the face sheet. Staff were able to describe CPR and to immediately start CPR if they did not know a resident's code status. On [DATE], the director of nursing began educating nursing staff and the interdisciplinary team (IDT) via a mock code blue training scenario. Nursing staff will receive the training vs a mock training scenario to be completed at 100% by end of day [DATE]. A. Record review of Inservice Attendance Sheet, titled: Code Blue, began [DATE] presented by the DON and ADON revealed signatures of attendance by 24 staff, to include 6:00 a.m.-2:00 p.m. shift:1 medication aide, 3 CNA's, 6 LVN's,3 department heads. 2:00 p.m.-10:00 p.m.-1 RN, 1LVN, 2 dietary aides, 2 CNA's, 10:00 p. m.-6:00 a.m. shift- 1 LVN, 1 RN, 1 CNA. B. Record review of facility employee and agency sample which included: (RN's 2 of 2, LVN's 4 of 14, CNA's 1 of 9, Agency CNA's 7 of 7) files revealed active CPR cards.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455724	A. Building B. Wing	09/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterside Nursing & Rehabilitation	1213 Water St 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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42402 Based on interview and record review the facility failed to ensure licensed nurses demonstrated competency in skills and techniques to assure resident safety and to maintain the highest practicable physical, mental, and psychological well-being for 1 of 5 residents (Resident #1), reviewed for competent nursing staff, in that: 1. The facility did not have a process in place to ensure staff were trained to initiate CPR and Code Blue and to monitor staff for competency. 2. LVN A failed to initiate CPR immediately upon finding Resident #1 unresponsive with no pulse or respirations, resulting in Resident #1 passing away at hospital. This failure placed residents who requested a full code status at risk of not receiving necessary life-saving measures, which could result in death. The findings were: Record review of Resident #1's face sheet, undated, revealed a [AGE] year-old female with an admitted [DATE], and diagnoses which included End stage renal disease (A condition where the kidney reaches advanced state of loss of function. This causes changes in urination, fatigue, swelling of feet, high blood pressure, and loss of appetite.), Acquired hemolytic anemia (Hemolytic anemia is a disorder in which red blood cells are destroyed faster than they can be made. The destruction of red blood cells is called hemolysis.), peripheral vascular disease (is a blood circulation disorder that causes the blood vessels outside of your heart and brain to narrow, block, or spasm.), Type 2 diabetes mellitus(A condition results from insufficient production of insulin, causing high blood sugar.), orthopedic aftercare following surgical amputation both lower limbs, dependence on renal dialysis(When your kidneys fail, dialysis keeps your body in balance by: removing waste, salt and extra water to prevent them from building up in the body), and depression, unspecified. Advanced Directive indicated Full Code (full code allows for all interventions needed to restore breathing or heart functioning, including chest compressions, CPR, a defibrillator, and a breathing tube.) on face sheet. Record review of Resident #1 initial MDS dated [DATE] revealed a BIMS score of 10, which indicated cognitively impaired. (Scores closer to 0 indicate severe cognitive impact whilst scores closer to 15 indicate an intact cognitive response: 08 - 12: moderately impaired.) Section GG: Mobility indicated able to turn self in bed, required mild assist of 1 with transfers to wheelchair. Record review of Resident #1 Care plan start date of [DATE] revealed problem: Resident /or family member has requested Full code status. Goal: Full code status will be honored through next review date. Approach: Notify MD/family of any change in condition. Observe for change of condition. Refer to hospice as needed or desired. Staff will be aware of where to locate Code status information. Staff will initiate CPR and notify EMS for transport to hospital. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455724	A. Building B. Wing	09/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterside Nursing & Rehabilitation	1213 Water St 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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of progress notes written by LVN A on [DATE] at 4:46 a.m. revealed, resident found unresponsive and called all available staff to room, CPR initiated, and call placed to EMS.5:10 a.m. EMS here this nurse (LVN A) writer assisted with CPR EMS transported resident to {local er} at this time. 6:00 a. m. Called report to local hospital ER and she reports that resident has passed. And that family notified daughter is on her way to hospital and spouse cannot come.] Record review of Resident #1's admission agreement signed by legal representative on [DATE] page 14, titled; Cardiopulmonary Resuscitation (CPR)Determinator revealed an x beside statement YES, I do wish CPR efforts in the event of cardiac arrest. I agree to full 911 protocol and transportation to the nearest hospital. Record review of Resident #1's hospital medical record titled Emergency Department Report dated [DATE] revealed Resident #1 arrived at local emergency room at approximately 5:24 a.m. on [DATE] via EMS with CPR in progress. Her initial heart rhythm asystole, with CPR in progress and intubated. There were no obtainable vital signs. Resident #1 was pronounced deceased at 5:31 a.m. on [DATE] by emergency room physician. During an interview on [DATE] at 5:06 a.m. with LVN A revealed she received report from LVN D for the 10:00 p.m. to 6:00 a.m. shift beginning on [DATE] and there were no issues regarding Resident #1. She further revealed at around 1:30 a.m. on [DATE] Nurse aide B, told me that (resident #1) was gurgling. I (LVN A) went and checked on (Resident #1) at about 1:45 a.m. and she was sleeping, no distress, her respirations were unlabored and so I (LVN A) did not want to disturb her. I took her temperature, and it was normal. LVN A further revealed on the morning of [DATE] around 4:46 a.m., Resident #1 was found unresponsive by Nurse Aide B and Hospitality Aide C who informed LVN A of Resident #1 not breathing and having no pulse. LVN A stated she went to Resident #1's room immediately when she was informed of the concern about Resident #1. She said she checked Resident #1 and found no pulse or respirations. LVN A stated she told Nurse Aide B and Hospitality Aide C, I am going to go get the crash cart and call for extra staff in building to help us, and to see if she (Resident #1) is a full code or a DNR. LVN A revealed she then left the room leaving Nurse Aide B and Hospitality Aide C with Resident #1. 4:54 a.m. LVN A stated she did an overhead page on the facility intercom which she said: All staff come to hall 200 for assistance, all staff come to hall 200 for assistance. LVN A further revealed at approximately 4:55 a.m. LVN D and CNA E immediately responded to the nurse's station on hall 200, LVN A then directed both to Resident #1's room. LVN A stated about 4:56 a.m. LVN D and CNA E took crash cart to Resident #1's room and CNA E began CPR on Resident #1 after LVN D determined there was no pulse or respirations present for Resident #1. At 5:10 a.m. LVN A stated EMS arrived and took over CPR from LVN D and CNA E. Resident #1 was transported via ambulance to local hospital emergency room where she was declared deceased at 5:31 a.m. LVN A further revealed she did not stay with Resident #1 and perform CPR when she determined by assessment that Resident #1 had no pulse or respirations. She further revealed she should have stayed with Resident #1 and sent other staff to call for help and get the crash cart. When asked why she did not call a code blue over the intercom, instead of saying All staff come to hall 200 for assistance, she stated I do not know I just wanted to get help. When asked if it was required for staff to have an active CPR card and training, she stated she did not know but she was CPR certified since June of 2022. LVN A stated she had not had any training at the facility regarding CPR or calling a Code Blue. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455724	A. Building B. Wing	09/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterside Nursing & Rehabilitation	1213 Water St 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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 3:32 a.m. LVN D confirmed LVN A called on the overhead speaker, All staff come to hall 200 for assistance, all staff come to hall 200 for assistance. He further revealed LVN A did not call a Code Blue overhead. He stated he and CNA E performed CPR on Resident #1 until EMS arrived. When asked if it was a requirement at the facility to have an active CPR certification, he stated he was not sure. He stated at this time he did not have one, but he knew how to do CPR and call Code Blue. He further revealed there had been no training in the facility for CPR or Code Blue procedure. During an interview on [DATE] at 4:05 a.m. with Nurse Aide B she revealed first had gone into Resident #1's room to check on her for rounds about 1:30 a.m. on the morning of [DATE]. She stated when she found Resident #1, she was making a gurgling noise and was slumped over in her bed appearing to be sleeping. She stated she informed the nurse (LVN A) who later checked her. She stated no other issues on rounds occurred until about 4:45 a.m. when she went into Resident #1's room and found her not breathing. Nurse Aide B stated she told Hospitality Aide C to go and get the nurse (LVN A) quickly because she wasn't breathing, and she could not feel a pulse. Nurse Aide B stated she repositioned Resident #1's head and raised her head with a pillow to help her breath. She revealed LVN A and Hospitality Aide C arrived in room approximately a minute after sending Hospitality Aide C to get help. Nurse Aide B stated LVN A assessed Resident #1 and stated she is not breathing. Nurse Aide B stated she told Nurse Aide B and Hospitality Aide C, I am going to go get the crash cart and call for extra staff in building to help us, and to see if she (Resident #1) is a full code or a DNR. LVN A then left the room leaving Nurse Aide B and Hospitality Aide C with Resident #1. Nurse Aide B stated she heard an overhead page on the facility intercom which she said: All staff come to hall 200 for assistance, all staff come to hall 200 for assistance. Nurse Aide B further revealed at approximately 4:55 a.m. LVN D and CNA E responded to Resident #1's room with the crash cart and stated LVN D stated she was a full code. CNA E began CPR on Resident #1 after LVN D determined there was no pulse or respirations present for Resident #1. Nurse Aide B stated she and Hospitality Aide C left the room to go and take care of the other residents. When asked why she did not start CPR or call a Code Blue on Resident #1, Nurse Aide B stated, I am not CPR certified, and I do not know how to do that. She further revealed she felt that LVN A should have stayed with Resident #1 and sent her and Hospitality Aide to get the crash cart and find out if Resident #1 was a full code or DNR. When asked if she had been trained in facility regarding CPR and Code Blue procedure, she stated no. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455724	A. Building B. Wing	09/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterside Nursing & Rehabilitation	1213 Water St 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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 5:37 a.m. a.m. with Hospitality Aide C she revealed about 4:45 a.m. when she went into Resident #1's room with Nurse Aide B and saw that Nurse Aide B had a startled look on her face. She stated she asked Nurse Aide B what was wrong, and she stated she (resident #1) is not breathing. Hospitality Aide C stated Nurse Aide B told her to go and get the nurse (LVN A) quickly because she (resident #1) wasn't breathing, and she could not feel a pulse. Hospitality Aide C revealed she and LVN A arrived in room approximately in a minute. Hospitality Aide C stated LVN A checked Resident #1 and stated she is not breathing. Hospitality Aide C stated she told Nurse Aide B and herself, I am going to go get the crash cart and call for extra staff in building to help us, and to see if she (Resident #1) is a full code or a DNR. LVN A then left the room leaving Nurse Aide B and Hospitality Aide C with Resident #1. Hospitality Aide C stated she heard an overhead page on the facility intercom which she said: All staff come to hall 200 for assistance, all staff come to hall 200 for assistance. Hospitality Aide C further revealed at approximately 4:55 a.m. LVN D and CNA E responded to Resident #1's room with the crash cart and she heard LVN D stated she was a full code. CNA E began CPR on Resident #1 after LVN D determined there was no pulse or respirations present for Resident #1. Hospitality Aide C stated she and Nurse Aide B left the room to go and take care of the other residents. When asked why she did not start CPR or call a Code Blue on Resident #1, Hospitality Aide C stated, I do not know how to do that. She stated, why didn't the LVN stay with the resident and send one of us to get the crash cart and find out if Resident #1 was a full code or DNR? When asked if she had been trained in facility regarding CPR and Code Blue procedure, she stated no. During an interview on [DATE] at 6:15 a.m. the facility DON revealed: a Code Blue should be called overhead when a resident is found unresponsive. She further revealed the primary nurse should stay with the resident if they are found unresponsive and perform the appropriate treatments. The DON further revealed she was investigating the death of Resident #1 which had occurred on [DATE]. She further revealed she had initiated an in-service on [DATE] regarding crash cart locations, AED devices, how to call a Code Blue and who should lead a Code Blue. She stated she had approximately 14 staff who had signed the in-service but could not locate it at time of investigation. She stated it was not a requirement for nursing staff to have a CPR certification to work at the facility. She stated staff have not been regularly trained or in-serviced on CPR, Code Blue, or crash carts. The DON further stated the failure to understand the appropriate code for the resident could cause residents to receive a delay in life sustaining measures and possibly die. During a phone interview on [DATE] at 10:59 a.m. CNA F she was working on the secure unit of 100 hall and she heard someone on the overhead intercom but could not understand the sentence that was being said. She stated, I did not here Code Blue called. CNA F stated she went to see what was happening on the 200 hall where the resident (resident #1) was located, but did not stay because there was another nurse and another aide there. When asked if she was CPR certified she stated no. When asked if she had been trained in facility regarding CPR and Code Blue procedure, she stated no. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455724	A. Building B. Wing	09/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterside Nursing & Rehabilitation	1213 Water St 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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 11:35 a.m. with CNA E she revealed she was working on the 300 hall when around 4:50 a.m. she heard on the facility overhead intercom, something like come to the 200 hall. She stated she thought at first it was an in-service. She further revealed she went with LVN D to the 200 hall nurses' station and was told to go to Resident #1's room with the crash cart and that Resident #1 was a Full code and not breathing. She stated she was CPR certified and after the nurse (LVN D) and she determined there was no pulse or respirations, she started CPR while the LVN (D) pulled items off the crash cart. She stated that her and LVN D continued CPR until EMS arrived, and they took over. CNA E stated she never felt a pulse or respirations from Resident #1. She stated she then left the room. When asked if she had been trained in facility regarding CPR and Code Blue procedure, she stated no. During an interview on [DATE] at 9:45 a.m. the COO stated per facility policy, it does not specify who initiates CPR. The DON was present during the interview and stated the strongest and most qualified person would begin CPR on a resident. During an interview on [DATE] at 12:01 p.m. the facility DON stated all Licensed staff will be certified on Wednesday [DATE] by having training for CPR certification provided at the facility and cna's are not required to have training but are encouraged to. When asked if there had been any training the facility regarding CPR and Code Blue procedure, she stated no. During an interview on [DATE] at 3:00 p.m. with facility ADON she revealed there was no actual paper just a visual walk around and reference to where things are for Employee new hire training regarding crash carts and general information. During an interview on [DATE] at 3:15 p.m. with facility DON she revealed there was no actual paper for Employee new hire training regarding crash carts and general information. She stated I go and show new staff where the crash cart is, the disaster book and doctor phone numbers. Record review of facility policy titled: Cardiopulmonary Resuscitation Code Blue, dated [DATE] revealed: Policy: Basic Life Support will be delivered to any resident in need of this service, who does not have a DNR order in place. All licensed staff will be trained in basic life support. The Nurse Supervisor at the time of the incident will determine the initiation of basic life support and direct staff to assist and to activate the emergency response system, by calling CODE BLUE. Procedure (For One Person Rescue) 1. The nurse will verify the physician order at the medical record to determine appropriate care. 2. Determine unresponsiveness by tapping or gently shaking the resident and shouting, Are you okay?.3. Call out for help: Alert the staff with a call for a CODE BLUE, room number and building location.4. Delegate a specific person to check the resident's chart for DNR or Full Code status. If the resident is a Full Code, the designee should overhead page and report a CODE BLUE and the location of the incident, three times in a succession overhead and through the phone system. Available CPR certified personnel, especially RNs should report to that location. The designated person should call the paramedics/ambulance, attending physician and administrative personnel if available. The designee should report back to you as soon as possible with an update. During an interview on [DATE] at 9:58 a.m. the facility DON and COO stated prior to HHS investigation the facility had not checked to see if staff had active CPR certification cards in their personnel files and in-services related to CPR/Code Blue were not completed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455724	A. Building B. Wing	09/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterside Nursing & Rehabilitation	1213 Water St 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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 2:46 p.m. with Regional Nurse Consultant, informed Investigator #2, the facility utilizes the Nurse Orientation Form, not dated, when on-boarding new staff. She further revealed competencies for Wound Care, Trach Care and G-Tube annually. Record review of Nurse Orientation Form revealed no documentation of verifying CPR competency, CPR certification or Code Blue. Record review of LVN A's employee personnel file revealed no evidence of staff education or competency for CPR or Code Blue. Record review of 3 LVN, 1 certified nurse aide, 1 hospitality aide and 1 aide employee personnel files revealed there was no facility training for staff related to CPR or Calling CODE BLUE and there was no system in place to ensure competency of staff. Record review of facility policy titled Cardiopulmonary Resuscitation Code Blue dated [DATE] revealed: Policy: Basic Life Support will be delivered to any resident in need of this service, who does not have a DNR order in place. All licensed staff will be trained in basic life support. Section titled Procedure: 3) Call out for help, Alert staff with a call for a CODE BLUE, room number and building location.