

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/02/2025
NAME OF PROVIDER OR SUPPLIER Riverside Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1750 Stockton St Jacksonville, FL 32204	

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents in regard to 1) call light not properly working in Resident #6's room, and 2) water dripping from a vent in the ceiling going into a trash bin in Resident #5's room, out of 8 resident rooms sampled. The findings include: 1. During a tour of the Memory Care unit in the facility on 9/2/2025 at 10:05 am, a flashing red light making an audible sound was observed above room [ROOM NUMBER]. Two (2) staff members were at the nurses' station approximately 5 feet away room as well as several residents in the lounge area approximately 3 feet away from the room. Several staff members were observed walking on the unit. None of them made an effort to respond to the flashing red call light or the audible sound that it was making. Further observation revealed a housekeeper was cleaning the room. The light remained flashing, making an audible sound after the housekeeper exited the resident's room. The housekeeper was asked about the observation of the illuminated light. She stated that she believed the light was broken and needed to be fixed. She reentered the room, without knocking, and examined the call light box affixed to the wall and said it was broken. Employee C, a Licensed Practical Nurse (LPN) and Unit Manager of the Memory Care unit, entered the room and intervened. He asked if he could provide additional information. He explained that the room with the flashing light belonged to Resident #6. An interview was conducted on 9/2/2025 at 10:11 am with Employee C. He was advised of the observation of the flashing light and the audible sound it was making. When asked about the observation, he stated that a contractor had been in and attempted to repair the issue. He explained that a repair order had been submitted through the facility's electronic maintenance reporting system. When asked how long the issue had persisted, he stated that it had been about 2 days, possibly longer. He stated that initially there were two call lights in need of repair. One was repaired, and this one had remained broken. He explained that the light located in the resident's restroom needed repair. He confirmed that Resident #6 used the restroom and was assisted with toileting. When asked what would happen if the aide assisting the resident with toileting required assistance. He stated, The aide would have to verbally call for help. An interview was conducted on 9/2/2025 at 10:25 am with Employee D, a Certified Nursing Assistant (CNA) who was assigned to Resident #6. She was asked about the observation of the flashing call light. She stated that it had been broken for less than a week. She stated that she reports repairs to the Memory Care Director or Unit Manager who then reports it to the Maintenance Director. She confirmed she had not reported the call light issue. 2. On 9/2/2025 at 1:50 pm, a trash bin collecting water dripping from a vent in the ceiling was observed in room [ROOM NUMBER] (Resident #5's room). The resident was observed sitting up in bed with a yellow wrist band labeled fall risk on her left wrist. A wooden cane and wheelchair were located near the bed. An interview was conducted with Resident #5 on 9/2/2025 at 1:54 pm. The resident confirmed the wheelchair and cane belonged to her. She was able to stand and take steps but required assistance. When the resident was asked about the trash bin collecting water dripping from the vent in the ceiling. She was not sure how long it had been in place. She explained that she did not toilet independently. The resident could not provide any additional information on the trash bin located near the entrance of her room. An interview was conducted on 9/2/2025 at 2:12 pm with the Maintenance Director. After conducting a search via the facility's electronic maintenance reporting system. He confirmed there were no active orders for the two resident rooms in question. He conducted a search for work orders that had been completed within 30 days prior to the survey and confirmed there were no completed orders for those rooms either. He confirmed there were no active repair orders for the call light in Resident #6's room. He explained that he was made aware of the issue the day before the interview. He had contacted a technician to repair the call light; however, there was no availability for 2 more days. When asked about the process if the resident needed to call for assistance. He stated that the resident would be moved but did not say when this would occur. On 9/2/2025 at 2:40 pm a tour of Resident #6 and Resident #5 rooms was conducted with the Maintenance Director. Upon entering the Memory Care Unit where Resident #6's room was located a muffled sound could be heard throughout the unit. The red light continued to flash above the resident's room door. Resident #6's personal belongings were still present in the room. The tour continued to Resident #5's room. Upon approaching the resident's room, the Maintenance Director immediately acknowledged the trash bin collecting water dripping from a vent in the room. He stated he was not aware of the concern and again confirmed that there had not been a work order received for repairs</p>		