

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 12/04/2025
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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on interviews, record review, and a review of the facility's policies and procedures, the facility failed to ensure completion of the Pre-admission Screening and Resident Review (PASRR) process for two (Residents #51 and #127) residents who were identified with a newly evident or a possible serious Mental Disorder (MD), Intellectual Disability (ID) or related condition, from a total survey sample of 33 residents who were reviewed for PASRR. The findings include: 1. A 12/2/25 review of Resident #51's PASRR, dated 9/14/22, revealed in Section I: PASRR Screen Decision-Making, that the resident did not have diagnoses or suspected diagnoses of anxiety disorder, bipolar disorder, depressive disorder, or schizophrenia. (Copy obtained) A review of Resident #51's record revealed an admission date of 12/31/22. Her diagnoses as of 8/7/24 included schizophrenia, unspecified; depression, unspecified; generalized anxiety disorder, and bipolar disorder, unspecified. A review of Resident #51's physician's orders included: Alprazolam (benzodiazepine) often used to treat anxiety) oral tablet 0.25 mg (milligrams), give 1 tablet by mouth every 8 hours for anxiety (ordered 8/20/25). Escitalopram oxalate (antidepressant) oral tablet 10 mg, give 1 tablet by mouth one time a day for depression with anxiety (ordered 10/23/25). Olanzapine (antipsychotic) 10 mg tabs, give 1 tablet orally at bedtime for schizophrenia (ordered 10/22/25). Trazodone (antidepressant) 50 mg tabs, give 1 tablet orally at bedtime for depression (ordered 11/11/25). A review of the resident's Annual Minimum Data Set (MDS) assessment, dated 11/19/25, revealed that the resident entered this facility from a short-term general hospital (acute care hospital), and her Brief Interview for Mental Status (BIMS) score was documented as 4 out of 15 possible points, indicating severe cognitive impairment. An interview was conducted with Social Services Director (SSD) K on 12/3/25 at 3:52 p.m. She provided the only PASRR she stated she had for Resident #51 which was dated 9/14/22. She stated at the time this evaluation was completed there was no indication that the resident suffered from anxiety, bipolar disorder, depressive disorder, or schizophrenia. Section IV of the screening indicated that no diagnosis or suspicion of Serious Mental Illness Disability was indicated, and that the Level II PASRR evaluation was not required. On 8/7/24 (almost two years after the resident's admission and completion of the 9/14/22 PASRR), Resident #51 was diagnosed with schizophrenia, depression, generalized anxiety disorder and bipolar disorder. SSD K stated the PASRR provided was the only PASRR on file for this resident and another one had not been completed. Another interview was conducted with SSD K on 12/4/25 at 8:57 a.m. She stated there was no PASRR on file (other than the one dated 9/14/22) for Resident #51 when she was interviewed yesterday (12/3/25 at 3:52 p.m.). She said she was aware that the facility was out of compliance. SSD K provided a PASRR that was completed on 12/3/25 for Resident #51. SSD K detailed the facility's process for identifying residents with a possible MD, ID, or related condition. SSD K said this process was the primary responsibility of the psychiatric provider. The psychiatric provider assessed residents at the facility. The provider then completed blood work to check for underlying issues or possible UTIs. The provider would assess/evaluate the resident a few times before diagnosing them. 2. A review of Resident #127's medical record on 12/1/25 at 12:20 p.m. revealed the resident's PASRR dated 12/11/24. (Copy Obtained) Further review of Resident #127's record revealed an admission date of 12/13/24. Her diagnoses included bipolar disorder, current episode depressed, mild or moderate severity, (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 105358
		If continuation sheet Page 1 of 10

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unspecified; depression, unspecified; unspecified dementia, unspecified severity, with other behavioral disturbance; other insomnia. A review of Resident #127's physician's orders revealed:Memantine HCl Oral Tablet 5 mg (milligrams - Namenda, primarily used to treat the symptoms of moderate-to-severe Alzheimer's disease), give 1 tablet by mouth one time a day for dementia (ordered 12/14/24).Zyprexa oral tablets 5 mg (Olanzapine - antipsychotic), give 1 tablet by mouth at bedtime for psychosis (ordered 10/22/25).Ramelteon tablets 8 mg (Rozerem - sedative/hypnotic), give 1 tablet by mouth at bedtime for insomnia (ordered 10/22/25).Monitor for side effects of anti-psychotic medications every shift which may include but is not limited to sedation, drowsiness, dry mouth, constipation, blurred vision, extrapyramidal reaction, weight gain, edema, postural hypotension, sweating, loss of appetite, urinary retention, other (specify in progress notes) every shift (ordered 12/13/24)Monitor for side effects of hypnotic medications every shift, which may include but is not limited to sedation, drowsiness, morning hangover, ataxia, other (specify in progress notes) every shift (ordered 12/13/24).Behavior intervention #1: Monitor for biting, hitting, intervention codes may include but are not limited to: 1.Redirection 2.(1:1) 3.Activity 4.Toilet 5.Food/Fluid Offered 6.Position Change 7.Other Intervention (specify in progress notes) 8. Medication every day shift (ordered 12/14/24).Behaviors/intervention: Monitor for (sign/symptoms difficulty sleeping) intervention codes may include but are not limited to 1. Redirection 2. (1:1) 3. Activity 4.Toilet 5 .Food/Fluid Offered 6. Position Change 7. Other Intervention (specify in progress notes) 8. Medication every night shift (ordered 12/15/24).Other orders included Acetaminophen Oral Tablet 500 mg, give 1 tablet by mouth two times a day for Pain (ordered 8/26/25), andDo Not Resuscitate (DNR) (ordered 12/13/24). A review of the Minimum Data Set (MDS) assessment, dated 9/21/25, revealed that the resident entered from a short-term hospital (acute care hospital) and her Brief Interview for Mental status (BIMS) score was 7 out of 15 possible points, indicating severe cognitive impairment. An interview was conducted with Social Services Director (SSD) K on 12/4/25 at 12:13 p.m. When she was asked to explain the facility's process for identifying residents with a possible MD, ID, or related condition prior to admission to the facility, she replied that residents were discussed in clinical meetings. SSD K or any staff member would inform the primary provider when the nurse identified a resident's unusual behavior. Residents were assessed by the psychiatric provider. Hospital records were reviewed for new residents with no documented history of mental illness or behaviors. SSD K also stated she was responsible for ensuring that a referral was sent to the appropriate state-designated authority. When asked if a resident was identified as having a newly evident or possible MD, ID, or related condition after admission, what the facility's process was for referring the resident to the appropriate state-designated authority, SSD K replied that if she knew of the concern, she would contact the family member and complete/update the care plan. When asked if the resident was identified as having an evident or possible MD, ID, or related condition, and a referral to the appropriate state-authority was not made, why that was. SSD K stated she was not notified by the psychiatric provider. SSD K confirmed the resident had a new diagnosis and the PASRR should have been updated.A review of the facility's policy and procedure titled admission Criteria (effective 2001), revealed:Policy Statement: Our facility admits only residents whose medical and nursing care needs can be met. Policy Interpretation and Implementation: . 8. All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-admission Screening and Resident Review (PASRR) process. a. the facility conducts a level I PASRR screen for all potential admissions, regardless of payer source, to determine if the individual meets the criteria for a MD, ID or RD. b. if the level I screen indicates that the individual may meet the criteria for a MD, ID, or RD, he or she is referred to the state PASRR representative for the Level II (evaluation and determination) screening process. 1. The admitting nurse notifies the social services department when a resident is identified as having a possible (or evident) MD, ID, or RD. 2. The social worker is responsible for making referrals to the appropriate state-designated authority. c. Upon completion of the Level II evaluation, the State PASRR representative determines if (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the individual has a physical or mental condition, what specialized or rehabilitative services he or she needs. And whether placement in the facility is appropriate. d. The State PASRR representative provides a copy of the report to the facility. e. The interdisciplinary team determines whether the facility is capable of meeting the needs and services of the potential resident that are outlined in the evaluation. f. Once a decision is made, the State PASRR representative, the potential resident and his or her representative are notified. (Copy Obtained)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observations, record reviews, interviews, and a review of facility policies and procedures, the facility failed to provide appropriate fingernail care for two (Residents #182 and #196) residents who required assistance with grooming out of 56 residents whose fingernails were observed. Failure to provide consistent grooming and hygiene for residents who require assistance can negatively impact their sense of self-worth and dignity, as well as potentially spread infection and/or contribute to skin tears or other injuries. The findings include:1.A review of Resident #182's medical record revealed an admission date of 7/15/24 and diagnoses including hemiplegia/hemiparesis following a cerebral infarction (stroke) affecting the resident's right dominant side and seizures.On 12/01/25 at 12:33 PM, Resident #182 was observed propelling himself in a wheelchair down a corridor within the facility. He was observed to be speech impaired but was able to answer simple yes or no questions. He was able to understand what was being conveyed, but could only answer verbally, yeah. He also used gestures to convey his answers. The fingernails on his left hand were observed to be elongated and soiled. The fingernails on his right hand were difficult to observe because his fingers were contracted. (photographic evidence obtained)On 12/02/25 at 12:36 PM, Resident #182 was observed sitting up in a wheelchair in his room watching television. He was speech impaired but understood what was being asked and responded appropriately. He was asked if he'd received any fingernail care from the staff today. He shook his head no. He was asked if he desired fingernail care and he stated, Yeah. The fingernails on his left hand were elongated with brown matter underneath the nails. (photographic evidence obtained)On 12/02/25 at 12:46 PM, an interview was conducted with Certified Nursing Assistant (CNA) D who stated her resident assignment today included both Resident #182 and Resident #196.She was asked if the facility provided training/education for abuse and neglect prevention and reporting. She stated, Yes. She was asked if the facility provided training/education on (ADL) Activity of Daily Living Care. She stated, Yes. She was asked to describe what ADL care consisted of. She stated, Bathing, changing clothes, showers, bed baths, and fixing the bed. She was asked what she thought grooming consisted of. She stated, Shaving the resident, brushing the teeth, combing the hair, and cutting the nails. She was asked how often grooming should be provided. She stated, Daily and when needed. For instance, I need to change his [Resident #182] shirt often because he has lots of dry skin from his hair that falls on his shirt. She was accompanied to the resident's room where he was watching television. He was asked if we could observe his fingernails. He held up his left hand. He was unable to hold up his right hand. The CNA was asked if she thought he needed fingernail care. She stated, Yes. The resident was asked if he would allow the CNA to provide fingernail care. The resident stated, Yeah.On 12/02/25 at 1:58 PM, an interview was conducted with Licensed Practical Nurse (LPN) E/Unit Manager. She was asked if the facility provided training/education for abuse and neglect prevention and reporting. She stated, Yes. She was asked if the facility provided training/education on (ADL) Activity of Daily Living care. She stated, Yes. She was asked to describe what ADL care consisted of. She stated, Dressing, feeding, toileting, changing, showering, bathing, and hygiene. She was asked what she thought grooming consisted of. She stated, Hair, trimming nails, peri-care, washing the hands and face, toenails, facial hair, and shaving. She was asked how often grooming should be provided. She stated, Daily and when needed. For instance, trimming nails should be every two weeks. Nail care should be provided with showers. On 12/3/25 at 10:38 AM, further review of Resident #182's record revealed a modification of the resident's Quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 9/20/25. The modification revealed adequate hearing and vision, unclear speech, he usually understands, and was usually understood. His BIMS (brief interview for mental status) scored 11/15 which was indicative of moderate cognitive impairment. The resident required clean-up or set-up assistance from staff for eating and bed mobility. He required supervision/touching assistance with toileting, and partial/moderate staff assistance with transfers and personal hygiene. A review of the (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's physician's orders revealed:Keppra Oral Tablet (anticonvulsant) 500 mg (milligrams) by mouth two times a day for seizures (ordered 10/25/24).Escitalopram Oxalate Oral Tablet (antidepressant), 20 mg by mouth daily for depression (ordered 10/25/24).Gabapentin Oral Capsule (anticonvulsant used to treat nerve pain), 100 mg, 2 capsules by mouth every 8 hours for neuropathy (ordered 10/30/24).Lacosamide Oral Tablet (anticonvulsant) 200 mg by mouth two times a day for seizures (ordered 2/15/25).Baclofen Oral Tablet (muscle relaxant) 5 mg by mouth three times a day for muscle spasms (ordered 4/6/25). A review of the active care plan revealed the following Focus Areas:Focus: I have an ADL/Self-Care Performance Deficit r/t (related to) CVA (stroke) with hemiplegia (paralysis affecting one side of the body). Date Initiated: 10/23/2024 Revision on: 10/23/2024. Goal: I will maintain current level of function in bed mobility, transfers, eating, dressing, toilet use and personal hygiene through the next review date. Date Initiated: 10/23/2024 Revision on: 01/03/2025 Target Date: 09/13/2025. Interventions: Personal Hygiene: I require staff assistance with grooming/personal hygiene. Date Initiated: 10/23/2024 2.A review of Resident #196's medical record revealed an admission date of 12/21/22 and diagnoses including unspecified dementia without behavioral disturbances, psychotic disturbance, mood disturbance, and anxiety. On 12/01/25 at 12:16 PM, Resident #196 was observed in bed, alert and answering questions appropriately. Her fingernails were elongated with brown matter underneath them. She was asked if the staff provided her fingernail care. She stated, Yes, I guess they do. I was going to try to do them myself. (photographic evidence obtained)On 12/02/25 at 12:33 PM, Resident #196 was observed in bed. She was asked if the staff had provided any fingernail care for her today. She stated, No. Her fingernails were elongated with brown matter underneath, just as they were observed on 12/01/25 at 12:16 PM. (photographic evidence obtained)On 12/04/25 at 10:01 AM, an interview was conducted with CNA F. She confirmed that she was assigned to Resident #196 today. She was asked if the facility provided any training or education on prevention and reporting of abuse/neglect. She stated, Yes. She was asked if the facility provided any training/in-service education on how to perform ADL care. She replied, Yes. She was asked to describe what ADL care consisted of. She stated, ADL care is how you take care of them on a daily basis. She was asked what grooming consisted of. She stated, Combing the hair, making sure they are well dressed, keeping them nice and dry. She was asked how often grooming should be provided. She stated, For me, I do it two to three times daily. She was asked how often the residents' fingernails should be cleaned. She stated, Daily. She was asked how often the resident's fingernails should be trimmed. She stated, I don't cut the fingernails, I only file them. She was asked what she would do if she was caring for a resident and she observed that the resident's fingernails needed to be trimmed. She stated, I would tell the nurse. She was accompanied to Resident #196's room. The resident was observed in bed, alert and responding appropriately. She was asked if the staff could look at her fingernails. The resident complied. CNA F was asked if she believed Resident #196 needed fingernail care. She stated, Yes, she does.On 12/3/25 at 3:38 PM, a review of Resident #196's Quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 9/21/25 revealed adequate hearing and vision, clear speech, she understands and was understood. Her BIMS (brief interview for mental status) scored 14/15, which was indicative of intact cognitive function. The resident required clean-up or set-up assistance from staff for eating and substantial/maximal staff assistance for bed mobility and personal hygiene. She was dependent on staff for toileting and transfers. A review of the resident's physician's orders revealed:Gabapentin 100 mg orally three times a day for neuropathy (ordered 9/8/24).Meloxicam Oral Tablet (nonsteroidal anti-inflammatory drug), 7.5 mg by mouth one time a day for pain (ordered 2/19/25).Trazodone HCl Tablet (antidepressant), 150 mg by mouth at bedtime for insomnia (ordered 8/19/25). A review of the resident's active care plan revealed the following focus areas:Focus: I have an ADL/Self Care Performance Deficit r/t Impaired Balance, Impaired Mobility. I am bedfast all or most of the time. I prefer to stay in bed most days and get out of bed to go to the hair salon and do special activity outings and appointments. Date Initiated: 10/08/2024 Revision on: 12/09/24. Goal: I will be clean, (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	well groomed, and appropriately dressed daily with staff assistance through the next review date. Date Initiated: 10/08/24 Revision on: 01/03/25 Target Date: 09/11/25, Intervention: Personal Hygiene: I require staff assistance with grooming/personal hygiene. Date Initiated: 10/08/24. A review of the facility's policy and procedure titled Care of Fingernails/Toenails (Version 1.2 (H5MAPR0043), Revision Date: February 2018), revealed:Purpose:The purpose of this procedure is to clean the nail bed, to keep nails trimmed, and to prevent infections.General Guidelines:Nail care includes daily cleaning and regular trimming.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and facility policy and procedure review, the facility failed to provide respiratory therapy, consistent with professional standards of practice, for three (#9, #63, and #181) of 21 residents receiving oxygen therapy. Oxygen flow rates set for these residents were not in accordance with their physicians' orders. The findings include: 1. On 12/01/25 at 11:46 AM, Resident #9 was observed resting in bed with oxygen infusing at 4 liters per minute (LPM) via nasal cannula (NC). (photographic evidence obtained) On 12/02/25 at 9:25 AM, a review of the resident's active physician's orders revealed an order for oxygen at a flow rate of 3 LPM via NC for Congestive Heart Failure (CHF) (ordered 10/29/25). On 12/02/25 at 1:37 PM, Resident #9 was observed sitting up in bed with her lunch meal on the bedside table in front of her. Oxygen was infusing at 4 LPM via NC. (photographic evidence obtained) A review of Resident #9's medical record revealed an admission date of 2/13/24 and diagnoses including Chronic Obstructive Pulmonary Disease (COPD), unspecified, and Congestive Heart Failure (CHF). On 12/03/25 at 12:29 PM, a review of the Significant Change MDS (minimum data set) assessment with an ARD (assessment reference date) of 11/5/25, revealed a BIMS (brief interview for mental status) score of 7 out of 15 possible points, indicating severe cognitive impairment. The resident required set-up or clean-up assistance with eating, and she was dependent on staff assistance for toileting, bed mobility and toileting. The resident was documented as receiving oxygen and hospice services. A review of the resident's active care plan revealed the following focus areas: Focus: I have an ADL/Self-Care Performance Deficit r/t polyneuropathy and deconditioning s/p hospitalization, impaired mobility, and pain Date Initiated: 12/13/24 Revision on: 10/29/25. Focus: I have altered respiratory status r/t COPD., respiratory failure and OSA (obstructive sleep apnea). Date Initiated: 05/08/25 Revision on: 09/03/25. Goal: I will have no complications of altered respiratory status through the next review date. Date Initiated: 05/22/25 Revision on: 09/23/25. Interventions: Administer oxygen as ordered. Date Initiated: 05/22/25. Focus: At risk for respiratory complications r/t COPD Date Initiated: 05/08/25 Revision on: 05/22/25. Goal: My risk for respiratory complications and infections will be mitigated through the next review date. Date Initiated: 05/08/25 Revision on: 09/23/25 Target Date: 12/25/25. Interventions: Administer respiratory treatments and inhalants as ordered. Monitor effectiveness and for side effects. Report abnormal findings to practitioner. Document findings and interventions. Date Initiated: 05/08/25. On 12/04/25 at 4:30 PM, an interview was conducted with Certified Nursing Assistant (CNA) H. She was asked if the facility provided any training/education for prevention and reporting abuse/neglect. She stated, Yes. She was asked if the facility provided any training/education about how to care for a resident who received oxygen. She stated, Yes. She was asked what her role was in taking care of a resident who received oxygen. She stated, I look at the number on the concentrator and make sure it's (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	correct per the nurse, and I make sure the tubing is in place on their face and the line is clear. On 12/04/25 at 4:34 PM, an interview was conducted with CNA I. She was asked if the facility provided any training/education for prevention and reporting of abuse/neglect. She stated, Yes. She was asked if the facility provided any training/education about how to care for a resident who received oxygen. She stated, Yes. She was asked what her role was in taking care of a resident who received oxygen. She stated, I notice if the resident is struggling to breathe and get the nurse. I also make sure the tubing is in the right position on their face. She was asked if there was ever a circumstance in which she would change the flow rate setting on an oxygen concentrator. She stated, No, that is for the nurse to do, not me. On 12/04/25 at 4:40 PM, an interview was conducted with Licensed Practical Nurse (LPN) J. She was asked if the facility provided any training/education for prevention and reporting of abuse/neglect. She stated, Yes. She was asked if the facility provided any training/education about how to administer oxygen therapy. She stated, Yes. She was asked to explain the proper way to administer oxygen therapy. She stated, First check for orders, gather the equipment, set the oxygen setting per order, connect the water and the tubing and place the cannula. I always check to see if I feel the air coming out. A review of the facility's oxygen administration policy and procedure (Version 1.1 H5MAPR0207), revealed: Policy: The purpose of this policy is to provide guidelines for safe oxygen administration. Preparation: Verify that there is a physician's order for this procedure. Review the physician's order or the facility protocol for oxygen administration. Steps in the procedure: 10: Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered. 2. On 12/01/25 at 2:06 PM, Resident #63 was observed resting in bed with his oxygen cannula dislodged and resting against his right cheek. He was coughing and said he didn't know how long the cannula had been dislodged. He explained that he did not know how to insert the cannula nor manipulate the oxygen flow rate on his concentrator. An observation of the concentrator revealed that oxygen was infusing at 2.50 &ndash; 3 liters per minute (LPM). (photographic evidence obtained) On 12/03/25 at 11:09 AM, an observation of the resident's oxygen concentrator revealed a flow rate of 2.5 &ndash; 3 LPM. (photographic evidence obtained) A review of the resident's medical record revealed an admission date of 09/09/25 with diagnoses including alcoholic hepatic failure, Parkinson's disease, chronic congestive heart failure (CHF), pleural effusion, chronic obstructive pulmonary disease (COPD), asthma, chronic respiratory failure with hypoxia, and pneumonia. A review of the resident's active physician's orders revealed: O2 (oxygen) at 2L (two liters) via nasal cannula as needed for SOB (shortness of breath), administer (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for O2 SAT (saturation) <92% (ordered 11/6/25). A review of the resident's November 2025 and December 2025 medication administration records (MARs) revealed, O2 at 2L via nasal cannula as needed for SOB. A review of the minimum data set (MDS) assessment dated [DATE], revealed a brief interview for mental status (BIMS) score of 14 out of 15 possible points, indicating intact cognition. A review of the resident's active care plan revealed the following focus areas: Focus: I require supplemental oxygen r/t (related to) CHF. Date Initiated: 10/29/2025 Revision on: 11/17/25. Goal: I will remain free of symptoms and complications of low oxygen levels, such as shortness of breath, dizziness, tachycardia, headache through next review date. Date Initiated: 10/29/2025 Target Date: 11/13/2025 Interventions: Add humidity to oxygen as needed. Date Initiated: 10/29/25. Change tubing as per facility protocol. Date Initiated: 10/29/25. Monitor and document breath sounds, breathing patterns, and dyspnea with exertion or while lying flat. Report abnormal findings to physician or designee. Document findings and interventions. Date Initiated: 10/29/25. Monitor skin on ears and nose for breakdown from oxygen tubing. Pad tubing as needed. Report abnormal findings to practitioner. Document findings and interventions. Date Initiated: 10/29/25. Monitor vital signs, including pulse oximeter, as ordered and clinically indicated. Report abnormal findings to practitioner. Document findings and interventions. Date Initiated: 10/29/25. On 12/04/25 at 12:20 PM, Licensed Practical Nurse (LPN) C was interviewed. She reported she had worked at the facility for six weeks. She observed Resident #63 and stated she saw the resident was receiving oxygen via nasal cannula at a flow rate of 2 LPM. She reviewed the Resident's O2 order in the electronic medical record and said she thought the resident's order was for continuous oxygen. She verified that the MARs lacked documented evidence that the resident was currently receiving O2 and verified that the MAR for December 2025 was blank. She stated the resident was capable of pulling out the nasal cannula but was not mentally or physically capable of independently inserting the cannula, turning the oxygen concentrator on/off, or manipulating the oxygen flow rate. 3. On 12/02/25 at 10:24 AM, Resident #181 was interviewed. She stated she was supposed to receive her oxygen at a flow rate of 4 LPM. An observation of her oxygen concentrator revealed that the flow rate was set at 3 LPM. (photographic evidence obtained) A review of the resident's active physician's orders revealed: Oxygen at 4 liters per minute via nasal cannula continuously every day and night shift for COPD (chronic obstructive pulmonary disease). (ordered 11/05/25)		

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 12/04/2025
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interviews, record review, and a review of facility policies and procedures, the facility failed to demonstrate safe, sanitary infection control and prevention procedures while providing resident care and services. The findings include: On 12/04/25 at 12:18 PM, an observation was made of Registered Nurse (RN) G performing scheduled fingerstick blood glucose testing/monitoring. After checking the resident's blood glucose, the nurse discarded the used lancet in a trash container in the resident's bathroom. When the act of throwing the used lancet in the trash container was brought to RN G's attention, she acknowledged that she had disposed of the lancet in the trash container and not the used sharps container. RN G then extended her ungloved hand into the trash container and retrieved the used lancet. She stated, It doesn't have a sharp end on it after we use it. She did not wash her hands before returning to her medication cart. Once there, she applied hand sanitizer and proceeded to move her medication cart to the next resident she intended to service. On 12/04/25 at 12:28 PM, an interview was conducted with RN G. She was asked to explain the facility's process for resident fingerstick blood glucose monitoring. The following was her step-by-step account of the facility's procedure: Make sure we have an order. Make sure we have all equipment. Clean equipment, wipe down the glucometer. Wash my hands. Apply gloves. Wipe the site with alcohol. Let it dry. Poke the finger to get the blood specimen. Get the blood on the test strip. Get the result. Administer the insulin according to the order. Make sure the patient is dry and clean. Dispose of gloves and dispose of your lancet and trash. Document what you gave. Tell the resident how much insulin they got. When she was asked where she was expected to dispose of used lancets, she replied, In the sharps container. She acknowledged that she did not wash her hands after the procedure, nor did she wash her hands after retrieving the used lancet from the trash container. On 12/4/25 at 12:43 PM, an interview was conducted with the Director of Nursing (DON). She was asked how she expected the nursing staff to dispose of used sharps materials. She stated, They've been trained to dispose of it in the sharps containers, and we have plenty of them. On 12/04/25 at 4:40 PM, an interview was conducted with Licensed Practical Nurse (LPN) J. She was asked to explain the facility's procedure for resident fingerstick blood glucose monitoring. She stated the process was to gather the equipment (alcohol, test strips, lancet, clean glucometer, gloves), enter the resident's room and explain the procedure to the resident, then wash your hands, put on clean gloves, wipe the resident's finger with alcohol, wipe the first drop of blood with a napkin, squeeze another drop, test the blood, tell the resident what the result was and how much insulin they should get, then check the sliding scale order, and give the insulin. She was asked what was done after this. She stated, I dispose of the lancet in the sharps, remove my gloves and wash my hands. A review of the facility's policy and procedure titled Sharps Disposal (2011 MED-PASS, Inc., version 1.1 (H5MAPL0817), revealed: Policy Statement: This facility shall discard contaminated sharps into designated containers. Policy Interpretation and Implementation: Whoever uses contaminated sharps will discard them immediately or as soon as feasible onto designated containers. A review of the facility's policy and procedure titled Obtaining a Fingerstick Glucose Level (Revision Date: January 2012), revealed: Steps in the procedure: . 16. Dispose of the lancet in the sharps disposal container . 20. Wash hands.		