STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455726	A. Building B. Wing	04/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Oaks	3103 E Airline Dr Victoria, TX 77901

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 - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39251 Based on observations, interviews, and record reviews, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 3 of 3 residents (Resident #1, Resident #4, and Resident #5) reviewed for infection control. 1. The facility failed to ensure CNA C performed Resident #1's catheter care according to facility policy and professional standards on 4/27/25. 2. The facility failed to ensure LVN E performed hand hygiene appropriately and donned PPE when providing catheter care to Resident #4 on 4/27/25. 3. The facility failed to ensure RN D performed hand hygiene appropriately when providing wound care to Resident #5 on 4/27/25. This deficient practice could affect all residents who require wound/catheter care placing them at risk for infection. Findings included: 1. Record review of Resident #1's Admission Record, dated 4/25/25, revealed the resident was readmitted to the facility on [DATE] with diagnoses which included: Acute Pyelonephritis (bacterial infection in the kidney), Acute Kidney Failure (condition in which kidneys suddenly are unable to filter waste from blood) , and Benign Prostatic Hyperplasia (prostate gland enlargement that can cause difficulty with urination). Record review of Resident #1's Order Summary, dated 4/25/25, revealed an order for Foley catheter care every shift, dated 3/23/25. Observation of catheter care for Resident #1's indwelling urinary catheter, on 4/27/25 beginning at 10:12 am, revealed CNA C performed catheter care for Resident #1. Further observation revealed CNA C held the indwelling catheter at the meatus (opening leading inside the body) and wiped the catheter four times from the point of insertion with outward strokes, away from the meatus. Further observation revealed CNA C did not clean Resident #1's genitals, perineum, or meatus. (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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/27/25 at 11:32 am, CNA C said peri-care included catheter care and thought that catheter care only included the catheter. CNA C said not cleaning the resident's genitals could negatively affect the resident because if the glans (tip of the penis in males or clitoris in females) was not cleaned the resident could get an infection, start stinking, or sometimes feces could get on the genitals. 2. Record review of Resident #4's Admission Record, dated 4/27/25, revealed the resident was admitted to the facility on [DATE] with diagnoses which included: Obstructive and Reflux Uropathy (obstruction in the urinary tract and backflow of urine into the bladder). Record review of Resident #4's Order Summary, dated 4/27/25, revealed orders for: Enhanced Barrier Precautions every shift. Follow Facility Policy - **USE for patients with any of the following .indwelling medical devices, regardless or MDRO colonization status Infection or colonization with an MDRO**, dated 3/23/25; Suprapubic Catheter Care every shift, dated 3/23/25. Observation of catheter care for Resident #4's suprapubic catheter, on 4/27/25 beginning at 9:19 am, revealed LVN E washed her hands for 10 seconds when she entered Resident #4's room. Further observation revealed LVN E exited Resident #4's room to retrieve a bedside table, and when LVN E returned to the resident's room she washed her hands for 8 seconds. Further observation revealed LVN E performed catheter care for Resident #4 without donning a gown. Once the procedure was completed LVN E removed her gloves and washed her hands for 9 seconds, donned clean gloves, and applied a clean dressing to Resident #4's catheter insertion site. During an interview on 4/27/25 at 10:52 am, LVN E said when she washed her hands during Resident #4's catheter care, she thought she washed her hands for at least 20 seconds each time, adding she was counting and thought she counted to twenty. LVN E further stated she sometimes counted 1 and 2 and or just lathered for a good while. LVN E said she was expected to wash her hands for 20-30 seconds. LVN E further stated it was important to perform hand hygiene as recommended to stop from spreading germs or contamination. LVN E said Resident #4 was on EBPs. LVN E further stated EBPs were required when providing care to residents with Foley catheters, suprapubic catheters, feeding tubes, and wounds. LVN E said she was supposed to wear a gown when she provided catheter care for Resident #4, but she forgot to put it on. LVN E said it was important to follow EBPs to prevent spread of germs and infections. 3. Record review of Resident #5's Admission Record, dated 4/27/25, revealed the resident was admitted to the facility on [DATE] with diagnoses which included: Type 2 Diabetes, and Hypertension. Record review of Resident #5's Order Summary, dated 4/27/25, revealed an order for Wound Treatment - Triple Antibiotic Ointment / Dry Dressing one time a day Cleanse the Skin Lesion/(Biopsy site) to the Left Anterior Lower Leg with w/c, pat dry, apply a thin layer of Triple antibiotic Ointment and cover with a dry dressing ., dated 4/22/25. Observation of wound care to Resident #5's left lower leg biopsy site, on 4/27/25 beginning at 10:46 am, revealed RN D performed wound care to Resident #5's left lower leg. Further observation of RN D revealed she washed her hands for 9 seconds once the wound care to Resident #5's left lower leg was completed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/27/25 at 11:09 am, RN D said to her knowledge, she washed her hands for at least 30 seconds, but did not know for sure. RN D said she was expected to wash her hands for 20-30 seconds. RN D further stated it was important to perform hand hygiene as recommended to make sure all the germs were adequately cleaned off. RN D said not performing hand hygiene as recommended could affect residents negatively because not doing so could cause cross contamination and residents were prone to infection. During interview on 4/27/25 at 12:37 pm, the DON said staff were expected to perform hand hygiene before and after providing care, when going from dirty to clean, and when hands were visibly soiled for 20 seconds. The DON said it was important to perform hand hygiene as recommended to avoid infections or cross contamination. The DON further stated she, the IP, and the nurse managers were responsible for ensuring staff washed their hands as recommended/per facility policy. The DON said it was important to perform hand hygiene as recommended because it could potentially cause infection otherwise. The DON said staff were expected to follow EBPs when performing high contact care, such as, ADLs, catheter care, IVs, feeding tubes, ostomy care, and wound care for draining wounds. The DON further stated staff were expected to wear glove and gown when providing care for resident on EBPs. The DON said it was important to follow EBPs because the residents were at risk for infection when they had open areas or any type of invasive lines. The DON further stated she, the IP, and the ADONs were responsible for ensuring staff followed EBPs. The DON said not following EBPs could increase the residents' risk for infection. The DON said the staff were expected to follow the skills competency check-off when performing catheter care. The DON further stated when staff performed catheter care staff just cleaned the catheter, adding peri-care and catheter care were different and catheter care only included cleaning the catheter. The DON said it was important to perform catheter care according to facility policy/procedure, so the catheter was kept clean, and the resident did not get an infection. The DON further stated she, the IP, and the ADONs were responsible for ensuring catheter care was completed per facility policy. During the interview, the DON said the IP was out of town. During the interview, the State Investigator asked for a copy of the skills check-off list for catheter care; the document was not submitted prior to exit. During an interview on 4/27/25 at 1:00 pm, the Administrator said the facility followed CDC guidelines for hand hygiene and so staff were expected to perform hand hygiene for at least 20 seconds. The Administrator further stated it was important for staff to wash their hands as recommended to prevent the spread of bacteria and germs to the residents and the staff. The Administrator said staff were expected to follow EBPs when providing care to residents that required EBPs, such as residents with open draining wounds or catheters. The Administrator further stated the staff were expected to wear gloves, a gown, and face shield or glasses if needed when providing care to residents on EBPs. The Administrator said it was important for staff t follow EBPS because it prevented the spread of infection and germs to the resident and staff. Record review of the facility's policy titled Catheter Care, Urinary, revised September 2014, revealed: .Steps in the Procedure .7. Wash the resident's genitalia and perineum thoroughly .16 .cleanse around the meatus. Cleanse the glans using circular strokes from the meatus outward .17 .cleanse and rinse the catheter from insertion site to approximately four inches outward . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy titled Enhanced Barrier Precautions dated August 2022, revealed: .1. Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDROs) to residents. 2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gown are applied prior to performing the high contact resident care activity .3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include .g. device care or use (.urinary catheter .) Record review of the facility's guidance titled Hand Hygiene Guidance, undated, revealed: .Healthcare facilities should: Require healthcare personnel to perform hand hygiene in accordance with Centers for Disease Control and Prevention (CDC) recommendations . Record review of CDC webpage https://www.cdc.gov/clean-hands/about/index.html, titled Clean Hands, dated February 16, 2024, revealed: .How it works .2. Lather your hands by rubbing them together with the soap. Lather the backs of your hands, between your fingers, and under your nails. 3. Scrub your hands for at least 20 seconds .