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	04/16/2026

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to ensure the assessment accurately reflected the resident's status for one (1) of six (6) residents (Resident #1) reviewed for accuracy of assessments. The facility failed to ensure Resident #1 was coded on his Discharge Return Not Anticipated MDS assessment, observation end date 12/01/2025, for a physical behavioral symptom directed toward others that was exhibited on Sunday, 11/30/2025. This failure could place residents at risk of improper or incorrect care and services necessary for their physical, mental, and psychosocial well-being. The findings included: Record review of Resident #1's admission Record, dated 04/14/2026, revealed a [AGE] year-old male. He was admitted on [DATE] and discharged on 12/01/2025. Resident #1 had a Responsible Party noted on his contact list along with himself. Resident #1 and his Responsible Party had the same contact phone number. Record review of Resident #1's Medical Diagnosis tab in Resident #1's electronic medical record, undated and accessed 04/14/2026 at 05:38 p.m., revealed diagnoses included sepsis (a condition in which the body's extreme response to an infection become life-threatening), epilepsy (a brain disorder that causes seizures), and down syndrome (a genetic condition that can affect how the brain and body develop). Record review of Resident #1's Discharge Return Not Anticipated MDS Assessment, dated 12/01/2025 and signed as complete by the MDS Coordinator on 12/09/2026, revealed the resident was rarely/never understood and had severe cognitive impairment with a memory problem. Under Section E - Behavior of the MDS Assessment, Resident #1 was noted to have not exhibited any physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually). Frequency options for the behavior included: behavior not exhibited, behavior of this type occurred one (1) to three (3) days, behavior of this type occurred four (4) to six (6) days, and behavior of this type occurred daily. The Section Z- Assessment Administration of the MDS Assessment revealed the SW completed section, section(s) not identified, on 12/01/2026 and the MDS Coordinator completed section, section(s) not identified, on 12/09/2026. Record review of Resident #1's Progress Notes, dated 04/14/2026 for effective date range: 11/25/2025 to 12/07/2025, revealed:- On 11/30/2025 at 02:03 p.m., LPN A wrote Res passing female res who was sitting in her W/C in front of Nurses Station wheeled himself around res and punched her & kept going, res was not provoked, res is non-verbal & only oriented to self. Record review of facility incident report titled #285 Resident to Resident Altercation, dated 11/30/2025 at 01:30 p.m. with LPN A noted as person preparing report, revealed Res passing female res who was sitting in her W/C in front of Nurses Station wheeled himself around res and punched her & kept going, res was not provoked, res is non-verbal & only oriented to self. The date of closure for incident was not identified in the report. Record review of Resident #1's Care Plan Report, dated as Care Plan Closed Date: 12/02/2025, revealed the following focus: CANCELLED: the resident has a behavior problem - he wheeled passed a female resident sitting up at nurses' station and hit her in the face, which was unprovoked, date initiated 11/30/2025, date revised and cancelled 12/02/2025. Attempted interview with Resident #1 or Resident #1's Resident Representative on 04/16/2026 at 11:31 a.m. and 02:35 p.m. Left message with request for return call but unable interview. During an interview on (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	04/16/2026 at 09:29 a.m., the MDS Coordinator stated the SW completed Section E of the MDS. She stated the SW did her part, signed for her sections, and when the MDS was closed, she, the MDS Coordinator would sign the MDS as complete. She stated she did not go in and change or review the sections the SW completed. She stated if Resident #1's Discharge MDS was after 11/30/2025, the date of physical behavior, then the physical behavior should have been documented on the Discharge MDS. She stated if the facility incident report was not closed at the time of the MDS Assessment, the facility procedure was to go back to the MDS Assessment after the incident report was closed and to modify the MDS Assessment. She stated that there was not a follow up modification for this Discharge MDS Assessment and there possibly should have been. She stated the facility incident report for this incident was closed on 12/01/2026 at 01:00 p.m. She stated after reviewing the facility incident report, from what she read and from her personal experience, she would have coded the physical behavior. She stated the failure to document the physical behavior would not have impacted the resident's care or the care they would receive where they were discharging to, and it would not have impacted facility reimbursement. During an interview on 04/16/2026 at 02:00 p.m., the SW stated she worked on Section E for the MDS Assessments. She stated she reviewed information from the resident's progress notes and would use knowledge of having been notified of an incident to complete the information for that section of the MDS Assessment. She stated she was notified of resident-to-resident incidents either during her workday or the next workday morning if the incident occurred after her scheduled work hours, Monday to Friday 08:00 a.m. to 05:00 p.m. She stated she did not recall completing Resident #1's Discharge MDS Assessment; however, she did recall Resident #1. She stated the Discharge MDS Assessment not capturing his physical behavior could have been a mistake. She stated she did not believe the lack of documentation of a physical behavior symptom for Resident #1's Discharge MDS Assessment would not have impacted Resident #1's care. During an interview on 04/16/2026 at 03:02 p.m., ADON B stated the SW completed Section E- Behavior of the MDS Assessments. She stated she was not involved in the MDS Assessment documentation. She stated she did not believe Resident #1's Discharge MDS Assessment not including his physical behavioral symptom would have impacted anything, including his care. During an interview on 04/16/2026 at 03:28 p.m., the ED stated, to him Resident #1's Discharge MDS Assessment not including his physical behavioral symptom would not have impacted the resident's care, since the resident was discharging. He stated a missed MDS Assessment documentation of a physical behavioral symptom for a resident that would receive continued care by the facility might have impacted the resident's care planning. He stated the requested documentation for a resident, such as Resident #1, having been discharged or transferred would not generally include the MDS Assessment. Record review of facility policy Conducting an Accurate Resident Assessment, date implemented 12/20/2025, revealed: Policy:The purpose of this policy is to assure that all residents receive an accurate assessment, reflective of the resident's status at the time of assessment, by staff qualified to assess relevant care areas.Policy Explanation and Compliance Guidelines: .3. The appropriate, qualified health professional will correctly document the resident's medical, functional, and psychosocial problems and identifies resident strengths to maintain or improve medical status, functional abilities, and psychosocial status.7. A registered nurse will sign and certify that the assessment/correction request is completed. Each individual who completes a portion of the assessment will sign and certify the accuracy of that portion of the assessment. Whether the MDS assessments are manually completed, or computer generated following data entry, each individual assessor is responsible for certifying the accuracy of responses relative to the resident's condition and discharge or entry status.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, in accordance with accepted professional standards and practices, the facility failed to maintain medical records on each resident that are complete, accurately documented, readily accessible, and systematically organized for one (1) of six (6) residents (Resident #2) reviewed for clinical records. The facility failed to accurately document the location of Resident #1's 03/07/2026 fall in her care plan report. This failure could place residents at risk of not receiving the care and services needed due to inaccurate or incomplete clinical records. The findings included: Record review of Resident #2's admission Record, dated 04/15/2026, revealed an [AGE] year-old female. She was initially admitted on [DATE] and re-admitted on [DATE]. Record review of Resident #2's Medical Diagnosis tab in Resident #2's electronic medical record, undated and accessed 04/15/2026 at 02:08 p.m., revealed diagnoses included parkinsonism (a disorder of the nervous system that affects movement, often including tremors), dementia (a general term for impaired ability to remember, think, or make decisions), and unspecified lack of coordination. Record review of Resident #2's Quarterly MDS Assessment, dated 02/06/2026, revealed the resident had a BIMS score of 9, indicating she was moderately cognitively impaired. She used a wheelchair and required partial/moderate assistance to transfer from sitting to lying, lying to sitting, sitting to standing, and from chair/bed to chair. She had not had a fall since admission/entry or reentry or the prior assessment. Record review of Resident #2's Progress Notes, dated 04/15/2026 for effective date range: 03/07/2026 to 03/09/2026, revealed:- On 03/07/2026 at 11:45 a.m., LPN C entered a SBAR Summary for Providers note. The note included: Situation :[sic] Change In Condition/s reported on this CIC Evaluation are/were: Falls and Nursing observations, evaluation, and recommendations are:Resident [sic] had a fall with no injuries.- On 03/07/2026 at 11:45 a.m., LPN C entered a Nursing-General Note and wrote Resident observed sitting on wheelchair pedals in dining room. Record review of Resident #2's Care Plan Report, undated and accessed 04/15/2026 at 03:59 p.m., revealed the following focus: The resident is [sic] risk for fall r/t BLE [bilateral lower extremities or both sides of lower legs] weakness.3/7/25 [sic]; [Resident #2] initially admitted on [DATE]]- fall in room ., date initiated 08/18/2025 and revised 03/23/2026. During an interview on 04/16/2026 at 10:38 a.m., LPN C stated she vaguely remembered Resident #2's change of condition and fall on 03/07/2026. LPN C stated Resident #2 fell in the facility dining room. LPN C stated she would enter interventions into a resident's care plan if she identified there was something that she could do to prevent a fall; however, she stated she did not enter any interventions into Resident #2's care plan following Resident #2's 03/07/2026 fall because Resident #2 had all the fall interventions already in place. LPN C denied entering in the room on Resident #2's care plan for the fall location. LPN C stated she thought the ADONs or DON entered the historical information in the residents' fall care plans. LPN C stated if the documentation of the location of the fall was inaccurate, it could be a safety issue for the resident by impacting the ability to find the resident. During an observation and interview on 04/16/2026 at 01:37 p.m., Resident #2 was observed lying in her bed with the bed positioned at a low height with the right side of the bed against the wall, a fall mat on the floor next to the left side of the bed, and the call light within reach. Resident #2 stated she had had a couple of falls while living at the facility due to accidents. She stated she did not really remember what happened but was not injured. She stated the staff took care of her and she had no concerns about the staff's response to her falls. During an interview on 04/16/2026 at 03:02 p.m., ADON B stated she was not present for Resident #2's fall. She stated the ADONs and DON were completing the care plans. She stated she was not sure why there would have been a discrepancy in Resident #2's care plan and stated she was unsure if she had completed the documentation or the DON. She stated she would have completed the care plan documentation if the DON was not present. She stated the documented location of the fall would not (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have impacted the resident, since the response to the fall, indicating the fall assessments and documentation forms, were the same. During an interview on 04/16/2026 at 03:28 p.m., the ED stated the charge nurse was responsible for completing the incident report and usually the charge nurse, the MDS Coordinator, or one of the administrative nurses, ADONs or DON, would complete the care planning. He stated he did not think the documentation of location of the fall would impact a resident's care. He stated the interventions were more based on the action of the fall or how the fall occurred. Record review of facility policy Incidents and Accidents, date implemented 10/01/2025 and date reviewed/revised 12/01/2025, revealed: Policy:It is the policy of this facility for staff to utilize the risk management- incident report in the electronic health record to report, investigate, and review any accidents or incidents that occur or allegedly occur, on facility property and may involve or allegedly involve a resident.Compliance Guidelines: .2. Licensed staff will utilize the incident report under the risk management tab in the electronic health record to report incidents/accidents and assist with completion of any investigative information to identify room causes.10. Documentation should include the date, time, nature of the incident, location, initial findings, immediate interventions, notifications and orders obtained or follow-up interventions. Record review of facility policy Fall Prevention, date implemented 10/01/2025 and date reviewed/revised 12/02/2025, revealed: Policy:Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls.Policy Explanation and Compliance Guidelines: .8. Each resident's risk factors and environmental hazards will be evaluated when developing the resident's comprehensive plan of care. a. Interventions will be monitored for effectiveness. b. The plan of care will be revised as needed.9. When any resident experiences a fall, the facility will: . c. Complete an incident report. d. Notify physician and family. e. Review the resident's care plan and update as indicated. Record review of facility policy Maintenance of Electronic Clinical Records, date implemented 10/01/2025, revealed: Policy:This facility will maintain electronic clinical records for each resident in accordance with acceptable standards of practice. Policy Explanation and Compliance Guidelines:1. A complete and accurate electronic clinical record will be maintained on each resident and kept accessible and systematically organized for appropriate personnel to deliver the appropriate level of care for each resident while maintaining the confidentiality of the residents' information.4. Electronic clinical records will contain at least, but are not limited to: . d. Nursing documentation . f. Care plans and services provided .