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	07/12/2024

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46131 Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals were secured properly for 1 of 5 residents (Resident #30) reviewed for medication storage in that: The facility failed to ensure medications were not left on Resident #30's bedside table. This failure could place residents at risk for not receiving the intended therapeutic benefit of their medications as ordered. The findings were: Record review of Resident #30's face sheet, dated 7/9/24, revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnose that included unspecified Dementia (loss of memory, language, problem-solving, and other thinking abilities that are severe enough to interfere with daily life), Chronic Kidney Disease (medical term for the gradual loss of kidney function over three months), and Hypertension (is when the force of blood pushing against your artery walls is consistently too high). Record review of Resident#30's Quarterly MDS Assessment, dated 5/26/24, revealed a BIMS score of 99, which indicated resident was unable to complete the interview. Record review of Resident #30's Patient medication summary for July 2024 did not reveal an order to self-administer medications. Record review of Resident #30's care plan, dated 7/9/24, revealed [Resident's Name] self-administers medications at bedside Saline nasal spray. Observation on 7/9/24 at 10:10 a.m. revealed there was an over-the-counter pain relieving cream tube on Resident #30's bedside table. In an interview with Resident #30 on 7/9/24 at 10:30 a.m., the resident stated his family brings him any over-the-counter medications he may need as he did not like to bother the staff. (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON on 07/09/24 at 1:10 p.m., the DON stated Resident #30 should only have a nasal spray at the bedside and not an over-the-counter pain-relieving cream. The DON stated a self-medication assessment had been conducted only for the nasal spray. The DON also stated Resident #30 might self-administer more medication than was ordered by the physician. The DON stated she currently had the ADON monitoring medications at the bedside weekly, and she oversaw this task monthly. Record review of the facility's policy titled, Self-administer medications, dated June 14, 2006, revealed, All medications for self-administration must be secured, patients' room in safe area.

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28619 Based on observation, interview, and record review, the facility failed to provide drinks, including water and other liquids consistent with resident needs and preferences and sufficient to maintain resident hydration for 1 of 24 residents (Resident #4) reviewed for dietary services, in that: The facility failed to provide Resident #4 with milk at every meal which was noted on the resident's meal ticked and preference sheet, dated 10/30/2023 and signed by the NS, on 07/09/2024 at 1:15 PM which was lunchtime. This deficient practice could affect residents who have dietary preferences and result in weight loss or diminished quality of life. The findings included: Record review of Resident #4's electronic face sheet, dated 07/11/2024, reflected she was admitted to the facility on [DATE] with diagnoses that included: dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), intellectual disabilities (a chronic neurodevelopmental disorder that can affect a person's intellectual and adaptive functioning), major depressive disorder (a mental illness that can cause a persistent low mood, low self-esteem, and loss of interest in activities for at least two weeks), and disorder of bone density and structure (bone mineral density and mass decrease). Record review of Resident #4's quarterly MDS assessment, dated 05/26/2024, reflected the resident had scored an 11 out of 15 on her BIMS, which signified the resident was moderately cognitively intact. Further review revealed it was indicated the resident could understand and be understood, the resident required set-up or clean up assistance with meals, and the resident was not on a mechanically altered or therapeutic diet. Record review of Resident #4's comprehensive person-centered care plan (undated) reflected the resident was on a regular diet and preferred milk with each meal. Record review of Resident #4's Physician Orders dated 07/11/2024 reflected the resident was prescribed a regular diet. Record review of Resident #4's Diet History/Food Preference List dated 10/30/2023 reflected C, Current Beverage Preferences milk was checked off to be her preferred beverage with each meal, breakfast, lunch, and dinner. Observation on 07/09/2024 at 1:15 PM of Resident #4 in her room at lunchtime revealed the resident had her tray and there was no milk. Record review on 07/09/2024 at 1:15 PM of Resident #4's meal ticket revealed milk with each meal. (continued on next page)

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Resident #4 on 07/09/2024 at 1:16 PM, the resident stated she liked milk with each meal and the staff never brought it. When asked if she had informed the staff she shrugged her shoulders and shook her head. During an interview with the NS on 07/10/2024 at 10:22 AM, the NS stated he was the one who had assessed Resident #4 for her preferences and the milk should have been on her tray. The NS stated it was missed either by the nurse checking the tray or dietary staff, and further stated a resident's preference was important because it improved quality of life and would make the resident feel more at home. During an interview with the RD on 07/11/2024 at 1:28 PM, the RD stated the protocol for food preferences was the NS meets the resident and talks about their preference, and it they want the item each day. The RD stated it was noted on Resident #4's meal ticket that she was supposed to receive milk with every meal, and when the dietary staff and nurses were asked about why Resident #4 did not get milk, they did not know. The RD stated a resident's food preferences were important to assist in limiting weight loss and for the overall well-being of the resident. Record review of the Nutrition Services Policy & Procedure Manual, revised 10/2019, revealed, Food preferences will be honored as reasonable.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47622 Based on observation, interview, and record review, the facility failed to store, prepare, and serve food in accordance with professional standards for food service safety for 4 of 4 plates with 2 of 3 staff. 1. DA A placed food on the plates-meat, baked potato, and carrots. While DA A fixed the plates, DA A left the work station several times, doffed (removed) his gloves and donned (put on) new gloves without performing hand hygiene. 2. DA B placed condiments, a roll, a carton of milk, and a cup of ice tea on the tray used a plate cover then placed on the cart to serve to the residents in the dining room. DA B left the work station once and doffed his gloves and donned clean gloves without using hand sanitizer or washing his hands. This deficient practice could effect residents that receive food from the kitchen and place them at risk for contamination of food. The findings included: 1. Observation on 07/10/24 at 11:46 AM revealed DA A left the work station four times where he served food on the plates, returned and doffed his gloves and donned a new pair of gloves without washing his hands or using hand sanitizer. During an interview with DA A on 07/10/24 at 11:46 AM, at the same time as the observation, DA A stated he knew to wash his hands when he changed gloves, but he was in a rush to get the plates served to the residents because of time. 2. Observation on 07/10/24 at 11:55 AM revealed DA B left his work station once and returned, doffed his gloves and donned a new pair of gloves without washing his hands or using hand sanitizer. During an interview with DA B on 07/10/24 at 11:55 AM, at the same time as the observation, DA B stated he did not think he needed to wash his hands since he was using gloves. During an interview with the NS on 07/10/24 at 11:46 AM, the NS stated that as long as he had been a cook, he was taught to use gloves during serving plates from set up to delivery. The NS stated he was not aware they needed to use hand sanitizer if they did not wash their hands before they put on new gloves. During an interview with the RD on 7/11/2024 at 2:20 PM, the RD stated if the staff were to wear gloves, they should either wash or sanitize their hands before donning clean gloves. The RD stated there was no policy on wearing gloves for dietary services. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy titled, Use of Plastic Gloves, dated 11/3/2004, revealed, Plastic gloves will be worn when handling food directly with hands to ensure that bacteria is not transferred from the food handlers' hands to the food product being served. Procedure: 1. Hands are to be washed before putting on gloves.