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	08/13/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident for 1 of 1 narcotic destruction storage area.The facility failed to ensure that all narcotics matched the accompanying logs. Two of Resident #31's Morphine Sulfate oral solution bottles did not match their accompanying logs as medication was being removed from one bottle to be administered and logged on the record for a second Morphine Sulfate oral solution which had not been opened. This failure could place the residents at risk of receiving a medication error or receiving less than therapeutic benefits from medications.Findings included:Record review of Resident #31's face sheet dated [DATE], revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including Cerebral Infarction (disorder when blood flow to a part of the brain is blocked leading to lack of oxygen and nutrients). Record review of Resident #31's quarterly MDS dated [DATE], section C revealed a BIMS score of 3 that indicated severe cognitive impairment. Record review of Resident #31's narcotic records revealed a Controlled Substance Count Sheet for Morphine Sulfate Oral Solution with 29.25 milliliters documented and a Controlled Drug Receipt/Record/Disposition Form for Morphine Sulfate Solution with 20.5 milliliters documented. Observation of the facility's medication room for narcotic destruction storage on [DATE] at 3:25 p.m. revealed Morphine Sulfate oral solution for Resident #31 was 16 milliliters. The accompanying record log for the Morphine Sulfate oral solution had 29.25 milliliters as being documented as the current amount of medication. There was a small amount of liquid that was seen in the bottom of the accompanying Morphine Sulfate oral solution box that was the same color as the Morphine Sulfate liquid but not enough to account for the discrepancy. All other narcotics in the narcotic destruction storage matched their accompanying logs that were in the narcotic storage. Narcotics for destruction were kept behind two locks with the DON being the only person with access to the second lock's key. During interview on [DATE] at 3:25 p.m., the DON said she would investigate regarding the discrepancy regarding the Morphine Sulfate oral solution for Resident #31.During interview on [DATE] at 3:59 p.m., the DON said that Resident #31 had two Morphine Sulfate oral solution bottles with the second bottle being on the medication cart. One bottle had come from the facility's pharmacy and the other bottle had come from an outside pharmacy. The facility pharmacy's Morphine was full and unopened at 30 milliliters, but the accompanying log sheet had recorded 20.5 milliliters left. The DON said that staff had been charting on the wrong narcotic sheet which explained the discrepancy. The DON said she would notify the Consultant Pharmacist and correct the narcotic sheets. During interview on [DATE] at 4:14 p.m., the DON said the Morphine Sulfate oral solution record sheets for Resident #31 were corrected and the Consultant Pharmacist had been notified.During interview on [DATE] at 11:27 a.m., the DON said they did random medication cart audits a few times a month that included checking the carts for anything that was open that needed to be dated, for expirations, there were no loose pills, narcotics and everything was accounted for. The DON said the nurses counted narcotics every shift going on and off. The DON said the (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pharmacist came once a month and did medication cart audits and destroyed narcotics with the DON and one other nurse and verified that the paper and the medication matched what was to be destroyed. The DON said she did quite a bit of education regarding medications for the staff and did in-services whenever a problem like a medication error occurred. The DON said narcotic counts not being documented on the correct sheet would not negatively affect the resident unless the resident received the wrong medication. During interview on [DATE] at 4:06 p.m., the Pharmacist Consultant said she opened the narcotic boxes on the medication carts and checked two or three quantities to ensure they matched the perpetual inventory form and spot checked that medications were not expired. The Pharmacist Consultant said she checked that when medications were signed out on the inventory form that it was documented in the EHR, the pain level was documented and matched the pain level that was on the written form. The Pharmacist Consultant said she checked for trends of nurses signing out narcotics. The Pharmacist Consultant said she made sure the form matched the quantity being presented for destruction. The Pharmacist Consultant said she made sure they were discarding each medication individually into the drug destruction box, made sure they started the dissolution process in the box, made sure all proper documentation of drug destruction was completed, taped the box up after ensuring all controlled medication had been placed in the box then signed and dated the box. The Pharmacist Consultant said she made sure the box was behind two locks until the biohazard company could pick the box up. The Pharmacist Consultant said she had been the pharmacist a little over three years at the facility and had no concerns regarding drug diversion. The Pharmacist Consultant said a medication error could occur if the correct narcotic was not being documented on the correct form as the supply could be incorrect, a resident could run out and potentially be shorted resident care. The Pharmacist Consultant said she did in-services when requested. The Pharmacist Consultant said she came to the facility monthly unless requested to come special for something like an in-service.Record Review of facility's policy Management of Controlled Medications revised [DATE] revealed the facility staff will follow the method of accounting for controlled medications through receiving, administration, storage and destruction which meets the requirements of state and federal narcotic enforcement agencies.