STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676246	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Nursing and Rehabilitation Center	6801 E Riverside Dr Austin, TX 78741

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42600 Based on observation, interview and record review, the facility failed to ensure that residents had the right to reside and receive services in the facility with reasonable accommodation) of needs and preference for 4 of 5 (Resident #1, Resident #2, Resident #3 and Resident #4) who were reviewed for accommodation of needs. The facility failed to ensure on 09/11/2024 the call light was in place for Resident #1, Resident #2, and Resident #3. The facility failed to ensure there was an order to check functioning of Resident #3 and Resident #4's air mattresses. The facility failed to ensure the air mattress order dated 09/02/2024 was plugged in and functioning for Resident #1 on 09/11/2024. These failures could place residents at risk of being unable to obtain assistance when needed and help in the event of an emergency and at risk for malfunction of their air mattresses. Findings included: Review of Resident #1 face sheet reflected a [AGE] year-old woman admitted on [DATE] with diagnoses of cerebral palsy, autistic disorder, congenital malformation of brain. Review of physician orders for Resident #1 revealed an order dated 09/02/2024 that stated low air loss mattress with wings for skin maintenance and positioning and check placement and function. Review of Resident #1 quarterly MDS dated [DATE] revealed that resident was unable to complete the BIMS and indicated that Resident #1 was non-interviewable. Further review of quarterly MDS revealed that Resident #1 was at risk for developing pressure injuries. MDS revealed that Resident had pressure reducing device for bed. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #1 care plan dated 11/02/2022 revealed that Resident #1 has contractures and weakness and interventions included to be sure call light is within reach and respond promptly to all requests for assistance. Further of care plan dated 11/10/2022 revealed Resident #1 has communication problem related to intellectual disability and that resident is nonverbal with intervention to ensure/provide a safe environment and have call light within reach. Care plan dated 11/10/2022 revealed that Resident #1 is a risk for falls and intervention included to ensure call light is within reach and have winged air mattress for positioning. Review of care plan dated 11/10/2022 revealed resident has potential for pressure ulcer development and intervention included that Resident #1 required pressure reliving/reducing device on bed (low air loss mattress). Observation on 09/11/2024 at 9:29 AM revealed Resident #1 asleep in bed with call light under fall mat and not within reach. Observation on 09/11/2024 at 11:37 AM revealed Resident #1 laying in bed with call light under fall mat. Further observation revealed Resident #1's air mattress appeared to be deflated. Observation revealed that the pump for the air mattress was not on. Review of Resident #2 face sheet revealed a [AGE] year-old woman admitted on [DATE] with diagnoses of unspecified dementia, contracture of right hand, muscle weakness and anxiety disorder. Review of Resident #2 quarterly MDS dated [DATE] revealed no BIMS score. MDS revealed that Resident #2 has impairment on one side for her upper and lower extremities. Review of Resident #2 care plan dated 01/24/2023 revealed resident has alteration in musculoskeletal status related to contractures to right wrist and right hand with intervention to be sure call light is within reach and respond promptly to all requests for assistance. Review of care plan dated 01/24/2023 revealed Resident #2 has communication problem with intervention to ensure/provide safe environment with call light in reach. Review of care plan dated 12/13/2022 revealed Resident #2 was a risk for falls and intervention included to be sure the call light is within reach. Observation 09/11/2024 at 9:29 AM revealed Resident #2 asleep in bed with call light cord wrapped around bed from on right side with call button laying on the floor and not within reach. Observation on 09/11/2024 at 11:37 AM revealed Resident #2 awake in bed and call light button remained on floor next to her bed out of reach. Review of Resident #3 face sheet revealed a [AGE] year-old male admitted on [DATE] with diagnoses of Parkinsonism, unspecified dementia, unspecified intellectual disabilities and muscle weakness. Review of Resident #3 quarterly MDS date 07/01/2024 revealed BIMS score of 0 which indicated severe cognitive impairment. Review of Resident #3 care plan dated 03/22/2023 revealed Resident #3 was at risk for calls with interventions to be sure the call light was within reach. Further review of care plan dated 03/22/2023 revealed Resident #3 had potential for pressure ulcer development related to impaired mobility with intervention that Resident #3 required pressure relieving device. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #3's physician orders dated 03/21/2023 to 09/11/2024 which revealed no order for monitoring function and placement or low air loss mattress. Observation on 09/11/2024 at 9:41 AM revealed Resident #3 was lying in bed on air mattress and the overhead light cord laid on his chest. Further observation revealed Resident #3's soft touch call light cord was wrapped around the bed rail and the call light button hung down. During an interview on 09/11/2024 at 9:42 AM, Resident #3 stated that he was unable to reach his call light. Review of Resident #4's face sheet revealed a [AGE] year-old male admitted on [DATE] with diagnoses of spastic quadriplegic cerebral palsy, spinal stenosis, stiff-man syndrome and muscle weakness. Review of Resident #4's quarterly MDS dated [DATE] revealed a BIMS score of 15 which indicated he was cognitively intact. Review of Resident #4 physician orders dated 11/02/2022 to 09/11/2024 which revealed no order for monitoring function and placement or low air loss mattress. Observation of Resident #4 on 09/11/2024 at 9:40 AM revealed Resident laying in bed with air mattress. Settings observed on pump for air mattress revealed they were turned up to if Resident weighed 1000 lbs. During an interview on 09/11/2024 at 9:40 AM Resident #4 stated that his bed deflates every two hours. Observation on 09/11/2024 at 11:30 AM revealed Resident #4's air mattress was still inflated, but observed staff adjusted settings on pump of air mattress. During an interview and observation on 09/11/2024 at 11:54 AM, CNA A stated that Resident #1's bed (air mattress) was not working. CNA A was observed to pick the plug up off the ground and stated that the bed was not plugged in. CNA A plugged the air mattress. CNA A was observed exiting the room and did not check call light placement for Resident #1 or Resident #2 before exiting the room. CNA A stated that Resident #1 and Resident #2's call lights were not within in reach and stated that residents should have their call light within reach. He stated that when doing rounds or assisting residents, staff should check that air mattresses are plugged in and that call lights are within reach. During an interview on 09/11/2024 at 11:57 AM, LVN B stated that residents who had a fall risk should have their bed in lower position and call lights in place. LVN B stated that staff should have checked that the call light was in place and that the air mattress worked. She stated that it was a problem if the air mattress was unplugged. She stated that depending on the health and nutrition status of the resident it could cause a pressure injury. She stated that setting for the air mattress were usually in the order and there should be an order for the air mattress because it is specialized equipment, and it is apart of the plan of care. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/11/2024 at 12:13 PM, CNA C stated that when you assist a resident you check to see if they are okay, wet and safe. She stated that staff should make sure they have their call light where they can reach. CNA C stated that if they have an air mattress staff should make sure its on the right setting and ensure its plugged in. She stated that if it is unplugged you should tell a nurse. During an interview and observation on 09/11/2024 at 12:23 PM, LVN D stated it was trial and error to get the correct settings with air mattresses and that the setting depends on the resident's preferences. She stated that Resident #4 wants his air mattress at a certain setting and prefers it to be firm. She stated there should be an order for the air mattress and usually there are settings on it. She stated that Resident #3 and Resident #4 should have an order for their air mattresses. During the interview, LVN D was observed viewing orders for Resident #3 and Resident #4. LVN D stated that she did not see an order for the air mattresses for Resident #3 or Resident #4. LVN D stated that the setting should match the weight of the residents and if it is too firm it could be uncomfortable, and the pressure could stay in one place. During an interview on 09/11/2024 at 12:24 PM, LVN E stated that staff should look to see that call lights are within reach and supposed to ensure air mattresses are plugged in and working. During an interview on 09/11/2024 at 1:14 PM, LVN F stated that she was also the wound care nurse. She stated that the nurses should have checked the settings of air mattresses daily and the setting depended on what the resident wanted. She stated that nurses should have checked to ensure that air mattresses were plugged in and on the correct setting. She stated that air mattresses should have had an order to ensure that the air mattress is inflated. She stated that this was usually on the MAR so that nurses could check off that they checked the settings. She stated that it was important to have an order for air mattresses to ensure there is a need for it or if the resident had wounds or unable to reposition themselves. LVN F stated that if there was not an order for the air mattress the nurse would not be able to tell if it was functioning. LVN F stated that the potential for harm is that the would be no way to know if the resident had an air mattress in their room to see that it was functioning, and it could be misplaced or harm the resident's skin. During an interview on 09/11/2024 at 2:06 PM, LVN G stated that normally there should have been an order for an air mattress. She stated that there is an order for the resident to have the mattress and an order to check the function. LVN G stated that staff are supposed to check call light placement for residents when they go in and assist. She stated that she has completed in-services with staff on placement and it should have been within reach of residents. She stated that if it is not within reach the resident would be unable to ask for assistance. During an interview on 09/11/2024 at 2:20 PM, the DON stated that she expected that staff ensure residents are met, they have needed items within reach, that the call light was in reach and that devices are functioning. She stated that residents should have an order for an air mattress to ensure function and placement each shift. During an interview on 09/11/2024 at 2:37 PM, the ADM stated that he expects that residents are being care for properly. ADM stated that he expected call lights to be within reach of residents and that specialized equipment and adaptive equipment be functioning. He stated that he did expect air mattresses to be plugged in and that the residents should have had an order to check the functioning of the mattress. The ADM stated that there was not a facility policy regarding air mattresses. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of in-service dated 06/04/2024 was completed regarding call light placement and that call lights should be within reach for all residents. Review of facility in-service dated 07/11/2024 with subject on call lights stated call lights should be placed in reach at all times. Review of facility policy dated 05/2007 titled Policy/Procedure - Nursing Clinical with subject of Call Light/Bell revealed It is the policy of this facility to provide a resident a means of communication with nursing staff. Further review revealed to leave the resident comfortable and place the call light device within resident's reach before leaving the room.