

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676246	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/25/2024
NAME OF PROVIDER OR SUPPLIER Riverside Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0563</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50176</p> <p>Based on interviews and record review, it was determined that the facility failed to ensure residents have the right to receive visitors of his or her choosing at the time of his or her choosing for 1 (Resident #1) of 10 Residents reviewed for resident rights.</p> <p>The facility did not allow Resident #1 to visit with a family member.</p> <p>This failure could place residents at risk of isolation, decreased emotional wellbeing, and diminished quality of life.</p> <p>Findings included:</p> <p>1. Review of Resident #1's face sheet dated 09/25/2024 reflected that Resident #1 was a [AGE] year-old male admitted on [DATE] with diagnoses of alcoholic polyneuropathy (a neurological disorder in which peripheral nerves throughout the body malfunction simultaneously), Wernicke's encephalopathy (a type of brain injury), chronic obstructive pulmonary disease (an ongoing lung condition caused by damage to the lungs), alcohol dependence (being unable to stop drinking without experiencing symptoms of withdrawal), in remission, and other psychoactive substance abuse (refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs).</p> <p>Review of Resident #1's quarterly MDS dated [DATE] reflected the resident had a BIMs score of 15 which indicated no cognitive impairment.</p> <p>Review of Resident #1's care plan revised on 02/05/2024 reflected that resident had verbally abusive behaviors towards staff related to substance use disorder. Approach for this care plan included assess resident's coping skills and support system. Resident #1 was at risk for unexpected weight loss or gain related to new admission, malnutrition, diabetes, depression, and other medical conditions. Interventions included encourage snacks between meals, honor resident rights to make personal dietary choices, monitor and report to doctor as needed for any symptoms of decreased appetite or unexpected weight loss, and monthly weights if stable. Care plan did not include any information regarding visitation limitations or concerns from the facility or Resident #1.</p> <p>Review of Resident #1's progress notes dated 07/26/2024 through 09/26/2024 did not include any information regarding visitation limitations or concerns from the facility or Resident #1.</p> <p>(continued on next page)</p>

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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<p>F 0563</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #1's progress notes dated 07/26/2024 through 09/26/2024 reflected no conversations with ADM regarding visitors/visitation.</p> <p>Review of Resident #1's psychological services progress note dated 09/04/2024 completed by LCSW, revealed Resident #1 reported feeling depressed because he had not seen his family member in several days and was worried because the family member was homeless.</p> <p>Review of Resident #1's psychiatric initial assessment dated [DATE] completed by PMHNP, revealed Resident #1 endorsed depression, sadness, loss of interest, fatigue, and guilt because his family member was banned from the facility, and he did not know why.</p> <p>Review of Resident #1's electronic medical record did not include any information regarding visitation limitations or concerns from the facility or other residents regarding Resident #1's family member.</p> <p>Review of Resident #1's weight records showed stable weight with no weight loss.</p> <p>During an interview on 09/24/2024 at 1:20 PM, the Ombudsman stated Resident #1 was upset because his family member could not visit him. Resident #1 stated that the ADM told him they had on video that the family member brought Resident #1 drugs and alcohol. Resident #1 denied this and had asked to see the video, but that request was denied. The Ombudsman stated that she talked to the ADM on 09/06/2024, who stated that Resident #1's family member had been banned from the facility because he was bringing drugs and alcohol into the facility. The ADM further stated that the family member was homeless, and Resident #1 had allowed family member to sleep in his bed, which was not allowed. The ADM told the Ombudsman that he called the police, but the family member left, and the police did not respond and there was not a no trespass order. The Ombudsman asked the ADM for proof or documentation of disruptive behaviors or suspected drug, and none was provided. The Ombudsman stated the ADM refused to allow supervised visitation between Resident #1 and the family member. The Ombudsman stated the ADM told her Resident #1 could transfer to another facility if he wanted to visit with his family member; otherwise, the ADM would start the discharge process because Resident #1 was not following the facility rules.</p> <p>During an interview on 09/25/2024 at 10:05 AM, LVN A stated family members can visit at any time. LVN A stated he observed Resident #1 at the nursing station complaining about his family member not being allowed to visit. LVN A had not seen Resident #1's family member in a few weeks and did not know why. LVN A had never seen Resident #1's family member bring alcohol or drugs into the facility, be disruptive, or aggressive. LVN A stated Resident #1 would allow the family member to sleep in resident's bed during the daytime when Resident #1 was not using the bed. LVN A stated the facility had a lot of social activities and family members came often to visit and engage in these activities. LVN A stated since Resident #1's family member had not been allowed to visit, Resident #1 appeared quieter and more withdrawn. LVN A stated he was not aware Resident #1's family member had been banned from the facility.</p> <p>(continued on next page)</p>		

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<p>F 0563</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 09/25/2024 at 10:59 AM, Resident #1 stated the facility limited his visitors and that he was unable to visit with his family. Resident #1 stated he missed his family member and would like to see him. Resident #1 stated the ADM banned his family member from the facility because he had a video of the family member giving the resident alcohol. Resident #1 stated this was not true and he asked the ADM to view the video and his request was denied. Resident #1 stated he could get his own alcohol. He denied his family member being disruptive or causing any problems. Resident #1 stated he allowed his family member to sleep in his bed, during the daytime, never at night. Resident #1 stated the ADM never offered him supervised visitation with his family member or provided him anything in writing about the family member being banned. Resident #1 stated not allowing visits from his family member went against the facility's mission statement and against his resident rights. Resident #1 stated since his family member had been banned from the facility, he had lost his appetite, and was depressed as hell. Resident #1 stated since the family member was banned, he could not visit Resident #2 either.</p> <p>During an interview on 09/25/2024 at 12:00 PM, LVN B stated she was Resident #1's nurse. LVN B recalled an incident with Resident #1's family member about two months ago when Resident #1's family member yelled at her, Do you have a problem with me? You have a problem with me!. LVN B reported this to the ADM and the ADM stated he would talk to the resident and family member about this. LVN B had never observed any disruptive behaviors from Resident #1's family member prior to this and never had a problem with family visiting Resident #1. LVN B stated this was an isolated incident. LVN B stated she was never told Resident #1's family member was banned from the facility, and she does not know what the ADM did to address the situation.</p> <p>During an interview on 09/25/2024 at 12:15 PM, the OT stated that she had seen Resident #1's family member visit Resident #1, but not recently. The OT stated that she heard Resident #1's family member was not supposed to visit, but she did not know why. The OT had not observed any disruptive behaviors from Resident #1's family member. The OT stated that residents could have family member visit, but there might be restrictions on visiting hours.</p> <p>During an interview on 09/25/2024 at 12:20 PM, CNA B stated he found alcohol in Resident #1's backpack in his room and thought it might have been brought into the facility by Resident #1's family member. CNA B stated Resident #1's family member was always mad and yelled at staff, but he could not give specific dates of incidents or names of staff involved. He stated Resident #1's family member would sleep in Resident #1's bed and ate the food at the facility. CNA B stated he had not seen Resident #1's family member recently.</p> <p>During a telephone interview on 09/27/2024 at 8:35 AM Resident #1's family member A stated her family was mourning that family member B was not allowed to visit Resident #1 and Resident #2. She believed both Resident #1 and Resident #2 benefited from visits from family member B. Family member A stated she had never observed family member B be disruptive or disrespectful. She does not believe family member B would bring in alcohol or drugs into the facility as that was not the kind of person he was. Family member A stated she talked to both Resident #1 and family member B and they both denied family member B brought alcohol or drugs into the facility or was being disruptive and she believed them.</p> <p>(continued on next page)</p>		

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<p>F 0563</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>2. Review of Resident #2's face sheet dated 09/25/2024 revealed a [AGE] year-old female admitted on [DATE] with primary diagnoses of Huntington's Disease (an inherited disorder that causes nerve cells (neurons) in parts of the brain to gradually break down and die), Alcoholic cirrhosis (liver damage caused by chronic alcohol use) of the liver with ascites (buildup of fluid in the stomach), dysarthria (a speech disorder caused by problems controlling the muscles used for speech) and anarthria (the most severe form of dysarthria where the individual is unable to speak at all). Special instructions listed the resident enjoys spending time with her family.</p> <p>Review of Resident #2's quarterly MDS dated [DATE] reflected Resident #2 BIMS score selection was not completed. Resident was completely dependent for all functional abilities. Resident's speech was unclear and her ability to make herself understood and understand others was marked as sometimes. The cognitive patterns section had blanks and was not scored. Most items on the MDS were not scored.</p> <p>Review of Resident #2's care plan revised on 06/29/2023 reflected Resident #2 was identified as being at risk for delirium and impaired cognitive function/dementia due to Huntington's disease. Resident #2 was at risk for a communication problem related to hearing deficit, dementia, and aphasia. Under Activity Preferences, it was noted that resident would maintain involvement in cognitive stimulation such as outings with family and interventions included: Resident needed 11 beside/in-room visits and activities if she was unable to attend activities out of her room.</p> <p>Review of Resident #2's progress notes dated 08/26/2024 to 09/26/2024 reflected no conversations or requests regarding visitors/visitation.</p> <p>During an observation on 09/25/2024 at 3:05 PM, Resident #2 was observed lying in bed. Resident #2 was non-verbal but did respond to the surveyor calling her name and reached her hand out to shake the surveyor's hand.</p> <p>During an interview on 09/25/2024 at 12:57 PM, family member C stated Resident #2 was related to family member B. She had seen family member B at the facility when she went to visit Resident #2 and had not observed any disruptive behaviors. Family member C had never heard of facility staff or other residents complaining about Resident #1's family member. Family member C stated family member B primarily visited Resident #1, but also Resident #2. Family member C stated about a month ago, the ADM called her to inform her that Resident #1's family member had been banned from the facility. Resident #1 told her that the ADM had a video of family member B taking Resident #1 to buy alcohol. Family member C stated she had no concerns with family member B visiting Resident #2 and thought it was good for Resident #2 to see familiar family faces. She also had no concerns with the family member B visiting Resident #1.</p> <p>During an interview on 09/25/2024 at 9:46 AM, CNA A stated family members can visit all times of the day and she was not aware of any restrictions of family visiting residents. CNA A had not observed any disruptive family members or heard any complaints from residents about family members visiting.</p> <p>(continued on next page)</p>		

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<p>F 0563</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 09/25/2024 at 11:37 AM, the SW stated residents could have family members visit any time 24 hours a day. The SW stated a potential negative outcome of a family member not being able to visit a resident was a change to their mental health. The SW stated Resident #1's family member was a regular visitor to Resident #1 until recently. The SW stated Resident #1's family member was suspected of bringing alcohol into the facility and he made LVN B feel uncomfortable and had been banned from the facility. The SW stated she had seen Resident #1's family member visiting and had never observed any disruptive behaviors. The SW described the family member as calm. The SW had observed Resident #1's family member sleeping in Resident #1's bed or on the floor during the daytime, but never at night. The SW stated residents could not have family members sleep overnight, but she was not aware of any policy that would prohibit that during the day. The SW stated Resident #2 was also impacted by Resident #1's family member not visiting, but she had never seen this family member visit Resident #2. There was one occasion when Resident #1 was upset after a visit from his family member and said they argued, and Resident # 1 did not want his family member to visit. The facility had a sign in sheet for the visitors, but it is not used or enforced or regulated.</p> <p>During an interview on 09/25/2024 at 1:15 PM, the DON stated that residents could have family members visit any time with no restrictions. Potential negative outcome of a family member not being able to visit a resident was psychosocial. The DON observed Resident #1's family member yelling at staff and sleeping in Resident #1's bed. The DON stated that based on family member B's presentation of red eyes and slurred speech, she thought he was under the influence of something. The DON stated that the ADM had spoken to both Resident #1 and family member B about these concerns and the facility restricted family member B's visitation for the safety of residents and staff. The DON stated that the ADM provided verbal discussion and that this was not documented anywhere. The DON was not aware of any documentation regarding family member B being banned from the facility.</p> <p>(continued on next page)</p>		

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<p>F 0563</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 09/25/2024 at 1:35 PM, the ADM stated residents could have visitors 24 hours a day, but they could restrict visits if a visitor was disruptive to protect the safety of residents. Potential negative outcome of a family member not being able to visit was psychosocial harm. Resident #1 was very high functioning and would sign himself out on pass daily and when he would return to the facility, he appeared intoxicated. When Resident #1's family would visit, the resident appeared more intoxicated and would yell at staff. The ADM stated there were residents at the facility that did not want family member B to visit, and he needed to protect their rights. The ADM stated family member B would yell at the nurse or demand services (such as cleaning the room). The ADM talked to Resident #1 about not having his family member bring in substances. The ADM stated family member B was homeless and came into the facility to live there by sleeping on the bed and eating the food during the day when Resident #1 was not in the facility. The ADM educated Resident #1 on visitation rights and that the services were for residents and not his family. These conversations were not documented. The ADM stated family member B brought alcohol into the facility because he heard glass bottles when family member B walked by. The ADM denied having video or other proof that family member B brought in alcohol but suspected he had brought in illegal substances. The ADM stated family member B yelled at him because of this accusation, and he called the police, but family member B left the facility, and the ADM told the police not to respond. The ADM stated they did not have a police report or file number. The ADM stated he had not made any law enforcement referrals. The ADM stated he offered Resident #1 supervised visits with his family, but Resident #1 refused. The ADM stated the facility does not have a policy about family bringing alcohol into the facility nor about family members drinking alcohol while in the facility. Residents can drink alcohol in the facility but need a doctor's order. The ADM stated Resident #1's family member was also a family member of Resident #2. Family member B stated that he would go visit Resident #2 when he was at the facility. The ADM stated Resident #2's family did not want family member B to visit Resident #2. The ADM stated Resident #1 could leave on pass to visit his family member outside of the facility. The ADM stated he banned family member B from the facility and from visiting Resident #1 and Resident #2 because of these behaviors. The ADM stated he had not put any of this in writing or documented it anywhere. The ADM did not know family member B's name. The ADM stated staff had not been trained or given notice that family member B had been banned. The ADM could not recall when family member B was banned or how long that ban would last. The ADM stated that all of this was not documented in Resident #1 or Resident #2's electronic medical record nor anywhere else, because it was a family member and not a resident.</p> <p>During an interview on 09/25/2024 at 2:53 PM, the local Police Department stated they did not have any incident records for Resident #1 or his family member for the last two months. They did not have any records on file.</p> <p>During an interview on 09/25/2024 at 3:00 PM, CMA stated Resident #2's family visits often but had not seen family member B in a while and had never seen any problems with family member B's behavior.</p> <p>Review of facility grievance logs dated 06/03/2024 through 09/23/2024 revealed no complaints about visitation with family members.</p> <p>Review of facility policy titled Resident Rights and Responsibilities, Notice of dated November 2016 and revised in December 2023 reflected, It is the policy of the facility to inform the resident both orally and in writing of their rights as a resident, as well as the rules and regulations governing the resident's conduct and responsibilities during their stay in the facility.</p> <p>(continued on next page)</p>		

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<p>F 0563</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of facility policy titled Residents Rights dated 07/13/2017 reflected residents had the right to receive visitors of your choosing at the time of your choosing, subject to your right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. Further review reflected residents had the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language you understand.</p> <p>Review of facility policy titled Visitation Rights of Residents dated November 2016 and revised in December 2023, reflected It is the policy of the facility to inform each resident and/or resident representative of the rights to receive visitors based on their preferences and any clinical or safety restrictions or limitations on these rights. The facility will respect the rights of a resident to consent to receive visitors of their choosing at the time of their choosing and the right to deny or withdraw consent for visitation at any time, when applicable, and in a manner that does not impose on the rights of another resident. Visitation will not be restricted, limited, or denied based on race, color, national origin, religion, sex, gender identity, sexual orientation, or disability. Further review reflected the resident had the right of immediate access to immediate family and visitation would be person-centered, consider the psychosocial well-being of the resident, and support their quality of life. Policy included The facility will ensure all visitors enjoy full and equal visitation privileges consistent with resident preferences. And Notify resident and/or their representative of the facility policy regarding visitation, to include the resident right to consent to, withdraw consent for, or deny visitors and any potential limitation or restrictions for visitation.</p> <p>Further review reflected, Reasonable clinical and safety restrictions include a facility's policies, procedures, or practices that protect the health and security of all residents and staff. These may include, but are not limited to:</p> <p>o Denying access to individuals who are inebriated or disruptive;</p> <p>1. If the resident exhibits signs or symptoms or triggers of illegal substance use, ask the resident whether they possess or have used an illegal substance.</p> <p>2. If the facility determines illegal substances have been brought into the facility by a visitor:</p> <p>Make a referral to law enforcement.</p> <p>The facility may need to provide additional monitoring or supervision or resident and/or visitation restrictions.</p>		