

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  03/26/2025
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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42949</p> <p>Based on observation, interview, and record review, the facility failed to ensure the residents environment remained as free of accident hazards as is possible and ensure each resident received adequate supervision for one (Resident #1) of three residents reviewed for accidents and hazards.</p> <p>The facility failed to ensure Resident #1 did not elope from the facility without staff's knowledge on 03/25/25 by following a contract worker out the front door. Resident #1 self-propelled to the driveway where she rolled down into and across the street to the median where she bumped into the curb and fell out of her wheelchair.</p> <p>An Immediate Jeopardy (IJ) existed on 03/25/25. The IJ was determined to be at past noncompliance as the facility had implemented actions that corrected the deficient practice prior to the beginning of the investigation.</p> <p>This deficient practice could place residents at risk for elopements, falls, injuries, and hospitalization .</p> <p>Findings included:</p> <p>Review of Resident #1's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including profound intellectual disabilities, dementia, muscle wasting and atrophy (wasting away), and cognitive communication deficit.</p> <p>Review of Resident #1's quarterly MDS assessment, dated 01/17/25, reflected a BIMS could not be conducted due to her rarely/never being understood. Section E (Behavior) reflected she had not exhibited wandering behaviors. Section GG (Functional Abilities and Goals) reflected she utilized a wheelchair for mobility. Section P (Restraints and Alarms) reflected she did not have a wander/elopement alarm.</p> <p>Review of Resident #1's quarterly care plan, revised 03/25/25, reflected was a high risk for elopement risk/wanderer related to disoriented to place, impaired safety awareness, and wandering aimlessly with an intervention of monitoring her wander guard placement on her right ankle.</p> <p>Review of Resident #1's Elopement/Wandering Evaluation, dated 02/25/25, reflected she was a low risk of elopement.</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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #1's progress note, dated 03/25/25 at 2:50 PM and documented by LVN A, reflected the following:</p> <p>Reported to this nurse that staff member observed [Resident #1] at top of driveway. Staff member (HA B) followed behind her attempting to stop [Resident #1]. Staff member unable to reach resident d/t incline and momentum. [Resident #1] reached curb and fell as staff approached. Staff states resident did not strike head . Upon return to facility head to toe assessment completed by nurse, ADON, and WCN, noted with superficial abrasions to knee, pain assessment completed. No s/s of pain.</p> <p>Review of Resident #1's progress note, dated 03/25/25 at 9:15 PM and documented by LVN C, reflected the following:</p> <p>This nurse was given a verbal order by (doctor) to send [Resident #1] out to the hospital for further evaluation. [Resident #1] is alert x 1 and at baseline .</p> <p>Review of Resident #1's hospital records, dated 3/25/25, reflected the following:</p> <p>You were seen today for: FALL</p> <p>No obvious injury to the knees on ultrasound.</p> <p>Review of Resident #1's progress note, dated 03/26/25 at 12:11 AM and documented by LVN D, reflected the following:</p> <p>[Resident #1] arrived back to facility via (non-emergency medical transport) @ 0008 (12:08 AM). [Resident #1] transferred into bed by nursing staff. [Resident #1] is alert x 1 and at baseline. No s/s of pain or discomfort observed from resident during transfer.</p> <p>Review of Resident #1's Elopement/Wandering Evaluation, dated 03/25/25, reflected she was a high risk of elopement.</p> <p>Review of Resident #1's physician order, dated 03/25/25, reflected Monitor placement and functioning of wander guard q shift: Right ankle EXP date 1/20/28. Check skin under wander guard: Notify NP/MD if irritation occurs.</p> <p>Review of the facility's self-report to HHSC, dated 03/26/25 at 9:18 AM, reflected the ADM self-reported the incident with Resident #1 within the 24-hour timeframe: [Resident #1] exited the facility without staff knowledge and lost control of her wheelchair. A staff member on the patio saw [Resident #1] and immediately went to intervene. However, she rolled down the driveway and fell out of her wheelchair before staff could reach her. Staff assisted her back into the facility.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 03/26/25 at 10:24 AM revealed Resident #1 in the lobby. The ADM spoke to her in Spanish and asked if it was okay to take her to her room after the Surveyor requested to observe her knees. RN E attempted to explain to Resident #1 she was going to pull up her pant legs. RN E pulled up her left pant leg which revealed a small red abrasion. RN E began to pull up her right pant leg which revealed a wander guard on her right ankle. At that point, Resident #1 raised her arm and grunted, No!. RN E pulled down her pant leg and thanked Resident #1. RN E stated Resident #1 leaving the day before (03/25/25) was completely out of character for her. She stated she had never attempted to leave and had never even seen her at the entrance of the facility. She stated Resident #1 was unable to communicate or voice her needs but did let staff know when she did not want something or for care to be provided. She stated she was in-serviced yesterday (03/25/25) after the incident on the elopement process and abuse and neglect. She stated she was also in-serviced on the nursing staff being responsible for covering the front door after the Receptionist's shift had ended each day.</p> <p>During an interview on 03/26/25 at 10:34 AM, the MDSC stated she was in the conference room yesterday (03/25/25) when she heard commotion outside (front of facility). She stated she got up and saw through the window HA B moving fast towards the driveway where she saw Resident #1. She ran outside with the DON and ADON and ran after Resident #1. She stated they did not catch up to her as she rolled into the street and to the median. She stated HA B got the cars to stop. She stated when she got to the median she bumped into the curb and fell out of the wheelchair. She stated she was gotten up and was taken into the facility where she was assessed by a nurse. She stated she was in-serviced yesterday on abuse and neglect, the elopement process, which residents can leave the facility, and the elopement binders located at the Receptionist's desk and nurses' station. She stated there should always be someone manning the Receptionist's desk.</p> <p>During an interview on 03/26/25 at 10:39 AM, the HRD stated on 03/25/25 around 2:45 PM, she was in her office (which is close to the entrance of the facility) when she heard yelling and commotion coming from outside in the front. She stated she immediately went outside and saw everyone running so she took off running. She stated by the time she made it down the driveway, Resident #1 was already back in her wheelchair. She stated the Receptionist was their first line of defense when it came to determining if a resident should be exiting the facility or not. She stated she was supposed to ask if they were going out to smoke or going out on pass. She stated there was an elopement binder at her desk and the nurses' station that contained all residents that were a high risk for elopement. She stated they were in-serviced yesterday (03/25/25) on abuse and neglect, the elopement process and their policy. She stated if a resident was missing, they would check all rooms, all exit doors, and the perimeter of the facility.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 03/26/25 at 10:46 AM, the ADM stated he reviewed the video footage, and it revealed a contract worker exiting the facility around 2:50 PM and another resident in a powered wheelchair was able to catch the door before it closed completely. A third resident that was outside held the door and Resident #1 exited. He stated it was the Receptionist's responsibility to ask residents if they were going out on pass or if they were going outside to smoke. He stated if they were going out on pass, she would then need to verify it with the nurse and have the resident sign out. He stated because they have so many residents that were able to smoke independently, it was not unusual to have a lot of traffic at the front door. He stated after the incident, REC F quit. He stated he tried to interview her about what happened, but she did not give him a clear response. He stated since the contract worker did not utilize the keypad to exit, he assumed REC F used the remote to allow her to exit and did not verify or notice the other residents that were exiting. He stated if she needed to run an errand or go to the bathroom, his expectations were that she notified him so he could watch the door. He stated HA B exited the building approximately a minute after and saw Resident #1 self-propelling to the top of the driveway. He stated she immediately ran after her. He stated once she rolled to the bottom of the hill, the MDSC, DON, and ADON were seen running out of the facility and down to the resident. He stated once she hit the curb of the median, he was told the wheelchair bounced back and she fell out. He stated Resident #1 had no history of wandering or exit-seeking. He stated he had never seen her in the front lobby area. He stated she was sent to the ER and returned shortly after with no injuries. He stated she now had a wander guard and he and the DON completed an audit on all residents' elopement risk assessments as well as the elopement binders. He stated he ordered speed bumps that would be delivered that day (03/26/25) and would be installed across the driveway in order to assist in preventing a resident to go down it. He stated he also purchased a fish-eyed mirror to put in the foyer so the Receptionist would have an easier time seeing anyone that was near the door. He stated he began in-services the day prior (03/25/25) for all staff on abuse and neglect and their elopement policy. He stated they were also in-serviced on coverage of the front desk and that the nurses were responsible for covering who exited the facility after the Receptionist's shift had ended each day. He stated no one started their shift until they were in-serviced, and no one will be able to work going forward until they were.</p> <p>During an interview on 03/26/25 at 12:02 PM, REC G stated she had worked as an aide at the facility for a couple of months but was now working as the Receptionist. She stated she was trained before her shift on never using the remote to let someone out of the front door before ensuring residents were not exiting behind them. She stated she was to ask any resident that wanted to leave if they were going to smoke or going out on pass. She stated if they told her they were going out on pass, she would go verify that with their nurse and would have them sign out. She stated if she was unsure if a resident was able to exit the facility independently, she could ask a nurse or look in the elopement binder. She stated she was not to leave the front desk at any time unless she found a designee.</p> <p>During a telephone interview on 03/26/25 at 3:59 PM, HA B stated on 03/25/25 around 2:50 PM, she was coming outside after her lunch break and noticed Resident #1 going towards the driveway and then down the driveway. She stated she ran after her and tried to catch her, but her wheelchair kept picking up speed. She stated when she got to the bottom, she managed to get traffic to stop by waving her hands. She stated when her wheelchair hit the curb of the median, she fell out of her wheelchair onto her knees. She stated the MDSC, DON, and ADON arrived shortly after. She stated she was in-serviced that same day on abuse and neglect and their elopement policy. She stated it was the Receptionist's responsibility to ensure residents who were unable to leave the facility independently did not do so. She stated the Receptionist's desk should never be left unattended.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>It is the policy of this facility to provide a safe environment for all residents through appropriate assessment and interventions to prevent accidents related to unsafe wandering or elopement . Elopement is when a resident leaves the facility premises or a safe area without authorization and/or any necessary supervision to do so.</p> <p>An Immediate Jeopardy (IJ) existed on 03/25/25. The IJ was determined to be at past noncompliance as the facility had implemented actions that corrected the deficient practice prior to the beginning of the investigation.</p>		