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	05/28/2025

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 - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to accommodate the needs and preferences for one(Resident #1) of five residents reviewed for accommodation of needs, in that: The facility failed to provide a working communication system, that was easily at reach, that would allow Resident #1 the ability to safely call to staff for assistance. This failure could place residents at risk of not having a means of directly contacting caregivers in an emergency or when they need support for daily living. The findings included: Review of Resident #1's face sheet dated 05/27/25 revealed a [AGE] year old female admitted to the facility on [DATE] with diagnosis that included hemiplegia (paralysis on one side of the body) and hemiparesis (one sided muscle weakness) following cerebral infarction (stroke) affecting right dominant side, dysphagia (difficulty swallowing) following cerebral infarction (stroke), generalized anxiety disorder (condition characterized by excessive worry), and major depressive disorder-recurrent-moderate (condition characterized by persistent feeling of sadness and loss of interest). Review of Resident #1's Quarterly MDS assessment reflected a BIMS score of 10 indicating moderate cognitive impairment. Section GG for functional abilities reflected Resident #1 was dependent-helper does ALL of the effort, resident does none of the effort to complete activity or the assistance of 2 or more helpers is required for the resident to complete the activity which was marked as such for oral hygiene, toileting hygiene, shower/bathe, dressing, personal hygiene, sit to lying and lying to sit, toilet transfer, tub/shower transfer, and chair to bed transfer. Section I for active diagnosis reflected Resident #1 was identified as having a diagnosis of a stroke, non-Alzheimer's dementia, and hemiplegia/hemiparesis. Review of Resident #1's care plan included a section last revised 01/04/25 with a focus on ADL self-care performance deficit related to limited mobility, hemiplegia, impaired balance, dementia, stroke with interventions that included encourage to use call bell for assistance. An additional focus area last revised 01/04/25 also included Resident #1 is at high risk for falls related to gait/balance problems, incontinence, vision/hearing problems with interventions that included be sure call light is within reach and encourage to use it to call for assistance as needed. (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 - Few	In an observation and interview on 05/27/25 at 11:07 AM in Resident #1's room, Resident #1 was observed lying in bed and stated she had right sided pain and was not able to call staff for help because she did not know where the call light was. Resident #1's right arm was observed in a sling supporting her arm near to her chest and the call light was observed wrapped around the right bed rail and dangling off the bed close to the floor. In an observation on 05/27/25 at 11:10 AM CNA A entered the room to ask Resident #1 if she needed assistance and Resident #1 stated she was in pain. CNA A stated she would let the nurse know and was observed leaving the room without adjusting the call light (which was still near the floor) to be used by Resident #1. In an observation on 05/27/25 at 11:18 AM RN B was observed entering Resident #1's room with a medicine cup to provide Resident #1 with pain medication. After RN B completed the medication administration, he was observed leaving the room without adjusting the call light (which was still near the floor) to be used by Resident #1. In an interview on 05/27/25 at 12:11 PM with RN B, he stated it is his responsibility to ensure call lights are on the bed with the resident and in reach where it can be used before leaving a resident's room after providing care. RN B stated he just had a moment and didn't notice it. RN B stated a negative outcome of the call light not being in reach would be the resident would not be able to call for help as needed. In an interview on 05/27/25 at 12:40 PM with the DON, she stated it was her expectation that call lights are within reach of the resident. The DON stated that Resident #1 has hemiparesis to the right side as well as her sling and she would expect for staff to place the call light in reach and on the side she is able to use. In an interview on 05/28/25 at 01:26 PM with CNA A she stated that it is the expectation of the facility that staff are to ensure call lights are in reach, bed are in the lowest position, and hands are sanitized. CNA A stated that a negative outcome of residents not having call lights in reach would be they would not get the assistance they need. CNA A stated Resident #1 can only use her left side and that call lights should be placed on her left side. In an interview on 05/28/25 at 02:55 PM with the ADM, he stated it was his expectation that staff place call lights within residents' reach. He stated some call lights are specialized and can be used with their chin; he stated the call lights should be placed on the resident's usable side. The ADM stated a potential negative outcome of not placing the residents call light within reach would be the resident would not be able to get the assistance they need or communicate their needs. Review of the facility Call Light/Bell policy last revised 05/2007 revealed: It is the policy of this facility to provide the resident a means of communicating with nursing staff.

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F 0755 Level of Harm - 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 observations, interviews, 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 5 residents (Resident #1), reviewed for pharmaceutical services. The facility failed to ensure that Resident #1 was administered her 2 tablets of Acetaminophen 325 MG crushed due to her diagnosis of Dysphagia and difficulty swallowing. The medication administered by RN B (2 tablets of acetaminophen non-crushed) caused the resident to cough uncontrollably. This failure could place residents at risk for not receiving medications as ordered, aspiration, psychosocial harm/fear, and decreased quality of life. The findings included: Review of Resident #1's face sheet dated 05/27/25 revealed a [AGE] year old female admitted to the facility on [DATE] with diagnosis that included hemiplegia (paralysis on one side of the body) and hemiparesis (one sided muscle weakness) following cerebral infarction (stroke) affecting right dominant side, dysphagia (difficulty swallowing) following cerebral infarction (stroke), generalized anxiety disorder (condition characterized by excessive worry), and major depressive disorder-recurrent-moderate (condition characterized by persistent feeling of sadness and loss of interest). Review of Resident #1's Quarterly MDS assessment reflected a BIMS score of 10 indicating moderate cognitive impairment. Section GG for functional abilities reflected Resident #1 was dependent-helper does ALL of the effort, resident does none of the effort to complete activity or the assistance of 2 or more helpers is required for the resident to complete the activity which was marked as such for oral hygiene, toileting hygiene, shower/bathe, dressing, personal hygiene, sit to lying and lying to sit, toilet transfer, tub/shower transfer, and chair to bed transfer. Section I for active diagnosis reflected Resident #1 was identified as having a diagnosis of a stroke, non-Alzheimer's dementia, and hemiplegia/hemiparesis. Review of Resident #1's care plan last revised 05/27/25 reflected a focus area swallowing problem related to Dysphagia, coughing or choking swallowing meds, swallowing assessment results with interventions all staff to be informed of residents special dietary and safety needs: CRUSH MEDICATION. Review of Resident #1's swallow study physician consult summary dated 01/16/25 reflected: Diagnosis- dysphagia, dysphagia following cerebral infarction, dysphagia following unspecified cerebral vascular disease. Chief complaint: coughing, feeding difficulties, difficulties swallowing. Recommendations: Meal Diet: Pureed, thin liquids Strategies for pills: Choking risk- crush meds. Pertinent positive swallowing history: Current diet: Solids- Pureed, Liquids-thin. (continued on next page)

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F 0755 Level of Harm - Actual harm Residents Affected - Few	Indication for Dysphagia consultation- life limiting or threatening dysphagia disorder with: feeding difficulties, complaints of difficulty or pain when swallowing, coughing, determine safe diet, determine least restrictive diet. Modified Barium Swallow Study Results: Strategies for pills: choking risk- crush meds Pill trial not provided due to choking risk. Review of Resident #1's EMR undated face sheet special instructions capture on 05/27/25 reflected Special instructions: crush medication as well as Diet: REGULAR diet, PUREED texture, THIN LIQUIDS consistency. Review of Resident #1's EMR undated face sheet special instructions capture on 05/28/25 reflected, Special instructions: **CRUSH MEDS** as well as Diet: REGULAR diet, PUREED texture, THIN LIQUIDS consistency. Review of Resident #1's physician orders reflected an order dated 09/22/22, may crush meds prn, empty capsules & mix with applesauce or Jello as indicated/desired/needed. Review of Resident #1's physician orders reflected an order dated 05/27/25, Crush meds, empty capsules & mix w/ applesauce or pudding unless contraindicated. Review of Resident #1's physician orders reflected an order dated 04/04/24, acetaminophen tablet 325 mg- Give 2 tablets by mouth every 4 hours as needed for pain. Review of Resident #1's medication administration note dated 05/27/25 at 11:18 AM entered by RN B reflected, acetaminophen tablet 325 mg- give 2 tablets by mouth every 4 hours as needed for pain 1-10 do not exceed 3G/day. Resident was complaining of pain in her right shoulder where she has a fracture and administered acetaminophen per orders. Arm in sling for comfort. Will continue to monitor. In an observation on 05/27/25 at 11:18 AM RN B was observed providing pain medication to Resident #1 and walked in her room with a clear pill container that contained 2 tablets not crushed. RN B asked Resident #1 if she required crushed medications, Resident #1's response to RN B was not heard. RN B provided the medication to Resident #1 and then Resident #1 was heard immediately coughing forcibly and uncontrollably. RN B was heard asking Resident #1 continuously if she was ok and if she required more water, attempted to provide her more water which Resident #1 refused as she continued to cough to clear her throat. (continued on next page)

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F 0755 Level of Harm - Actual harm Residents Affected - Few	In an interview and observation on 05/27/25 at 12:11 PM with RN B, he stated he did not know if Resident #1 required crushed medication. He stated he doesn't usually work this building. RN B stated he would have to check Resident #1's chart and was then observed logging into Resident #1's chart. RN B stated that Resident #1 did require her medications to be crushed as stated in the special instructions located on top of the face sheet/ medical record which is where he said he would look to find that information. He stated the special instructions give you the important stuff as soon as you log into the residents' chart, as an alert located at the top being one of the first things you see. RN B stated the last time he worked with Resident #1 was 6 months ago. He stated the medication he gave which were 2 acetaminophen tablets are able to be crushed and should have been. RN B stated he did not look at the chart to determine if Resident #1 required crushed medications prior to the administration of the acetaminophen tablets but should have done so to verify correct administration. RN B stated a potential negative outcome of not providing crushed medications to Resident #1 is the resident has the potential to choke on the medication. In an interview on 05/27/25 at 12:40 PM with the DON, she stated that if residents require crushed medications its communicated through special instructions on the residents chart. The DON stated that if the special instruction say to crush medications its her expectation that medications are crushed when provided to the resident. The DON stated that any staff member that is here can see the special instructions and said, PRN staff members, CNAs, everyone know its there, its quick and it shows up at the top so they can see it. The DON stated that a negative outcome to not reviewing the chart prior to providing care, staff could provide something that is not part of their plan of care. She stated failing to crush medication for a resident that required it has the potential to result in the resident not being able to swallow the medication appropriately. The DON stated Resident #1 has good recall but that she did not believe Resident #1 had the cognition to answer the question appropriately if asked if her medication needed to be crushed instead of her chart being reviewed by staff. In an interview on 05/27/25 at 01:14 PM with Resident #1 she stated she preferred her medication to be crushed. Resident #1 stated that when she was administered the medication in the morning, when she started to choke and cough it made her scared. In an interview on 05/27/25 at 04:04 PM in a follow up interview again with Resident #1, she was once again asked about the morning medication administration and stated she recalled the incident. Resident #1 stated it made her feel terrible. In an interview on 05/27/25 at 04:09 PM with SW, she stated she believed Resident #1 would be able to say if she was in pain or scared. She said if Resident #1 said she was scared she would take it seriously but would question if Resident #1 fully understood what that meant. She stated given Resident #1's cognitive stance she is more likely to recall events tied to a strong emotion like fear or pain. (continued on next page)

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F 0755 Level of Harm - Actual harm Residents Affected - Few	In an interview on 05/28/25 at 11:10 AM with ST, she stated that when there are concerns with a residents ability to swallow they will do a bedside swallow test or have a swallow study done. ST stated that after the swallow study is completed if there is anything on the residents chart that needs to be updated, they will do so based on the swallow study providers recommendations which comes from the third party provider. ST stated since Resident #1 is on a pureed diet there is a risk of choking to occur so they will recommend pills to be crushed as a precaution. ST stated that they have attempted a mechanical soft diet in the past with Resident #1 such as with pleasure feedings but she requires a lot of cueing and would still cough. ST stated that she has worked with Resident #1 for a while and that even with the pureed diet she appears to cough a lot and looks like she's choking which can appear scary. ST stated that Resident #1 has not done well enough on pleasure feedings with a mechanical soft diet to be upgraded from a full pureed texture. ST stated that based on the swallow studies and their work with her crushed medications would go down easier and be safer for her. In an interview on 05/28/25 at 02:31 PM with the DON she stated she made the updates to Resident #1's chart pertaining to the order from may crush medications to crush medications unless contraindicated in order to ensure more consistent care. In an interview on 05/28/25 at 02:55 PM with the ADM, he stated it was his expectation that physician orders and special instructions in a resident's medical record were reviewed prior to the administration of medication. He stated a potential negative outcome of not reviewing the chart prior to providing medications is there could be a medication error. The ADM stated that a negative outcome of not following a providers recommendation related to the swallow study would be it would depend on the order or recommendation provided. Record Review of the undated Medication and Treatment Administration policy reflected: Residents shall be identified prior to the administration of a medication or treatment. Record review of the Resident Rights policy last revised 2023 reflected: You have a right to a safe, clean, comfortable, and homelike environment including but not limited to receiving treatment and supports for daily living safely.