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 03/10/2026

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure all residents were free from physical abuse for 1 of 7 (Resident #1) residents reviewed for resident-resident altercations.The facility failed to ensure Resident #2 did not hit Resident #1 on 3/06/2026.This failure could place residents at risk for psychological and physical harm.The noncompliance was identified as PNC. The noncompliance began on 3/06/2026 and ended on 3/09/2026. The facility had corrected the noncompliance before the survey began.Resident #1A record review of Resident #1's face sheet dated 3/10/2026 reflected a [AGE] year-old female admitted on [DATE] with diagnoses of congestive heart failure, cirrhosis (scarring) of the liver, type 2 diabetes (uncontrolled blood sugar), cognitive communication deficit (difficulty communicating), coagulation deficit, bipolar disorder (manic depression), major depressive disorder, hemiplegia and hemiparesis (paralysis) following cerebral infarction (stroke), chronic kidney disease, unspecified lack of coordination, vascular dementia (decreased blood flow to the brain), foot drop (right foot), and contracture (right hand).A record review of Resident #1's MDS assessment dated [DATE] reflected a BIMS of 9, which indicated moderately impaired cognition. Section E reflected that Resident #1 had no verbal, physical, or other behaviors in the 7-day look-back period. Section GG reflected that Resident #1 was dependent on staff for toileting, lower body dressing, and putting on footwear.A record review of Resident #1's care plan last revised on 1/16/2026 reflected she had ADL self-care performance deficit related to CVA with hemiparesis and staff were to observe her skin for bruising.A record review of Resident #1's change of condition assessment dated [DATE] reflected No changes observed regarding her mental status evaluation and skin evaluation.A record review of Resident #1's psychological services progress note dated 3/09/2026 reflected the following: Provider obtain report from the facility, regarding an incident with another resident and this patient, met with patient at bedside and discussed incident and distress related.Patient's Response to Intervention: Patient laying in bed, presented calm and pleasant engaged with provider in session, patient described incident in dining room, reports she doesn't know the resident buthas seen him around before, reports when he hit her in the arms and that it didn't hurt her, but it was more shocking that it happened. Patient reports staff broke it up right away, report staff have been good to her and providing her with a feeling of safety since incident happened. Patient reports she has not seen the resident since the incident, but is scared of him and that if she does see him out in the common areas, she won't engage and she will go the other way or get staff. Patient describes the situation is frustrating as she has never had problems with anyone before. Patient reportsshe feels safe in the facility because she knows the staff care for her.A record review of Resident #1's assessment dated [DATE] reflected the following: Called by the staff to the dining room to witness the resident crying and the staff was consoling. From the staff the writer came to know that another resident hit the resident on her right arm for blocking the way to the kitchen. This resident was waiting in line to talk to the speech therapist.The staff separated both of them immediately before any escalation. Head to toe assessment completed. Skin is intact. No new skin issues noticed. Resident has old bruises to both rt and lt. arm from previous hospitalization. (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 0600 Level of Harm - Actual harm Residents Affected - Few	Vitals are stable. skin assessment every 3days.During an interview on 3/10/2026 at 2:07 PM, the ADON stated that she separated Resident #2 and Resident #1 after the incident on 3/06/2026 and talked with Resident #1. The ADON stated that both residents were referred to psych and that both had already been seen. The ADON stated that the SW met with both Resident #1 and Resident #2. The ADON said that the Psych NP visited with both residents that day (3/10/2026). The ADON said that the Psych NP told her that Resident #1 was okay. The ADON stated that prior to the Psych NP coming to the facility, the Psych NP had a tele-visit with Resident #1 and Resident #2 on 3/06/2026. Resident #2A record review of Resident #2's face sheet dated 3/10/2026 reflected a [AGE] year-old male admitted on [DATE] with diagnoses of unspecified sequelae of cerebral infarction (stroke), cognitive social or emotional deficit following cerebral infarction (stroke), cognitive communication deficit (difficulty communicating), intermittent explosive disorder (sudden episodes of unwarranted anger and violent outbursts), vascular dementia, severe, with mood disturbance, adjustment disorder with anxiety, epilepsy (seizure disorder), aphasia (language disorder) following cerebral infarction, and hemiplegia and hemiparesis (paralysis) following cerebral infarction (stroke) affecting right dominant side.A record review of Resident #2's MDS assessment dated [DATE] reflected a BIMS score of 00, which indicated severely impaired cognition. Section E reflected that Resident #1 had not exhibited any verbal, physical, or other behaviors in the 7-day lookback period. Section GG reflected that Resident #1 required substantial assistance with oral hygiene and dressing.A record review of Resident #2's care plan last revised on 3/10/2026 reflected that he demonstrated physical behaviors related to expressive aphasia. Resident #2's care plan reflected that he struck another resident on 4/19/2025 and on 3/06/2026. Resident #2's interventions included analyzing triggers, increasing monitoring, psych medication review, and redirecting the resident when stressed. Date Initiated: 04/22/2025A record review of Resident #2's progress note dated 3/09/2026 reflected the following: over the weekend, reports of pt hitting another resident aggressive outburst; attempted to have UA and labs taken to assess if 2/2 acute illness causing mood disturbance, but pt refusedA record review of Resident #2's psychiatric subsequent assessment dated [DATE] reflected that Resident #2 met with the Psych NP for agitation. The note reflected that Resident #2's behaviors, diagnoses, labs, triggers, and medications were reviewed. The note reflected the Resident #2 was back at his baseline and no other behavioral disturbances had been reported over the weekend. The note reflected that Resident #2 has aphasia, and the behavior may have been related to difficulty communicating his needs effectively.A record review of the facility's one-to-one monitoring log dated 3/06/2026-3/09/2026 reflected that Resident #2 was being monitored every 15 minutes.During an observation and interview on 3/10/2026 at 3:50 PM, Resident #2 was observed sleeping in bed. CNA B was in Resident #2's room monitoring him and she said that Resident #2 could not talk but could shake his head yes or no. Resident #2 was unavailable for interview.A record review of the facility's investigation report dated 3/06/2026, indicated the incident involving Resident #1 and Resident #2 reflected safe surveys were conducted with 12 residents with no concerns regarding abuse noted.During an interview on 3/10/2026 at 1:04 PM, the Administrator stated that abuse prevention started with education and in-services on de-escalation. The Administrator stated that residents should be separated immediately and after an incident and that responsible parties were notified. The Administrator stated that Resident #2 did not have a history of physical behaviors but that he had verbal behaviors and would grunt at times. The Administrator stated that Resident #1 was not injured as a result of the resident-resident incident on 3/06/2026.During an interview on 3/10/2026 at 1:28 PM, CNA A stated that Resident #1 and Resident #2 were in the dining room on 3/06/2026 when he heard Resident #1 crying out he hit me. CNA A stated that a housekeeper was there and intervened, but he did not know their name. CNA A said that he let Resident #1 know that it would not happen again. CNA A stated that they put Resident #2 on one-to-one monitoring. CNA A stated that he had never seen Resident #2 be physical before. CNA stated that . CNA A stated that since the incident, staff made sure to monitor Resident #2 and ensure he did not come close to Resident #1. CNA A (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	stated, as soon as we see Resident #1, we make sure he's not near her and we are always observing them.During an interview on 3/10/2026 at 1:30 PM, CNA B stated that on 3/06/2026, she saw Resident #2 trying to get by Resident #1 in the dining room and she wasn't moving fast enough so Resident #2 tried to hit Resident #1. CNA B stated that RN C was the one who saw Resident #2 hit Resident #1. CNA B stated she did not hear Resident #1 state that she was in pain. CNA B stated that the residents were immediately separated and the facility did an in-service on abuse.During an observation and interview on 3/10/2026 at 1:41 PM, Resident #1 was observed sitting in her wheelchair in her room. Resident stated no she did not feel safe in the facility and started tearing up. Resident #1 stated the man did this and made a fist shape with her hand. Resident #1's left arm was observed to be bruised, but she said it was from the hospital. Resident #1 stated she did not know the man's name but when asked if it was Resident #2, she said it's him. Resident #1 then started crying and said that she was scared. Resident #1 pointed to her right arm and said this is what he did to me and said again that she was scared. Resident #1's right arm was observed to be bruised.During an interview on 3/10/2026 at 1:52 PM, RN C stated that on 3/06/2026 Resident #1 was waiting in the cafeteria to see the speech therapist and she was in Resident #2's way. RN C stated that Resident #1 could not move very quickly because she was a stroke patient and Resident #1 could not move her right side. RN C stated that Resident #2 was frustrated because Resident #1 could not move fast enough and he was pushing her chair out of the way. RN C stated Resident #2 raised his hand and started hitting Resident #1 on the right side of her arm as Resident #1 was yelling stop. RN C stated that by the time she got up from the nurses station, Resident #2 was already hitting Resident #1. RN C stated that Resident #1 had spasms on her right side, so it was painful for her to be struck on that side and Resident #1 was crying. RN C stated they separated the residents and Resident #2 started swinging at LVN D. RN C stated that Resident #2 had no history of physical aggression that she knew of.During an interview on 3/10/2026 at 2:22 PM, the SW stated that she visited with Resident #1 on 3/09/2026 about how she felt, if she was in pain, and if she felt safe.The SW stated that she did not visit with Resident #2 regarding the resident-resident incident, but that she spoke with his family member and they would have a care plan on 3/11/2026. The SW stated that Resident #1 was crying when she talked to her about the incident and she was scared but she felt safe. The SW said that the Psych NP saw Resident #1 the day prior (3/09/2026).During an interview on 3/10/2026 at 2:27 PM, the DON stated that the facility's policy on abuse included reporting allegations immediately to the Administrator, de-escalating, and investigating. The DON said that for resident-resident altercations, they put the perpetrator on one-to-one monitoring, do a change of condition assessment, monitor, and refer them to psych. The DON stated that staff were trained on prevention abuse verbally and through computer-based trainings. The DON stated that residents were monitored to ensure they were free from abuse all the time by CNAs, nurses, and all staff. The DON stated if residents experienced abuse, they could be depressed, they could cry or be secluded. The DON stated that she was aware of the bruising on Resident #1's arm and that some of the bruising was from a hospital visit. The DON stated she was aware that Resident #1 was tearful, and that was why she was scheduled to see a psychologist. The DON stated that MD saw both Resident #1 and Resident #2 on 3/09/2026. The DON stated yes, possibly that Resident #1 was affected by the altercation. The DON stated they would continue one-to-one monitoring with Resident #2 despite the Psych NP giving them the go ahead to take him off.During an interview on 3/10/2026 at 4:35 PM, the Administrator stated that residents were monitored by identifying aggression or anything out of the ordinary. The Administrator stated that Resident #1 had been upset following the incident with Resident #2, but that each time she talked with her family member, she seemed a little better.A record review of an in-service dated 3/06/2026 reflected that all staff were trained on types of abuse and reporting abuse and neglect.A record review of an in-service dated 3/06/2026 reflected that all staff were trained on resident-resident deescalation techniques. A record review of the facility's policy titled Abuse: Prevention of and Prohibition Against most recently reviewed in December of 2023 reflected the following: It is the (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	policy of this Facility that each resident has the right to be free from abuse, neglect, exploitation. and mistreatment.The Facility will provide oversight and monitoring to ensure that its staff, who are agents of the Facility, deliver care and services in a way that promotes and respects the rights of the residents to be from abuse, neglect, misappropriation of resident property, exploitation, or use of technology that would infringe on the resident's right to personal privacy.Abuse is willful infliction of injury, unreasonable confinement, intimidation, or punishment withresulting physical harm, pain, or mental anguish. This includes the deprivation by an individual,including a caretaker, of goods or services that are necessary to attain or maintain physical, mental,and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physicalcondition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physicalabuse, and mental abuse including abuse facilitated or enabled through the use of technology.