

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 06/25/2026
Form Approved OMB
No. 0938-0391

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 04/12/2026
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)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 3 residents in the 400-hall. 3 of 3 residents reviewed for infection control. The facility failed to ensure hand hygiene was completed when passing residents' breakfast trays to residents in the 400 hall. These failures could place residents at risk of disease and infection transmission. Findings include: Observation on 04/12/2025 at 8:40 AM revealed during breakfast service in the 400-hall dining room, CNA D was passing food trays to the residents. CNA D was not sanitizing her hands between handing out food trays for 3 residents. During an interview on 04/12/2026 at 11:36 AM with CNA D, she revealed she had worked at the facility for 9 months. CNA D stated she had been trained on infection control. CNA D stated that she was supposed to sanitize her hands between each tray given to residents. CNA D stated that failing to sanitize her hands could contaminate the food given to the residents. The CNA D stated that she has had in-service training on infection control, and the last time was 2 weeks ago. She stated that she forgot to sanitize her hands while passing out trays today, but she normally does sanitize her hands when passing out food trays. During an interview on 04/12/2026 at 12:37 PM with CNA E, he revealed that he had worked at the facility for 9 months. CNA E stated that when passing out food trays to residents, he double-checks the ticket. CNA E stated that he sanitizes his hands before passing out the first tray, and will sanitize his hands between each tray after that. CNA E stated that if he sees staff not sanitizing their hands, then he will remind them to do it. CNA E stated that it is important to sanitize hands while passing food trays to prevent infections in vulnerable residents. CNA E stated that he has had in-service training on hand hygiene, and the last time was about two weeks ago. During an interview on 04/12/2026 at 1:08 PM with LVN F, she revealed that she had worked at the facility for 1 year. LVN F stated that when passing out food trays, your hands should be cleaned in between passing food to each resident. LVN F stated that if she sees another staff member not sanitizing their hands while passing food to residents, she will remind them to do so. LVN F stated that she has not witnessed any staff failing to sanitize their hands while passing out food. LVN F stated that she has had in-service training on infection prevention and hand sanitizing. LVN F stated that the last time she had end-of-service training on infection control was about two weeks ago. During an interview on 04/12/2026 at 1:19 PM with CNA G, she revealed that he had worked at the facility for 1 year and 5 months. The CNA G stated that when passing out food trays, staff hands should be sanitized in between each tray passed out. CNA G stated that she has not witnessed any staff failing to sanitize their hands when passing out food to residents. CNA G stated if she did see staff not sanitizing their hands, she would mention it to them. CNA G stated that she had in-service training on hand sanitation and infection control two or three weeks ago. CNA G stated that if hands are not cleaned before passing out trays, residents could get an infection. During an interview on 04/12/2026 at 1:23 PM with DON H, she revealed that he had worked at the facility for 3 months. DON H stated that the expectations for staff to sanitize their hands in between each tray given to a resident. The DON stated that she has not witnessed any staff failing to sanitize their hands while passing out food trays. DON H stated that if she witnesses staff (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not sanitizing their hands correctly, she will correct them and have them sanitize their hands. DON H stated that she would start in-service training on hand hygiene and infection control if she sees staff not sanitizing their hands. DON H stated that if hands are not cleaned when passing food trays, it is an infection-control issue, and residents could get sick. DON H stated that she has received in-service training on infection control and hand sanitizing. The DON H stated that the last time she had in-service training was about two weeks ago. During an interview with ADM on 04/12/2026 at 1:41 PM, she revealed that it was her expectation that staff sanitize their hands while serving meals to residents. The ADM stated that if she sees staff not sanitizing their hands, she will remind them that they are supposed to do so and then start in-service training on hand sanitation and infection control. The ADM stated that if hands are not cleaned before passing out trays, it is an infection control issue and residents could get sick. The ADM stated that she had already started an in-service training after hearing that staff did not sanitize their hands while passing out food trays to residents. The ADM stated that prior to this incident, the last in-service training on hand sanitation and infection control was about two weeks ago. Record review: Policy titled, Policy/ Procedure - Nursing Clinical Meal, Serving reflected the following: 3. Sanitize hands before and after touching each tray. Policy - Infection Prevention and Control Program b. Facility personnel will wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.		