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	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Nursing and Rehabilitation Center	6801 E Riverside Dr Austin, TX 78741

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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38073 Based on observation, interview and record review, the facility failed to ensure the residents' right to be treated with respect and dignity during personal care for 2 of 4 residents (Resident #408 and Resident # 21) reviewed for respect and dignity in that: The facility failed to ensure LVN E provided privacy when providing Resident #21 with wound care. The facility failed to ensure CNA F provided privacy when providing Resident #408 with incontinent care. This failure could place residents at risk of emotional distress and low self esteem Findings included: 1. Record review of Resident #21's face sheet dated 10/29/24 revealed a [AGE] year-old male who was initially admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses were COPD, Heart Failure, Obesity, Chronic Kidney Disease, Type 2 Diabetes Mellitus, Lack of coordination, Weakness, and Dementia. Record review on 10/29/24 of Resident #21's initial MDS assessment, dated 10/16/24 revealed the assessment was not completed. Record review on 10/29/24 of Resident #21's care plan dated 10/22/24 reflected the resident had a Diabetic Ulcer r/t Diabetes and related intervention was carefully drying between toes but do not apply lotion between toes. During an observation on 10/28/24 at 12:10 p.m., LVN E provided wound care to Resident #21 while he was sitting on his wheelchair. LVN E did not close the door and drew the privacy curtain of Resident #21's room during the entire process. Resident #21's wound care was visible to the hallway. During an interview on 10/28/24 at 12:55 p.m., Resident #21 stated he did not notice if the door and privacy curtain was not closed properly. He said he would be visible to others if the door and the curtain was not closed properly. He said it would not make any difference for him personally. (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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/28/24 at 1:35pm LVN E stated, by not closing the door and the curtain, the privacy and dignity of Resident #21 was compromised as anyone passed by the room could see the wound care. When asked about the training she received on resident's rights, LVN E stated she was fully aware of resident right to have privacy, dignity, and respect and received in-service on resident's rights at least once a year. 2. Record review of Resident #408's face sheet dated 10/29/24 revealed a [AGE] year-old male who was initially admitted to the facility on [DATE]. His diagnoses were Sepsis, COPD, Cellulitis of left upper limb, Infection of the skin and subcutaneous tissue, Type 2 diabetes, muscle weakness and Unsteadiness on feet. Record review on 10/16/24 of Resident #408's initial MDS assessment, dated 10/04/24 revealed a BIMS of 14 indicating intact cognition. Further review of MDS revealed Resident #408 was always incontinent with bowel. Record review on 10/29/24 of Resident #408's care plan dated 10/08/24 reflected the resident had an ADL Self Care Performance Deficit r/t weakness, cellulitis and debility and related intervention was supporting resident with his ADLs. During an observation on 10/29/24 at 10:45 a.m., CNA F provided peri care to Resident #408. Resident #408 shared the room with another resident and Resident #408's bed was next to the door. LVN F closed the door before commencing peri care however did not close the privacy curtain so that Resident #408's body was visible to anyone who tried to enter the room. During an interview on 10/29/24 at 11:05 a.m., Resident #408 stated he did not notice about the privacy curtain. When investigator asked him how he would have felt if his naked body was exposed to others Resident #408 stated, that would be very embarrassing. During an interview on 10/29/24 at 10:55 a.m., CNA F stated he forgot to close the privacy curtain of Resident #408 and did not noticed until the investigator pointed it out. He said by not closing the curtain he did not respect resident's privacy and dignity and need to be careful about it in the future. CNA F stated Resident #408's body would have been visible to anyone who entered the room as his bed was exposed to the door without the privacy curtain. During an interview 10/17/24 at 4:35 p.m., the DON stated privacy and dignity must be provided during nursing care and the door and privacy curtain to Resident #21 and Resident #408's room should have been closed completely by LVN E and CNA F. She said the trainings was ongoing process and resident rights was one of them. The DON stated the facility ensured all the new hires had gone through skill checks. Every nursing staff also had to complete an annual evaluation to ensure their nursing skills and knowledge including competency in respecting resident's rights. During an interview on 10/17/24 at 3:30 p.m., the ADM stated the residents' rights at the facility should be maintained during nursing care. He said staff was expected to respect privacy and dignity by making sure doors to rooms were closed, privacy curtains fully drawn, and the window blinds was shut properly. During the review of facility's policy Quality of Life -Dignity revised in August 2009, reflected: (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff shall promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38073 Based on observation, interview, and record review, the facility failed to provide safe, clean, comfortable, and homelike environment and to exercise reasonable care for the protection of the resident's property from loss or theft for 1 of 24 residents (Resident #76) reviewed for personal belongings and 1 of 1 smoking area reviewed for cleanliness. 1. The facility failed to ensure Resident #76's clothes and belongings were reasonably protected from loss or theft. 2. The facility failed to ensure staff and residents disposed of cigarette butts in the designated receptacle in the facility smoking area and front porch/sidewalk on 10/29/24. These failures placed residents at risk of diminished quality of life. Findings included: 1. Review of Resident #76's face sheet revealed a [AGE] year-old man admitted on [DATE] with diagnoses of schizoaffective disorder, bipolar type (a rare mental health condition that combines symptoms of schizophrenia and bipolar disorder), paranoid schizophrenia (type of schizophrenia that involves paranoia and delusions), and mild neurocognitive disorder (mild cognitive impairment). Review of Resident #76's quarterly MDS dated [DATE] revealed resident's BIMS score of 12 which indicated a mild cognitive impairment. Review of Resident #76 medical record revealed no inventory sheet listed. During an interview on 10/28/24 at 02:36 PM, Resident #76 stated that he is missing several items. Resident #76 stated he is missing several shirts and shoes. He stated he was unsure when the items were missing and that he had mentioned in passing to a staff and was unsure who. During a resident group interview on 10/29/24 at 11:00 AM, the group stated when they send clothes to the laundry, they do not always all come back. The group stated that sometimes they end up with other residents' clothes. The group stated the facility does not take inventory of new clothes, but they put their name in the clothing. The group stated they will sometimes find their clothing in other resident's rooms or see other residents' wearing their clothing. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/30/24 at 09:02 AM, CNA A stated that there should be a list in the resident's chart of items they [NAME] in. She stated that the CNAs and nurses were responsible for writing the information on the list. She stated that CNAs or central supply was responsible for writing the residents' name on their clothing. CNA A stated that if a resident stated they were missing clothing, the CNA would help them find their clothes in the laundry area. She stated she would also let other CNAs know what clothing the resident was missing incase it was in a different resident's room. She stated that if she could not find the clothing item she would notify the DON. During an interview on 10/30/24 at 09:23 AM, CNA B stated there is a list written down with the amount of clothing the resident has. CNA B stated they reviewed the list during orientation and she believed human resources was responsible for writing down the list. She stated that no residents are missing clothing because every piece of clothing is marked when it goes to the laundry. During an interview on 10/30/24 at 09:30 AM, RN C stated that there is an inventory sheet for when a new resident comes in and it was supposed to be completed every time there was a new resident. She stated that all items the resident had were supposed to get written down on the space. She stated that new items could also be added later. She stated that new items do not always get added. RN C stated the CNAs could write down resident's name in the clothes or the resident would. She stated normally the CNA was responsible for writing down the information on the inventory sheet. RN C stated if residents were missing clothes then they would go to the laundry room and look for it and let laundry staff know. RN C stated if they still could not find the item then they were supposed to do a grievance. RN C stated the facility may replace some items. RN C stated normally the CNAs write the information on the inventory list and the nurse would verify. RN C stated that if a resident was missing items they would sometimes be upset, but the facility tried to compensate for the missing items. During an interview on 10/30/24 at 09:38 AM, LVN D stated there was a new admission packet and an inventory sheet is in there. LVN D stated typically whoever nursing was completing the admission was responsible for writing the information on the inventory list. LVN D stated CNAs help out, but the nurse filled out the form. LVN D stated if they get new items while they are here, and was brought to the staff's attention then they could add it to the inventory. LVN D stated an inventory list was supposed to be done for every new admission to keep track of things. LVN D stated the inventory list was sent to medical records and it was filed or scanned into the resident's chart. LVN D stated if something was missing, he would notify CNA to let them look for it. LVN D stated if they could not find it, he will let DON know. LVD D stated that was as far as the nurses would go. During an interview on 10/30/24 at 11:33, the BSW stated that the CNAs were responsible for marking down items that the resident comes in with. The BSW stated that typically when items were reported missing, they would go through the grievance process which goes to the BSW. She stated once the grievance is filled out, it would go the appropriate party, such as missing clothing grievances would go to laundry. The BSW stated she got quite a few grievances on missing clothing, maybe 1-2 a week. The BSW stated she does not go and look for the inventory sheet and it would be more of searching for the item when it is reported missing. The BSW stated she generally trusted that the resident had them item since she would not check them inventory sheet. The BSW stated when residents were missing items that they may be worried about their items missing, but not overly upset and may be concerned, but it depended on the resident. Resident #76 let him know she was missing items. He has been talking about missing items for quite some time. The BSW stated that concerns from resident council were brought up to social worker and then they go through the grievance process and would get assigned to the appropriate department. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on10/30/24 at 11:45 AM, HSK E she stated that nurses and CNAs were responsible for writing residents' names in their clothing. HSK E stated that there were a lot of clothes currently that do not have names on them. HSK E stated she had noticed an increase in clothing without resident names in the last few months. HSK E stated that sometimes laundry aides or CNAs would bring residents to the laundry area to look at the clothing without names if there were missing items. During an interview on 10/30/24 at 01:53 PM, the AD stated she attended every resident council meeting. The AD stated that she recorded the minutes from the meetings. AD stated that any concerns brought up during the meeting were put on a grievance form brought to morning meeting. AD stated she will hand the grievance to the responsible department. AD stated they will discuss in morning meeting the outcome or solution or how to better the concerns. The AD stated that the facility was trying to do new inventory sheets. The AD stated she believed inventory sheets will be done by marketing director, but she was unsure if CNAs or housekeeping would be responsible. The AD stated the facility does not have inventory sheets right now and stated that is how they are in the lost clothes situation. AD stated that during her four months of working here, missing clothing has been an issues during each of the resident council meetings. During an interview on 10/30/24 at 02:28 PM DON stated the activity director will go over concerns in morning meeting from resident council and then they go through grievance process. [NAME] stated sometimes resolutions were discussed in morning meetings from resident council concerns. DON stated they have discussed missing clothing concerns during morning meeting. [NAME] stated the staff discussed to ensure labeling is correct, that the labeling can be read by staff handing out clothing. DON stated missing clothes are put on a grievance form. DON stated it was a team effort for labeling clothing. DON stated the CNAs and laundry can also help with labeling. DON stated there was supposed to be an inventory sheet that is done upon admission. DON stated it was not being consistently. DON stated the inventory sheet was a part of the admission packet that the nurses completed. DON stated she was unsure who oversaw that labeling was being done. During an interview on 10/30/24 at 04:12 PM ADM stated that new admissions items brought in were supposed to be documented on the inventory sheets. ADM stated that concerns from resident council were documented on the grievance log and then given to each department to address. ADM stated that he was aware that almost monthly resident council minutes showed clothes are missing or not being return from laundry and stated that it was being addressed by upon admission writing names on clothing. ADM stated on admission, CNA, family or resident is responsible for labeling the clothing. ADM stated that inventory sheets were part of the admission process and medical records was responsible for uploading the inventory sheet as well. ADM stated that there was no facility policy regarding missing clothing or inventory. Review of facility in-services dated October 2023 to October 2024, no in-service completed on missing items, labeling items, inventory sheet. 2. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 10/29/24 at 01:29 PM revealed a large white pop-up pavilion in facility parking lot in front of the building where residents smoked throughout the day in the presence of a staff member. 91 cigarette butts were observed on the sidewalk, patio, and landscaped area in front of the building and the area underneath the smoking pavilion. There were two metal ashtrays under the pavilion, both filled with cigarette butts. Three residents were under the pavilion smoking with the DSD present, supervising. During an interview on 10/29/24 at 01:29 PM, the DSD stated she did not usually supervise the smoking tent, but the regular full time smoking aide was coming in late that day. The DSD stated she did not know who was responsible for picking up cigarette butts on the ground or what process was in place to keep the grounds clean. During an interview on 10/29/24 at 02:35 PM, the ADM stated he was not sure who exactly should have ensured cigarette butts were picked up, but the residents were supposed to extinguish their own butts in the ashtray. He stated all the residents had smoking assessments and could smoke safely and independently. He stated the presence of cigarette butts on the ground outside the facility could be a quality of life for the residents. He stated he would not want to see cigarette butts all over his front porch, and the residents might feel the same way. Review of facility policy dated 2023 and titled Resident Rights reflected the following: You have the right to a safe, clean, comfortable, and homelike environment, and use of your personal belongings to the extent possible, including, but not limited to receiving treatment and supports for daily living safely. 42600 50872

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38073 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights , that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 3 of 8 residents (Residents #100, 70, and 104) reviewed for care plans. The facility failed to ensure Residents #100, 70, and 104 had activities care plans that were person-centered and specific. This failure placed residents at risk of boredom and diminished quality of life. Findings included: 1. Review of the undated face sheet for Resident #100 reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnosis included neuromuscular dysfunction of bladder (the brain and nervous system cannot properly communicate with the bladder), pressure ulcer, polyarthritis (arthritis that affects more than five of your joints at the same time), chronic pain, acute embolism and thrombosis of deep veins of lower extremity (formation of blood clots in the blood vessels of the legs), colostomy status (surgical procedure that changes the way stool moves through the body), gastroesophageal reflux disease (chronic disease where liquid contents of the stomach reflux back into the esophagus), and congestive heart failure (a progressive disease that affects the pumping mechanism of the heart). Review of the admission MDS assessment for Resident #100 dated 09/27/24 reflected a BIMS score of 07, indicating severe cognitive impairment. The section for Activity Preferences reflected it was somewhat important to him to have books, newspapers, and magazines to read, to be around animals such as pets, do things with groups of people, and to participate in religious services or practices and very important to him to listen to music he liked, keep up with the news, and go outside to get fresh air when the weather is good. The section for ADL care reflected he was dependent on staff for all ADL care, including mobility. Review of the Admission Activity assessment dated [DATE] and completed by the AD reflected Resident #100 was currently interested in games, puzzles, arts/crafts/woodworking/ceramics, knitting/crocheting, drawing/painting, music/singing, reading/writing, spiritual/religious, trips outside the facility, walking/wheeling outdoors, watching television, gardening, exercise, talking/conversing, helping others/volunteering, parties, visits with pets, and reminiscing. Review of the care plan for Resident #100 dated 09/22/24 reflected no care planning related to recreational activities. Review of activity progress notes for Resident #100 reflected no notes from admission on 09/20/24. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of activity task documentation for Resident #100 reflected no tasks documented from 09/30/24 to 10/30/24. 2. Review of the undated face sheet for Resident #70 reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included pulmonary fibrosis (a disease in which the lungs become scarred (fibrosed) and damaged causing difficulty in breathing), hemiplegia and hemiparesis following cerebral infarction (paralysis on one side of the body following death to brain tissue), cognitive communication deficit (difficulty communicating due to cognitive impairment), lack of coordination, muscle wasting and atrophy, unsteadiness on feet, dementia, adult failure to thrive, major depressive disorder, anxiety disorder, and chronic pain. Review of the admission MDS assessment for Resident #70 dated 08/23/24 reflected a BIMS score of 12, indicating moderate cognitive impairment. The section for Activity Preferences was not completed. Review of the care plan for Resident #70 dated 10/26/24 reflected the following: Dependent on staff for activities, cognitive stimulation, social interaction r/t Cognitive deficits, Immobility, Physical Limitations. Will attend/participate in activities of choice by next review date. All staff to converse with resident while providing care. o Assistance with ADLs as required during the activity. o Assure that the activities attending are: Compatible with physical and mental capabilities; Compatible with known interests and preferences; Adapted as needed (such as large print, holders if resident lacks hand strength, task segmentation), Compatible with individual needs and abilities; and Age appropriate. o Encourage ongoing family involvement. Invite family to attend special events, activities, meals. o Invite to scheduled activities. o Provide with activities calendar. Notify resident of any changes to the calendar of activities. Review of activity progress notes for Resident #70 reflected no notes from admission on 08/19/24. Review of activity task documentation for Resident #70 reflected no tasks documented from 09/30/24 to 10/30/24. Observation and interview on 10/28/24 at 10:11 AM, revealed Resident #100 laying in bed in a hospital gown with his window open. He stated he liked to look out the window but had not done anything else in the facility. He stated he liked to do anything for fun. He stated he did not remember anyone inviting him to activities. Observation on 10/28/24 at 11:25 AM, 12:42 PM, 01:38 PM, and 02:50 PM, on 10/29/24 at 09:15 AM, 10:20 AM, 11:22 AM, 01:20 PM, 02:15 PM, 03:20 PM, and 04:34 PM, and 10/30/24 at 09:10 AM, 10:32 AM, 11:30 AM, 01:00 PM revealed Resident #100 was laying in his bed in a hospital gown with the window open and not engaged in any activities. There were no supplies or materials for any activity present in his room. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of the undated face sheet for Resident #104 reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included bilateral primary osteoarthritis of the carpometacarpal joints (arthritis in both wrists), muscle weakness, unsteadiness on feet, cognitive communication deficit (difficulty communicating due to cognitive impairment), need for assistance with personal care, bilateral (both sides) primary osteoarthritis of knee, spinal stenosis (spinal column narrowed and compressed the spinal cord), repeated falls, depression, low back pain, and malaise. Review of the admission MDS assessment for Resident #104 dated 09/02/24 reflected a BIMS score of 15, indicating intact cognition. The section for Activity Preferences reflected he was somewhat important to her to keep up with the news, and go outside to get fresh air when the weather is good, to be around animals such as pets, do things with groups of people, and to participate in religious services or practices and very important to her to have books, newspapers, and magazines to read, and to listen to music she liked. The section for ADL care reflected she was dependent on staff for transfers. Review of the Admission Activity assessment dated [DATE] and completed by the AD reflected she was currently interested in puzzles, arts/crafts/woodworking/ceramics, drawing/painting, music/singing, and reminiscing. Review of the care plan for Resident #104 dated 10/07/24 reflected the following: Dependent on staff for activities, cognitive stimulation, social interaction r/t Cognitive deficits, Immobility. Will attend/participate in activities of choice by next review date. All staff to converse with resident while providing care. o Assistance with ADLs as required during the activity. o Encourage ongoing family involvement. Invite family to attend special events, activities, meals. o Invite to scheduled activities. o Provide with activities calendar. Notify resident of any changes to the calendar of activities. There were no care plan items describing Resident #104's specific activity interests. Review of activity progress notes for Resident #104 reflected no notes from admission on 08/29/24. Review of activity task documentation for Resident #104 reflected no tasks documented from 09/30/24 to 10/30/24. Observation and interview on 10/28/24 at 11:35 AM, revealed Resident #104 was laying in bed in a hospital gown. She stated nobody from the facility had invited her to activities. There were no supplies or materials for any activity present in her room. Observation on 10/28/24 at 12:41 PM, 01:37 PM, and 02:49 PM, on 10/29/24 at 09:14 AM, 10:19 AM, 11:21 AM, 01:19 PM, 02:14 PM, 03:19 PM, and 04:33 PM, and 10/30/24 at 09:09 AM, 10:31 AM, 11:29 AM, 01:04 PM revealed Resident #104 was laying in her bed in a hospital gown and not engaged in any activities. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/30/24 at 10:52 AM, the MDSN stated she initiated the care plan items based on the MDS assessment, but the department heads, particularly the AD, were expected to go into the care plan and personalize it to reflect the specific needs of the resident. The MDSN stated the AD was new and might not have known she needed to update the care plans. The MDSN stated she did not know who was responsible for ensuring the AD updated the care plans to be personalized, but the ADM was the AD's direct supervisor. She stated the potential negative outcome of not having activities care plans personalized with specific resident interests was isolation. During an interview on 10/30/24 at 01:32 PM, the AD stated sat in the care plan meetings, asked if they liked activities, and took notes. She stated she had not learned how to update care plans to be personalized. She stated she did try to update the care plan if she discovered a specific activity a resident liked, but she was not aware until that day that she was fully responsible for that. She stated residents might feel forced to do something they did not like to do if their care plans weren't personalized with their specific activity preferences. During an interview on 10/30/24 at 02:27 PM, the DON stated she helped with care plans by initiating most of them, the MDSN added the care plan areas, and then some of the department heads added some specific information. She stated The AD was fairly new and was supposed to go train to learn more of her job, but the facility where she was supposed to train with that facility's activity director had HHSC enter for full book survey the day she was supposed to go there. The DON stated the care plan should have been person-centered and specific to the residents. During an interview on 10/30/24 at 03:50 PM, the ADM stated he monitored the activity program by having a one-to-one meeting with the AD each week. He stated she was responsible for making sure care plans were personalized and for making sure the activities program was compliant. He stated one one-to-one activity per month was not enough. The ADM stated he expected the AD to document resident activities, and specific resident interests should have been care planned. He stated a potential negative effect of residents not receiving activities or having their specific preferences care planned was it could diminish quality of life. Review of facility policy dated 01/2022 and titled Comprehensive Resident Centered Care Plans reflected the following: It is the policy of this facility that the interdisciplinary team shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives, and time frames to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. 50872

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Riverside Nursing and Rehabilitation Center	6801 E Riverside Dr Austin, TX 78741

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38073 Based on observation, interview, and record review, the facility failed to provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community for 3 of 24 residents (Residents #27, 100, and 104) reviewed for activities. The facility failed to ensure Residents #27, 100, and 104 received activities according to their preferences on their comprehensive assessments. This failure placed residents at risk of boredom and diminished quality of life. Findings included: 1. Review of Resident #27 face sheet revealed a [AGE] year-old woman admitted on [DATE] with diagnosis of senile degeneration of brain (progressive decline in cognitive functioning that can lead to memory loss, impaired thinking, and loss of independence) unspecified dementia (chronic condition that causes a decline in mental abilities such as thinking, remembering and reasoning that interferes with daily life), unspecified visual loss, unspecified sensorineural hearing loss (type of heading loss that occurs when there is no identifiable cause), absence of eye, major depressive disorder (mood disorder that causes a persistent low mood and loss of interest in activities) and anxiety disorder (mental illness that causes excessive and uncontrollable feelings of fear that can impact a person's daily life). Review of Resident #27's special instructions on her medical profile revealed she is blind, hard of hearing and enjoys listening to music or tv, religious practices, going outdoors or feeling the sun on her face. Review of Resident #27's care plan dated 12/11/2023 revealed activity preferences as relaxing to calming music with interventions to provide encouragement, reminds and transport to activities as needed. Review of Resident #27's quarterly activity assessment dated [DATE] revealed room visits were provided weekly with music therapy during meals. During an attempted interview on 10/28/2024 at 9:48 AM, Resident #27 did not respond to questions. Observation on 10/28/24 at 09:49 AM, revealed Resident #27 lying in bed. Observation on 10/28/2024 at 12:30 PM, revealed Resident #27 lying in bed. There was no music playing and the television was not on. Observation on 10/28/24 at 01:04 PM, revealed Resident #27 lying in bed. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 10/28/2024 at 2:24 PM, revealed Resident #27 lying in bed. There was no music on and the television was not on. Observation on 10/29/24 at 09:23 AM, revealed Resident #27 lying in bed. Resident had no music on. Roommate's television was on, but not Resident #27's. Observation on 10/29/24 at 11:43 AM, revealed Resident #27 lying in bed. There was no music or television on. Observation on 10/29/24 at 01:02 PM, revealed Resident #27 lying in bed. There was no music or television on. Observation on 10/30/24 at 09:01 AM, revealed Resident #27 lying in bed. There was no music or television on. 2. Review of the undated face sheet for Resident #100 reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnosis included neuromuscular dysfunction of bladder (the brain and nervous system cannot properly communicate with the bladder), pressure ulcer, polyarthritis (arthritis that affects more than five of your joints at the same time), chronic pain, acute embolism and thrombosis of deep veins of lower extremity (formation of blood clots in the blood vessels of the legs), colostomy status (surgical procedure that changes the way stool moves through the body), gastroesophageal reflux disease (chronic disease where liquid contents of the stomach reflux back into the esophagus), and congestive heart failure (a progressive disease that affects the pumping mechanism of the heart). Review of the admission MDS assessment for Resident #100 dated 09/27/24 reflected a BIMS score of 07, indicating severe cognitive impairment. The section for Activity Preferences reflected it was somewhat important to him to have books, newspapers, and magazines to read, to be around animals such as pets, do things with groups of people, and to participate in religious services or practices and very important to him to listen to music he liked, keep up with the news, and go outside to get fresh air when the weather is good. The section for ADL care reflected he was dependent on staff for all ADL care, including mobility. Review of the Admission Activity assessment dated [DATE] and completed by the AD reflected he was currently interested in games, puzzles, arts/crafts/woodworking/ceramics, knitting/crocheting, drawing/painting, music/singing, reading/writing, spiritual/religious, trips outside the facility, walking/wheeling outdoors, watching television, gardening, exercise, talking/conversing, helping others/volunteering, parties, visits with pets, and reminiscing. Review of the care plan for Resident #100 dated 09/22/24 reflected no care planning related to recreational activities. Review of activity progress notes for Resident #100 reflected no notes from admission on 09/20/24. Review of activity task documentation for Resident #100 reflected no tasks documented from 09/30/24 to 10/30/24. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 10/28/24 at 10:11 AM, revealed Resident #100 laying in bed in a hospital gown with his window open. He stated he liked to look out the window but had not done anything else in the facility. He stated he liked to do anything for fun. He stated he did not remember anyone inviting him to activities. Observation on 10/28/24 at 11:25 AM, 12:42 PM, 01:38 PM, and 02:50 PM, on 10/29/24 at 09:15 AM, 10:20 AM, 11:22 AM, 01:20 PM, 02:15 PM, 03:20 PM, and 04:34 PM, and 10/30/24 at 09:10 AM, 10:32 AM, 11:30 AM, 01:00 PM revealed Resident #100 was laying in his bed in a hospital gown with the window open and not engaged in any activities. There were no supplies or materials for any activity present in his room. 3. Review of the undated face sheet for Resident #104 reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included bilateral primary osteoarthritis of the carpometacarpal joints (arthritis in both wrists), muscle weakness, unsteadiness on feet, cognitive communication deficit (difficulty communicating due to cognitive impairment), need for assistance with personal care, bilateral (both sides) primary osteoarthritis of knee, spinal stenosis (spinal column narrowed and compressed the spinal cord), repeated falls, depression, low back pain, and malaise. Review of the admission MDS assessment for Resident #104 dated 09/02/24 reflected a BIMS score of 15, indicating intact cognition. The section for Activity Preferences reflected he was somewhat important to her to keep up with the news, and go outside to get fresh air when the weather is good, to be around animals such as pets, do things with groups of people, and to participate in religious services or practices and very important to her to have books, newspapers, and magazines to read, and to listen to music she liked. The section for ADL care reflected she was dependent on staff for transfers. Review of the Admission Activity assessment dated [DATE] and completed by the AD reflected she was currently interested in puzzles, arts/crafts/woodworking/ceramics, drawing/painting, music/singing, and reminiscing. Review of the care plan for Resident #104 dated 10/07/24 reflected the following: Dependent on staff for activities, cognitive stimulation, social interaction r/t Cognitive deficits, Immobility. Will attend/participate in activities of choice by next review date. All staff to converse with resident while providing care. o Assistance with ADLs as required during the activity. o Encourage ongoing family involvement. Invite family to attend special events, activities, meals. o Invite to scheduled activities. o Provide with activities calendar. Notify resident of any changes to the calendar of activities. There were no care plan items describing Resident #104's specific activity interests. Review of activity progress notes for Resident #104 reflected no notes from admission on 08/29/24. Review of activity task documentation for Resident #104 reflected no tasks documented from 09/30/24 to 10/30/24. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 10/28/24 at 11:35 AM, revealed Resident #104 was laying in bed in a hospital gown. She stated nobody from the facility had invited her to activities. There were no supplies or materials for any activity present in her room. Observation on 10/28/24 at 12:41 PM, 01:37 PM, and 02:49 PM, on 10/29/24 at 09:14 AM, 10:19 AM, 11:21 AM, 01:19 PM, 02:14 PM, 03:19 PM, and 04:33 PM, and 10/30/24 at 09:09 AM, 10:31 AM, 11:29 AM, 01:04 PM revealed Resident #104 was laying in her bed in a hospital gown and not engaged in any activities. During an interview on 10/30/24 at 01:33 PM, the AD stated she was not very familiar with Resident #27. The AD stated that Resident #27 does not come out of her room but that she gets one to one activities. The AD stated that Resident #27 listens to music and will get massage therapy and watch tv. AD was not aware that Resident #27 had a visual and auditory impairment. AD then stated Resident #27 listens to television. AD stated that Resident #27 gets out of her room when she works with therapy, but therapy is not at the facility on the weekends so Resident #27 does not come out of her room then. AD stated she will play whatever music is on the radio for Resident #27. AD stated that Resident #27 has one to one activities done once a month. She stated when Resident #27 does not get a one-to-one activity she is not sure what she does. She stated the CNAs will usually put on country music for Resident #27 but no checks to ensure that music is put on. The AD stated Resident #100 usually stayed in bed, so his activities were more one-on-one. She stated he liked to watch the bird feeders out the window. She stated Resident #104 did not like to come out of her room, and the AD tried to go get her, but she needed to do more with Resident #104. The AD stated that sometimes Resident #88 did gardening. AD stated that on the weekends they have university students come and they will bring math, history writing activities and cup pong. AD stated Resident #88 does not participate in that activity. AD stated Resident #88 does comes out for social activities. AD stated that he has not come out this week for any activities. AD stated she was not sure why he has not come out for activities. AD stated she would not consider watching television with no volume on activity. AD stated everyone is responsible for ensuring that the television is on with something they like and volume is on. The AD stated she did not log her activities anywhere and had no documentation of specific residents participating in specific activities. She stated the one-to-one activities were completed on the weekends, and she rotated a hall each weekend, so each resident who required one-to-one activities received them once every four weeks. During an interview on 10/30/24 at 02:27 PM, the DON stated before the AD, they had someone doing the activities program who did a terrible job, and the AD is so much better. The DON stated they had seen a liveliness return to the activities program as a result of the AD being there. The DON stated one activity per month was not enough. She stated she did not know what would be enough, but she would think one one-to-one activity per week at least was the minimum. During an interview on 10/30/24 at 03:50 PM, the ADM stated he monitored the activity program by having a one-to-one meeting with the AD each week. He stated the AD was responsible for making sure care plans were personalized and for making sure the activities program was compliant. He stated one one-to-one activity per month was not enough. The ADM stated he expected the AD to document resident activities, and specific resident interests should have been care planned. He stated a potential negative effect of residents not receiving activities or having their specific preferences care planned was it could diminish quality of life. He stated there was no written policy related to activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	42600

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50872 Based on observation, interviews, and record review the facility failed to assist residents in obtaining routine dental services to meet the needs of 1 of 7 (Resident #15) reviewed for dental services. The facility failed to assist Resident #15 with obtaining dental services in a timely manner when her bottom dentures broke sometime after May 2024. This deficient practice could affect residents by placing them at risk of not receiving necessary care and services to maintain the highest practicable physical, mental, and psychosocial well-being which could result in decreased quality of life. Findings included: Record review of Resident #15's face sheet dated 10/29/2024 with an admitted [DATE] reflected a [AGE] year-old female with diagnoses including but not limited to rotator cuff tear or rupture of left and right shoulders (damage to the shoulder muscle), chronic obstructive pulmonary disease (an ongoing lung condition caused by damage to the lungs), dysphagia (difficulty swallowing), cognitive communication deficit (difficulty communicating), muscle weakness, lack of coordination, major depressive disorder (a mood disorder that causes persistent feelings of sadness and loss of interest), and peripheral vascular disease (disorder of the blood vessels in the legs causing decreased blood circulation). Record review of Resident #15's quarterly BIMS assessment dated [DATE] reflects a BIMS score of 15 which indicated no cognitive impairment at the time of assessment. Record review of Resident #15's quarterly MDS dated [DATE] reflected Resident #15 required setup or clean-up assistance for eating. Resident #15 was completely dependent on staff for showering, upper and lower body dressing and putting on and taking off footwear. The MDS also reflected Resident #15 required partial/moderate assistance for personal hygiene such as combing hair, washing and drying face, and washing hands. MDS reflected no weight loss of 5% in the last month or 10% or more in the last 6 months under the swallowing/nutritional status section. MDS reflected under oral/dental status, no broken or loosely fitting full or partial denture and no mouth or facial pain, discomfort, or difficulty chewing. Record review of Resident #15's orders dated 10/11/2024 reflected resident is on a regular diet with regular texture and thin liquid consistency. Record review or Resident #15's care plan dated initiated 10/7/2022 reflected Resident #15 had ADL self-care performance deficit related to impaired balance, limited ROM, OA to bilateral (both) shoulders and knees with interventions of staff assist for toilet use, bed mobility, bathing, dressing and transfers. Intervention reflected resident requires 1 staff to set up and assist with meals. Record review of Resident #15's dental visit progress noted dated 7/12/2024 indicated broken bottom dentures. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of dental progress note dated 8/13/2024 reflected insurance approval for repair of bottom denture and dentures sent off to lab for repair. Record review of dental progress note dated 9/26/2024 reflected Patient tells me she does not have her repaired denture, I contacted lab and they gave me tracking number from when it was delivered, shows 8/27/24 around 11am. I have spoken with receptionist, her nurse, another nurse nobody knows where it is. I have tried speaking to social worker but not available, not sure what to do at this time. Record review of emails between BSW and priority care specialist with dental office dated 10/2/2024 at 4:09 PM, stated Resident #15 turned in a pair of dentures to be fixed and asked for delivery details. Email response from dental office on 10/3/2024 at 10:17 AM provides tracking number and (wrong)date/time of delivery. Follow up email on 10/08/24 at 10:15 AM from BSW to dental office stated they were unable to locate the dentures and to set up appointment for resident to be fitted for new bottom dentures. Response from dental office to BSW on 10/08/2024 at 11:11 AM indicated resident was put on the schedule for 10/21/2024. Record review of dental progress note on 10/21/24 revealed Patient was scheduled to be treated today but was not treated. Reason: Patient was Not Due for treatment: patient doesn't have lower, I have tracking Number from ups that shows date, time and place it was left. nobody that I have spoken with seems to know, will include copy of tracking # in the fax. During observation and interview on 10/28/2024 at 12:11 PM, Resident #15 was sitting up in wheelchair with food tray on table. Food appeared untouched. Resident stated her dentures were broken and she wanted them repaired. Not having dentures make it uncomfortable to chew food. Resident also stated she is unaware of any process to find or replace her dentures at this time. Denied any communication from staff related to this issue. During interview on 10/29/2024 at 4:24 PM, with ADM stated that lost items was to go through the grievance process and if a resident stated that a package was delivered, and they did not receive it then a tracking number is needed to follow up to see when it was delivered, and cameras would be reviewed. The ADM also stated the social worker was supposed to find out what happened to the missing dentures, but stated he told the social worker if her dentures could not be found to order new ones for the resident. During interview on 10/30/2024 at 2:08 PM, the DON stated her expectation of staff for broken dentures are to notify her or the social worker to follow up. Stated having broken or missing dentures could put a resident a risk because they have no proper way to chew which could cause choking. The DON also stated not having bottom dentures could negatively affect a resident's dignity. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 10/30/2024 at 3:01 PM, the BSW stated missing items were to go through the grievance process and she oversees that process. She stated the forms are outside of her door and she or any other staff can assist a resident in filling out the form as needed. The BSW stated if a missing article is not located then she works with the resident to come up with an appropriate agreement for the missing item. If a resident's dentures were reported broken to her then she schedules a dentist appointment for the resident to be seen as soon as possible. She stated that she contacted the dentist about the missing broken dentures and has gone back and forth in multiple emails since the dentures have not been located. The BSW stated Resident #15 has reported uncomfortable chewing since not having her bottom dentures. The BSW stated she would provide all emails and follow ups with the dental office related to the dentures. During interview on 10/30/2024 at 3:54 PM, the ADM revealed cameras reviewed for missing packages only go back for 30 day and he was unable to look back at when the package was delivered. He also stated if dentures were broken, he would expect for staff to document it in the resident's chart. The ADM stated he just reviewed the policy for dental care and realized he only has 3 days to start working on getting the resident seen by the dentist. Record review of facility Dental Services policy dated 1/1/2024 reflected under heading Policy: It is the policy of this facility to ensure that its residents who require dental services on a routine or emergency basis have access to such services without barrier. It is likewise the policy of the facility to repair or replace dentures of a resident except in those situations where the loss or damage directly results from the action of an alert and oriented resident who is responsible for his/her own medical decisions. Under heading Procedure: 1.In the event that a Facility resident experiences loss or damage to his/her dentures, the Facility will: o Gather the necessary facts and information in order to make a determination as to whether the loss/damage directly results from the action of an alert and oriented resident who is responsible for his/her own medical decisions. o If so, and absent some extenuating or unusual circumstance, the Facility will not be financially responsible for the repair or replacement. o If not, and absent some extenuating or unusual circumstance, the Facility will be financially responsible for the repair or replacement. o If it is determined that the Facility is responsible for the loss of or damage to the dentures, there will be no charge to the resident for the repair or replacement. Repair or replacement will be accomplished in a reasonable manner, with the goal of returning the resident to his/her dentition baseline pre-loss or damage. 2. In the event that a Facility resident requires emergency dental services, for the repair or replacement of dentures or otherwise, the Facility will: (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	o Promptly and, in any event, no later than three (3) business days from the date of loss/damage, refer the resident for dental services. o Assist the resident in making the necessary dental appointments, when necessary or requested. o Arrange for transportation to and from the dental services appointment/location, using the lowest cost or no cost option to minimize the financial burden on the resident. 3. If a referral for dental services does not occur within three (3) business days from the date of the loss/damage, the Facility will: o Document what actions were taken to ensure the resident could eat, drink and communicate (if applicable) adequately while awaiting dental services. o Document the nature of the extenuating circumstances which led to the delay.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38073 Based on observation, interview, and record review, the facility failed to provide food that accommodated resident allergies, intolerances, or preferences for 1 of 9 residents (Resident #24) reviewed for meal preferences. The facility failed to cut Resident #24's meat according to her meal ticket during lunch 10/28/24, dinner 10/29/24, and lunch 10/30/24 and failed to ensure she was not served squash, which her meal ticket reflected she disliked. This failure placed residents at risk of weight loss and diminished quality of life. Findings included: Review of the undated face sheet for Resident #24 reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included essential tremor (a nervous system condition, also known as a neurological condition, that causes involuntary and rhythmic shaking), lack of coordination, muscle weakness, and need for assistance with personal care. Review of the Functional Performance Observation (Section GG of the MDS assessment) for Resident #24 dated 10/30/24 reflected she required set up or clean up assistance with eating . Review of the BIMS assessment for Resident #24 dated 09/25/24 reflected a score of 15, indicating intact cognition. Review of the care plan for Resident #24 dated 05/02/24 reflected the following: ADL Self Care Performance Deficit r/t Limited Mobility. Will safely perform Bed Mobility, Transfers, Eating, Dressing, Grooming, Toilet Use and Personal Hygiene with modified independence through the review date. EATING: resident requires set up and supervision of staff to eat. Observation and interview on 10/28/24 at 12:25 PM, revealed Resident #24 revealed an aide delivered her lunch meal of fried chicken breast with gravy, mashed potatoes, and green beans. The chicken breast was whole, and the aide did not offer to cut it. Resident #24 presented her meal ticket, which had the words, Cut all meats at all meals printed on it. It also listed her dislikes as beans, beets, Mexican food, seafood, and squash. Resident #24 stated the staff never cut her meat at meals and often sent food out on her plate that her meal ticket indicated she disliked. Resident #24 stated she was capable of cutting her own meat, but it was hard for her, because her hands shook. She stated that it also made her feel unimportant that nobody at the facility paid attention to her meal ticket. Observation on 10/29/24 at 05:23 PM, revealed an aide served Resident #24 a dinner meal with a smothered pork chop, mashed potatoes, and greens. The pork chop was not cut up, and the aide did not offer to cut it up. Resident #24 cut her own pork chop slowly and with trembling hands. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 10/30/24 at 12:20 PM, revealed the ADOR served Resident #24 her lunch plate which had Swiss steak, rice, and mixed vegetables including squash. The ADOR did not cut the meat for Resident #24 or note that the tray had a vegetable on it that was listed in her dislikes. The ADOR stated she did not know who was responsible for cutting meat on the resident's plate if the resident's meal ticket reflected the resident's meat should be cut. The ADOR stated she did not know who should have looked at the ticket to ensure disliked foods were not served to the residents, but she thought it might have been the dietary staff. She offered to cut Resident #24's meat for her, and Resident #24 stated it was okay, and she would do it herself at that time. The ADOR walked away, and Resident #24 stated she did not like to bother people or complain but she wished they would read the ticket. During an interview on 10/30/24 at 01:40 PM, the DM stated he added resident likes and dislikes to the meal tickets and the aides, cooks, and nurses were supposed to look at follow the meal tickets as they were preparing and serving the meals. The DM stated he had not received any complaints from Resident #24. He stated the aides went around taking meal orders from the residents, and they would strike off anything the residents did not want, but the menu item that day was called Italian vegetables and it did not say what was in them. He stated someone in the process to get the meals out- dietary aides, cooks, and nursing staff- should have noticed there was food on the tray Resident #24 did not want, and that was a three-fold failure. He stated the people responsible for cutting Resident #24's meat according to her meal ticket were the staff who brought meals to the table. He stated that was the nursing staff, usually the CNAs. The DM stated a potential negative impact of the failure was Resident #24 was dissatisfaction. During an interview on 10/30/24 at 02:27 PM, the DON stated the responsibility for cutting meat according to the meal ticket was the responsibility of whoever served it. She stated the staff were trained to check the tickets and read what was on the meal ticket. She stated she could not remember when the last training was about the topic. She stated it could be a problem for residents if they did not get their meat cut by the staff serving the food. During an interview on 10/30/24 at 03:50 PM, the ADM stated the people responsible for ensuring the meal ticket was followed if it said to cut all meats were the staff who served the meals. He stated the ADOR had said Resident #24 declined to have her meat cut when served the tray, but he was aware that the offer came after the surveyor asked about the instructions on the meal ticket and why they had not been followed. The ADM stated it could lessen the residents' quality of life if the staff serving their meal trays ignored instruction on their meal tickets. Review of facility policy dated 2023 and title Resident Rights reflected the following: Self determination. You have the right to self-determination through support of your choice, including the right to: choose activities, schedules, healthcare, and providers of healthcare services, consistent with your interests, assessments, plan of care; make choices about aspects of your life and the facility that are significant to you.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45070 Based on observation, interview and record review, the facility failed to maintain an infection and prevention control program that included, at a minimum, a system for preventing and controlling infections for 5 of 12 residents (Resident #7, Resident #16, Resident #47, Resident #104, and Resident #408) reviewed for infection control, as indicated by: The facility failed to ensure : 1. CNA G and CNA F performed clean practices during peri care for Resident # 104 and Resident 408 2. CNA J sanitized her hands between residents while passing meal trays to Residents in Hall #100. 3. MA I sanitized her hands before preparing medications, medical equipment after contact with Resident #7 , Resident #16 and Resident #47. These failures could place the residents at risk of transmission of diseases and infection. Findings included: 1. Record review of Resident #104's face sheet dated 10/29/24 revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Her diagnoses were unsteadiness on feet, low back pain, cognitive communication deficit and need for assistance with personal care. Record review on 10/29/24 of Resident #104's initial MDS assessment, dated 09/11/24 revealed her BIMS was 15 indicating her cognition was intact. MDS indicated he needed support with ADLs. Record review on 10/29/24 of Resident #104's care plan dated 08/30/24 reflected the resident had ADL self-care performance deficit r/t pain, decreased mobility, and weakness and the relevant intervention was helping him with the ADLs. During an observation on 10/28/24 at 10:10 a.m., CNA G was performing peri care for Resident #104 with the help of CNA H. CNA G donned gloves without washing or sanitizing her hands. She then opened the brief and cleaned the fecal matters from the front and back with wet wipes that she took directly from the packet ,with her soiled gloves. After finishing the cleaning, she changed the gloves and applied the new brief . After the completion of the task, she saved the contaminated wet wipe packet with remaining wipes, on the side table; beside an incentive spirometer (A mechanical hand-held breathing device that gives the patient visual feedback on the volume of the inhalation), lotions, creams and shampoo. CNA G did not wash or sanitize her hands after the completion of the peri care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/28/24 at 1:45 p.m., CNA G stated she thought she was following the infection control protocol while providing peri care., CNA G stated she should have washed her hands before and after the peri care. She stated she contaminated the wet wipe packet by handling it with gloves soiled with fecal matters. CNA G said since the wet wipe packet was contaminated , she should have thrown it away. CNA G said unhygienic practices caused contamination that eventually spread germs. CNA G said she started working at the facility about a month ago and received training on infection control during the orientation classes. 2. Record review of Resident #408's face sheet dated 10/29/24 revealed a [AGE] year-old male who was initially admitted to the facility on [DATE]. His diagnoses was Sepsis, COPD, Cellulitis (deeper bacterial skin infection) of left upper limb, Type 2 diabetes, Muscle weakness and Unsteadiness on feet. Record review on 10/16/24 of Resident #408's initial MDS assessment, dated 10/04/24 revealed a BIMS of 14 indicating intact cognition. Record review on 10/29/24 of Resident #408's care plan dated 10/08/24 reflected the resident had chemotherapy r/t leukemia (Blood cancer) and relevant intervention was keeping the environment clean as he was at the risk for contracting infections due to chemotherapy. During an observation on 10/29/24 at 10:45 a.m., CNA F provided peri care to Resident #408. CNA F put on a new pair of gloves, he did not wash or sanitize his hands before donning the gloves. CNA F removed the old brief and cleaned Resident #408's front and back with wet wipes. During this process he handled the wet wipe packet with soiled gloves. After the completion of peri care he stored the contaminated wet wipe packet on the side table and left the room without washing or sanitizing his hands and moved on to the next resident. During an interview on 10/29/24 at 11:15 a.m., CNA F requested the investigator to walk through the peri care process that he did so that he would be able identify the mistakes. After the completion he said he should not have handled the wet wipe packet with dirty gloves. He stated he knew washing hands before and after the peri care was instructed at the facility however forgot to practice it at the time of peri care. He said his wrong practices could promote spreading various diseases. Record review of the in-service records revealed since 05/01/2024 there was one in service conducted on peri care. On 10/08/24 'Check off on peri care was conducted and CNA G and CNA F had not attended the in-service 3. Record review of Resident #7's face sheet dated 10/20/2024 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included but were not limited to dementia (difficulty with thinking processes), hypertension (high blood pressure), diabetes mellitus (inability to maintain blood sugars), and paroxysmal atrial fibrillation (an abnormal heart rhythm). Record review of Resident #7's quarterly BIMS assessment dated [DATE] revealed a BIMS score of 0 which indicated severe cognitive impairment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #16's face sheet dated 10/29/2024 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included but were not limited to Chronic Obstructive Pulmonary Disease (a progressive disease affecting the lungs and making it difficult to breathe), diabetes mellitus (inability to maintain blood sugars), cognitive communication deficit (difficulty communicating), and chronic kidney disease (the kidneys are not able to filter toxins as well). Record review of Resident #16's quarterly BIMS assessment dated [DATE] revealed a BIMS score of 12 which indicated mild cognitive impairment. Record review of Resident #47's face sheet dated 10/29/2024 revealed a [AGE] year-old-male admitted to the facility on [DATE] with diagnoses that included but were not limited to Diabetes Mellitus (inability to maintain blood sugars), dementia (difficulty with thinking processes), hypertension (high blood pressure), and chronic kidney disease (the kidney's inability to filter toxins in the blood). Record review of Resident #47's quarterly BIMS assessment dated [DATE] revealed a BIMS score of 6 which indicated moderate cognitive impairment. Observation on 10/28/2024 at 1:14 PM, revealed CNA J came out of a resident's room down the 100-hall with a dirty breakfast tray, set tray down on lower part of the meal cart, walked around to other side of the meal cart, pulled a lunch tray and delivered it to different room across the hall. Observation on 10/29/2024 at 7:47 AM, revealed MA I picked up wrist blood pressure cuff off top of medication cart, approached Resident #7 and checked blood pressure using wrist blood pressure cuff. MA I returned to medication cart, set the blood pressure down cuff on top of the cart (without sanitizing it or her hands), pulled keys from pocket, unlocked medication cart and proceeded to pull medication cards for Resident #7. MA I proceeded to gather scheduled medications for the resident. She returned the medication cards to the cart, locked the cart and returned to Resident #7 to administer medications (without sanitizing hands). MA I asked resident if he wanted his pain patch today. Resident stated yes. MA I returned to medication cart. Unlocked cart, pulled Lidocaine patch from cart, locked cart, then opened the package and dated the patch. MA I then put on gloves and returned to the resident to apply patch to lower back and took off gloves and threw them away. She then returned to the cart and sanitized her hand with hand sanitizer. Observation on 10/29/2024 at 7:57 AM, revealed MA I unlocked the medication cart, applied gloves, pulled out purple top sanitizing wipes from bottom drawer and sanitized the wrist blood pressure cuff, then took off gloves. MA I then approached Resident #16 and checked blood pressure. MA I then returned to medication cart and set blood pressure cuff down on top of cart (without sanitizing blood pressure cuff or hands), unlocked cart and pulled medication cards from the medication cart. MA I prepared scheduled medication then returned to Resident #16 (without sanitizing hands) to administer medication. After administering medications to Resident #16, MA I walked into the bathroom and washed hands with soap for approximately 5 seconds, hands dried and MA I returned to medication cart. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 10/29/2024 at 8:07 AM, MA I applied gloves, unlocked medication cart, removed sanitizing wipes and proceeded to sanitize wrist blood pressure cuff and removed gloves, then locked cart. MA I approached resident and checked vital signs on Resident # 47. MA I returned to medication cart, set blood pressure cuff down on top of the cart, unlocked cart, took medications out of cart and prepared scheduled medications by putting tablets in a cup and a capsule in a separate cup. She then put all tablets into a pill crusher pouch and used the pill crusher to crush all tablets. The crushed tablets were poured into a plastic cup. MA I then applied gloves, opened the remaining capsule and poured it over the other crushed medications. She removed her gloves, grabbed a new container of vanilla pudding and opened it. With a new spoon she put a spoonful of pudding on top of the medications in the cup. MA I then dated the top of the pudding with a sharpie that way laying on top of the medication cart. She stirred the medications in with the pudding, locked the cart and returned to Resident # 47 and administered medications. After returning the medication cart MA I then sanitized her hands. Interview on 10/30/2024 at 12:13 PM, LVN D stated hands should be sanitized before preparing medication, before going into room to administer medications, and after administering medications. LVN D stated not doing so could cause infection or sickness. LVN D stated all medical equipment for checking vital signs should be sanitized before use and not doing so could cause cross contamination, skin infections by transferring bacteria and viruses. Phone Interview on 10/30/2024 at 3:37 PM, MA I stated hands should be sanitized between each resident and washed for a minute every third resident. She also stated that the blood pressure cuff should be sanitized prior to use. Stated that during medication pass she used hand sanitizer from her pocket but does not recall how long she washed her hands for. She stated she was unsure if blood pressure cuffs were to be sanitized after use or before use. MA I said she did not think about a cuff not being sanitized before setting on the cart could contaminate the cart and the medication does not touch the top of the cart. MA I stated not sanitizing her hands could cause contamination from resident to resident and transmit viruses and disease to others or ourself. Phone interview attempted on 10/30/2024 at 3:45 PM, with CNA J attempted, but phone number was not in service. Interview on 10/30/2024 at 2:08 PM, the DON stated she expected the staff to wash or sanitize their hands and clean the relevant surfaces before and after any nursing care like wound care, peri care, between passing food trays and when preparing and administering medications. The DON said medical equipment like the blood pressure cuff should be sanitized before and after use. She stated not sanitizing hands and equipment appropriately could cause spreading infections and diseases. Record review of Policy/Procedure named Infection Control: General Cleaning and Maintenance of Equipment dated 1/2024 stated It is the policy of this facility that all resident care equipment will be cleaned and decontaminated after use and will be prepared for reuse by the same or another resident. Equipment will be cleaned and decontaminated according to manufacturer's recommendation. Procedures: All equipment and supplies will be cleaned and decontaminated immediately after use. Record review of policy named Specific Medication Administration Procedures dated 11/13/2018 states: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. General procedures to follow for all medications. G. Cleanse hands before handling medication and before contact with resident. Record review of Policy/Procedure: Nursing Clinical revised in January 24 reflected: It is the policy of this facility to cleanse hands to prevent transmission of possible infectious material and to provide clean, healthy environment for residents and staff. 50872

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 38073 45070 Based on observation, interview, and record review the facility failed to maintain an effective pest control program so that the facility is free of pests for 1 of 1 facility reviewed for physical environment. The facility failed to provide an effective pest control program for flies and cockroaches in the facility. This deficient practice could place residents at risk of remaining in an environment that was not free of pests. The findings include: Observation on 10/29/2024 at 10:07 AM, in Resident #9's room of a dark brown cockroach (about the size of a quarter) crawled out from under the closet door, across the floor, and went under the bed. Interview on 10/29/2024 at 10:07 AM, with Resident #9 stated she has not seen a bug like that before in her room. Resident #9 stated she does not like the thought of having bugs in her room. During an observation and interview on 10/29/24 at 10:15 AM, in Resident #408's room there were 2 flies crawling on the side table, bed, and Resident #408's body. Resident #408 stated there were flies always in his room since his admission to the facility. He stated he complained to the staff numerous occasions however no actions taken. During an interview and observation on 10/29/24 at 10:45 AM, two flies was crawling on Resident #408. CNA F who was present in the room stated he saw the flies however did not report to anyone. He stated flies could spread diseases through contamination. Observation on 10/29/24 at 05:18 PM, in the dining room revealed a fly landed on the surveyor's leg during observations of the dinner meal. During interview on 10/30/2024 at 11:35 AM, with CNA L stated she had not seen any bugs in the facility but if she were to see one, she would inform the nurse on duty or housekeeping manager. Observation on 10/30/2024 at 12:13 PM, in 100-hall revealed a fly. The fly landed on top of the computer. During an interview on 10/30/24 at 1:30 PM, the ADM stated the pest control agency did the treatment twice a month and it was up to date. The ADM said the pest control treatment might not be fully effective since there were insect activities at the facility. The ADM stated he was committed to have a post-free facility as they were harmful to residents many ways like causing insect bites or spreading various diseases however no one reported to him about any insect activities at the facility. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of pest control records revealed the pest control agency visited the facility and did the treatment on 10/22/24. It was also revealed they visited the facility every 15 days for treatment. Record review of the facility's undated policy Pest Control reflected : Policy - It is the policy of this facility to utilize pesticides and rodenticides in a safe and efficient manner to control pests with at least amount of contamination to the environment . 1. Report any pest sightings and file a report using the TELS system. 2. Document problems found during inspection and the remedial actions taken 3. Advise staff on preventive measure, unsanitary conditions, etc 4. Secure services of a Pest Control company for routine and PRN services to control pests with the least amount of contamination to the environment. Pest Identification: The following guidelines for pest identification: 1. When pests are sighted, determine why the infestation is occurring and advise department on preventive measures 2. Use pesticides only after all other channels of control are exhausted 3. Use pesticides only as a preventive measure and in conjunction with proper mechanical controls 4. Report insect or pest sightings to the housekeeping/maintenance supervisor immediately. Include the following information: a. Type of problem b. Location c. Person reporting and time reported