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	01/15/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure that a resident received services with reasonable accommodation of the resident's needs and preferences for 1 of 5 residents (Resident #66) reviewed for resident rights. The facility failed to ensure Resident #66's call light was within reach on 01/13/2026. This failure could place residents at risk for unmet needs, delayed care, and injury.Findings included: Record Review of Resident #66's face sheet dated 01/15/2026 reflected the resident was an [AGE] year-old male admitted on [DATE]. His diagnoses included heart failure, atherosclerotic heart disease of native coronary artery (heart disease involving the reduction of blood flow to the cardiac muscle due to a buildup of atheromatous plaque in the arteries of the heart), chronic obstructive pulmonary disease (COPD) (a lung disease characterized by chronic respiratory symptoms and airflow limitation), polyneuropathy (a condition that involves damage to multiple nerves throughout the body) and chronic pain. Record Review of Resident #66's Quarterly MDS dated [DATE] reflected Resident #66 had almost constant pain, received oxygen therapy, used a wheelchair, and required partial or moderate assistance for toileting, lower body dressing, oral and personal hygiene, bathing, and transfers. The MDS reflected Resident #66 had a BIMS score of 14 which indicated no cognitive impairment. Record review of the Resident #66's care plan dated 12/23/2025 reflected the resident was at high risk for falls r/t gait and balance problems. Interventions included: Be sure the call light is within reach . Furthermore, the resident had potential for pressure ulcer development r/t history of pressure ulcers and immobility. Interventions included: Call light within reach. Record review of Resident #66's orders dated 01/15/2026 reflected the resident was admitted to hospice care and received oxygen therapy and multiple pain medications, including Morphine Sulfate oral solution, Methadone, and Hydrocodoneˆ Acetaminophen. During an observation and interview on 01/13/2026 at 11:28 AM, Resident #66 was lying in bed with an oxygen nasal cannula in place. The resident stated he was in pain. The surveyor observed the resident's call light lying on the floor directly behind the bed and out of the resident's reach. The resident stated he did not know where his call light was, could not reach it, and would have to wait until staff passed by his room to get help. He stated he did not know how long the call light had been on the floor. In an interview on 01/13/2026 at 11:45 AM, CNA C stated all residents' call lights should always be within reach. He stated Resident #66 could not have reached the call light where it was lying on the floor when the surveyor saw it. He stated he had been inˆserviced on call light placement and that a call light out of reach could cause injury or delay in care. CNA C was observed picking up the call light and clipping it to the resident's bed sheet. He stated it was everyone's responsibility to check for call light placement. In an interview on 01/14/2026 at 9:10 AM, LVN E stated all residents' call lights should always be within reach. She stated a call light out of reach could cause a resident to fall or prevent the resident from alerting staff, resulting in unmet needs or delayed response. She stated Resident #66 could not have reached the call light where it was lying on the floor when the surveyor saw it.She stated she was trained in call light placement, and it was everyone's responsibility to check for call light placement. In an interview on 01/14/2026 at 3:39 PM, the ADON stated it was her expectation that all residents' call lights should always be within reach. She stated a call light out of reach could cause a resident to (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	fall, become injured, or experience delayed care. She stated Resident #66 could not have reached the call light where it was lying on the floor when the surveyor saw it. She stated staff have been trained in call light placement, and it was everyone's responsibility to check for call light placement. In an interview on 01/15/2026 at 11:21 AM, the DON stated it was her expectation that all residents' call lights always be within reach. She stated that a resident unable to reach their call light could not communicate needs, which could result in injury, pain, or delayed care. She stated Resident #66 could not have reached the call light where it was lying on the floor when the surveyor saw it.She stated staff have been trained in call light placement and it was everyone's responsibility to check for call light placement during morning rounds. In an interview on 01/15/2026 at 11:44 AM, the ADM stated it was his expectation that all residents always had their call lights within reach. He stated a call light out of reach could cause anxiety or delay in receiving pain medication or other needed care. He stated a call light on the floor behind a resident's bed would be out of reach and did not meet his expectations. He stated it was everyone's responsibility to check for call light placement. Record review of the facility policy titled Call Light/Bell, dated 05/2007 (revised 2026), reflected: Policy: It is the policy of this facility to provide the resident a means of communication with nursing staff. Procedures: 5. Place the call device within residents' reach before leaving the room. Record review of facility Inˆservice Training dated 10/01/2025 and 10/08/2025 reflected staff were trained that Call lights should be placed in reach of all residents at all times.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents were given the appropriate treatment and services to carry out the activities of daily living (ADLs) for 1 of 6 residents (Resident #69) reviewed for ADL abilities, in that: Resident #69's nails were long, jagged, and dirty and had built-up dirt and grime underneath all fingernails on 01/13/26. This deficient practice could place residents who required assistance for trimming, cleaning, and filing their nails which could put residents at risk for infections and skin concerns. Findings included: Record Review of Resident #69's face sheet dated 01/15/26 reflected the resident was a [AGE] year-old male admitted on [DATE]. His diagnoses included cerebral infarction (a pathologic process that results in an area of necrotic tissue in the brain), hemiplegia/hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles), dysarthria (a speech disorder that occurs when the muscles used for speech are weak or difficult to control, leading to slurred or slow speech that can be hard to understand. It is often caused by neurological injuries affecting the motor component of the speech system), and schizophrenia (a severe mental disorder that affects how a person thinks, feels, and behaves, often leading to hallucinations, delusions, and disorganized thinking). Record review of Resident #69's modification of annual MDS dated [DATE] reflected Resident #69 had a BIMS score of 05 which reflected Resident #69 was severely cognitively impaired. MDS reflected Resident #69 required set-up or clean-up assistance with eating, substantial/maximal assistance with toileting, showering, upper and lower body dressing, and personal hygiene. Record review of Resident #69's care plan dated 01/28/25 reflected:Focus: Resident #69 was at risk for a communication problem r/t CVA, Dysarthria.Goal: Resident #69 will be able to make basic needs known dailythrough the review date.Interventions included: Anticipate and meet needs. Record review of Resident #69's care plan dated 01/28/25 reflected:Focus: ADL Self Care Performance Deficit r/t CVA.Goal: Will maintain current level of function in Bed Mobility, Transfers, Eating, Dressing, Grooming, Toilet Use and Personal Hygiene; ADL Score through the review date.Interventions included: BATHING (SHOWER/BATHE SELF): I require x1 staff assistance with bathing/showering (FREQ) and as necessary. Resident's preference is to shower once a week on Mondays. PERSONAL HYGIENE/ORAL CARE (ORAL HYGIENE): Requires x1 staff participation with personal hygiene and oral care. In an interview and observation on 01/13/26 at 12:06 PM, Resident #69 stated he was doing ok and the staff treated him well. He stated he had been at the facility for a while. He stated he was getting his showers correctly. He stated he had a call light but had not used it or needed it so far. He stated the staff checked on him frequently and made sure he was ok. He stated he would like his nails trimmed and no one has offered to cut them or clean under them. He stated he had not been able to use his phone very well like this. Resident #69 demonstrated how his fingernails got in his way when he attempted to use the screen on his phone. Observed Resident #69's fingernails on left and right hands. Resident #69's fingernails were long, jagged, and dirty with built-up dirt and grime underneath each nail. In an interview on 01/14/26 at 2:57 PM, RN F stated he has worked in the facility for about a year and a half. He stated he was in-serviced on ADL care including nail care. He stated the nurse's aides were able to do the nail care of non-diabetic residents and nurses did the nail care for residents that were diabetic. He stated the CNAs should have offered to do nail care for residents, even those that were able to make their own personal hygiene decisions, during showers, shaving, and ADL care. He stated dirty, long, jagged fingernails could have caused skin tears or skin issues or could also hoard bacteria which could have caused an infection, and it could have also affected the resident's dignity. In an interview on 01/14/26 at 3:13 PM, LVN D stated she had worked in the facility for about 3-4 years off and on. She stated she was in-serviced on ADL care such as nail care. She stated the nurse's aides did the nail care for those residents which were not diabetic, and nurses do the nail care for residents that are diabetic. She (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated the CNAs should have offered to do nail care during showers, shaving, and ADL care, even for those residents that are able to make their own personal hygiene decisions. She stated dirty, long, jagged fingernails could have caused skin tears, nail injuries, ingrown nails, or infection. In an interview on 01/14/26 at 3:40 PM, CNA A stated she had worked in the facility for about 3 years. She stated she was in-serviced on ADL care including fingernails. She stated even for residents that had long, dirty, jagged nails, she would have offered to trim, file, and clean the residents' nails. She stated if a resident had dirty, long, jagged fingernails, it could have caused skin tears. In an interview on 01/14/26 at 3:44 PM, CNA B stated she had worked in the facility for about a year. She stated she was in-serviced on ADL's including nail care. She stated for residents that had long, dirty, jagged nails, she would have offered to trim, file, and clean the residents' nails. She stated the CNAs did not trim the nails of residents with diabetes. She stated if a resident had dirty, long, jagged fingernails, it could have caused infections. In an interview on 01/15/26 at 11:12 AM, the DON stated she started working in the facility 9 days ago. She stated she was not sure when the staff were in-serviced last on ADL care including nail care but that was something she was going to implement as part of being a new DON. She stated for residents that they had long, dirty, jagged nails it was her expectation the staff offered to trim, file, and clean the residents' nails. She stated if a resident had dirty, long, jagged fingernails, it could have caused the spread of infection. In an interview on 01/15/26 at 11:39 AM, the ADM stated he had worked in the facility for about 6 months as the operations manager and he is now the Administrator. He stated he had in-serviced staff on ADL care such as nail care. He stated for residents that had long, dirty, jagged nails, it was his expectation that the staff offered to trim, file, and clean the residents' nails. He stated if a resident had dirty, long, jagged fingernails it could have caused a possible skin tear. Record review of facility policy titled Policy/ Procedure - Nursing Clinical Section: Licensed Nurse Procedures, Subject: Nails, Care of Finger and Toe and dated Revised 05/2007, Revised 11/2017, Reviewed 12/2025 reflected Policy: It is the policy of this facility to perform nail care to: 1. Clean the nail bed 2. Keep nail trimmed 3. Prevent infections. PROCEDURES: 1. Wash your hands thoroughly before and after completing the procedure. 2. If permitted, and to make trimming nails easier, allow nails to soak in warm soapy water for five (5) minutes. 5. Nails can be partially cleaned during bath care. 6. Nail care includes daily cleaning and regular trimming, during ADL care. 7. Proper nail care can aid in the prevention of skin problems around the nail bed. 8. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin. 9. Watch for and report any changes in the color of the skin around the nail bed, blueness of the nails, any signs of poor circulation, cracking of the skin between the toes, any swelling, bleeding, etc. 10. Stop and report to your charge nurse if there is evidence of ingrown nails, infections, pain, or if nails are too hard or too thick to cut with ease.