

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676475	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/20/2025
NAME OF PROVIDER OR SUPPLIER Riverwood Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 600 Bacon Street Madisonville, TX 77864	

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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident had the right to reside and receive services in the facility with reasonable accommodations of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for 3 of 10 residents (Resident #1, Resident #2, and Resident #3) reviewed for resident rights.</p> <p>The facility failed to ensure Resident #1, Resident #2, and Resident #3's call lights were within reach on 05/20/2025.</p> <p>This failure could place residents at risk of their needs not being met.</p> <p>Findings include:</p> <p>1. Record review of Resident #1's admission record, dated 05/20/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included: Rheumatoid arthritis (chronic autoimmune disease that causes inflammation and damage to the joints), muscle weakness (decrease ability of muscles to contract and move), and unspecified dementia mild without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety (memory loss and thinking difficulties).</p> <p>Record review of Resident #1's Quarterly MDS assessment, dated 03/19/2025, reflected the resident had a BIMS score of 12, which indicated moderate cognitive impairment. Resident #1 required partial/moderate assistance in the area of shower/bathe self. Resident #1 required setup or cleanup assistance in the areas of eating, oral hygiene, toileting hygiene, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene.</p> <p>Record review of Resident #1's care plan, dated 05/20/2025, reflected Resident #1 was care planned for high risks for fall and had an intervention of be sure my call lights is within reach and encourage me to use it for assistance as needed.</p> <p>During an observation on 05/20/2025 at 9:54 AM., Resident #1's call light was observed hanging towards the floor on the right side of Resident #1's bed. Resident #1 was asleep in bed at the time of the observation.</p> <p>During an observation on 05/20/2025 at 11:37 AM., Resident #1's call light was observed hanging towards the floor on the right side of Resident #1's bed. Resident #1 was asleep in bed at the time of the observation.</p> <p>(continued on next page)</p>

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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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 05/20/2025 at 12:10 PM., Resident #1 stated that CNA A had picked up her call light and placed it in her reach about five minutes before I entered to talk to her. Resident #1 stated that the call lights were never within reach and residents must yell or go find a staff member when they needed assistance.</p> <p>2. Record review of Resident #2's admission record, dated 05/20/2025, reflected a [AGE] year-old female who was re-admitted to the facility on [DATE]. Resident #2 had diagnoses which included: parkinsonism (a brain condition that affects movement and can cause non movement symptoms like fatigue, sleep problems, and depression), muscle weakness (decrease ability of muscles to contract and move), morbid serve obesity due to excess calories (having a high amount of body fat) and chronic obstructive pulmonary disease (lung disease that makes it difficult to breathe).</p> <p>Record review of Resident #2's Quarterly MDS assessment, dated 03/13/2025, reflected the resident had a BIMS score of 11, which indicated moderate cognitive impairment. Resident #2 was dependent in the areas of toileting hygiene, shower/bathe self, lower body dressing and putting on/taking off footwear. Resident #2 required substantial/maximal assistances in the area of upper body dressing.</p> <p>Record review of Resident #2's care plan, dated 05/20/2025, reflected Resident #2 was care planned for ADL self-care performance and had an intervention of place call light with reach.</p> <p>During an observation on 05/20/2025 at 9:54 AM., Resident #2's call light was observed hanging approximately two feet behind the resident's bed against the wall. Resident #2's call light was not within reach. Resident #2 was asleep in bed at the time of the observation.</p> <p>3. Record review of Resident #3's admission record, dated 05/20/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #3 had diagnoses which included: chronic obstructive pulmonary disease (lung disease that makes it difficult to breathe), muscle weakness (decrease ability of muscles to contract and move), hyperlipidemia (having too much fat in your blood, specifically too much cholesterol and or triglycerides) and essential primary hypertension (high blood pressure).</p> <p>Record review of Resident #3's Quarterly MDS assessment, dated 03/06/2025, reflected the resident had a BIMS score of 13, which indicated cognitive intact. Resident #3 required substantial/maximal assistance in the area of shower/bathe self. Resident #3 required supervision or touching assistance in the areas of putting on/taking off footwear and personal hygiene.</p> <p>Record review of Resident #3's care plan, dated 05/20/2025, reflected Resident #3 was care planned for risks for falls r/t gait/balance problems and had an intervention of be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed.</p> <p>During an interview and observation on 05/20/2025 at 4:00 PM., Resident #3 was yelling for assistance. Resident #3's call light was observed not within her reach near her nightstand. Resident #3 stated that her call light was never within reach and she must yell out for help all the time.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with CNA A on 05/20/2025 at 4:55 PM, CNA A stated she was the CNA for Resident #1 and Resident #2. CNA A stated that she was not aware that the residents' call lights were not within reach. CNA A stated that it was anyone, who entered the resident's room, responsibility to ensure call lights were within reach. CNA A stated if a resident's call light was not within reach, then the resident would not be able to call for assistance.</p> <p>During an interview with the CMA A on 05/20/2025 at 5:10 PM, CMA A stated she was present during my observation of Resident #3 call light. CMA A stated she observed Resident #3's call light near her nightstand and out of the resident's reach. CMA A stated that all staff were responsible for ensuring call lights were always within reach. CMA A stated that if a resident call light was not within reach the resident would not be able to call for assistance.</p> <p>During an interview with the DON on 05/20/2025 at 5:15 PM, the DON stated all residents call lights should be always within reach. The DON stated it was everyone's responsibility to ensure residents call lights were always within reach. The DON stated if a resident's call light was not within reach, the resident would not be able to receive assistance if they needed it.</p> <p>During an interview with the ADM on 05/20/2025 at 5:25 PM, the ADM stated call lights should always be within reach. The ADM stated it was everyone's responsibility to ensure the call light were within reach. The ADM stated if a resident call light was not within reach, then the resident's needs would not be met in a timely manner. The ADM stated her expectation was for staff members to ensure call lights were within reach prior to exiting the resident's rooms.</p> <p>A record review of the facility's Call Lights: Accessibility and Timely Response dated 2024 reflected, The purpose of this policy is to assure the facility is adequately equipped with a call light at each resident's bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response.</p> <p>Policy Explanation and Compliance Guidelines:</p> <ol style="list-style-type: none"> 1. <p>All staff will be educated on the proper use of the resident call system, including how the system works and ensuring resident access to the call light.</p> <ol style="list-style-type: none"> 5. <p>Staff will ensure the call light is within reach of a resident and secured, as needed .</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents had the right to personal privacy and confidentiality of his or her personal and medical records for 1 of 1 resident (Resident #4) reviewed for personal privacy and confidentiality of records.</p> <p>The facility failed to ensure the LVN provided privacy by closing the laptop and leaving the laptop unattended in the hallway which displayed Resident #4's information on 05/20/2025.</p> <p>This failure could place residents at risk of having medical information personal or care instructions exposed to others and misuse of personal information.</p> <p>The findings included:</p> <p>Record review of Resident #4's admission record, dated 05/20/2025, reflected an [AGE] year-old female who was readmitted to the facility on [DATE]. Resident #4 had diagnoses which included: unspecified sequelae of cerebral infarction (having lingering problems or conditions as a result of a stroke), muscle weakness , muscle wasting and atrophy (a condition where muscle tissue shrinks and weakens, resulting in reduce muscle mass and strength), and unspecified convulsions (uncontrollable shaking that is rapid and rhythmic, with the muscle contracting and relaxing repeatedly)</p> <p>Record review of Resident #4's Annual MDS assessment, dated 03/31/2025, reflected the resident had a BIMS score of 08, which indicated moderate cognitive impairment.</p> <p>During an observation on 05/20/2025 at 2:00 PM., LVN A's laptop was left unattended with Resident #4's information on the screen. The ADM was present at the time of the observation. The ADM was observed closing the laptop and left to go talk with LVN A about the incident.</p> <p>During an interview with the LVN A on 05/20/2025 at 4:05 PM, LVN A stated she did not leave her laptop unattended with Resident #4 information on the screen.</p> <p>During an interview with the DON on 05/20/2025 at 5:15 PM, the DON stated the staff that used the laptop should ensure the resident's information was not displayed if not attended. The DON stated that a negative outcome would be that someone could see the resident personal health information or have access to it. The DON stated it was her expectation that staff locked their laptops when walking away from them.</p> <p>During an interview with the ADM on 05/20/2025 at 5:25 PM, the ADM stated she was present at the time of the observation of the unattended laptop. The ADM that the last user of the laptop was responsible for ensure the residents information was not displayed before leaving the laptop unattended. ADM stated a negative outcome would be the resident public health information could be released to the public. The ADM stated her expectation were for staff to follow policy and not leave the resident health information unattended.</p> <p>(continued on next page)</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's Security of Portable Electronic Devices dated 2025 reflected To aid in prevention of disclosure of confidential information, our company has adopted procedures for the safety and security of confidential business and protect health information. The purpose of this policy is to define the requirements to safeguard sensitive data contained on portable devices and portable electronic storage media on or off company premises, and the procedures to be followed. This policy applies to all company employees and business associated that create, store, or access sensitive data.</p> <p>Policy Explanation and Compliance Guidelines:</p> <p>1.</p> <p>All portable electronic devices, irrespective of device ownership, that are used in conjunction with any computer, data, or network device owned or managed by our company must follow our established policies and standards for the secure use of portable electronic devices (portable devices). This policy also includes personal portable devices that are used to access our company systems.</p> <p>3.</p> <p>Employees (or authorized business associate) who use portable devices to access our company network must ensure that they keep the device, associated media, and its data secure at all times .</p>		