STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115144	A. Building B. Wing	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverdale Center for Nursing and Healing	315 Upper Riverdale Road Riverdale, GA 30274

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** 49138 Based on observations, staff interviews, record review, and review of the facility policy titled, Accommodation of Needs, the facility failed to ensure that one of 50 sampled residents (R) (R60) needs were being met in regards to the call light being within reach. Findings include: Review of the policy titled Accommodation of Needs revised March 2023 revealed under Policy: The facility will treat each resident with respect and dignity and will evaluate and make reasonable accommodations for the individual needs and preferences of a resident, except when the health and safety of the individual or other residents would be endangered. Under Policy Explanation and Compliance Guidelines: .2. The facility will ensure that common areas frequented by residents are accommodating physical limitations and enhance their abilities to maintain independence. 3. Based on individual needs and preferences, the facility will assist the resident in maintaining and/or achieving independent functioning, dignity, and wellbeing to the extent possible. Review of the electronic medical record (EMR) revealed R60 was admitted to the facility with diagnoses including but was not limited to dysphagia, muscle weakness (generalized), cerebral palsy, hypothyroidism, gastro-esophageal reflux disease without esophagitis, hypertension, other seizures(g40.89), diverticulum of esophagus, convulsions, shortness of breath and systemic inflammatory response syndrome (SIRS). Review of R60's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score was not assessed. Section GG- Functional Status, revealed-Upper/ Lower extremity-on one side and Section O - Special Treatments, Procedures, and Programs revealed oxygen therapy. Review of R60's care plan dated 12/26/2024 did not reveal goals or interventions related to R60's call light being within reach. An observation on 3/17/2025 at 10:53 pm revealed R60 to be nonverbal. R60 was lying in bed watching tv. The call light was out of reach. An observation on 3/17/2025 at 1:35 pm revealed R60 lying in bed watching tv. The call light was out of reach. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115144	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2025
NAME OF PROVIDER OR SUPPLIER Riverdale Center for Nursing and Healing		STREET ADDRESS, CITY, STATE, ZIP CODE 315 Upper Riverdale Road Riverdale, GA 30274	

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	An observation on 3/17/2025 at 2:01 pm revealed R60 lying in bed watching tv. The call light was out of reach. During an interview/observation at 3/17/2025 at 3:25 pm with Licensed Practical Nurse (LPN) JJ confirmed the call light was out of reach as she has never seen R60 use her call light button. During an interview on 3/19/2025 at 1:45pm with the Unit Manager (UM) KK confirmed R60 cannot use her call light, however staff checks on her frequently. UM KK confirmed something should be put in place for R60 to alert staff if she was in any distress due to her not being able to utilize the call light. During an interview on 3/20/2025 at 12:15 pm with the Administrator confirmed she was not aware that R60 could not use her call light as she can offer her a bed light. The Administrator confirmed that R60 needed to have something in case of an emergency as she cannot rely on her roommate to assist.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115144	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverdale Center for Nursing and Healing	315 Upper Riverdale Road Riverdale, GA 30274

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 49138 Based on observations, staff interviews, record review, and review of the facility policy titled, Care Plans, Comprehensive Person-Centered, the facility failed to implement an oxygen (O2) care plan for one of 50 sampled residents (R) (R60) to ensure the resident reaches his/her highest practicable physical, mental, and psychosocial well-being. The deficient practice had the potential for R60's needs to go unmet. Findings include: Review of the facility policy titled Care Plans, Comprehensive Person-Centered updated December 2022 revealed under Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Under Policy Interpretation and Implementation: 1. The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 2. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 8. The comprehensive, person-centered care plan will: .b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Review of R60's care plan dated 12/26/2024 revealed Focus Area R60 requires oxygen therapy r/t (related to) ineffective gas exchange. R60 often removes oxygen from her nose and can be resistant to allowing staff to replace. Goal-R60 will have no signs of poor oxygen absorption through the review date. Intervention-change oxygen tubing as ordered, give medications as ordered by physician, monitor/document side effects and effectiveness. If R60 is resistant to have oxygen (O2) delivery through a nasal cannula (NC), replaced, explain why oxygen is needed and try again. Review of the Physician's Orders for R60 included but was not limited to an order dated 12/2/2024-Oxygen at 3.5 L/min (LPM) via nasal cannula (NC) continuously. During an observation on 3/17/2025 at 10:53 am, R60 was noted to be nonverbal. R60 was lying in bed watching tv, O2 not attached, with tubing sitting on her forehead. The oxygen flow was set at 2.5 LPM. During an observation on 3/17/2025 at 1:35 pm, R60 was noted to be lying in bed watching tv, O2 not attached, with tubing sitting on her forehead. The O2 flow was set at 2.5 LPM. During an observation on 3/17/25 at 2:01 pm, R60 was lying in bed watching tv, O2 not attached, with tubing sitting on her forehead. The O2 flow was set at 2.5 LPM. During an interview/observation at 3/17/2025 at 3:25 pm with Licensed Practical Nurse (LPN) JJ confirmed that R60's O2 was not attached to her nose with the tubing sitting on her forehead. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115144	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverdale Center for Nursing and Healing	315 Upper Riverdale Road Riverdale, GA 30274

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 3/19/2025 at 1:45 pm with Unit Manager (UM) KK confirmed that R60's O2 should be set at 3.5 LPM per physician orders and it should be in her care plan. UM KK confirmed the O2 flow level was set at 2.5 LPM and the physician order was not noted in the care plan. During an interview on 3/20/2025 at 11:25 am with the Director of Nursing (DON), she confirmed there was no documentation in the care plan for R60's O2 orders. She stated that staff should be following orders per physicians' recommendations. If the resident was known for taking off her O2, staff should visit the room more frequently. The DON stated the physician's orders, care plan, and O2 flow should be consistent with each other. The DON also stated the RT (Respiratory Therapist) should be communicating with medical team to include nurses, the DON, Assistant Director of Nursing (ADON), and the physician, as well as sharing information during clinic meetings regarding attempts to wean residents to a lower O2 flow. The DON expected staff to follow the physician's orders with all residents. An interview on 3/20/2025 at 12:15 pm with the Administrator confirmed orders, antibiotics and behaviors should be added to the care plan. The administrator stated all orders should be followed according to the physician's recommendations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115144	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2025
NAME OF PROVIDER OR SUPPLIER: Riverdale Center for Nursing and Healing		STREET ADDRESS, CITY, STATE, ZIP CODE: 315 Upper Riverdale Road Riverdale, GA 30274	

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 48338 Based on observations, staff interviews, record review, and review of the facility's policy titled, Care Plans, Comprehensive Person- Centered, the facility failed to revise a care plan for three of 50 sampled residents (R) (R17, R60, and R98). The deficient practice had the potential for residents not to receive prescribed and needed care and services. Findings include: Review of the policy titled Care Plans, Comprehensive Person-Centered, revised December 2022 revealed under Policy Interpretation and Implementation: . 13. Assessments of residents are ongoing, and care plans are revised as information about the resident and the resident's condition change. 1. Review of R17's care plan dated 2/16/2025 indicated a focus problem of altered respiratory status/difficulty breathing r/t (related to) chronic respiratory failure, chronic obstructive pulmonary disease (COPD) and requires oxygen 3L (liters) continuously. Goals included but not limited to R17 will maintain normal breathing pattern as evidenced by normal respirations, normal skin color, and regular respiratory rate/pattern. Interventions included but not limited to administer medication/puffers as ordered. Elevate the head of bed to 45 degrees. Medication and oxygen as ordered. Oxygen (O2) settings: O2 via nasal cannula NC as ordered. Review of the Physician's Orders for R17 included but not limited to: 1/22/2025 Trelegy Ellipta Inhalation aerosol powder breath activated 100-62.5-25 MCG/ACT (micrograms per actuation) (fluticasone-umeclidinium-vilanterol) 1 puff inhale orally in the morning for (COPD). 1/23/2025 albuterol-budesonide inhalation aerosol 90-80 MCG 2 puffs inhaled orally every 6 hours as needed for wheezing or shortness of breath (SOB). 2/12/2025 oxygen at 3 L/min (LPM) via nasal cannula continuous every shift for oxygen management-(COPD). An observation of R17 on 3/16/2025 at 3:27 pm revealed she received O2 continuously which she placed the NC on and off at her discretion. She did not have it on during this time when checked to see where the dosage was on the concentrator (machine that delivers O2) via flow meter. The flowmeter was set at 3 LPM as ordered. An observation on 3/17/2025 11:05 am revealed the O2 NC lying in bed with the concentrator on. Also, an O2 tank hanging on the back of the wheelchair while the resident was not present in the room. Observation on 3/17/2025 at 11:32 am revealed R17 was not in her room. She was in the dining area in activities. She was not wearing her O2 via concentrator nor tank to the wheelchair, as ordered continuously. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115144	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2025
NAME OF PROVIDER OR SUPPLIER: Riverdale Center for Nursing and Healing		STREET ADDRESS, CITY, STATE, ZIP CODE: 315 Upper Riverdale Road Riverdale, GA 30274	

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation of R17 on 3/20/2025 at 11:00 am revealed she was in the hallway not wearing her O2. Interview on 3/17/2025 at 3:17 pm in the resident's room with Licensed Practical Nurse (LPN) EE revealed the resident was prescribed O2 at 3 LPM continuously. R17 was not wearing O2. Interview on 3/20/2025 at 11:25 am with the Director of Nursing (DON), she confirmed there was no documentation in the care plan that stated R17 was allowed to take her O2 off when she wanted to. She said staff should be following orders per physicians' recommendations and if the resident was known for taking off her O2, staff should be visiting the room more frequently. The DON stated the orders, care plan and O2 flow should be consistent with each other. The DON also stated the Respiratory Therapist (RT) should be communicating with the medical team to include nurses, DON, ADON (Assistant Director of Nursing), and physician, and sharing information during clinic meetings regarding attempts to wean resident to a lower O2 flow. The DON expectations were that the staff would follow the physician's orders with all residents. During an interview with the DON on 3/20/2025 at 11:30 am it was revealed that the MDS Staff were responsible for developing care plans for residents when they are non-complaint with doctors' orders and not wanting O2 or any other medical device on as ordered. 49138 2. Review of R60's care plan dated 12/26/2024 not reveal O2 orders per physician's orders. Review of the Physician's Orders for R60 included but was not limited to: 3/7/2025-Oxygen at 3.5L/min via nasal cannula continuously every shift for oxygen management. Observation on 3/17/2025 at 10:53 am revealed R60 to be nonverbal, lying in bed watching tv, O2 not attached, with tubing sitting on her forehead. The O2 flow was on 2.5 LPM. Observation on 3/17/2025 at 1:35 pm revealed R60 lying in bed watching tv, O2 not attached, with tubing sitting on her forehead. The O2 flow was on 2.5 LPM. Observation on 3/17/2025 at 2:01 pm revealed R60 lying in bed watching tv, O2 not attached, with tubing sitting on her forehead. The O2 flow was on 2.5 LPM. During an interview on 3/19/25 1:25pm with MDS Coordinator HH stated the care plan for R60 was correct and the physician oxygen order of 3.5 LPM did not need to be included in the care plan. During an interview/observation at 3/17/2025 at 3:25 pm with Licensed Practical Nurse (LPN), LPN JJ confirmed that R60's O2 was not attached to her nose as the tubing was sitting on her forehead. During an interview on 3/19/2025 at 1:45 pm with Unit Manager (UM) UM KK confirmed that R60's O2 should be set at 3.5 LPM per physician orders and it should be in her care plan. UM KK confirmed the flow level was set at 2.5 LPM and the physician order was not noted in the care plan. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115144	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverdale Center for Nursing and Healing	315 Upper Riverdale Road Riverdale, GA 30274

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/19/2025 at 1:57 pm with RT LL revealed the level of R60's O2 changed in efforts to wean her off O2. RT LL stated he did not document his attempts or talk with the physician about his efforts to wean R60's O2 level. During an interview on 3/20/2025 at 11:25 am with the DON, she confirmed there was no documentation in the care plan for R60's O2 orders. Review of R98's care plan dated 2/9/2025 revealed the care plan was not updated to address to incident of sexual abuse/inappropriate touching to identify R98 as being vulnerable. Review of the Physician's Orders for R60 included but was not limited to: Order dated 2/26/2025-trazodone HCl (hydrochloride) Oral Tablet (trazodone HCl)-Give 12.5 mg by mouth at bedtime for insomnia/restlessness. Order dated 2/1/2024-Observation: Antidepressant Behavior Monitoring - Observe for change in mood or depressed state, little interest or pleasure doing things, hopelessness, sad facial expression, crying, sleep pattern changes, appetite changes trouble concentrating, moving and speaking slowly, fidgety, restlessness, or thoughts of harming oneself (every shift for antidepressant behavior monitoring). Order dated 11/26/2024-Skin Assessment to be done on Tuesdays (3-11). Open Skin Check Form and Complete from UDA. Durning an observation on 3/17/2025 at 10:42 am, R98 was observed sitting in the activity room watching television. The surveyor attempted to speak with R98, but she did not reply. During an interview on 3/19/2025 at 1:25pm with MDS Coordinator confirmed that she did not see an update on the care plan regarding the inappropriate touching. During an interview on 3/19/2025 at 2:45 pm with MDS HH and the Social Services Director confirmed there was no care plan for R98 to address the incident that occurred regarding inappropriate touching. During an interview on 3/20/2025 at 11:25 am with the DON confirmed that R98's care plan should have been updated after the incident that occurred between. The DON stated adding R98 being vulnerable to inappropriate behavior made sense. During an interview on 3/20/2025 at 12:15 pm with the Administrator confirmed that R98's care plan should have been updated after the incident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115144	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2025
NAME OF PROVIDER OR SUPPLIER Riverdale Center for Nursing and Healing		STREET ADDRESS, CITY, STATE, ZIP CODE 315 Upper Riverdale Road Riverdale, GA 30274	

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 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** 49138 Based on observations, staff and resident interviews, record review, and review of the facility policy titled, Activities of Daily Living (ADLs), the facility failed to provide grooming care for one of 50 sampled residents (R)(R70) dependent on staff for care. This deficient practice had the potential to cause a decline in R70. Findings include: Review of the facility policy titled Activities of Daily Living (ADLs) revised January 2024 revealed under Policy: The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care. Under Policy Explanation and Compliance Guidelines: . 3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Review of the electronic medical record (EMR) revealed R70 was admitted to the facility with pertinent diagnoses including but not limited to abnormal electrocardiogram, unspecified diastolic (congestive) heart failure, hypertension, paroxysmal (comes and goes) atrial fibrillation, chronic kidney disease, chronic respiratory failure with hypoxia (low oxygen (O2) level) and dependence on supplemental oxygen. Review of R70's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 06, which indicates R70 had severe cognitive impairment and Section GG, Functional Status, revealed R70 had no impairment but required assistance with ADLs. Review of R70's care plan dated 10/1/2024 indicated a problem of R70 has an ADL self-care performance deficit. Goals included but not limited to R70 will show Interventions improvement in current level of ADL function through the review date. Interventions included but not limited to one staff assistance with bathing, showering, eating, with personal hygiene. Staff will also check for nail length and trim and clean on bath day and as necessary. Review of the Physician's Orders for R70 included but was not limited to: Order dated 1/18/2024-Enhanced barrier precautions with high contact care activities every shift. Order dated 2/25/2025-mirtazapine 30 mg tablet-give one tablet by mouth daily for depression (30 mg (milligram). *Order dated 12/28/2024-albuterol sulfate HFA (hydrofluoroalkane) 90 mcg (micrograms), Inhaler-inhale two puffs by mouth every four hour(s) as needed for chronic obstructive pulmonary disease. An interview/observation with R70 on 3/16/2025 at 2:25 pm revealed staff refused to shave R70. R70 stated he told staff he needed a shave but was denied a shave. Observation revealed R70 needed a shave by evidence of hair on R70's face. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115144	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverdale Center for Nursing and Healing	315 Upper Riverdale Road Riverdale, GA 30274

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview/observation on 3/17/2025 at 9:25 am with R70 revealed staff would not shave him. Observation revealed R70 still needed shave by evidence of facial hair. Durning an interview/observation with R70 on 3/17/2025 at 11:02 am revealed R70 was not feeling well as his foot was hurting due to wearing his foot brace. R70 stated he was still in need of a shave. Observation revealed R70 still needed a shave by evidence of facial hair. R70 stated he asked for a shave several times but was told staff did not have time. Interview on 3/20/2025 at 9:25 am with Licensed Practical Nurse (LPN) II the facility does not keep a grooming log. LPN II was not able to provide documentation of resident grooming. Interview on 3/20/2025 11:25 am with the Director of Nursing (DON) confirmed residents should not have waited days to get a shave if requested. The DON stated all staff should document if a resident refused care. Interview on 3/20/2025 at 12:15 pm with the Administrator confirmed she conducted monthly meetings regarding grooming. Staff have been informed that all residents must be touched with water weekly, bedding needs to be changed, and residents should be groomed. The Administrator stated if a resident requested a shave, it should have been honored.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115144	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2025
NAME OF PROVIDER OR SUPPLIER Riverdale Center for Nursing and Healing		STREET ADDRESS, CITY, STATE, ZIP CODE 315 Upper Riverdale Road Riverdale, GA 30274	

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49138 Based on observations, staff interviews, record review, and review of the facility policy titled, Oxygen (O2) Administration, the facility failed to ensure that two of four residents (R) (R60 and R17) receiving O2 were administered O2 therapy in accordance with the physician orders. The sample size was 15. The deficient practice had the potential to place R60 and R17 at risk for medical complications, unmet needs, and a diminished quality of life. Findings include: Review of the facility policy titled Oxygen Administration revised December 2022 revealed under Policy: Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. Under Policy Explanation and Compliance Guidelines: 1. Oxygen is administered under the orders of a physician, except in the case of an emergency. In such cases, oxygen is administered and orders for oxygen are obtained as soon as practicable when the situation is under control.3. Staff shall document the initial and ongoing assessment of the resident's condition warranting oxygen and the response to oxygen therapy. 4. The resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders, such as, but not limited to: .2. When to administer, such as continuous or intermittent and/or when to discontinue. C. Equipment setting for the prescribed flow rates. D. Monitoring of SpO (oxygen saturation) levels and/or vital signs, as ordered. 1. Review of the electronic medical record (EMR) revealed R60 was admitted to the facility with diagnoses including but not limited to dysphagia, muscle weakness (generalized), cerebral palsy, hypothyroidism, gastro-esophageal reflux disease without esophagitis, hypertension, other seizures, diverticulum of esophagus, convulsions, shortness of breath, and systemic inflammatory response syndrome (SIRS). Review of R60 quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score was not assessed. Section GG, functional status, revealed R60 GG-Upper/ Lower extremity- on one side and Section O - Special Treatments, Procedures, and Programs revealed oxygen therapy. Review of R60 care plan dated 12/26/2024 revealed no O2 goals and interventions. Review of the Physician's Orders for R60 included but was not limited to an order dated 3/7/2025-Oxygen at 3.5L/min (LPM) via nasal cannula (NC) continuously every shift for oxygen management. An observation on 3/17/2025 at 10:53 am revealed R60 to be nonverbal. R60 was lying in bed watching tv, O2 not attached, with tubing sitting on her forehead. The O2 flow was noted to be on 2.5 LPM. An observation on 3/17/2025 at 1:35 pm revealed R60 lying in bed watching tv, O2 not attached, with tubing sitting on her forehead. The oxygen flow was noted to be on 2.5 LPM. An observation on 3/17/2025 at 2:01 pm revealed R60 lying in bed watching tv, O2 not attached, with tubing sitting on her forehead. The oxygen flow was noted to be on 2.5 LPM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115144	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2025
NAME OF PROVIDER OR SUPPLIER Riverdale Center for Nursing and Healing		STREET ADDRESS, CITY, STATE, ZIP CODE 315 Upper Riverdale Road Riverdale, GA 30274	

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation at 3/17/2025 at 3:25 pm with Licensed Practical Nurse (LPN) JJ confirmed that R60's O2 was not attached to her nose and the O2 tubing was sitting on her forehead. An interview on 3/19/2025 at 1:45 pm with Unit Manager (UM) KK confirmed that R60's O2 should be set at 3.5 LPM per physician orders and it should be in her care plan. UM KK confirmed the flow level was set at 2. 5 LPM and the physician orders were not noted in the care plan. During an interview on 3/19/2025 at 1:57 pm with Respiratory Therapist (RT) LL revealed the level of R60's O2 changed in efforts to wean her off O2. RT LL stated he did not document his attempts or talk with the physician about his efforts to wean R60's O2 level. During an interview on 3/20/2025 at 11:25 am with the Director of Nursing (DON), she confirmed staff should be following orders per physicians' recommendations. The DON expected staff to follow the physician's orders with all residents. During an interview on 3/20/2025 at 12:15 pm with the Administrator confirmed all orders should be followed according to the physician recommendations. 48338 2. Review of the EMR revealed R17 was admitted with diagnoses of but not limited to chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), diabetes mellitus 11 (DM11), paroxysmal atrial fibrillation, morbid severe obesity, anxiety disorder, osteoarthritis of the right shoulder and dysphasia. Review of the quarterly MDS dated [DATE] revealed R17 had a BIMS score of 13, indicating intact cognition, Section GG, Functional Status, required extensive assistance of one person with Activities of Daily Living (ADLS), Section O, Special Treatments, Procedures, and Programs, dependence on supplemental oxygen. Review of the Care Plan revealed a focus of R17 has COPD, chronic respiratory failure, history of chronic respiratory failure with and hypoxia. Shortness of breath lying flat and on exertion. She is on oxygen via nasal cannula at 3 liters per minute. The goal was for R17 to be free of signs of respiratory infections through the next review date. Interventions included keeping the head of bed elevated to at least 45 degrees or out of bed upright in a chair during episodes of difficulty breathing; monitor for difficulty breathing on exertion; Remind resident not to push beyond endurance; monitor for signs of acute respiratory insufficiency; administer medication/puffers as ordered, oxygen settings via nasal cannula at 3 liters per minute. Review of the physician's orders revealed an order dated 2/12/2025 for oxygen 3 liters per minute through nasal cannula continuous, every shift for oxygen management, (COPD). Observations on 3/16/2025 at 3:27 pm and on 3/17/2025 at 8:35 am of R19 revealed the resident was receiving O2 at 3 LPM via NC. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115144	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverdale Center for Nursing and Healing	315 Upper Riverdale Road Riverdale, GA 30274

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 3/17/2025 at 11:32 am revealed R17 was not in her room. R17 was in the dining area in an activity. She was not wearing her O2 via concentrator nor tank to the wheelchair, as ordered continuously.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115144	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2025
NAME OF PROVIDER OR SUPPLIER: Riverdale Center for Nursing and Healing		STREET ADDRESS, CITY, STATE, ZIP CODE: 315 Upper Riverdale Road Riverdale, GA 30274	

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49140 Based on observations, staff interviews, record review, and review of the facility's policy titled, Food Preparation and Service - Sanitation, the facility failed to ensure residents were free from safety and sanitation hazards in the kitchen to include: keeping an air vent soiled with dust and debris; allowing an electrical outlet without a face plate in the dishwashing room; allowing paint chips to hang over the stove and oven area; using metal food trays that were warped and unserviceable; and maintaining an eye wash sink with a visible, brown substance pooled in it. The deficient practice had the potential to affect 121 of 121 residents who receive an oral diet. Findings include: Review of facility policy, Food Preparation and Services - Sanitation last revised April 2024 documented in Guidelines: 2. All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks, and chipped areas that may affect their use or proper cleaning. Seals, hinges and fasteners will be kept in good repair. Observations on 3/16/2025 at 1:25 pm of the facility kitchen during the initial tour with [NAME] AA revealed the ceiling vent in the dietary hallway was soiled with dust and debris. An exposed electrical outlet was observed in the dishwashing room right beside the dishwasher. Observed peeling paint above the oven/stove. Observed numerous food trays with visible dirt and debris on them. The eyewash sink area was noted to have a tray in it covering a dried, brown substance pooled in the sink. Observations on 3/18/2025 at 11:10 am of the kitchen area with the Dietary Services Manager (DSM) revealed the vent in the dietary hallway that previously had dust and lint on it was cleaned. The rack of trays that had been identified as dirty and unserviceable had been replaced with brand new trays. The electrical outlet in the dishwashing room that had previously been missing had been repaired. The eyewash sink area that had been previously dirty had appeared clean. The paint above the stove no longer has loose paint hanging off it and was recently painted. Interview on 3/19/2025 at 7:22 am with DSM revealed the Maintenance Director (MD) was responsible for in-house repairs. She stated that some equipment must be ordered, and it took time. She went on to reveal that the eye wash sink was repaired this week. The pipe dropped, and that's what caused the need. A repair request was entered in the electronic work order system. The sheet pans do need to be clean and free of debris. We disposed of the old pans. The pans we threw away were warped and junked up. When I saw peeling paint above the stove, I put a work order in the system. Maintenance scraped and repainted the area. I didn't know about the face of the electrical outlet in the dishwashing room. The MD repaired the electrical outlet on 3/16/2025. The front plate was off the outlet, and that's why we repaired it. I wasn't aware that the vent in the hallway was dirty. Maintenance cleaned the vent. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115144	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2025
NAME OF PROVIDER OR SUPPLIER: Riverdale Center for Nursing and Healing		STREET ADDRESS, CITY, STATE, ZIP CODE: 315 Upper Riverdale Road Riverdale, GA 30274	

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 3/19/2025 8:34 am with the MD revealed the facility had an electronic system for making work orders. The DSM knew how to use the work order system, and he could enter them. The MD stated it did need cleaning. The MD personally scraped and painted the area where the paint was chipping. He stated it needed painting. A metal cover was put on the electrical outlet. It was missing the cover, and it needed replacement. We fixed the drain in the eyewash sink, and it needed it. Interview on 3/19/2025 at 9:10 am with the Administrator revealed expectations were that food was stored and prepared in a clean environment. The Administrator stated they weren't aware of the dirty vent in the hallway, chipping paint over the stove, and the sink needing repair.