STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115375	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Health Care Center	5100 West St NW Covington, GA 30014

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50272 Based on observations, record review, resident and staff interviews, and review of the facility's policy titled, Self-Administration of Medication, the facility failed to ensure one of 56 sampled residents (R) (R150) was assessed for self-administration of medications prior to leaving medications at her bedside. This deficient practice had the potential to place R150 at risk of medical complications and a diminished quality of life. Findings Include: A review of the facility's policy titled, Self-Administration of Medication, dated April 2022, revealed the General Guidelines section included, 1. A resident may not be permitted to administer or retain any medication in his/her room unless so ordered, in writing, by the attending physician and approved by the Interdisciplinary Care Plan Team. A review of R150's electronic health record (EHR) for R150 revealed diagnoses including, but not limited to, chronic respiratory failure with hypoxia, acute chronic diastolic congestive heart failure (CHF), acute pulmonary edema, asthma, chronic obstructive pulmonary disease (COPD) with acute exacerbation, and bronchitis. A review of R150's admission Minimum Data Set (MDS) dated [DATE] revealed Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) of nine (indicating moderate cognitive impairment). A review of R150's care plan, with a start date of 2/10/2025, revealed no care areas or interventions for self-administration of medications. A review of R150's Physicians Orders revealed an order dated 3/21/2025 for Breztri Aerosphere inhalation aerosol 160-9-4.8 microgram (MCG)/actuator (ACT), two puffs inhaled orally two times a day (a medication used to treat COPD). Further review revealed an order dated 2/10/2025 for albuterol sulfate high flow aerosol (HFA) solution 108 (90 base) MCG/ACT, two puffs orally every four hours as needed (a medication used to prevent and treat wheezing, difficulty breathing, chest tightness, and coughing). A review of R150's EMR revealed that no self-administration of medication assessments were completed. (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a concurrent observation and interview on 3/31/2025 at 11:17 am, in R150's room, observation revealed one medicated oral inhaler on the bedside table and one medicated oral inhaler on her bed. In an interview, R150 stated the facility had left the medications at her bedside and stated the inhalers had been in her room for a month. R150 stated the facility staff told her she could administer the medications on her own. R150 further stated that a nurse could be down the hall, and she might need the medications immediately, and staff might not be around all the time. In an interview on 3/2/2025 at 3:13 pm, Certified Nursing Assistant (CNA) HH stated she was aware that R150 had medicated inhalers in her room and was unsure if there was an order to leave the inhalers at the bedside. CNA HH stated the facility protocol for medications at the bedside was that residents were allowed to have medications at the bedside if they were competent enough. In a concurrent observation and interview on 3/2/2025 at 3:13 pm, Licensed Practical Nurse (LPN) II stated R150 has an order for the inhalers at the bedside. LPN II stated that the facility procedure was that medications were not allowed at the bedside, but they made an exception for R150 because she has respiratory issues. LPN II stated R150 had been assessed to have medications at the bedside, but was unsure of how many inhalers. LPN II verified R150's physician's orders and confirmed that R150 did not have a physician's order for the medicated inhalers to be kept at the bedside and self-administered. In an interview on 4/2/2025 at 4:17 pm, the Director of Nursing (DON) stated that if a resident desired to self-administer a medication, the physician would provide the order, and the facility would assess the resident's ability to self-administer the medication. She stated the resident must demonstrate the ability to self-administer the medication before the medication would be left at the bedside. The DON further stated her expectations were for nurses to be aware of what residents are allowed to have medications at the bedside. She stated risks of having unauthorized medications at the resident's bedside were overuse of the medication, the wrong resident could use it, and further stated it was against the five rights of medication administration.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52214 Based on observations, staff interviews, record review, and review of the facility's policy titled Care Plan Policy, the facility failed to develop a comprehensive person-centered care plan for one of 12 residents (R) (R120) with an indwelling urinary catheter and one of 26 R (R147) receiving oxygen (O2). This deficient practice had the potential to place R120 and R147 at risk for medical complications, unmet needs, and a diminished quality of life. Findings include: Review of the facility's policy titled Care Plan Policy, revised 11/15/2022, revealed the Policy Statement included, Each resident will have a plan of care to identify problems, needs, and strengths that will identify how the facility staff will provide services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The Standards of Practice section included, . 9. A comprehensive plan of care will be developed by the interdisciplinary team, resident and/or resident representative as applicable. The plan of care will address the resident's status in triggered CAA [Care Area Assessments] areas, a rationale for deciding whether to proceed with care planning and provide evidence that the facility considered the development of care planning interventions for all CAA's triggered by the Minimum Data Set 3.0. 1. Review of R120's Admission Minimum Data Set (MDS) dated [DATE] revealed Section H (Bowel and Bladder) revealed R120 had an indwelling urinary catheter. Review of R120's comprehensive care plan dated 2/15/2025 revealed there was no focus area or interventions for an indwelling urinary catheter. Observations on 3/31/2025 at 11:45 am and 4/2/2025 at 2:28 pm revealed R120 had an indwelling urinary catheter. During an interview on 4/3/2025 at 2:50 pm, the Director of Nursing (DON) stated that the MDS Coordinator was responsible for updating care plans, and nurses could also update care plans as needed. During an interview on 4/3/2025 at 3:58 pm, the MDS Coordinator revealed she updated care plans based on information during morning clinical meetings, information in resident charts, and discussion with other staff members. She further stated that indwelling catheters should be included in the care plan. 47947 2. Review of R147's clinical record for R147 revealed he was admitted to the facility on [DATE] with diagnoses including, but not limited to, pneumonia and cough. Review of the Admission MDS, dated [DATE], Section O (Special Treatments, Procedures, and Programs) documented R147 received oxygen while a resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R147's care plan revealed there was no care plan focus area or interventions addressing oxygen therapy. Observations on 3/31/2025 at 10:30 am and on 4/1/2025 at 11:07 am and 2:20 pm revealed R147 receiving oxygen via a nasal cannula at 2.5 liters per minute. During observation and interviews on 4/1/2025 at 3:20 pm, Licensed Practical Nurse (LPN) AA confirmed that R147 was receiving oxygen via nasal cannula. LPN BB verified that there was no care plan area or interventions for O2 on R147's care plan for oxygen administration. In an interview on 4/1/2025 at 3:00 pm, the DON stated oxygen administration should be included on a resident's care plan.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50940 Based on observations, staff interviews, and a review of the facility's, Care Plan policy, the facility failed to revise the comprehensive care plan to include a new sacral pressure injury with measurable goals and interventions for one of three residents (R) (R206) reviewed with pressure ulcers. The facility also failed to update the care plan for R47, whose oxygen treatment had been discontinued but was still listed on the care plan. Findings include: Review of the facility policy titled, Care plan policy updated 11/15/2022 revealed the policy statement: Each resident will have a plan of care to identify problems, needs, and strengths that will identify how facility staff will provide services to attain or maintain the resident highest practicable physical, mental and psychosocial wellbeing. Further review of the Policy revealed under Standard of Practice number 1. Each resident will be assessed by the interdisciplinary team on admission, quarterly, annually, and with a significant change in status 5 .Upon a resident's readmission to facility, the care plan will be updated as indicated 10. Areas of concern or potential concern and residents strengths will be addressed with measurable goals and specific person-centered approaches to promote attainment or maintenance of the goal(s) .12. The plan of care is to be reviewed and updated as necessary at the completion of every assessment by the interdisciplinary team and resident reprehensive party if so desired. Record review for R 206 revealed resident was admitted to the facility on [DATE] following a transfer from a local hospital, where she underwent a right hip hemiarthroplasty (hip repair surgery), for physical/occupational therapy and assistance with activities of daily living (ADLs). At the time of admission, she was alert and oriented to person, place, and time, able to express her needs, and capable of following simple commands. Initial and ongoing skin assessments through 10/31/2024 documented an intact sacrum. Continued record review revealed R206 had a hospital return on 11/1/2024, nursing staff identified a new deep tissue injury (DTI) to the sacrum and initiated treatment. However, the care plan was not updated upon her return to reflect the new skin integrity concerns. Care plan review did not reveal interventions related to the newly developed deep tissue injury (DTI) on the sacrum. Interview on 4/1/2025 at 2:25 pm with the treatment nurse, LPN EE revealed that when a resident develops a pressure ulcer, she notifies the nurse practitioner or physician, documents any new orders, informs the family, updates the care plan, and provides treatment as prescribed. The treatment nurse confirmed that she could not locate an updated care plan addressing the sacral wound for the resident; only the surgical incision was included in the care plan. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A subsequent interview on 4/1/ 2025, at 3:15 pm, with the Director of Nursing (DON) indicated that care plans are expected to be revised when a resident experiences a change in condition. The DON acknowledged that the facility failed to update resident R206's care plan to reflect the presence of a sacral wound. Interview on 4/3/2025 at 3:58 pm with LPN and MDS Coordinator LL revealed that she updates care plans based on information shared during morning clinical meetings. She added that if a resident develops a new wound, it would be care planned accordingly. 47947 2. Record review for R254 revealed resident was admitted to the facility on [DATE] with diagnoses that include but not limited to Alzheimer's disease, sequelae of cerebral infarction, and unspecified convulsions. Review of R47 electronic medical records revealed physician order for oxygen therapy at 2 liters per minute with start date of 3/29/2024 and end date of 5/30/2024. Review of Cerebral Vascular Accident care plan dated 2/14/2025 revealed an intervention in place to give oxygen as ordered. Interview on 4/3/2025 at 4:50 pm with LPN, MDS Coordinator LL revealed that the care plan should be updated if oxygen order is discontinued. LPN LL confirmed that intervention for oxygen administration was in R47's current care plan and stated that this intervention should be resolved. LPN LL continued stating that she and MDS Director are responsible for updating care plans, and all nurses have access to care plans updates.

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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** 47947 Based on observations, staff interviews, records reviews, and review of the facility's policy titled, Oxygen Administration, the facility failed to ensure a physicians order for oxygen administration was obtained for one residents R (R147), the facility also failed to ensure two of 26 residents (R254 and R69) oxygen was administered as ordered by the physician. Findings include: Review of undated facility policy titled Oxygen Administration revised date of October 2010 revealed under Preparation: 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 1.Review of the Electronic Medical Record (EMR) for R147 revealed resident was admitted to the facility with diagnoses of but not limited to pneumonia, anxiety, and cough. Continued review of the residents' physicians' orders did not reveal an order for oxygen therapy administration. Review of the 5-day Admission Minimum Data Set (MDS) dated [DATE] documented R147 had a Brief interview for Mental Status (BIMS) score of 4 indicating resident had severe cognitive impairment. Observation on 3/31/2025 at 11:30 am revealed R147 was receiving oxygen via nasal cannula at 2.5 liters per minute (L/M). Observation on 4/1/2025 at 11:07 am revealed R147 was receiving oxygen via nasal cannula at 2.5 (L/M). Observation and Interview on 4/1/2025 at 2:20 pm revealed R147 was receiving oxygen via nasal cannula at 2.5 (L/M). Interview on 4/1/2025 at 2:20 pm with Licensed Practical Nurse (LPN) AA confirmed the oxygen concentrator was set at 2.5 L/M. LPN AA checked R147's electronic medical records and was not able to locate a physician order for oxygen administration. Interview on 4/1/2025 at 2:22 pm with Unit Manager, LPN BB she stated that she was not able to find a physician order of oxygen for R147. 2. Review of the EMR for R254 revealed resident was admitted to the facility on [DATE] with diagnoses of but not limited to chronic obstructive pulmonary disease (COPD), acute and chronic respiratory failure with hypoxia, and pneumonia. Review of the 5-day MDS dated [DATE] for R254 documented a BIMS score of 15 indicating little to no cognitive impairment. Review of the physician order dated 3/27/2025 for R254 revealed an order for oxygen at three liters (3L) per minute via nasal canula (NC). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 3/31/2025 at 1:15 pm of the oxygen concentrator for R254 revealed a rate of delivery at four liters. Observation on 4/1/2025 at 11:03 am of the oxygen concentrator for R254 revealed a rate of delivery at four liters. Observation with LPN AA on 4/1/2025 at 2:20 pm of the oxygen concentrator for R254 confirmed the rate of delivery at four liters. LPN AA reviewed R254 medical records and confirmed that physician order was for 3 liters per minute. Interview with Director of Nursing (DON) on 4/1/2025 at 3:00 pm confirmed that all residents receiving oxygen therapy should have a physician order and care plan, and physician order must match oxygen concentrator setting. 52212 3. Review of the EMR for R69 revealed resident was admitted to the facility with diagnoses of but not limited to, acute respiratory failure with hypoxia, chronic obstructive pulmonary disease, and dependence on supplemental oxygen. Review of R69's Quarterly MDS assessment dated [DATE] revealed a BIMS of 14, which indicated R69 had little to no cognitive impairment. Section O, Special Treatments, indicate oxygen therapy. Review of care plan for R69 revealed focus for R69 is on oxygen therapy related to chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), ineffective gas exchange, oxygen dependency, recent history of acute respiratory failure with hypoxia. Outcome of R69 will have no signs and symptoms of poor oxygen absorption through the review date. Interventions, include but not limited to, the resident has oxygen (O2) via nasal prongs at two to three liters continuously, give oxygen as ordered by the physician. Review of the Physician's Orders for R69 included but was not limited to: Order dated for 5/30/2024 oxygen three liters (L) per minute by way of nasal cannula for shortness of breath (sob) intermittent use or pulse oximeter <92%. Observation and interview on 3/31/2025 at 2:06 pm of R69 stated she uses oxygen continuously. Oxygen concentrator noted at bedside with flow meter below 2 liters via nasal canula. Observation on 4/1/2025 at 9:31 am on R69 revealed resident lying in bed with O2 NC in place, oxygen flow rate was just below two liters. Observation on 4/1/2025 at 2:53 pm revealed R69 Oxygen setting on two liters. An interview on 4/1/2025 at 2:57 PM with LPN WW confirmed status of oxygen concentrator in the room of R69 was set at two liters and that the order for residents' oxygen was for three liters. An interview on 4/1/2025 at 3:00 pm with DON revealed that all residents receiving oxygen therapy should have physician order and care plan, and physician order must match oxygen settings.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 52214 Based on observations, staff interview, and review of the facility's policy titled, Medication Storage, the facility failed to ensure all medication labels were legible and that expired medications were disposed of after expiration date on one of five medication carts and in two of three medication storage rooms on (100 Hall and 300 Hall). Findings include: A review of the facility's policy titled, Medication Storage, revision date of November 2020 revealed under policy statement, the facility stores all drugs and biologicals in a safe, secure, and orderly manner. Policy Interpretation and Implementation: 3. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, and sanitary manner. 4. Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. Observation on 4/2/2025 at 9:36 am Certified Medication Aide (CMA) GG was observed during medication administration. An audit of the medication cart revealed two boxes of expired glucagon injection syringes. Each box contained 1 ready to use rescue pen for low blood sugar emergencies and were dated March 2025. CMA GG confirmed that the injections of glucagon were expired. She stated that no expired medications should have been on the cart. She also confirmed that the process is to take expired medication out the cart and put them in the return bin. Observation and interview on 4/2/2025 at 1:43 pm with Licensed Practical Nurse (LPN) FF of medication storage room on hall 100 revealed two boxes of expired pneumococcal vaccines dated September 2024 and December 2024 and one box of sodium chloride inhalation solution expired in October 2021. LPN FF confirmed that pneumococcal vaccines and the sodium chloride inhalation solution was expired. Observation and interview on 4/2/2025 at 2:09 pm with LPN AA of medication storage room on hall 300 revealed expired 1 bottle of Ketamine dated February 2025. There was a medication bottle in the locked narcotic box in the refrigerator that had an unreadable label. LPN AA verified and confirmed that the Ketamine was expired and confirmed and verified that second bottle of medication label was not legible and that it was no way to determine what the medication was or who it belonged to. LPN AA stated she was a new employee and revealed she did not know the process for the expired and discontinued medications. She also stated she did not know the process to follow when a label is not legible. Interview on 4/2/2025 at 1:58 pm an with LPN II revealed that he was a unit manager, and stated he did not know who was responsible for auditing medication rooms for expired drugs and supplies. He further revealed he did not know the process for removal of expired medications. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 4/3/2025 at 11:08 am with the Director of Nursing (DON) revealed that usually the night staff checks for expired medications on the medication carts and in the medication storage rooms. She also confirmed that pharmacy comes once a month to pick up the discontinued and expired items, and all medications are scanned and recorded in an electronic system. She stated over the counter medications are checked for expiration dates by the central supply clerk during her restocking process. The DON stated her expectations were for the staff to remove expired medications from the medication carts and the medication storage rooms. She also revealed that staff should not administer medications that are expired. Observation and interview on 4/2/2025 at 2:09 pm with LPN AA of medication storage room on hall 300 revealed expired 1 bottle of Ketamine dated February 2025. There was a medication bottle in the locked narcotic box in the refrigerator that had an unreadable label. LPN AA verified and confirmed that the Ketamine was expired and confirmed and verified that second bottle of medication label was not legible and that it was no way to determine what the medication was or who it belonged to. LPN AA stated she was a new employee and revealed she did not know the process for the expired and discontinued medications. She also stated she did not know the process to follow when a label is not legible. Interview on 4/2/2025 at 1:58 pm an with LPN II revealed that he was a unit manager, and stated he did not know who was responsible for auditing medication rooms for expired drugs and supplies. He further revealed he did not know the process for removal of expired medications. Interview on 4/3/2025 at 11:08 am with the Director of Nursing (DON) revealed that usually the night staff checks for expired medications on the medication carts and in the medication storage rooms. She also confirmed that pharmacy comes once a month to pick up the discontinued and expired items, and all medications are scanned and recorded in an electronic system. She stated over the counter medications are checked for expiration dates by the central supply clerk during her restocking process. The DON stated her expectations were for the staff to remove expired medications from the medication carts and the medication storage rooms. She also revealed that staff should not administer medications that are expired.