STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115641	A. Building B. Wing	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverview Health & Rehab Ctr	6711 Laroche Avenue Savannah, GA 31406

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, staff interviews, and review of the policy titled Falls - Clinical Protocol, the facility failed to ensure residents were free from accident hazards and falls for three of three residents (R55, R109, and R148) reviewed for fall assessments. In addition, the facility failed to ensure there were no freeˆstanding oxygen cylinder tanks in R148's room and in the facility's Medication Storage Room located near resident rooms. These practices created potential accident hazards and failed to ensure appropriate safety measures were in place for residents.1.Review of the facility's policy titled Falls-Clinical Protocol, reviewed 1/21/2026 revealed that under Assessment and Recognition .5. The staff will evaluate and document falls that occur while the individual is in the facility; for example, when and where they happen, any observations of the event, etc. Review of the Quarterly Minimum Data Set (MDS) assessment for R109, dated 3/6/2026, revealed Section C (Cognitive Patterns) that has a Brief Interview for Mental Status (BIMS) score of 10 indication moderate cognitive impairment. Section I (Active Diagnosis) revealed diagnosis of but not all -inclusive encephalopathy, syncope, non-Alzheimer's dementia, and muscle weakness. Section N revealed resident taking antipsychotics. Review of care plan for R109 dated 03/07/2026 revealed that resident was at risk for falls related to confusion, psychotropic medication use, incontinence, hypotension, and muscle weakness with intervention for resident to evaluated and treated as ordered or as needed. Record review revealed that R109 had a fall on 02/27/2026 and was evaluated by the on-call provider on 03/01/2026 after complaining of head and shoulder pain. R109 was sent to the hospital on [DATE]. Resident return to the facility on [DATE]. Review of record revealed last fall assessment was completed on 12/19/2025. Interview on 03/15/2026 at 2:49 PM with R109 revealed that he had a fall two weeks ago and was assisted by his roommate after the fall. He reports hitting his head and shoulder. Interview on 03/17/2026 at 1:34 PM with Unit Manager (UM) Licensed Practical Nurse CC revealed fall risk assessments are to be completed upon admission and anytime a resident has a fall. She called the Director of Nursing (DON) to confirm. Interview on 03/17/2026 at 1:54 PM with Director of Nursing(DON) revealed that fall risk assessments are completed upon admission, quarterly, and after a resident has a fall. She confirmed that R109 did not have a fall assessment for the fall on 02/27/2026. 2. A policy titled Falls-Clinical Protocol last reviewed January 21, 2026, revealed under assessment (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and recognition, 3. The staff will document risk factors for falling in the resident's record and discuss the resident's fall risk. Review of the medical record for R55 revealed the resident was admitted to the facility on [DATE] with the following diagnosis not limited to periprosthetic fracture around internal prosthetic left hip joint, subsequent encounter, multiple fractures of ribs, right side, subsequent encounter for fracture with routine healing, acute respiratory failure with hypoxia, unspecified dementia, moderate with other behavioral disturbance, fall on same level, unspecified subsequent encounter. Review of the Five Day Minimum Data Set (MDS) assessment for R55, dated 03/05/2026, revealed Section C (Cognitive Patterns) that has a Brief Interview for Mental Status (BIMS) score of 4 indicating severe cognitive impairment. Record review revealed an admission fall assessment dated [DATE] with a score of 13 indicating the residents were at risk for falls. Review of R55's medical record revealed the resident had falls on 1/25/2026, 1/27/2026, 2/4/2026, 3/7/2026, and 3/15/2026. Record review revealed no fall risk assessments were completed after any of the listed falls. Interview on 03/17/2026 at 1:31 PM with Licensed Practical Nurse (LPN) DD revealed residents receive a fall risk assessment at admission, after a fall, and quarterly. Interview on 03/17/2026 at 1:34 PM with the LPN CC who is also a Unit Manager revealed fall risk assessments are to be completed upon admission and anytime a resident has a fall. LPN CC looked in the medical record and confirmed there was an admission fall risk assessment, but no fall risk assessment was completed after each of the resident's falls. Interview on 03/17/2026 at 1:55 PM with the Director of Nursing (DON) confirmed that R55 did not have a fall risk assessment completed after his falls on 01/25/2026, 01/27/2026, 02/4/2026, 3/7/2026 and 3/15/2026 and stated they should be done after each fall. 3. Record review of R148 's electronic health record revealed the following diagnoses but not limited to acute chronic respiratory failure with hypoxia. Review of R148 's admission Minimum Data Set (MDS) dated [DATE] for Section C (Cognitive Patterns) revealed a Brief Interview Mental Status Score (BIMS) of 15 which indicates cognitive awareness with little to no periods of confusion. Section O (Special Treatment Procedures and Program) assessed R148's for oxygen therapy use. Review of R148's physician order stated oxygen at 2L VIA NC (two liter by nasal cannula) as needed for SOB (shortness of breath), Obtain SPOC. Observation on 03/16/2026 at 1:31 PM of R148 's room revealed oxygen cylinder tank sitting on the floor not in a holder and positioned in an upright position. R148 's room door was observed wide open and allowing accessibility to the tank to other residents and the public. Observation 03/16/2026 at 1:32 PM with Licensed Practical Nurse (LPN)AA confirmed the free-standing cylinder tank in the resident room. She confirmed that the resident uses an oxygen tank. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 03/16/2026 at 2:36 PM of the facility Medication Storage Room with LPN DD revealed a partially full tank was positioned upright in the medication room on the floor and not in a holder. During the interview with LPN DD revealed that oxygen tanks should be stored in a holder or a labeled closet (designated for oxygen cylinder tanks) located on another hall.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and review of the policy Storage of Medications, the facility failed to ensure two of eight medication carts were secured for medication storage. In addition, seven of 14 medication rooms and carts contained reviewed for medication storage contained expired medications. The deficient practice increased the risk of unauthorized access and administration of outdated medications.Findings Include:Review of the facility's policy titled, Storage of Medication, reviewed 01/21/2026 revealed that the Policy Heading included, The facility stores all drugs and biologicals in safe, secure, and orderly manner. The Policy Interpretation and Implementation section included, 3. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. 4.Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed.Observation on 3/16/2026 at 8:07 AM revealed that the wound care cart was unlocked with the keys in the lock between rooms [ROOM NUMBERS] on Evergreen Hall. There was no one near the cart. A staff member was observed walking past the cart without addressing the unlocked cart. The cart remained unlocked with the keys in it until 8:17 AM, when the Licensed Practical Nurse (LPN) Wound Care Nurse GG returned to the cart after exiting room [ROOM NUMBER].Interview on 3/17/2026 at 11:23 AM with LPN Wound Care Nurse GG confirmed that the cart was unlocked. She stated that the cart should be locked and the keys kept in her pocket before entering a resident's room.Observation of a medication pass on 3/16/2026 at 1:11 PM of Registered Nurse (RN) JJ revealed that she left the medication cart in the hallway outside room [ROOM NUMBER]. The lock was facing away from the room, and she could not view the cart from inside the room. She returned to the cart, cleaned supplies, and then pushed the cart-still unlocked-down the hall.A second observation at 1:22 PM on 3/16/2026 of RN JJ revealed that the medication cart was unlocked in front of room [ROOM NUMBER]. RN JJ's back was facing the cart, and she could not view it.Interview on 3/16/2026 at 1:25 PM with RN JJ revealed that the cart was unlocked during the medication pass. RN JJ confirmed that the cart was unlocked, unattended, and out of her direct line of sight while she was in room [ROOM NUMBER]. She also admitted that her back was to the medication cart and it was not in her direct eyesight during the medication pass in room [ROOM NUMBER].Interview on 03/16/2026 at 3:04 PM with LPN LL confirmed that the Lantus (insulin) pen without expiration date or open date and methotrexate vial were without expiration date or open date. She admits she was unsure when the vial and pen were open. She confirmed that the Arginaid (medical food) powder had expired. She states that medication carts are managed by the nurses to make sure medications are not expired.In a concurrent observation and interview on 03/17/2026 at 10:09 AM on Evergreen wing, LPN Wound care nurse GG confirmed that three tubes of hydrogel expired on 05/2025, one tube of slivasorb gel expired 04/2024, two tubes of Thera honey gel expired on 3/20/2024,one tube of Thera honey expired on 12/20/2024, two tubes of Medi honey expired on 10/1/2025, one tube of zinc oxide expired on 04/2024, one tube of mupirocin ointment two percent expired on 12/2025, and a box with packets of hydrocortisone 1% expired on 8/2024 and packets of Aquaphor (zinc oxide) expired on 7/2025. She confirmed that one tube of hydrocortisone cream 2.5 percent was prescribed for use for seven days and issued on 10/03/2024. Wound Care LPN GG admits that the hydrocortisone cream should have been removed from the cart. She admits that expired medications were supposed to remove from the cart and placed in disposable bin located on Peachtree/Jasmine medication room.In a concurrent observation and interview of [NAME] medication cart , LPN BB confirmed that sumatriptan 100mg expired 1/2026 and ondansetron 4mg expired on 01/29/2026. She states that night shifts are to manage the medication carts.In a concurrent observation and interview on 03/16/2026 at 1:45 PM in the Magnolia medication room, (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LPN KK confirmed that the hemorrhoidal suppositories had expired in January 2026. Two boxes of Carbamide Peroxide 6.5 percent ear drops expired in July 2024.In a concurrent observation and interview on 03/16/2026 at 1:57 PM in the [NAME] and Peachtree medication room, LPN EE confirmed that Acetaminophen 325 mg (1000 tablets) had expired in February 2026.In a concurrent observation and interview on 03/16/2026 at 2:11 PM in the Evergreen medication room, the LPN Unit Manager II confirmed that an insulin Lispro vial was open and did not have an open date or expiration date. LPN EE also confirmed that magnesium oxide 400 mg had expired in February 2026.In a concurrent observation and interview on 03/16/2026 at 2:24 PM in the Azelia and Camelia medication room, LPN DD confirmed that the nicotine patches, Step One 21 milligrams, had expired in October 2025.In a concurrent observation and interview on 03/17/2026 at 2:47 PM in the central supply room, the Central Supply staff confirmed that Dairy Aid had expired in February 2025; two Coricidin HBP products had expired in September 2025; one box of astringent solution had expired in September 2023; and three boxes of bisacodyl suppositories had expired in April 2025. She stated that she rotated stock so older items were placed in the front and newer items in the back. She explained that nurses were responsible for removing expired items from the medication rooms because she did not have access to those rooms. She admitted that the expired items were missed because they were not frequently used.Observation and interview on 03/16/2026 at 3:04 PM revealed that the [NAME] medication cart contained a Lantus (insulin) pen without an expiration date or open date, Arginaid (medical food) orangeˆflavored powder that expired on January 21, 2026, and a methotrexate vial without an open date or expiration date. Interview with LPN LL confirmed that the Lantus insulin pen and methotrexate vial did not have expiration dates or open dates. She admitted she was unsure when the vial and pen were opened. She confirmed that the Arginaid powder was expired. She stated that medication carts were managed by the nurses to ensure medications were not expired.In a concurrent observation and interview on 03/17/2026 at 10:09 AM on the Evergreen wing, LPN Wound Care Nurse GG confirmed that three tubes of hydrogel expired in May 2025; one tube of Silvasorb gel expired in April 2024; two tubes of Thera Honey gel expired on March 20, 2024; one tube of Thera Honey expired on December 20, 2024; two tubes of MediHoney expired on October 1, 2025; one tube of zinc oxide expired in April 2024; one tube of mupirocin ointment 2% expired in December 2025; a box containing packets of hydrocortisone 1% expired in August 2024; and packets of Aquaphor (zinc oxide) expired in July 2025. She confirmed that one tube of hydrocortisone cream 2.5% was prescribed for seven days and issued on 10/03/2024. Wound Care LPN GG admitted that the hydrocortisone cream should have been removed from the cart. She admitted that expired medications were supposed to be removed from the cart and placed in the disposal bin located in the Peachtree/Jasmine medication room.In a concurrent observation and interview of the [NAME] medication cart, LPN BB confirmed that sumatriptan 100 mg expired in 10/2026 and ondansetron 4 mg expired on 01/29/2026.Interview on 03/16/2026 at 2:49 PM with Unit Manager LPN CC revealed that night shift nurses are to make sure nothing is expired. The unit supervisor is to audit cart a couple of times a week. Insulin pens and vials are to have open dates and expiration dates.Interview on 03/17/2026 at 1:00 PM with Unit Manager LPN II revealed that medications carts are to be checked by the floor nurses. Nurses are to make sure the carts are clean and does not have expired medications. Unit Managers are to make sure carts are clean and no expired medications. Medications carts are to be locked, no medications left on top of the cart, no keys left and close the computer.Interview on 03/17/2026 at 1:54 PM with DON revealed that nurses are responsible for dating and labelling medications. Nurses are to keep carts clean and no expired medications. Nurse Managers, Nurses, and Central Supply manage medication rooms to ensure there were no expired medications. She confirmed that insulin and methotrexate do not have open or expiration date. She admits that methotrexate vial, insulin vial, and insulin pen are to have open date and expiration date. Medication carts and wound care carts are locked, and keys are kept with the nurse when they walk away from cart.

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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** Based on observations, resident and staff interviews and record review the facility failed to ensure that two of 56 sampled residents (R113 and R155) did not have unauthorized, unsecured medications at the bedside. This deficient practice had the potential to allow unauthorized access to medications by other residents and visitors in the facility.1. Review of R155's electronic health record (EHR) revealed the following diagnoses, including but not limited to acute kidney failure, hypertension, and sepsis.Review of the Physician Order Form and Medication Administration Record (MAR), both dated March 2026 for R155, revealed that the resident did not have an order in place for the prescription.Review of R155's admission Minimum Data Set (MDS) assessment dated [DATE] revealed that Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated cognitively intact. GG (Functional Abilities and Goals) assessed the resident as dependent to requiring partial or moderate assistance with ADLs and noted the resident to be nonˆambulatory.Review of R155's EHR revealed an omission of a completed assessment to determine whether the resident was capable of selfˆadministration of medications.Observation on 03/15/2026 at 1:00 PM and 3:03 PM, and again on 03/16/2026 at 1:26 PM, revealed nystatin cream on R155's bedside stand within public view of anyone entering the room.Interview on 03/15/2026 at 1:41 PM with R155 confirmed selfˆadministering the medication to her skin without any assistance from facility staff. R155 reported having the cream since admission.Observation and interview on 03/16/2026 at 2:00 PM with Licensed Practical Nurse (LPN) AA revealed confirmation of the unauthorized medication (nystatin cream) in R155 room. LPN AA also confirmed that R155 had not been assessed to selfˆadminister medications independently. She reported being unsure how the medication was left in the resident's possession. LPN AA then removed the medication from the room.Interview on 03/18/2026 at 1:15 PM with the Director of Nursing (DON) revealed that she was unaware of R155 having the cream in her possession. She stated that her expectation was for nurses and certified nursing assistants to monitor medications at the bedside.2. Review of R113's electronic health record (EHR) revealed the following diagnoses, including but not limited to nonˆtraumatic acute dural hemorrhage, unspecified dementia, and chronic lymphocytic leukemia of Bˆcell type in remission.Review of the Physician Order Form and Medication Administration Record (MAR), both dated March 2026 for R113, revealed that the resident did not have an order in place for the prescription.Review of R113's Quarterly MDS assessment dated [DATE] revealed that Section C (Cognitive Patterns) documented a BIMS score of 10, which indicated moderate cognition and periods of cognitive impairment. Section GG (Functional Abilities) assessed the resident for ambulatory status.Review of R113's EHR revealed an omission of a completed assessment to determine whether the resident was capable of selfˆadministration of medications.Observation on 03/15/2026 at 1:47 PM and on 03/16/2026 at 1:59 PM revealed eye drops located on R113's bedside stand. A bottle of peroxide and wound spray were observed on a dresser drawer stand next to the resident's television. All items were in view of anyone entering the room.Interview on 03/15/2026 at 1:41 PM with R113 reported selfˆadministering eye drops without any assistance from facility staff. R113 reported having eye drops for months.Observation and interview on 03/16/2026 at 1:59 PM with Licensed Practical Nurse (LPN) AA confirmed the unauthorized medication (eye drops) in the resident's room. LPN AA also confirmed that R113 had not been assessed to selfˆadminister medications independently. She reported being unsure how the medication was left in the resident's possession.Interview on 03/16/2026 at 2:02 PM with LPN BB confirmed that R113 has periods of confusion and was not assessed to self- administer medications. She reported being unaware of medication being left in the resident room.Interview on 03/17/2026 with the DON revealed that she was unaware of R113 having eye drops in his possession. She stated that her expectation was that nursing staff monitor medications sufficiently.

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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. Based on observation, staff interviews, record review, and review of the facility's policy titled Care Plans, Comprehensive Person-Centered, policy, the facility failed to develop or implement a comprehensive person-centered care plan for two of 32 sampled residents (R) (R56 and R6). This deficient practice had the potential to place R56 and R6 at risk of unmet needs, medical complications, and diminished quality of life.Findings Include:Review of the facility's policy titled Care Plans, Comprehensive Person-Centered, revealed that the facility's interdisciplinary team is responsible for the development of resident care plans. 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.1.Review of the Quarterly Minimum Data Set (MDS) assessment for R56, dates 12/30/2025, revealed Section C (Cognitive Patterns) that has a Brief Interview for Mental Status (BIMS) score of 00 indication severe cognitive impairment. Section I (Active Diagnosis) revealed diagnosis of but not all -inclusive cerebral infarction without residual deficits, dysphagia and muscle weakness. Section O (Special Treatments, Procedures, and Programs) documented that the resident received oxygen while a resident.Review of care plan for R56 dated 12/25/2025 revealed oxygen therapy was not addressed.Review of the physician orders R56 revealed an order dated 8/20/2025 for continuous oxygen at 2 LPM (liters per minute) via NC (nasal cannula), every shift for comfort. Observation on 03/15/2026 at 12:36 PM revealed that R56 was receiving oxygen via NC and the concentrator flow rate was set between 3.5 and 4 LPM.Observation on 03/16 at 7:42 AM and 4:44 PM revealed that R56 was receiving oxygen via NC and the concentrator flow rate was set between 3.5 to 4 LPM.Interview and observation on 03/17/2026 at 11:23 AM with Licensed Practical Nurse (LPN) EE confirmed that R56's oxygen flow rate was set between 3.5 to 4 LPM. She confirmed that the physician order was for oxygen 2 LPM. She states that she checks the level after she has completed her medication pass.Interview on 03/17/2026 at 1:23 PM with Registered Nurse (RN)/ (Resident Assessment Instrument) RAI Director confirmed that R56 oxygen therapy was not addressed in care plan. She also confirmed that MDS Section O for R56 reveals that he resides with oxygen therapy and the order dated 08/20/205 for 2 LPM. She also confirms that the baseline care plan does not address oxygen therapy.Interview with DON on 03/17/2026 at 1:54 PM revealed that a resident on oxygen therapy should be addressed in the care plan. She states that the oxygen order when entered in the electronic record should automatically create a generic care plan template. She states that residents are discussed in clinical meetings to capture care plans.2. Review of the Quarterly Minimum Data Set (MDS) assessment for R6, dates 01/14/2026, revealed Section C (Cognitive Patterns) that has a Brief Interview for Mental Status (BIMS) score of 12 indication moderate cognitive impairment. Section I (Active Diagnosis) revealed diagnosis of but not all -inclusive obstructive sleep apnea, cerebral infarction without residual deficits. Section O (Special Treatments, Procedures, and Programs) documented that the resident received non-invasive mechanical ventilator while a resident.Review of the physician orders for R6 revealed an order dated 09/5/2025 for Continuous Positive Airway Pressure (CPAP) removed in the morning.Observation on 03/15/2026 at 3:10 PM revealed that CPAP not bagged on top of toothpaste box in a basket of fruit.Observation on 03/16/2026 at 7:55 AM revealed that CPAP was not cleaned and laying on top of bottles of cleaning products.Observation on 03/17/2026 at 9:08 AM revealed that mask was not cleaned and was lying in a top of bottles in a basket.Interview with LPN BB on 03/17/2026 at 9:25 AM revealed that CPAP mask was not clean and laying on top of bottles in a basket. She states that mask should be bagged and night shift should have bagged and cleaned masked. She admits if not cleaned or stored correctly then day shift should be addressed.Interview on 03/17/2026 at 1:23 PM with RN/ RAI Director confirmed that care planned revealed care plan intervention was to clean mask daily.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observations, staff interviews, record review, and review of the facility document titled Central Venous and Midline Catheter Flushing, the facility failed to ensure professional standards were followed for one resident (R) (R103) of five residents receiving care for a peripherally inserted central catheter (PICC.) This deficient practice had the potential to place R87 at risk of adverse clinical outcomes.Findings include:A review of the facility's policy titled Central Venous and Midline Catheter Flushing reviewed 1/26/2026, Flushing Technique section included.3. Aspirate the CVAD (central venous access device) catheter for blood return to confirm patency prior to administration of medications and solutions.Review of the physician's orders for R103 revealed an order dated 02/27/2026 for Ertapenem sodium (an antibiotic medication used to treat infections) intravenous one gram every 24hours and daptomycin (an antibiotic medication used to treat infections) intravenous solution 700 milligrams (mg) every 24 hours. Further review revealed an order dated 1/16/2026 for: Flush RUA (right upper arm) PICC line with 10 cc normal saline 0.9 precent before and after each medication administration three times a day.Observation of medication pass on 03/16/2026 at 8:57 AM revealed that Licensed Practical Nurse (LPN) EE applied gloves, cleaned the PICC line lumen (an individual access point of the PICC line), connected a tenˆmilliliter (ml) syringe of 0.9 percent normal saline to the lumen, flushed the line with eight milliliters, and did not aspirate (draw back) to check for blood return to verify patency, disconnected the syringe, and connected the ertapenem sodium infusion.Interview on 03/16/2026 at 9:02 AM, LPN EE confirmed that she flushed the PICC line with normal saline and did not aspirate (draw back) for a blood return. She admits she should have aspirated blood (draw back) to check patency. She states that she did not flush to the end of syringe because of air in the syringe. She forgot to get the air out.Interview on 03/17/2026 at 1:54 AM with the Director of Nursing (DON) revealed that the nurse would verify the antibiotic order, prepare supplies, identify the patient, prime the antibiotic line, clean the PICC line hub, flush, and check for a blood return. Checking for blood return verifies patency of the PICC line.

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. Based on observations, interviews, record review, and the facility policy titled, Colostomy/Ileostomy Care, the facility failed to ensure care consistent with professional standards of practice for one of two sampled residents (R) (R78). This deficient practice placed R78 at risk for skin breakdown and discomfort.Findings Include:Review of the facility's policy titled Colostomy/Ileostomy Care, review date 01/21/2026, revealed that The purpose of this procedure is to provide guidelines that will aid in preventing exposure of the resident's skin to fecal matter.Review of the Quarterly Minimum Data Set (MDS) assessment for R78, dated 01/10/2026, revealed in Section C (Cognitive Patterns) a Brief Interview for Mental Status (BIMS) score of 15, indicating little to no cognitive impairment. Section I (Active Diagnosis) revealed diagnoses including, but not limited to, colostomy, cerebral infarction without residual deficits, and muscle weakness. Section H (Bladder and Bowel) revealed that R78 had an ostomy.Review of the care plan dated 02/05/2026 revealed that the resident was at risk for complications related to the colostomy. Interventions included performing colostomy care as ordered.Observation on 03/18/2026 at 11:25 AM of Certified Nursing Assistant (CNA) SS revealed that bed wipes were used to clean the skin area around the stoma. She used soap and water to wipe but ran out of soap. CNA SS then used bed wipes again to clean the area around the stoma, with blood observed on the wipes.Observation on 03/18/2026 at 12:15 PM of Licensed Practical Nurse (LPN) RR revealed that he used alcohol wipes to remove the wafer. He cleaned the area with soap and water. He sealed the bag to the wafer, wiped with a noˆsting barrier, and then applied powder to the skin. He applied the bag after removing the paper backing. He then removed gloves and washed his hands.Interview on 03/18/2026 at 1:28 PM with CNA SS revealed that she used wipes to clean the skin and observed blood on the wipes because she ran out of soap. She confirmed that she should not use wipes.Interview on 03/18/2026 at 1:18 PM with LPN RR confirmed that he used alcohol to remove the colostomy wafer. He admitted that staff should not use wipes to clean the site but should use soap and water.Interview on 03/18/2026 at 1:43 PM with LPN CC revealed that staff should not use bed wipes to clean the area but should use soap and water. She stated that staff should not use alcohol wipes to remove the wafer because the alcohol burns. Powder should be applied first, then the edges should be wiped with a skin prep wipe.Interview on 03/18/2026 at 2:14 PM with the Director of Nursing (DON) confirmed that CNAs should clean and empty the colostomy bag daily. CNAs should remove the bag and clean the area with soap and water to ensure the skin is clean.

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	115641	A. Building B. Wing	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverview Health & Rehab Ctr	6711 Laroche Avenue Savannah, GA 31406

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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. Based on observations, staff interviews, record review, and the facility's policies titled Oxygen Administration and CPAP/BIPAP, the facility failed to ensure that one of 40 sampled residents (R) R56 received oxygen as ordered by the physician. In addition, the facility failed to ensure that one(R)(R6) had their CPAP mask properly cleaned and stored. This deficient practice had the potential to place R56 and R6 at increased risk of respiratory complications.Findings Include:Review of the facility's policy titled Oxygen Administration policy, reviewed 1/21/2026, revealed that, The purpose of this procedure is to provide guidelines for safe oxygen administration. The Steps in the Procedure section included,. 7. Turn on the oxygen. Unless otherwise ordered, start the flow of oxygen at the rate of 2 to 3 liters per minute.Review of the Quarterly Minimum Data Set (MDS) assessment for R56, dated 12/30/2025, revealed in Section C (Cognitive Patterns) a Brief Interview for Mental Status (BIMS) score of 00, indicating severe cognitive impairment. Section I (Active Diagnoses) revealed diagnoses including, but not limited to, cerebral infarction without residual deficits, dysphagia, and muscle weakness. Section O (Special Treatments, Procedures, and Programs) documented that the resident received oxygen while a resident.Review of the medication administration record (MAR) dated 03/01/2026 through 03/17/2026 for R56 revealed an order dated 08/20/2025 for continuous oxygen at 2 LPM (liters per minute) via nasal cannula every shift for comfort.Observation on 03/15/2026 at 12:36 PM revealed that R56 was receiving oxygen via nasal cannula, and the concentrator flow rate was set between 3.5 and 4 LPM.Observations on 03/16/2026 at 7:42 AM and 4:44 PM revealed that R56 continued to receive oxygen via nasal cannula, and the concentrator flow rate remained set between 3.5 and 4 LPM.Interview on 03/17/2026 at 11:23 AM with Licensed Practical Nurse (LPN) EE confirmed that R56's oxygen flow rate was set between 3.5 and 4 LPM. She confirmed that the physician's order was for 2 LPM. She stated that she checked the oxygen level after completing her medication pass.Interview on 03/17/2026 at 1:07 PM with LPN II, Unit Manager (UM) for the 400, 500, and 600 halls, revealed that nurses were expected to check the oxygen flow rate upon coming on shift and ensure it was set to the ordered rate. Nurses were also expected to check the flow rate when checking on the residents.Interview on 03/17/2026 at 1:54 PM with the Director of Nursing (DON) revealed that nurses were to check the oxygen flow rate at the beginning of each shift to verify it matched the physician's order. Nurses were also expected to check the flow rate during the shift. If the flow rate did not match the order, the nurse was expected to adjust it to the correct setting.Review of the facility's policy titled CPAP/BiPAP Support, reviewed 01/21/2026, revealed that the purpose was to provide the spontaneously breathing resident with continuous positive airway pressure with or without supplemental oxygen. Under General Guidelines for Cleaning, item 7 stated: Masks, nasal pillows, and tubing: Clean or replace daily. Allow it to air dry between uses.Review of the Quarterly MDS assessment for R6, dated 01/14/2026, revealed in Section C a BIMS score of 12, indicating moderate cognitive impairment. Section I (Active Diagnoses) revealed diagnoses including, but not limited to, obstructive sleep apnea and cerebral infarction without residual deficits. Section O documented that the resident received nonˆinvasive mechanical ventilation while a resident.Review of the MAR dated 03/01/2026 through 03/17/2026 for R6 revealed an order dated 09/05/2025 for Continuous Positive Airway Pressure (CPAP), to be removed in the morning.Review of the care plan revealed that R6 was to use a CPAP machine related to obstructive sleep apnea, with interventions directing staff to clean the mask daily.Observation on 03/15/2026 at 3:10 PM revealed that the CPAP mask was not bagged and was lying on top of a toothpaste box in a basket of fruit.Observation on 03/16/2026 at 7:55 AM revealed that the CPAP mask was not cleaned and was lying on top of bottles of cleaning products.Observation on 03/17/2026 at 9:08 AM revealed that the CPAP mask remained uncleaned and was lying on top of bottles in a basket.Interview on 03/17/2026 at 9:25 AM with LPN BB confirmed that the CPAP mask was not clean and was lying on top of bottles in a basket. She stated that the mask should have been bagged and that night shift staff (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should have cleaned and bagged the mask. She admitted that if the mask was not cleaned or stored correctly, day shift staff should have addressed it.Interview on 03/17/2026 at 11:23 AM with LPN II, Unit Manager, revealed that the CPAP mask should be stored in a plastic bag at the bedside and cleaned daily.Interview with the Director of Nursing (DON) on 03/17/2026 at 1:54 PM confirmed that the CPAP mask was not cleaned or stored correctly. She stated that the mask should be washed daily and left to air dry. She stated she would expect the mask to be placed on a paper towel on the nightstand to air dry.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, staff interviews, record reviews, and review of the facility policies titled Enhanced Barrier Precautions and Hand Washing/Hand Hygiene, the facility failed to ensure proper hand hygiene during wound care and colostomy care for two of thirtyˆtwo sampled residents (R) (R78 and R97). In addition, the facility failed to ensure the correct use of required personal protective equipment during care provided to three residents (R103, R78, and R97) receiving intravenous therapy, wound care, and colostomy care under enhanced barrier precautions. These deficient practices had the potential to place residents at increased risk for infection.Findings include: 1.Review of the facility's policy titled, Enhanced Barrier Precautions, review date 01/21/2026, revealed that the Policy Interpretation and Implementation,. Enhanced barrier precatuions (EBPs) are used as an infection prevention and control intervention to reduce the transmission of multi-drug resistant organisms (MDROs) to residents. 3. Example of high contact resident care activities requiring the sue of gown and gloves for EBPs include: .b. bathing/showering.g.device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.); and h. wound care (any skin opening requiring a dressing). Review of the facility's policy titled, Handwashing/Hand Hygiene, review date 01/21/2026, revealed that Indications for Hand Hygiene . 1. Hand Hygiene is indicated: a immediately before touching a resident,. b. before performing an aseptic task (for example, placing an indwelling device or handling an invasive medical device);. c. after contact with blood, body fluids, or contaminated surfaces;. d. after touching a resident; . e. after touching the resident's environment;. f. before moving from work on a soiled body site to a clean body site on the same resident,; and. g. immediately after glove removal. Observation on 03/16/2026 at 9:02 AM of Licensed Practical Nurse (LPN) EE revealed she prepared supplies for intravenous (IV) therapy for Resident R103. LPN EE entered the room without wearing a gown. She washed her hands, applied gloves, and completed the IV connection. Interview on 03/16/2026 at 9:02 AM with LPN EE confirmed she was not wearing a gown. She stated she should have worn a gown because R103 has a peripherally inserted central catheter (PICC). She acknowledged that enhanced barrier precautions (EBP) are identified in the electronic medical record next to the resident's name and that signage is posted on the resident's door. Observation on 03/17/2026 at 9:32 AM revealed Wound Care LPN GG prepared a tray with supplies while wearing gloves. She removed gauze, ABD pads, and a superˆabsorbent dressing from their packaging with ungloved hands. She entered the resident's room wearing a gown and gloves. After packing the wounds, she did not change her gloves or wash her hands before applying the gauze, ABD pad, and superˆabsorbent dressing. Interview on 03/17/2026 at 10:09 AM with LPN GG confirmed she did not wear gloves while preparing supplies. She also confirmed she did not wash her hands or change gloves after packing the wound. Interview on 03/17/2026 at 1:07 PM with Unit Manager LPN II revealed that residents with PICC lines, wounds, feeding tubes, and catheters require staff to wear gowns and gloves during wound care, activities of daily living, transferring, and IV antibiotic administration. She stated there is a box outside the resident's room containing gowns and gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/17/2026 at 1:54 PM with the Director of Nursing (DON) revealed staff are required to wear gowns and gloves when caring for residents with open wounds, IV access, and dialysis. The DON stated residents on enhanced barrier precautions are identified in the electronic medical record and by signage on the door. She reported that carts in the hallway contain gowns, gloves, and masks. The DON stated the wound care nurse should use gloves when removing items from packaging and should change gloves and sanitize hands after packing the wound and before applying the outer dressings. Staff are required to wash hands and don new gloves when transitioning from dirty to clean tasks. 3.Review of the facility's policy titled, Handwashing/Hand Hygiene, review date 1/21/2026, revealed that Indications for Hand Hygiene . 1. Hand Hygiene is indicated: a immediately before touching a resident,. b. before performing an aseptic task (for example, placing an indwelling device or handling an invasive medical device);. c. after contact with blood, body fluids, or contaminated surfaces;. d. after touching a resident; . e. after touching the resident's environment;. f. before moving from work on a soiled body site to a clean body site on the same resident,; and. g. immediately after glove removal. Interview on 03/18/2026 at 1:19 PM with Licensed Practical Nurse (LPN) RR confirmed he did not wear a gown while providing care to Resident R78. LPN RR stated he was aware the resident was under enhanced barrier precautions and acknowledged he should have worn a gown, mask, and gloves. He further admitted he did not change his gloves or wash his hands after cleaning the colostomy site with soap and water and stated he should have changed gloves and washed his hands before cutting out the colostomy bag. Interview on 03/18/2026 at 1:25 PM with Certified Nurse Assistant (CNA) SS confirmed she was not wearing a gown while providing care. CNA SS stated she could not recall what precautions the resident was under but acknowledged she should have worn a gown and gloves. She confirmed she used wipes to clean the skin and wafer after removing the bag, reported she ran out of soap, and admitted she should not have used wipes to clean the area. Interview on 03/18/2026 at 1:41 PM with LPN CC revealed that residents with colostomies are under enhanced barrier precautions. LPN CC stated staff should wear gowns and gloves. She explained that nurses manage the colostomy, while CNAs empty and burp the colostomy bag. Staff are required to clean the area with soap and water and should not use bed wipes. LPN CC stated nurses should wash their hands and change gloves after cleaning the colostomy area, and staff should wash hands when moving from dirty to clean tasks. She further stated staff should not use alcohol wipes to remove the wafer because they can cause burning, and that powder should be applied first, followed by wiping the edges with skin prep. Interview on 03/18/2026 at 2:14 PM with the Director of Nursing (DON) revealed that residents with colostomies are under enhanced barrier precautions and staff should wear gowns, gloves, and goggles. The DON stated CNAs clean and empty the colostomy bag daily. She reported CNAs remove the bag and wash the area with soap and water to ensure it is clean. Staff should wash their hands and apply new gloves after cleaning the ostomy area, and again before cutting out the colostomy wafer. Staff are required to wash hands and don new gloves when transitioning from dirty to clean tasks.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observations, interviews, and the facility policy titled Call System, Resident, the facility failed to ensure the call light was within reach for one of 32 sampled residents (R) (R121). This deficient practice had the potential to place R121 at risk of not having their needs met when required.Findings Include:Review of the facility's policy titled Call System, Resident with a review date of 01/21/2026 revealed that Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation.Review of the Quarterly Minimum Data Set (MDS) assessment for R121, dated 03/03/2026, revealed in Section C (Cognitive Patterns) a Brief Interview for Mental Status (BIMS) score of 11, indicating moderate cognitive impairment. Section I (Active Diagnosis) revealed diagnoses including, but not limited to, vascular dementia, traumatic brain injury, repeated falls, and normal pressure hydrocephalus. Section GG (Functional Abilities) revealed that R121 was dependent for activities of daily living.Observation and interview with the resident on 03/15/2026 at 2:37 PM revealed that R121 was in bed on her right side. The call light was located in the overhead light. The resident stated that she did not have a call light, but her roommate had one. She stated she did not call for help.Observation on 03/16/2026 at 8:03 AM revealed R121 in bed lying on her right side, with the call light observed in the overhead light.Observation and interview on 03/16/2026 at 3:36 PM revealed that R121 was in bed on her right side. The call light remained in the overhead light. R121 stated that she did not have a call light and that she did not call for help.Interview on 03/17/2026 at 1:07 PM with Unit Manager, LPN II revealed that residents should have access to a call light. The call light should be clipped to the bedside within reach. Residents who could not push the button had access to a push pad.Interview on 03/17/2026 at 1:54 PM with the Director of Nursing (DON) revealed that all residents should have a call light near them. If they were unable to press the call light, then the resident would use a touch button.