

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235324	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2025
NAME OF PROVIDER OR SUPPLIER Riverside Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1149 West Monroe Road St. Louis, MI 48880	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #1322431. Based on observation, interview, and record review the facility failed to implement care planned interventions and ordered treatments for pressure ulcer prevention for 1 resident (R102) of 3 residents reviewed for pressure ulcers. Findings include: Review of a Face Sheet revealed R102 admitted to the facility on [DATE] with pertinent diagnoses which included cerebral infarction (stroke) and hemiplegia (muscle weakness or partial paralysis on one side of the body). Review of a Minimum Data Set (MDS) (a tool used for assessing a resident's care needs) assessment for R102, with a reference date of 8/5/2025 revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 6, out of a total possible score of 15, which indicated R102 was severely cognitively impaired. Further review of the same MDS assessment revealed R102 was dependent on staff for toileting hygiene, always incontinent of bowel, and at risk for developing pressure ulcers. Review of a current skin risk Care Plan interventions for R102, initiated 2/5/2025, directed staff to keep skin clean and dry as possible, minimize skin exposure to moisture, provide incontinence care after each incontinence episode, and use moisture barrier product to perineal area as needed. Further review of activities of daily living (ADL) interventions revealed R102 was incontinent of bowel and bladder and required extensive assistance with personal hygiene. Review of R102's Physician's Orders, active 9/3/2025, revealed an order for Calmoseptine ointment (a topical medicated ointment used to prevent skin irritation from incontinence) to be applied to buttocks after each episode of incontinence. In an observation on 9/3/2025 at 9:20 AM in R102's room, R102 was assisted back to bed by mechanical lift by Licensed Practical Nurse (LPN) C and Certified Nursing Assistant (CNA) D and was provided incontinence care. R102's brief was soaked, and urine had soaked through the brief and saturated his pants. R102 also had a bowel movement. Observation of buttocks revealed no evidence of barrier cream or ointment residue, and no barrier cream or Calmoseptine ointment were applied by staff at the time. In an interview on 9/3/2025 at 9:39 AM, CNA D reported that the previous shift got R102 up and into his chair at approximately 5:00 AM. CNA D reported she had not checked or changed R102 from when he was placed into his chair by the previous shift at approximately 5:00 AM until she assisted him back into his bed at 9:20 AM because she did not have time. CNA D reported incontinent residents should be checked and changed every two hours. Review of R102's Medication Administration Record (MAR) on 9/3/2025 at 2:00 PM revealed Registered Nurse (RN) F documented that she administered Calmoseptine ointment to R102's buttocks that morning. In an interview on 9/3/2025 at 2:15 PM, RN F reported that she had not administered Calmoseptine ointment to R102 that morning as documented. RN F stated The CNAs do this. In an interview on 9/3/2025 at 2:18 PM, CNA D reported she did not normally apply Calmoseptine ointment to residents. CNA D reported Calmoseptine ointment was stored in the treatment cart and nurses usually applied this. In an observation on 9/4/2025 at 9:05 AM in R102's room, R102 was assisted back to bed by mechanical lift by CNA E and CNA G and was provided incontinence care. R102's brief was soaked, and urine had soaked through the brief and saturated his pants. R102 also had a bowel movement. Observation of buttocks revealed no evidence of barrier cream or ointment residue, and no barrier cream or Calmoseptine ointment were applied by staff at the time. In an interview on 9/4/2025 at 9:20 AM, CNA E reported the previous shift got R102 up to his chair at approximately 5:30 AM. CNA E reported residents with incontinence should be checked and changed every 2 hours. CNA E reported she should have checked R102 for incontinence before breakfast, but he was escorted to breakfast by another staff member before she was able to do this. CNA E reported she did not believe R102 had an order for any kind of barrier cream. CNA E reported CNAs use barrier cream if it is in the room, but if it is in the treatment cart the nurse will administer the cream. In an interview on 9/4/2025 at 12:52 PM, RN F reported she was not aware R102 had a bowel movement that morning. RN F reported she was sure R102 had Calmoseptine ointment placed by the previous shift when they got him up that morning because that is the process. RN F reported CNAs have been getting the Calmoseptine ointment from the treatment cart to apply, but they should not because it is medicated and should be applied by a nurse. RN F reported she was not aware the Calmoseptine order for R102 was to be applied as needed for episodes of incontinence. In an interview on 9/4/2025 at 1:15 PM, the Director of Nursing (DON) reported Calmoseptine ointment was medicated and must be stored in the treatment cart and administered by a nurse. The DON confirmed the expectation that staff check and change incontinent residents every two hours. Review of Fundamentals of Nursing (INAME1 and INAME1) 11th</p>		