

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365272	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/09/2024
NAME OF PROVIDER OR SUPPLIER  Riverview		STREET ADDRESS, CITY, STATE, ZIP CODE 3710 Olentangy River Road Columbus, OH 43214	

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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 33019</p> <p>Based on medical record review, resident and staff interview, and review of a self-reported incident, the facility failed to ensure residents received proper assistance with transfers and toileting per the plan of care. This affected one (#1) of three residents reviewed for accidents. The facility census was 132.</p> <p>Findings include:</p> <p>Review of Resident #1's medical record revealed an admitted [DATE] with diagnoses included encounter for orthopedic aftercare (fractured right ankle), foot drop of the left foot, unsteadiness on feet, weakness, cerebral infarction, morbid obesity, chronic kidney disease, chronic pain syndrome, and chronic respiratory failure. The resident was discharged on [DATE].</p> <p>Review of Resident #1's admission Minimum Data Set (MDS) assessment, dated 03/12/24, revealed the resident had intact cognition. The assessment indicated the resident had no behaviors, including rejection of care. The resident required physical assistance and was dependent for sit-to-stand, chair/bed-to-chair transfers, and toilet transfers. The MDS assessment indicated the resident had impairment of both lower extremities and her mobility device was a wheelchair.</p> <p>Review of an activities of daily living (ADLs) self-care performance deficit care plan dated 03/09/24 revealed Resident #1 had an intervention for a two-person assist to the bedside commode for toileting and transfers using a wheeled walker and gait belt.</p> <p>Review of a self-reported incident (SRI) dated 04/01/24 at 7:22 A.M. revealed State tested Nurse Aide (STNA) #202 assisted and transferred Resident #1 to the bedside commode without the assistance of another staff member.</p> <p>Interview on 04/01/24 at 1:20 P.M., with Regional Director of Nursing #205 confirmed Resident #1 was at risk for falls and required assistance of two staff for transfers and toileting per her care plan. Regional Director of Nursing #205 also confirmed the information in the SRI dated 04/01/24 indicating STNA #202 assisted Resident #1 to the bedside commode without proper assistance.</p> <p>Telephone interview on 04/04/24 at 2:43 P.M., with Resident #1 stated STNA #202 always transferred her to the bedside commode without the assistance of a second staff member.</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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Interview on 04/05/24 at 2:20 P.M., the Director of Nursing confirmed Resident #1's care plan indicated she required assistance from two staff for transfers.		