STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365272	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverview	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)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 49039 Based on observation, review of facility policy, and staff interview, the facility failed to ensure the milk served during meal service remained in a safe and palatable temperature for serving. This had the potential to affect 56 residents (Residents #1, #2, #3, #5, #6, #8, #9, #10, #12, #13, #14, #15, #18, #19, #20, #21, #22, #23, #25, #27, #28, #32, #34, #35, #36, #37, #40, #41, #42, #43, #47, #48, #49, #51, #52, #54, #59, #60, #63, #69, #74, #75, #76, #81, #82, #84, #89, #93, #101, #102, #103, #113, #116, #120, #130 and #238) who regularly consume milk. The facility census was 133. Findings include: Observation of breakfast meal service on 01/28/25 at 8:29 A.M. revealed multiple residents trays had various types of milk on them, those milks included low fat milk, 2% milk and whole milk. Direct care staff removed a 2% milk from the cart to complete a test tray. The milk temperature was 60 degrees Fahrenheit (F). Interview on 01/28/25 at 8:31 A.M. with Certified Nursing Assistant (CNA) #350 confirmed the 2% milk was at 60 degrees F. CNA #350 stated she was unsure of the safe serving temperature for milk. Interview on 01/28/25 at 12:12 P.M. with Regional Culinary Director #500 and Food Services Director #170 denied the kitchen staff placed milk on trays. Facility policy stated the milk cartons should be placed in a bucket of ice on top of the serving carts to ensure they remain cold. Observation of tray arriving on the unit on 01/28/25 at 12:19 P.M. revealed low-fat, 2%, and whole milk were again placed on residents' trays. This observation was conducted with Food Services Director #170, who confirmed that dietary staff did not follow facility policy. Upon removal of the final tray, Food Services Director #170 and surveyor began temperature checks. The milk was measured at 60 degrees F. Food Services Director #170 requested a temperature re-check. Upon returning at 12:36 P.M. with a digital thermometer, his probe read 57.6 degrees F, while the surveyor's probe read 62 degrees F. Food Services Director #170 confirmed the milk was not within safe serving temperatures. Review of trayline food temperatures dated 08/01/24 revealed the facility will hold and serve food at acceptable temperatures to deter bacterial growth. The internal temperatures of potentially hazardous foods must be 41 degrees F or below for cold food. Additionally, the policy states that cold food shall remain under refrigeration or on ice during meal service to ensure that cold foods are served at no greater than 41 degrees F. (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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This deficiency represents non-compliance investigated under Complaint Number OH00161708.

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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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49039 Based on medical record review, review of hospital records, observation, staff interviews, interview with the Local County Health Department (LCHD), interview with the physician, review of a death certificate, review of the facility's Legionella bacteria prevention plan, review of email communications with the LCHD, review of facility policy and procedures, review of the Legionella risk assessment, and review of the Centers for Disease Control and Prevention (CDC) website, the facility failed to follow their water management plan to ensure all shower heads were descaled semi-annually and flushes were completed weekly which resulted in elevated risk levels of Legionella bacteria in the facility's water system and exposure to the residents. This resulted in Immediate Jeopardy and the potential for serious life-threatening harm, negative health outcomes, and/or death when on [DATE] one resident (#100) was found to have increased effort of breathing, fatigue and generalized weakness, was sent to the emergency room (ER) for evaluation, tested positive for Legionella pneumonia in the hospital, and subsequently died on [DATE]. In addition, Resident #118 tested positive for the Legionella urine antigen on [DATE]. The facility's failure to have an effective water management program in place to monitor control measures to prevent the growth of potential Legionella in the water system affected two (#100 and #118) of four residents reviewed for Legionella and placed an additional 131 current residents at potential risk for Legionella bacteria exposure. The facility census was 133. On [DATE] at 11:13 A.M., the Administrator, Director of Nursing (DON) and Regional Clinical Director #111 were notified that Immediate Jeopardy began on [DATE] when Resident #100 exhibited a change in condition and was hospitalized on [DATE] due to labored breathing, fatigue, and generalized weakness and subsequently passed away on [DATE]. Admitting hospital diagnoses included sepsis, anemia, Legionella infection, pneumonia, acute kidney injury and possible chronic heart failure exacerbation. Review of the death certificate dated [DATE] revealed Resident #100 died on [DATE] at 3:06 A.M. with an immediate cause of death as acute renal failure, septic shock, and bacteremia. Review of the facility's Legionella preventative measures and interview with Maintenance Supervisor #221 revealed the facility was not completing weekly dead-end flushes (a length of water pipework closed at one end through which no water passes) and semi-annually descaling per facility policy. On [DATE] at 4:44 P.M., the LCHD communicated to the facility, that a resident who previously resided in the facility had tested positive for the Legionella urine antigen and passed away. The facility failed to implement immediate action to protect further residents from Legionella infection when public health made recommendations, which included restricting water usage or installing point-of-use filters, and to follow the current CDC guidance or current water management plan if already developed. The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective actions: On [DATE], Resident #100 was transferred to the hospital. On [DATE], upon notification of the positive urine antigen test regarding Resident #100, facility staff followed LCHD guidance in reviewing all resident's medical records who were diagnosed with pneumonia for the past three months. Residents #44, #48, #99, #118, #250, #251, #252, #253, #254, and #301 were identified to have been diagnosed with pneumonia in the past three months. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE], the DON was made aware an additional resident (Resident #118) tested positive for the Legionella urine antigen. The facility's Certified Nurse Practitioner (CNP) #900 reviewed the urine analysis results and determined no other treatment was warranted. On [DATE], water filters on ice machines and water fountains were serviced and cleaned by Service Company #500 according to manufacturer guidelines and preventative maintenance agreement. On [DATE], Maintenance Supervisor #221 and Maintenance Staff #166 descaled faucets and shower heads and completed dead leg flushes. On [DATE] and [DATE], the LCHD collected data points for water temperatures, PH levels and chlorine levels. On [DATE], the DON/designee reviewed all current residents with a respiratory assessment with no new respiratory concerns identified. On [DATE], an additional seven water samples were obtained for Legionella testing by a third party (Water Treatment Company #600) initiated by the Administrator. Water Treatment Company #600 will provide the facility with their results of the seven water samples in eight to 11 days. On [DATE], Maintenance Supervisor #221, Maintenance Staff #166 and Maintenance Staff #311 were provided education by the Administrator regarding descaling and flushing dead legs (a length of water pipework leading to a fitting through which water only passes infrequently where there is draw off from the fitting, providing the potential for stagnation) per the facilities water management policy. The Administrator will monitor the maintenance staff to ensure they are following the facility's Legionella prevention plan. Beginning on [DATE], Maintenance Supervisor #221/designee will audit water temperatures, chlorine levels and flush all dead legs two times a week for two months. Any concerns will immediately be reported to the Administrator and follow up with the Quality Assurance and Performance Improvement (QAPI) committee as needed. On [DATE], the Water Management Committee (WMC) met to review the proposed issues and concerns from the Ohio Department of Health Survey. The WMC (including the Administrator, DON, Maintenance Supervisor #221, and Medical Director #112) reviewed the facility's Legionella Risk Assessment and Control Measures, proposed Plan of Correction (POC) and root cause analysis (RCA). The WMC will meet twice a month for two months to review on-going Legionella testing, interim measures, audits completed, RCA corrective action items and POC status. Thereafter, the DON and Infection Control Preventionist (ICP) will report to the Quality Assurance Committee to assure that issues identified at the time of the survey are corrected. On [DATE] and [DATE], the DON/designee provided in-services to all staff, residents, and residents responsible parties regarding the water management program, Legionella screening symptoms, facility remediation measures, and the plan for continued water management. Beginning on [DATE], the DON/designee will complete daily respiratory monitoring assessments until the results of the water testing are received. The findings of the respiratory monitoring will be reviewed with the attending physicians and medical director as needed. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE], the facility began utilizing bottled water. Residents #2 and #119, who resided in the former Residents #100 and #118's rooms (who tested positive for the Legionella urine antigen) were moved out of their rooms and were relocated in the facility. All ice in the ice machine was disposed of and the facility utilized bagged ice. Showers and baths were put out of service until the installation of point of use filters. No-rinse wipes (a pre-moistened, disposable wipe designed to clean and sanitize a surface without the need to rinse it with water afterwards) were provided to the residents for hygiene needs at that time. On [DATE], the facility engaged with Legionella Consultant #650 who reviewed the facility water management plan with the team and will provide 90-day point of use filters that will be installed facility wide by [DATE]. Beginning on [DATE], the DON/designee will complete audits three times a week regarding employee call-offs for four weeks for signs and any symptoms related to Legionella illness. Any concerns will immediately be reported to the Administrator and followed up on with the QAPI committee as needed. On [DATE], 20 additional water samples were obtained by Legionella Consultant #650. On [DATE], maintenance staff installed point of use filters on all water outlets (showers, sinks) in the facility. These filters were rated for 90-day efficacy from the date of installment. All water filters were inspected and then all sinks and showers were put back into service. Although the Immediate Jeopardy was removed on [DATE], the deficiency remained at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is still in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. Findings include: 1) Review of the closed medical record for Resident #100 revealed the resident was admitted to the facility on [DATE] and discharged on [DATE] to the local hospital. The resident had diagnoses including kidney and ureter disorder, paroxysmal atrial fibrillation, chronic kidney disease, and chronic diastolic (congestive) heart failure. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #100 was cognitively intact as evidence by a Brief Interview for Mental Status (BIMS) assessment score of 15. The resident was assessed to require supervision or touching assistance with bed mobility, transfers, toileting, and eating. Review of Resident #100's change in condition evaluation dated [DATE] revealed the resident was documented to have increased confusion, weakness, disorientation, and abnormal vital signs. The CNP #900 was notified with an order to send Resident #100 to the local hospital for evaluation. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of Resident #100's hospital discharge summary dated [DATE] at 6:29 A.M. revealed active hospital problems of rectal bleeding, Legionella infection, volume overload, acute kidney injury superimposed by chronic kidney disease, bacteremia, and electrolyte disorder. The hospital course included evaluation of the worsening shortness of breath, cough, and lower extremity edema. Laboratory results at that time were notable for leukocytosis, positive urine Legionella antigen, and x-ray with pulmonary edema with dense right upper lobe airspace opacity. Resident #100 started on oxygen to maintain adequate supply of oxygen, but in the morning of [DATE], he was seen to have recurrent hypoxia (inadequate supply of oxygen) requiring escalation to Bilevel Positive Airway Pressure (BIPAP) and transferred to the Intensive Care Unit (ICU). The residents' antibiotics were adjusted for Legionella coverage; however, overnight from [DATE] to [DATE], Resident #100 decompensated quickly resulting in passing on [DATE] at 3:06 A.M. Review of Resident #100's death certificate revealed the resident died on [DATE] at 3:06 A.M. with an immediate cause of death as acute renal failure, septic shock, and bacteremia. 2) Review of the medical record for Resident #118 revealed re-admitted [DATE]. The resident had diagnoses including hemiplegia, muscle weakness, chronic kidney disease, chronic pulmonary embolism, mild cognitive impairment, altered mental status and essential hypertension. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #118 was severely cognitively impairment. Resident #118 required setup or clean-up assistance with eating. Review of the progress notes revealed on [DATE] at 3:42 P.M., Resident #118 seemed congested with crackle sound and coughing, no fever, and oxygen low at 90 percent saturation. The progress note dated [DATE] at 7:12 P.M. revealed the nurse received a new order for chest x-ray for congestion. Review of physician orders dated [DATE] revealed chest x-ray: 2 views for chest congestion. The progress note dated [DATE] at 8:47 A.M. revealed the chest x-ray results were received with left perihilar atelectasis/infiltrates noted and CNP #900 was notified. New orders for Levaquin (antibiotic) 750 milligrams (mg), ipratropium-albuterol inhalation solution (used to help open airways and reduce inflammation in the lungs to help you breathe), and Mucinex (help symptom relief for cold, flu, sinuses and sore throat). Review of Resident #118's physician orders dated [DATE] revealed an order to obtain urine specimen for Legionella antigen. Review of Resident #118's strep pneumonia and Legionella pneumonia AG result dated [DATE] revealed Legionella antigen had a positive result. The progress note dated [DATE] revealed Resident #118's results of urine antigen discussed with provider, residents' treatment appropriate at this time, and no further treatment required. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the LCHD email dated [DATE] at 4:44 P.M. revealed a resident (#100) who previously resided in the facility had tested positive for Legionella urine antigen and passed away. The email communication included guidance as listed, perform a retrospective review of cases, develop a line list of possible and definite cases, work with health care facility staff to identify all new and recent patients with health care associated pneumonia and test them for Legionella, consider recommendations for restricting water exposures in the facility or other immediate control measures, and facilitate an environmental assessment and sampling. The email from Environmental County Health Division (ECHD) dated [DATE] at 3:38 P.M. revealed the typical steps in a full investigation are to protect current residents by restricting water usage or installing point-of-use filters and follow the current CDC guidance or current water management plan if already developed. The Administrator's email was incorrectly entered. The following email was resent to the correct Administrator's email address on [DATE] at 8:43 A.M., with an email response from the Administrator on [DATE] at 4:31 P.M. The email communication dated [DATE] at 12:34 P.M. from ECHD Supervisor #999 to the Administrator revealed guidance stating, we again advise you to protect current residents by restricting water usage or installing point-of-use filters. Review of Semi-Annual Faucet and Showerhead Scale Inspection documentation as part of the facility's Legionella bacteria prevention plan revealed the only record available for review was on [DATE]. There were no records available prior to [DATE]. Observations on [DATE] from 8:02 A.M. to 8:24 A.M. revealed the resident rooms' sinks did not have water filters in place and they were in working order. Shower rooms were in working order and no filters were in place on the shower heads. Interview on [DATE] at 2:00 P.M. with Maintenance Supervisor #221 denied issues with the water system in the facility, stating he regularly conducts temperature checks, flushes, and monitors chlorine levels in accordance with facility policy. He stated that most of the residents' showers in their rooms were shut off and were considered dead ends, as they do not receive water flow through them, often resulting in stagnant water sitting in the lines. Maintenance Supervisor #221 denied flushing all dead ends, specifically shower heads, on a weekly basis, which is the standard procedure according to the facility's policy. He confirmed descaling of faucets and shower heads should occur semi-annually. Additionally, he confirmed the most recent descaling was performed on [DATE]. However, the facility had no other available records regarding past descaling maintenance. Interview on [DATE] at 2:03 P.M. with Maintenance Supervisor #221 and the Administrator confirmed no additional records were available for Semi-Annual Faucet and Showerhead Scale Inspection. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Interview via telephone on [DATE] at 9:27 A.M. with ECHD Program Coordinator #113 confirmed he visited the building on [DATE] and [DATE]. During his visits, he discussed potential causes of increased Legionella growth, including the need for routine flushing of dead legs, descaling of faucets, monitoring water temperatures and chlorine levels, and interventions to prevent further spread (filters and water restrictions) with Maintenance Supervisor #221. The goal of the [DATE] visit was to limit potential exposure to other residents in the facility. ECHD Program Coordinator #113 stated the Administrator was concerned about placing filters on the water outlets. The Administrator felt if he placed filters on the water outlets, then the Legionella testing may not show accurate results. However, ECHD Program Coordinator #113 told the Administrator the filters could be placed on the water outlets, and he could remove the filter to test the water and then put the filter back on. ECHD Program Coordinator #113 confirmed he had sent guidance to the Administrator on [DATE], was notified of the email error, and resent it on [DATE] at 8:43 A.M. without issues. Interview on [DATE] at 11:32 A.M. with the DON and Regional Clinical Director #111 confirmed Resident #118 had a diagnosis of pneumonia, and confirmed Legionella is caused by aspiration of contaminated water. The DON confirmed Resident #118 has a history of aspiration. Interview on [DATE] at 3:00 P.M. with Physician #114, who completed Resident #100's death certificate, confirmed the diagnoses listed on Resident #100's death certificate could have been caused by Legionella bacterium. He also verified the resident was admitted with pneumonia, which could have contributed to the development of sepsis. Review of the undated Potable Water Systems Operation and Maintenance document as part of the facility's Legionella bacteria prevention plan revealed the task was to flush to drain all outlets that are used less than once per week. Purging one to three minutes, based on pipe supply length. Review of the Legionella environmental policy dated [DATE] revealed a confirmed case is one where the patient/resident has had a continuous inpatient stay of 10 or more days prior to illness onset. The facility's mission is to maintain policies ensuring actions are taken to identify infected patients/residents and reduce Legionella risk. Control measures include routine chlorine level testing, water temperature monitoring, flushing unused pipes, and monitoring conditions like water main breaks or equipment failures. Interim measures may include supplying bottled water, installing point-of-use filters, and relocating residents. Review of the Legionella clinical policy/procedure dated [DATE] revealed the facility's mission is to maintain policies ensuring actions are taken to identify infected residents and reduce Legionella infection risk. The DON or designee will collaborate with the local board of health on further actions, which could include using bottled water, discontinuing the ice machine, and utilizing filters on sinks and showers, as recommended by an outside consultant. Review of the Legionella risk assessment dated [DATE] revealed potential low use points, such as dead legs will increase stagnation and risk of bacterial growth. Recommendations made were to flush low use points and vacant units weekly to remove the volume of stagnant water to the connection point and draw water containing disinfectants into the line. Also, a recommendation is made to institute a procedure for routine flushing in vacant units and other hot water outlets deemed low use. Additionally, it is recommended to clean the showerhead and aerators on a semi-annual basis. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the CDC website at, https://www.cdc.gov/legionella/wmp/healthcare-facilities/water-mgmt-validation.html, revealed according to the CDC/Healthcare Infection Control Practices Advisory Committee (HICPAC), healthcare facilities have two options for confirming that their water management program is working as intended including performing environmental sampling for Legionella and performing active clinical surveillance for infections due to Legionella. This deficiency represents non-compliance investigated under Complaint Number OH00161885.