STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365429	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Manor Nrsg & Rehab Ctr	1100 East State Road Newcomerstown, OH 43832

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of a self-reported incident (SRI), interviews and policy review, the facility failed to ensure Resident #19 was free from verbal abuse. This affected one (Resident #19) out of three residents reviewed for abuse. The facility census was 70.Findings include:Review of the medical record revealed Resident #19 was admitted on [DATE] and readmitted on [DATE] with diagnoses that included hemiplegia and hemiparesis, dementia, anxiety, bipolar disorder, and schizophrenia. Review of the care plan dated 01/09/25 revealed Resident #19 had a behavior of yelling in the common area and in her room. Interventions included to return Resident #19 to her room after meals; if the resident is screaming, offer her favorite snacks ([NAME] Bar or potato chips); ask the resident if she would like to lie down in bed; and approach in a cheerful way. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #19 had a Brief Interview for Mental Status (BIMS) score of nine out of 15 which indicated cognitive impairment. Resident #19 had verbal behaviors one to three days during the seven-day assessment period. Review of the medication administration record (MAR) revealed Resident #19 had no behaviors on 07/22/25. Review of the facility SRI tracking #263082 dated 07/22/25 revealed Resident #19 was sitting in the dining room with other residents getting ready to eat lunch. Resident #19 began screaming. Certified Nursing Assistant (CNA) #110 said Resident #19's name. Licensed Practical Nurse (LPN) #115 yelled, (Resident #19's name) shut up. Resident #19 was taken out of the dining room and placed in the common area by LPN #115. Resident #19 continued to yell, and LPN #115 took the resident to her room. CNA #110 fed Resident #19 in her room. CNA #110 updated a Registered Nurse (RN) that LPN #115 verbally abused Resident #19. The facility investigation revealed a handwritten interview with LPN #115 by RN #116. LPN #115 stated Resident #19 was yelling in the dining room with other residents around. LPN #115 stated she probably told Resident #19 to shut up. LPN #115 verified she took Resident #19 out of the dining room into the common area, and Resident #19 continued to yell. LPN #115 then took Resident #19 to her room, and CNA #110 fed the resident her lunch. A written statement dated 07/22/25 by CNA #110 revealed they took Resident #19 to the dining room for lunch, and she began screaming loudly. CNA #110 and LPN #115 were in the dining room. CNA #110 shouted Resident #19's name because the resident would often stop when she heard her name. LPN #115 then yelled (Resident #19's name) shut up really loud. LPN #115 then took Resident #19 to the lobby area. Resident #19 continued screaming, so LPN #115 took the resident to her room. CNA #110 served lunch and fed residents as needed and reported the incident as soon as they were able to do so. A handwritten statement by LPN #115 dated 07/22/25 revealed Resident #19 had been screaming since before breakfast. When Resident #19 was brought to the dining room at lunch, the resident continued screaming. Two residents at another table started telling Resident #19 to shut up. LPN #115 removed Resident #19 from the dining room and put the resident at a table in the common area. Resident #19 continued to scream in the common area. LPN #115 then took Resident #19 to her room where CNA #110 fed the resident. LPN #115 wrote that she did not remember what she said. Resident #19's continuous screaming and the other residents getting upset took a toll on LPN #115. A handwritten statement revealed RN #116 interviewed Resident #69 (a resident on the memory care unit). Resident #69 stated nothing happened at lunch. When Resident #69 was asked if he heard yelling, he said yes, a lady was yelling. When asked if staff said anything, Resident #69 said staff did not do anything inappropriately. Resident #69 did state he did not see the staff member, but the staff member was on the other side of the room, but he did hear yelling from the staff member. Resident #69 did not know what the staff member yelled. A handwritten note by CNA #118 (no date) revealed they were walking down the hallway and heard yelling coming from the dining room but did not hear what was said. The facility investigation also included an email from a legal consultant dated 07/23/25 at 4:05 P.M. revealed the following topics should be covered with staff: customer service; abuse, neglect, mistreatment policy with emphasis on verbal abuse, and behavior management as it pertains to preventing abuse. It was recommended that the intradisciplinary team review the resident's chart, reasons for underlying behaviors, medications, other relevant items, and then review the resident's care plan to make sure it addresses the verbal behaviors and how to avoid. The facility should probably not say that Resident #19 was made to eat in her room due to verbal outbursts as it might sound like involuntary seclusion. It should be shown that the facility was working to address Resident #19's behaviors. A chart review would also serve to claim there was no adverse impact to the resident. It should also be said that social service

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. (continued on next page)

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of a self-reported incident (SRI), interviews, and policy review, the facility failed to ensure Resident #18 was not restrained in a wheelchair without adequate training, assessments, and orders. This affected one (Resident #18) out of three residents reviewed for abuse. The facility census was 70. Findings include:Review of the medical record revealed Resident #18 was admitted on [DATE] with diagnoses that included dementia, history of transient ischemic attack, down syndrome, type 2 diabetes, and dysphagia.Review of the plan of care dated 02/20/25 revealed Resident #18 had the potential for injury related to poor decision-making skills. An intervention dated 06/06/25 for the resident to have a custom fitted wheelchair with adaptations for safety when in chair to be delivered after measured and approved by Medicaid. Review of a general progress note dated 06/02/25 at 6:00 A.M. revealed Resident #18 was on the floor in front of the chair. The resident had red drainage noted from the mouth. The resident had a one centimeter (cm) long, 0.1 cm wide, and 0.1 cm deep cut on the inner upper lip and an abrasion 2.0 cm long and 3.0 cm wide in the middle of the forehead. A general progress note dated 06/02/25 at 9:50 A.M. revealed Resident #18's sister requested the resident be sent to the hospital for evaluation. A general progress note dated 06/02/25 at 7:47 P.M. revealed Resident #18 returned to the facility at 7:40 P.M. A general progress note dated 06/03/25 at 2:48 P.M. revealed Resident #18's sisters were concerned about how Resident #18 fell out of her chair. It was explained that the resident went forward out of the chair. The Director of Nursing (DON) spoke to therapy to do a face-to-face so the resident could get a new wheelchair adapted for the resident's body size and with support straps if warranted for safety. Review of the facility SRI tracking #261249 dated 06/05/25 revealed on 06/02/25 Resident #18 lunged forward in chair and fell to the floor. Resident #18 was sent to the hospital for evaluation. On 06/04/25 at 8:45 P.M. the emergency doctor called the facility and reported Resident #18 had a cervical five fracture. Resident #18's family asked if a chest strap could be used while Resident #18 was in the Broda chair (a specialized positioning wheelchair). The DON informed the family that Resident #18 could not release the strap upon command, and it would be considered a restraint. The DON talked with therapy about a custom wheelchair that could be adapted to the resident and consist of lateral supports, tilt in space mechanics, chest harness, and lap belt to promote correct posture and allow Resident #18 to be up in a wheelchair safely and ensure hips remained in the proper position when in the chair to reduce the resident's fall risk. Review of the medical record revealed on 10/06/25 at 6:13 P.M. Resident #18 weighed 106 pounds and was 56 inches tall.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #18 had severely impaired cognitive skills. The MDS also revealed the resident used a wheelchair and was dependent on staff for eating and transfers.Review of the quarterly fall risk tool dated 10/14/25 revealed Resident #18 did not have a fall in the last 30 days. The resident had agitated behavior that occurred less than daily and was confined to a chair and disoriented. The plan of care was ongoing. Review of a general progress note dated 10/21/25 at 12:07 P. M. revealed the DON was notified the new custom wheelchair would be delivered on 10/28/25 at 9:00 A.M. Resident #18's sister stated they would be present for the delivery and fitting of the wheelchair. The sister would be educated by the delivery representative on the safety features of the chair to include the harness which would allow the resident to be up in a chair longer and reduce leaning forward and to the side. In the resident's current chair, she scoots down and bends neck forward.Review of a general progress note dated 10/28/25 at 6:52 P.M. revealed Resident #18 received her new chair this morning. Resident #18 leaned to the right and forward and was repositioned several times.Review of a typed note (no date) revealed Resident #18's new chair ‘holister' is to be used only if needed. She does not need to be strapped in unless falling, combative, or leaning.Review of the Occupational Therapy (OT) evaluation dated 10/28/25 revealed treatment may include wheelchair management training. The reason for the referral was a new custom fit wheelchair delivered this date with vendors addressing education with Resident #18's family regarding fit, features/appliances and specialized seating. OT will be required to remain engaged with the wheelchair to promote highest comfort, skin integrity, and positioning in wheelchair. Occupational Therapist Registered (OTR) signed the evaluation and plan of treatment on 10/29/25 at 8:27 P.M. The OTR assessment summary revealed the OTR was not at the location when Resident #18 was fitted to the new wheelchair. Resident #18 was in bed and was no longer in custom wheelchair when OTR arrived to assess the resident. Review of a Safety Device Screen dated 10/29/25 at 4:56 P.M. revealed recommendations to achieve the residents

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of self-reported incidents (SRI), interviews and policy review, the facility failed to ensure allegations of verbal abuse by staff towards Resident #19 were immediately reported. This affected one (Resident #19) out of three reviewed for abuse. The facility census was 70.Findings include:Review of the medical record revealed Resident #19 was admitted on [DATE] and readmitted on [DATE] with diagnoses that included hemiplegia and hemiparesis, dementia, anxiety, bipolar disorder, and schizophrenia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #19 had a Brief Interview for Mental Status (BIMS) score of nine out of 15 which indicated cognitive impairment. Resident #19 had verbal behaviors one to three days during the seven-day assessment period. Review of SRI tracking #263082 dated 07/22/25 at 2:49 P.M. revealed Resident #19 was sitting in the dining room with other residents getting ready to eat lunch. Resident #19 began screaming. Certified Nursing Assistant (CNA) #110 said Resident #19's name. Licensed Practical Nurse (LPN) #115 yelled, (Resident #19's name) shut up. Resident #19 was taken out of the dining room and placed in common area by LPN #115. Resident #19 continued to yell, and LPN #115 took the resident to her room. CNA #110 fed Resident #19 in her room. CNA #110 updated a Registered Nurse (RN) that LPN #115 verbally abused Resident #19. The facility investigation revealed a handwritten interview with LPN #115 by RN #116. LPN #115 stated Resident #19 was yelling in the dining room with other residents around. LPN #115 stated she probably told Resident #19 to shut up. LPN #115 verified she took Resident #19 out of the dining room into the common area and Resident #19 continued to yell. LPN #115 then took Resident #19 to her room and CNA #110 fed the resident her lunch. A written statement dated 07/22/25 by CNA #110 revealed they took Resident #19 to the dining room for lunch and she began screaming loudly. CNA #110 and LPN #115 were in the dining room. CNA #110 shouted Resident #19's name because the resident would often stop when she heard her name. LPN #115 then yelled (Resident #19's name) shut up really loud. LPN #115 then took Resident #19 to the lobby area. Resident #19 continued screaming so LPN #115 took the resident to her room. CNA #110 served lunch and fed residents as needed and reported the incident as soon as they were able to do so. A handwritten statement by LPN #115 dated 07/22/25 revealed Resident #19 had been screaming since before breakfast. When Resident #19 was brought to the dining room at lunch, the resident continued screaming. Two residents at another table started telling Resident #19 to shut up. LPN #115 removed Resident #19 from the dining room and put the resident at a table in the common area. Resident #19 continued to scream in the common area. LPN #115 then took Resident #19 to her room where CNA #110 fed the resident. LPN #115 wrote that she did not remember what she said. Resident #19's continuous screaming and the other residents getting upset took a toll on LPN #115. The employee timesheet revealed LPN #115 worked on 07/22/25 at 6:45 A.M. to 1:30 P.M.An interview on 12/04/25 at 3:32 P.M. Administrator verified CNA #110 did not immediately report the allegation of abuse. LPN #115 moved Resident #19 from the dining room to the common area and then to the resident's room after allegedly verbally abusing Resident #19. The Administrator verified allegations of abuse should be reported to the Administrator or designee immediately. If the allegation involved a staff member, the staff member should be removed from the facility immediately until an investigation was completed. This deficiency represents non-compliance investigated under Complaint Number 2623349.