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	04/24/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	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 record review, review of therapy records, review of the facility's investigation, review of employee conference reports, and interviews with resident(s), family, and staff, the facility failed to ensure a resident was transferred safely following physical therapy recommendations. This resulted in Actual harm on 04/12/26 when Resident #1 was improperly transferred resulting in a fractured arm. This affected one (#1) of three residents reviewed for accidents and injuries.Findings include:Medical record review revealed Resident #1 was originally admitted to the facility 05/06/25 and re-admitted on [DATE] with diagnoses that included displaced fracture of base of neck of right femur, nondisplaced fracture of surgical neck of right humerus, anemia, orthopedic aftercare, restless legs, heart failure, kidney disease, and hyperlipidemia. Review of Resident #1's quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident was admitted [DATE] with diagnoses including heart failure, renal disease, and hyperlipidemia. The resident had moderate cognition impairment. No limited range of motion and used a walker and wheelchair. The resident had no falls, no orthopedic surgeries, and was in a restorative program for walking. The resident's functional assessment included set up for eating, oral care, upper body dressing, and personal hygiene. She required partial to moderate assistance for toileting, lower body dressing, rolling, sitting to lying, lying to sitting, sit to stand, chair/bed to chair transfer, toilet transfer, and tub to shower transfer. The resident required supervision or touching assistance for showers, walking 10 feet, walking 50 feet with two turns, and walking 150 feet. She required staff assistance with placing her footwear. Review of Resident #1's orders dated 04/01/26 revealed an active order to transfer with one assist walker and gait belt for transfers. On 04/09/26 new ordered added weight bearing as tolerated to right lower extremity and 04/20/26 transfer with two assistance and sit to stand. Review of Resident #1's progress note authored by the Director of Nursing (DON) dated 04/07/26 at 10:43 A.M., revealed on Easter Sunday the resident went out to church and then to family's home. She was up walking with daughter and didn't lift foot up high enough and had lost balance and family lowered her to the floor. The family then picked her up and placed her in a chair, got her to the car and brought her back to the facility. She was manually lifted by family to wheelchair and got back into the room to use bedside commode. She could not bear weight on the right leg. She was sent to emergency room for evaluation and diagnosed with a fractured hip per family and sent to another hospital for surgery. Plans were for her to return after stabilized. Review of Resident #1's progress note authored by Licensed Practical Nurse (LPN) #102 dated 04/09/26 at 7:51 P.M., revealed Resident #1 was re-admitted from the hospital following surgical repair of right femur neck fracture. The resident weight bearing status was noted as tolerated to right lower extremity.Review of Resident #1's hospital notes dated 04/09/26 revealed to follow the following intervention to prevent hip dislocation: do not pivot, do not bend hip beyond 90 degrees, do not bend forward, do not sit in a low chair, and weight bearing as tolerated to right lower extremity. Review of Resident #1's physical therapy note authored by Physical Therapist (PT) #106 dated 04/10/26 at 8:55 A.M., revealed the resident had poor standing balance and was unable to pivot. Recommend Sara Steady (manual lift) or sit to stand lifts for transfers.Record review revealed no (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 0689 Level of Harm - Actual harm Residents Affected - Few	evidence the PT's recommendation for Sara Steady or sit to stand lift was ordered or care planned.Review of Resident #1's discharge with anticipation to return MDS dated [DATE] revealed the resident had one major fall with injuries and was discharged on 04/05/26. She was now dependent on staff for toileting, partial assistance for showers, dependent for lower body dressing, and substantial to maximum assistance with rolling, sitting to lying, and lying to sitting. She was now dependent for sit to stand, bed/chair to chair transfer, toilet transfer, and tub to shower transfer. The walking section was skipped.Review of Resident #1's progress note authored by Registered Nurse (RN) #103 dated 04/12/26 at 7:33 P.M., revealed the RN was called to Resident #1's room after an incident during a two-person transfer. The resident was allowed to bear weight following a femur repair but had not been cleared to pivot yet. Two Certified Nursing Assistants (CNA's) were assisting the resident in transferring from wheelchair to recliner. The resident was bearing weight during transfer, then she stopped bearing weight allowing legs to slide out in front of her. The CNA on the resident's right side felt her shoulder move up and heard a crack noise. The CNAs were in front of the recliner and were able to safely set her down. One CNA stayed with the resident while the other got the nurse for an assessment. The resident complained of pain and mild numbness and had limited range of motion. No bruising or obvious deformity at this time. Offered pain medication but was declined, arm resting on pillow for comfort. The on call provider was made aware and x-rays were ordered to right shoulder. Resident #1's daughter and the DON were made aware. Review of Resident #1's x-ray results of the right shoulder dated 04/12/26 revealed no acute fractures or dislocation of the right shoulder. Review of the facility's investigation report dated 04/12/26 revealed Resident #1 was oriented to person, place, time, and situation. The resident had an injury to right shoulder. Updated provider and requested pain medication to be given and ice pack. Certified Nursing Assistant (CNA) #105 reported during a two assistant transfer of Resident #1 from the wheelchair to recliner, CNA #104 and CNA #105 each had the resident under the arm to support her weight on both sides. As we were turning her, her feet started sliding out from under her. CNA #105 heard a loud cracking noise and felt her shoulder move up like it dislocated. We were right in front of the recliner and were able to sit her down safely.CNA #104 reported that she and CNA #105 were assisting Resident #1 with a two person assist, transferring Resident #1 from her wheelchair to the recliner. They had their arms under her arms lifting her into her recliner. Midway through the transfer her feet started to come out from under her. She went dead weight and they quickly got her to the recliners seat. During that they heard a loud crack noise and Resident winced. They were able to lower her to the edge of the seat safely. Gripper socks were on.Further review of the investigation report revealed a note was added on the bottom dated 04/13/26 that revealed the initial x-ray indicated no fractures. Limited range of motion continued day two, so another x-ray was ordered and it showed angulated fracture of the humeral head. The resident was sent to the emergency room and will have an orthopedic follow up. The root cause of the injury was unsuccessful transfer of the resident when she began to slide, and staff had to bear all of her weight under her arms. Intervention was one on one conference with both aids and staff re-education on transfers. Review of Resident #1's progress note authored by Nurse Practitioner (NP) #101 dated 04/13/26 at 11:56 A.M., revealed staff reported during transfer the resident was noted to have a pop in the right upper extremity area. Resident complained of moderate pain. Shoulder x-ray was received and no acute process noted. Upon evaluation range of motion was limited to the right shoulder and the elbow had a large ecchymotic area noted to the internal portion of the right upper arm area and was warm and edematous. Will order for resident to have an x-ray of the clavicle, the proximal humerus, proximal radius and ulna, and venous doppler. Continue Oxycodone for pain or discomfort. Review of Resident #1's x-ray results of right clavicle, right humerus, right elbow, right forearm, and right wrist dated 04/13/26 revealed the right humerus had an acute mildly angulated fracture of the humeral neck, better seen on today's exam. Review of a progress note authored by LPN #102 dated 04/13/26 at 7:03 P.M., revealed the resident was transferred to the hospital due to humerus neck fracture. Review of Resident #1's emergency room note dated 04/13/26 revealed the (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	performance improvement plan, however it was related to staff not utilizing gait belts during transfers because she was not aware of staff not following recommendation from therapy until today. The DON confirmed after the resident had fractured her arm and was having difficulty transferring, she had reached out to therapy on 04/20/26 and the staff started utilizing the Sara Steady for transfers unaware the PT had recommended the Sara Steady on 04/10/26.Interview on 04/24/26 at 9:24 A.M. and 12:57 P.M. with CNA #104 confirmed she was one of the CNA's that was transferring Resident #1 on 04/12/26 that resulted in Resident #1's right arm fracture. The CNA confirmed the resident had a history of not bending her legs or help pushing up during transfers and she felt it was a safety issue, but the resident wanted to remain independent. The CNA reported herself and CNA #105 were transferring Resident #1 from her wheelchair to recliner on 04/12/26 using the under-arm technique (one aide on each side of the resident with their arm hooked under the residents arm) and the resident's feet started sliding and the resident started to panic and became dead weight requiring the staff to apply pressure on the residents arms to hold her up. They heard a pop sound and knew it wasn't good. The resident was in pain and couldn't move her arm. They got the resident to the recliner safely and CNA #105 went to get the nurse, and she stayed with the resident. The CNA confirmed they were not utilizing a gait belt because neither one had a gait belt and there was not one in the room. The CNA confirmed she was unaware that therapy recommended a Sara Steady or sit to stand lift for transfers on 04/10/26. The CNA reviewed the physical therapy note dated 04/10/26 with the surveyor and confirmed the therapist had recommended a mechanical lift for transfers. The CNA confirmed staff should follow therapy recommendations and a gait belt should be utilized for all transfers. The CNA confirmed she was provided one on one training on using gait belt with all transfers. Interview on 04/24/26 at 11:52 A.M. with Physical Therapy Assistant (PTA)/Rehabilitation Director #107 confirmed on 04/10/26 the Physical Therapist (PT) had evaluated Resident #1. The PTA originally reported Resident #1 was a two person assist with gait belt; however, she would print the PT's notes for the surveyor to review. After reviewing the PT notes dated 04/10/26 with the PTA, the PTA confirmed the resident should have been utilizing a Sara Steady or sit to stand lift with transfers and not two person assist with gait belt. The PTA confirmed she was not aware of the PT's recommendation on 04/10/26 until today. The PTA confirmed staff should have been utilizing a gait belt as well with all transfers and Resident #1's arm fracture could have potentially been prevented if staff were utilizing a gait belt during the transfer on 04/12/26. The PTA reported she had provided an in-service on gait belts with transfers last week because of the incident involving Resident #1.The facility did not have a policy on transfers.This deficiency represents non-compliance investigated under Complaint Number 2984910.