

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365498	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2025
NAME OF PROVIDER OR SUPPLIER Ottawa CO Riverview Nursing Ho		STREET ADDRESS, CITY, STATE, ZIP CODE 8180 W State Rt 163 Oak Harbor, OH 43449	
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 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview, coroner interview, coroner's office investigator interview, review of the U.S. Food and Drug Administration Guide to Bed Safety Bed Rails in Hospitals, Nursing Homes and Home Healthcare, review of Zenith 9000 Bed Service Manual, review of the Panacea Air Ease Owner's Manual review of policy on Bed Safety and Bed Rails, review of the facility investigation timeline, and review of the county coroner's preliminary findings, the facility failed to thoroughly assess the residents for the risk of entrapment when utilizing bed rails, when the facility assessment did not include compressing the alternating pressure relieving mattress (APM) to measure the potential gap between the mattress and the side rail, the medical needs that will be addressed with the use of bed rails, the risk from the use of bed rails and how these will be mitigated, alternatives that were attempted but failed to meet the residents ' needs, and alternatives that were considered but not attempted and the reasons. This resulted in Immediate Jeopardy and serious life-threatening harm/death for one resident (#200), when his head became wedged between the APM and the right-side grab bar rail, with his legs and lower body near the bed on the floor mat next to the bed, subsequently causing asphyxia leading to death. Additionally, five residents (#31, #35, #58, #60, and #69) were placed at potential risk for harm that was not Immediate Jeopardy as they were at risk of entrapment due to utilizing APM with bed rails and not fully assessed for the potential for possible entrapment. This affected six (#31, #35, #58, #60, #69, and #200) of six residents reviewed for use of bed rails. On 05/28/25 at 2:11 P.M., the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and Assistant Director of Nursing (ADON) were notified Immediate Jeopardy began on 05/19/25 at 4:05 A.M., when Resident #200 was discovered by Registered Nurse (RN) #335 with his head wedged between the mattress and the bed rail and his legs were observed in a kneeling position on the floor mat next to the bed. At this time, Resident #200 was documented to be without vital signs. The Immediate Jeopardy was removed on 05/29/25 at 1:52 P.M., when the facility implemented the following corrective actions: &bull; On 05/19/25, Resident #200 was transported from the facility. &bull; (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 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/19/25 at 5:25 A.M., the DON conducted initial staff interviews of Nursing Supervisor #252, RN #335, Certified Nursing Assistant (CNA) #336, and CNA #341, who were the pertinent staff members surrounding the incident. &bull; On 05/19/25 at 7:45 A.M., the DON conducted an initial audit of Resident #200's historical siderail assessments, physician progress notes, medication review audit, pertinent fall history and looking for similarities per facility and CMS guidelines. &bull; On 05/19/25 at 8:00 A.M., the DON, the ADON, RN #404, Registered Nurse Case Manager (RNCM) #385, and LPN #353 completed a whole house siderail audit on all residents utilizing side rails. &bull; On 05/19/25 at 8:10 A.M., LPN #353 ordered Bolsters with anticipation of need to replace side rails. &bull; On 05/19/25 at 8:25 A.M., the DON and Maintenance Director #411 confirmed manufacturer guidelines for air mattress use with siderails to ensure the siderails were compatible with the air mattress being used. &bull; On 05/19/25 at 10:00 A.M., the DON, the ADON, RN #404, RNCM #385, and LPN #353 had a discussion with the Ohio Health Care Association (OHCA) and created a siderail audit tool to be completed weekly for four weeks, monthly for two months, and then as needed thereafter. Results to be discussed with the Quality Assurance and Performance Improvement (QAPI) team. &bull; On 05/19/25 at 12:00 P.M., LPN #353 conducted fall meetings at each nursing station. &bull; On 05/19/25 at 1:00 P.M. and 6:00 P.M., the DON/designee began CNA and nursing education and roles in siderail safety policy and procedure, Food and Drug Administration (FDA) and facility guidelines with all staff present in facility at this time. All facility staff will receive the training that was given at 1:00 P.M. and 6:00 P. M. on 05/19/25 prior to starting their next shift. &bull; On 05/20/25 at 6:30 A.M. and 6:30 P.M., the DON and ADON conducted scheduled nurse's meetings with an agenda of side rail safety with nurses. (continued on next page)		

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	&bull; On 05/20/25 at 10:00 A.M., the DON/designee conducted a post siderail audit with the goal of discontinuation of siderails, where deemed medically appropriate and agreed upon by the resident. There were five residents (#07, #12, #27, #30, and #40) whose side rails were discontinued at this time. &bull; On 05/20/25 at 6:30 A.M and 6:30 P.M., the DON and ADON or designee completed education on side rail safety policy and procedures, with all nurses and nurse aides on both shifts. All staff education was completed on 05/28/25. &bull; On 05/23/25 on the dayshift, the DON and ADON completed one facility siderail audit tool. &bull; On 05/28/25 at 9:30 A.M., the DON, ADON, RN #404, and RN #384 performed additional audits for all residents utilizing siderail audits, including obtaining measurements when the resident is out of bed. &bull; On 05/28/25 at 10:30 A.M., the DON, ADON, RN #404, and RN #384 updated the facility policy to include gap measurements when resident is out of bed and mattress is compressed. &bull; On 05/28/25 at 10:45 A.M., the DON, ADON, RN #404, and RN #384, updated facility siderail assessment to include gap measurements with resident out of bed and mattress compressibility. &bull; On 05/28/25, the facility siderail use policy was updated to include utilizing appropriate alternative interventions prior to siderail utilization. &bull; On 05/28/25, the DON/designee notified all residents and/or resident representatives with education regarding the new policy and procedure to implement alternative interventions prior to the use of side rails. &bull; On 05/28/25, all siderails were removed facility-wide so that staff can identify appropriate alternative interventions prior to siderail use. (continued on next page)		

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	&bull; On 05/28/25, the facility implemented a new siderail assessment tool. Tool to be utilized upon resident request, family/resident representative request or identification of failed alternative interventions. &bull; On 05/28/25, the facility implemented a new Siderail Safety Questionnaire V4.2. Siderail questionnaire to be utilized upon initiation of siderail use, at minimum quarterly, and as needed (PRN). &bull; On 05/28/25, the facility implemented a new siderail use consent form to be included in all new admissions as well as upon siderail implementation. Assessment identifies risks such as entrapment and/or up to including death, as well as benefits, such as bed mobility and transfers. &bull; On 05/28/25, the DON/designee will provide education to agency staff before agency staff begin work. Education includes policy updates for siderail use, facility siderail assessment tool and Siderail Safety Questionnaire V4.2. &bull; On 05/28/25, the facility implemented a new bed inspection audit. Maintenance staff will inspect a sample selection of beds monthly along with related equipment to identify hazards or risks. &bull; On 05/28/25, the facility created a new side rail audit. Audits are to be performed weekly for four weeks, monthly for two months, quarterly, and PRN thereafter by the DON/designee. &bull; On 05/28/25, the DON/designee provided education to all nursing staff (nurses and aides) to include policy update for siderail use, facility siderail assessment tool and siderail safety questionnaire V4.2. The DON or designee to complete all facility nursing staff education by 05/29/25. &bull; On 05/29/25, the facility updated the admission checklist reflecting the changes to the side rail assessment. &bull; On 05/29/25, the facility updated the Discharge/Terminal Cleaning Inspection Form to reflect the removal of siderails from beds upon resident discharge. (continued on next page)		

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	&bull; On 05/29/25 between 8:55 A.M. and 10:00 A.M., interviews with RN #302, CNA #306, CNA #309, CNA #312, CNA #313, CNA #327, CNA #381, Agency RN #397, and Agency RN #398 revealed they were all provided updated side rail education from the facility. All staff that were interviewed could state what the education covered and how it pertained to them in their position. Although the Immediate Jeopardy was removed on 05/29/25, the facility remained out of compliance 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 plans and monitoring to ensure on-going compliance. Findings include: 1) Review of the electronic medical record (EMR) for Resident #200 revealed an admission date of 05/24/18, with diagnoses including hemiplegia and hemiparesis following other non-traumatic hemorrhage affecting the left non-dominant side, dysphagia, pain in the right lower leg, depression, hyperkalemia, unspecified lack of coordination, disorder of adrenal gland, iron deficiency anemia, cerebral infarction, cerebrovascular disease, speech and language deficits, atherosclerotic heart disease of native coronary artery, generalized muscle weakness, cognitive communication deficit, abnormalities of gait and mobility, anxiety, history of falling, type two diabetes mellitus, Charcot's joint in right foot and ankle, chronic sinusitis, hyperlipidemia, contact with and suspected exposure to other nonmedicinal chemical hazards, history of pneumonia, orthostatic hypotension, constipation, gastro esophageal reflux disease, pseudobulbar affect disorder and long-term use of insulin. Resident #200 was a do not resuscitate - comfort care (DNR-CC) for life saving measures. Review of the most recent quarterly Minimum Data Set (MDS) assessment, dated 05/16/25, revealed Resident #200 was severely cognitively impaired and was dependent on staff for assistance with activities of daily living. Resident #200 required a Hoyer mechanical lift for transfers. Review of nursing notes for May 1, 2025, to May 18, 2025, revealed Resident #200 would frequently yell out help repeatedly related to his diagnosis of pseudobulbar affect disorder, but could be easily comforted with playing videos of familiar things like farming or sharing memory book. Review of the active monthly physician orders for May 2025 revealed an order for air mattress to bed dated 06/23/23. There were no active orders for any type of side rail, grab bar or positioning devices. Review of Resident #200's care plans revealed no care plan to address the use of any type of side rail, grab bar or positioning device. The care plans had no mention of a bed being placed in a low position off the floor or a mat beside the bed. The care plans did mention Resident #200 being at risk for falls and alterations in sleep patterns. (continued on next page)		

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the most recent Siderail Safety Questionnaire for Resident #200, dated 03/01/25, revealed Resident #200 was not alert and oriented, was not able to utilize electric controls independently, was not able to reposition self without help, was a large (over 170 pounds) body type (scale for body types included small: under 120 pounds, medium: 120 pounds to 170 pounds, large: over 170 pounds), there was not a 4.5 inch gap between the mattress and siderail, there was a gap smaller than 2 3/8 inches at the end of the rail between the rail and headboard and/or footboard, the residents representative (Resident #200's brother) had been provided with education regarding risks associated with SR (siderail) used and gave consent for siderail use. The questionnaire did not contain information about the medical needs that will be addressed with the use of bed rails, the risk from the use of bed rails and how these will be mitigated, alternatives that were attempted but failed to meet the residents ' needs, and alternatives that were considered but not attempted and the reasons. Review of the EMR for Resident #200 revealed no documentation to support that the facility attempted any alternatives prior to the installation of side rails for Resident #200. Review of the nursing progress notes dated 05/19/25 at 4:45 A.M. revealed Resident #200 was found at 4:05 A.M., on floor with his head wedged between the bed and siderail. Resident #200 was found without vital signs and verified by the nursing supervisor. The DON, Nurse Practitioner (NP) and Coroner were notified. Coroner enroute to facility. Review of the facility's investigation timeline, dated 05/19/25, revealed at 4:06 A.M., Nursing Supervisor #352 was notified by RN #336 of finding Resident #200 with no pulse and wedged, face down, between the APM and the right-side grab bar, with his legs and lower body near the bed on the floor mat next to the bed. At 4:07 A.M., Nursing Supervisor #352 arrived at Resident #200's room and found Resident #200 wedged, face down, between the APM and the right-side grab bar, with his legs and lower body near the bed on the floor mat next to the bed. At 4:10 A.M., the DON/Nurse Practitioner (NP) was notified of the incident. At 4:16 A.M., the coroner was notified. At 4:19 A.M., the DON called back to the facility for more details, verified Resident #200's code status is DNR-CC, and his last side rail assessment was completed on 03/01/25. At 4:23 A.M., the coroner called back to the facility and will arrive in 30 minutes. At 5:04 A.M., the coroner on site, requested previous four days of documentation and face sheet. At 5:08 A.M., two Ottawa County Deputy Sheriffs arrive. At 5:21 A.M., the DON was on site. Review of the [NAME] County Coroner's Office undated preliminary report revealed the date of examination was 05/20/25, with findings for Resident #200's cause of death to be asphyxia due to neck compression caused by being wedged between safety rail and mattress. Further review revealed anatomic diagnoses (injuries) which included cervical compression mark, anterior and left side of neck, hemorrhage around left greater horn of hyoid bone, and bilateral palpebral conjunctival petechiae (small bruises in the whites of both eyes that can be a sign of compression of the neck and jugular veins from strangulation). Interview on 05/27/25 at 11:41 A.M. with Ottawa County Coroner #394 revealed Resident #200 was observed deceased at the time of his arrival with his head and or neck stuck between the bedrail and the APM. (continued on next page)		

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 05/27/25 at 11:56 A.M. with CNA #336 revealed she was the nurse aide assigned to Resident #200 at the time of his death. CNA #336 stated the last time she saw Resident #200 was approximately 2:30 A.M. on 05/19/25. At that time, Resident #200 was laying on his back in his bed sleeping. CNA #336 stated Resident #200 had been restless for most of the night; at one point he had one leg out of bed and his pressure relieving boot was off. CNA #336 stated at another point during the night, on 05/19/25, CNA #336 repositioned Resident #200 because he had used his right arm to pull himself to the right side of the bed and his face was against the side rail. Further interview with CNA #336 revealed she did not discover Resident #200, but she was notified by RN #335, after RN #335 found Resident #200. CNA #200 stated when she observed Resident #200 his head was wedged, in between the right handrail and the mattress, the handrail was on the temple, Resident #200 was on his right knee, and the other leg was stretched out on the left side, his right arm was holding the side rail. Interview on 05/27/25 at 1:17 P.M. with RN #335 revealed on 05/19/25 at 4:05 A.M., she entered Resident #200's room to administer medications. RN #335 discovered Resident #200 wedged, face down, between the APM and the right-side grab bar, with his legs and lower body near the bed on the floor mat next to the bed. RN #335 stated at the time of discovery; she checked for vital signs. Upon finding no vital signs, RN #335 notified Nursing Supervisor #352. RN #335 stated she was familiar with Resident #200's care and has provided care for him since admission. RN #335 stated Resident #200 has had a recent cognitive decline for the last couple of weeks. Resident #200 would frequently yell at night and would do a 3-5 day stretch of screaming and yelling out at night. Resident #200's cycle of yelling out would end, and he would only scream and yell for half the night until about midnight, then would sleep all night the next night. RN #335 stated staff would go through his memory book to help calm him down. RN #335 stated the nurse aides would report that Resident #200 would kick his feet out of the bed a couple times a night. RN #335 stated she is unaware of Resident #200 sliding out of the bed or having any falls in the night. RN #335 stated Resident #200 has fallen in the past, but it has been years. Interview on 05/28/25 at 6:33 A.M. with Nursing Supervisor #352 revealed he was notified by RN #335 on 05/19/25 at 4:06 A.M., that Resident #200 was found wedged, face down, between the APM and the right-side grab bar, with his legs and lower body near the bed on the floor mat next to the bed and did not have vital signs. Upon Nursing Supervisor #352's arrival to Resident #200's room, Nursing Supervisor #352 again assessed Resident #200 for vital signs, and found none. Observation on 05/28/25 at 7:40 A.M. of Resident #200's unoccupied bed revealed when moderate horizontal compression was applied to the APM, next to the side rail approximately 18 inches from the top of the APM, a gap of five and three-quarter inches was created between the APM and the right-side rail. The side rail was approximately 10 inches long at the top and angled down to approximately six inches at the bottom. There was one side rail on the right side of the bed. Concurrent observation of Resident #200's bed revealed when moderate vertical compression was applied to the APM, next to the side rail approximately 18 inches from the top of the APM, a gap of six inches was created between the APM and the right-side rail. Interview on 05/28/25 at 7:40 A.M. with the ADON verified the five and three-quarter inch gap was created between the APM and the right-side rail when horizontal compression was applied to the APM. Concurrent interview with the ADON verified the six-inch gap that was created between the APM and the right-side rail when vertical compression was applied to the APM. (continued on next page)		

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 05/28/25 at 7:52 A.M. with the DON revealed when assessing for side rail safety, the facility measures the gap between the APM and the side rail when the resident is laying in the bed, on their back. Concurrent interview with the DON revealed the facility does not measure the gap between the APM and side rail when the bed is unoccupied. When the APM is unoccupied, the mattress compresses with less force and causes a larger gap between the side rail and the mattress to be created. Further interview with DON revealed the facility does not measure the gap created when compression is applied to the APM, between APM and the side rail, occupied or unoccupied. Interview on 05/28/25 at 9:06 A.M. with Coroner's Office Investigator (COI) #393 revealed it was reported to him by Nursing Supervisor #352 that Resident #200 fell out of bed and was a DNR-CC. COI #393 was subsequently told by Nursing Supervisor #352 that Resident #200's head was between the side rail and the APM and the lower portion of his body was on the floor next to the bed. COI #393 stated when he arrived at the facility, he found Resident #200 with his head between the APM and the side rail with his lower body on the floor. COI #393 stated that at this time, he felt Resident #200's body and it was warm still, so he checked for a pulse and did not find one. COI #393 stated Resident #200 had no mottling (an irregular arrangement or patches of color on the skins surface), no rigor (stiffening of the joints and muscles of a body a few hours after death), or lividity (discoloration of the skin that occurs after death). Interview on 05/29/25 at 6:15 A.M. with the DON and the Administrator verified the Siderail Safety Questionnaire for Resident #200 did not address the medical needs that will be addressed with the use of bed rails, the risk from the use of the bed rails and how these will be mitigated, alternatives that were attempted but failed to meet the resident's needs, and alternatives that were considered but not attempted and the reasons were not assessed on Resident #200's most recent facility Siderail Safety Questionnaire, dated 03/01/25. Concurrent interview revealed that the facility does not have documentation to support that these items were completed by the facility for Resident #200. 2) Review of the EMR for Resident #31 revealed an admission date of 10/07/24 with diagnoses including central cord syndrome at C3 level of cervical spinal cord, unspecified lack of coordination, abnormal posture, depression, hyperglycemia, disorientation, macular degeneration, cognitive communication deficit, history of falling, and epilepsy. Review of the most recent quarterly MDS assessment, dated 04/10/25, revealed Resident #31 was severely cognitively impaired and required substantial/maximal assistance or was dependent on all functional abilities. Observation on 05/27/25 at 8:48 A.M. of Resident #31's room revealed an approximate seven-inch space between the APM and the half side rail. This observation was not able to be verified with facility staff but was made by two Ohio Department of Health (ODH) surveyors. There was no resident in bed, and there were two side rails on the bed. (continued on next page)		

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the most recent facility Siderail Safety Questionnaire for Resident #31, dated 05/19/25, revealed Resident #31 was not alert and oriented, was able to utilize electric controls independently, was not able to reposition self without help, was a medium (120 pounds to 170 pounds) body type, there was not a 4.5 inch gap between the mattress and siderail, there was a gap smaller than 2 and 3/8 inches at the end of the rail between the rail and headboard and/or footboard, the residents representative had been provided with education regarding risks associated with SR (siderail) use and gave consent for siderail use, and Resident #31's representative was his niece. The form did not include the medical needs that will be addressed with the use of bed rails, the risk from the use of bedrails and how these will be mitigated, alternatives that were attempted but failed to meet the residents ' needs, and alternatives that were considered but not attempted and the reasons. Review of the EMR for Resident #31 revealed no documentation to support that the facility attempted any alternatives prior to the installation of side rails for Resident #31. 3) Review of the EMR for Resident #35 revealed an admission date of 05/09/25 with diagnoses including unspecified intracapsular fracture of left femur, age-related osteoporosis with current pathologic fracture, chronic obstructive pulmonary disease (COPD), unspecified severe protein-calorie malnutrition, hypertension (HTN), carpal tunnel syndrome of the left upper limb, solitary pulmonary nodule, generalized muscle weakness, difficulty in walking, need for assistance with personal care, history of falling, presence of left artificial hip joint, and personal history of healed traumatic fracture. Review of the Medicare 5-Day MDS assessment, dated 05/16/25, revealed Resident #35 was cognitively intact and required assistance with all functional abilities. Review of the most recent facility Siderail Safety Questionnaire for Resident #35, dated 05/19/25, revealed Resident #35 was alert and oriented, was able to utilize electric controls independently, was able to reposition self without help, was a small (under 120 pounds) body type, there was not a 4.5 inch gap between the mattress and siderail, there was a gap smaller than 2 3/8 inches at the end of the rail between the rail and the headboard and/or footboard, the resident had been provided with education regarding risks associated with SR (siderail) use and gave consent for siderail use. The form did not include the medical needs that will be addressed with the use of bed rails, the risk from the use of bed rails and how these will be mitigated, alternatives that were attempted but failed to meet the residents ' needs, and alternatives that were considered but not attempted and the reasons. Review of EMR for Resident #35 revealed no documentation to support that the facility attempted any alternatives prior to the installation of side rails for Resident #35. 4) Review of the EMR for Resident #58 revealed an admission date of 11/29/24, with diagnoses including congestive heart failure (CHF), stage three chronic kidney disease (CKD3), type two diabetes mellitus (DM2), benign prostatic hyperplasia (BPH), ischemic cardiomyopathy, parkinsonism, right above the knee amputation, and diffuse large b-cell lymphoma. Review of the most recent quarterly MDS assessment dated [DATE] for Resident #58 revealed Resident #58 was cognitively intact and required assistance needs for all functional abilities ranging from needed substantial assistance to being dependent. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365498	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2025
NAME OF PROVIDER OR SUPPLIER Ottawa CO Riverview Nursing Ho		STREET ADDRESS, CITY, STATE, ZIP CODE 8180 W State Rt 163 Oak Harbor, OH 43449	
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 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the most recent facility Siderail Safety Questionnaire for Resident #58, dated 05/19/25, revealed Resident #58 was alert and oriented, was able to utilize electric controls independently, was not able to reposition self without help, was a medium (120 pounds to 170 pounds) body type, there was not a 4.5 inch gap between the mattress and siderail, there was a gap smaller than 2 and 3/8 inches at the end of the rail between the rail and the headboard and/or footboard, the resident had been provided with education regarding risks associated with SR (siderail) use and gave consent for siderail use. The form did not include the medical needs that will be addressed with the use of bed rails, the risk from the use of bed rails and how these will be mitigated, alternatives that were attempted but failed to meet the residents ' needs, and alternatives that were considered but not attempted and the reasons. Review of the EMR for Resident #58 revealed no documentation to support that the facility attempted any alternatives prior to the installation of side rails for Resident #58. 5) Review of the EMR for Resident #60 revealed an admission date of 04/19/25 with diagnoses of pyothorax without fistula, acute respiratory failure, unsteadiness on feet, cognitive communication deficit, chronic obstructive pulmonary disease, multiple sclerosis, BPH, neuromuscular dysfunction of the bladder, and obstructive sleep apnea (OSA). Review of the Medicare 5-Day MDS assessment, dated 04/21/25, revealed a BIMS Score of 14, indicating Resident #60 was relatively cognitively intact. Concurrent review of the most recent MDS assessment revealed Resident #60 required assistance with all functional abilities except for eating. Review of the most recent facility Siderail Safety Questionnaire for Resident #60, dated 05/19/25, revealed Resident #60 was alert and oriented, was able to utilize electric controls independently, was able to reposition self without help, was a medium (120 pounds to 170 pounds) body type, there was not a 4.5 inch gap between the mattress and siderail, there was a gap smaller than 2 and 3/8 inches at the end of the rail between the rail and headboard and/or footboard, the resident's representative had been provided with education regarding risks associated with SR (siderail) use and gave consent for siderail use. The form did not include the medical needs that will be addressed with the use of bed rails, the risk from the use of bed rails and how these will be mitigated, alternatives that were attempted but failed to meet the residents ' needs, and alternatives that were considered but not attempted and the reasons. Review of the EMR for Resident #60 revealed no documentation to support that the facility attempted any alternatives prior to the installation of side rails for Resident #60. 6) Review of the EMR for Resident #69 revealed an admission date of 02/10/25 with diagnoses of CHF, senile degeneration of brain, cognitive communication deficit, DM2, hypertensive heart disease, atherosclerotic heart disease, and dysphagia. Review of the most recent quarterly MDS assessment, dated 04/09/25, revealed a BIMS Score of 08, indicating Resident #69 was moderately cognitively impaired. Concurrent review of the most recent MDS assessment revealed Resident #69 required assistance with all functional abilities. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365498	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2025
NAME OF PROVIDER OR SUPPLIER Ottawa CO Riverview Nursing Ho		STREET ADDRESS, CITY, STATE, ZIP CODE 8180 W State Rt 163 Oak Harbor, OH 43449	
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 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the most recent facility Siderail Safety Questionnaire for Resident #69, dated 05/19/25, revealed Resident #69 was alert and oriented, was able to utilize electric controls independently, was able to reposition self without help, was a large (over 170 pounds) body type, there was not a 4.5 inch gap between the mattress and siderail, there was a gap smaller than 2 and 3/8 inches at the end of the rail between the rail and the headboard and/or footboard, the resident had been provided with education regarding risks associated with SR (siderail) use and gave consent for siderail use. The form did not include the medical needs that will be addressed with the use of bed rails, the risk from the use of bed rails and how these will be mitigated, alternatives that were attempted but failed to meet the residents ' needs, and alternatives that were considered but not attempted and the reasons. Review of the EMR for Resident #69 revealed no documentation to support that the facility attempted any alternatives prior to the installation of side rails for Resident #69. Interview on 05/29/25 at 6:15 A.M. with the DON and the Administrator verified that the medical needs that will be addressed with the use of bed rails, the risk from the use of the bed rails and how these will be mitigated, alternatives that were attempted but failed to meet the resident's needs, and alternatives that were considered but not attempted and the reasons, were not included on Residents #31, #35, #58, #60 and #69's most recent facility Siderail Safety Questionnaire. Concurrent interview revealed that the facility does not have documentation to support that these items were completed by the facility for Residents #31, #38, #58, #60, and #69. Review of the U.S. Food and Drug Administration (FDA) Guide to Bed Safety Bed Rails in Hospitals, Nursing Homes, and Home Health Care dated September 2013 indicated potential risks of bed rails may include strangling, suffocating, bodily injury or death when		