STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365498	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ottawa CO Riverview Nursing Ho	8180 W State Rt 163 Oak Harbor, OH 43449

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and policy review, the facility failed to ensure residents were treated in a dignified manner. This affected three (#31, #25, #67) of three residents reviewed for dignity. The facility census was 86.Findings include:1.Review of the medical record for Resident #31 revealed an admission date of 12/01/23. Diagnoses included Alzheimer's disease, dementia, muscle weakness, and dysphagia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severe cognitive impairment. The resident was dependent on staff for eating meals. Review of a physician order dated 02/10/24 revealed the resident was ordered a regular diet with mechanical soft texture and thin liquids. Observation on 02/24/26 at 8:45 A.M. revealed Certified Nursing Assistant (CNA) #363 was standing over Resident #31 while feeding the resident bites of food. Further observation revealed an empty chair was near where the resident was sitting at the dining table. Interview on 02/24/26 at 8:47 A.M., CNA #363 verified she was standing while feeding Resident #31. CNA #363 revealed she should be sitting while providing feeding assistance. 2. Review of the medical record for Resident #25 revealed an admission date of 08/06/24. Diagnoses included chronic obstructive pulmonary disease, hypertension, and anxiety. Review of the quarterly MDS assessment dated [DATE] revealed the resident had severe cognitive impairment. The resident required supervision or touching assistance for eating meals. Review of a physician order dated 07/07/25 revealed the resident had an order for a regular diet with pureed texture and nectar thickened liquids. Observation on 02/25/26 at 8:34 A.M. revealed CNA #368 was standing over Resident #25 while feeding the resident bites of food. Interview on 02/25/26 at 8:34 A.M., Licensed Practical Nurse (LPN) #336 revealed staff should not be standing when providing feeding assistance. LPN #336 revealed the staff should be sitting on a stool. Interview on 02/25/25 at 8:39 A.M., CNA #368 revealed Resident #25 normally ate on his own, but she was just helping to feed him. CNA #368 verified she was standing while feeding the resident. CNA #368 verified she should be sitting when feeding a resident. Review of the facility policy Dignity revised 02/2021, revealed residents would be treated with dignity and respect at all times. Resident would be provided with a dignified dining experience. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy Assistance with Meals, revised 03/2022, revealed residents who cannot feed themselves would be fed with attention to safety, comfort, and dignity including for staff to not stand over residents while assisting them with meals. 3. Review of the medical record for Resident #67 revealed an admission date of 11/06/23. Diagnosis included need for assistance with personal care, mild cognitive impairment, and Parkinson's disease. Review of the quarterly MDS assessment dated [DATE] for Resident #67 revealed he had mild cognitive impairment and required maximum assistance for personal hygiene. Review of the nursing progress note dated 01/21/26 at 3:30 P.M. authored by LPN #335 for Resident #67 revealed the resident was dependent for all hygiene needs. Observation on 02/23/2026 at 3:33 P.M. of Resident #67 revealed he had a brown stream like dried substance under his lower lip that ran down his chin and there was a small, pearl sized piece of brown dried clump of a substance that was located just under the bottom lip of Resident #67. Concurrent interview with Resident #67 stated he needs help with activities of daily living (ADL) care and sometimes needs help with eating. Observation on 02/23/2026 at 4:56 P.M. of, following dinner, Resident #67 revealed he remained with the same dried dark stain under his lip and down his chin. Interview with CNA #401 verified the brown stained food that remained under the lip and down the chin for Resident #67. Review of the facility policy titled, Activities of Daily Living (ADLs), Supporting, revised 03/18 revealed residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living. Appropriate care and services will be provided for resident who are unable to carry out ADLs independently to assist with hygiene (bathing, dressing, grooming, and oral care). Review of the facility policy titled, Dignity, revised 02/21 revealed each resident will be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. When assisting with care, residents are supported in exercising their rights, for example, groomed as they wish to be and dignified dining experience.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on record review and staff interview, the facility failed to ensure residents were informed about treatment options and alternatives before beginning treatment with psychoactive medications. This affected one (#9) of five residents reviewed for psychoactive medications. The facility census was 86.Findings include:Review of the medical record for Resident #9 revealed an admission date of 10/15/25 with diagnoses of depression, restlessness, anxiety, and protein-calorie malnutrition. Resident #9 was admitted to hospice on 02/21/26. Review of the quarterly Minimum Data Set (MDS) assessment, dated 01/22/26, revealed Resident #9 had intact cognition and received an antianxiety medication, and an antidepressant. Review of the physician order initiated 11/15/25 and discontinued 02/23/26 revealed Resident #9 received buspirone (an antianxiety medication) hydrochloride oral tablet 10 milligrams (mg), one tablet twice daily for anxiety. Review of the physician order initiated 12/03/25 and discontinued 02/23/26 revealed Resident #9 received mirtazapine (an antidepressant) tablet 15 mg, one tablet once daily for appetite stimulant/malnutrition. Review of the physician order initiated 01/15/26 and discontinued 02/23/26 revealed Resident #9 received lorazepam (an antianxiety medication) oral tablet 0.5 mg, one table every 8 hours as needed for anxiety. Interview on 02/25/26 at 11:27 A.M. with MDS Licensed Practical Nurse (LPN) #342, and concurrent review of Resident #9's chart, revealed no informed consents were signed prior to initiating the psychoactive medications buspirone, mirtazapine, and lorazepam for Resident #9. MDS LPN #342 verified there should have been consents obtained prior to initiating psychoactive medications.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the electronic and paper medical records, review of care conference meeting progress notes, review of a signed Do Not Resuscitate (DNR) order, review of physician orders, review of the plan of care, staff interview, and policy review, the facility failed to ensure a resident's code status was consistent throughout the medical record. This affected one (#8) of 29 residents reviewed for code status in the initial sample pool. The facility census was 86. Findings include:Review of the medical record revealed Resident #8 had an admission date of [DATE]. Diagnoses included Parkinsonism, dementia, type two diabetes mellitus, hypertension, depression, and anxiety.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had moderate cognitive impairment. Review of Resident #8's plan of care revised [DATE], revealed the resident had chosen a Do Not Resuscitate (DNR), (no Cardiopulmonary Resuscitation (CPR)) code status order. Review of the resident's care plan interventions revealed Resident #8's code status would be reviewed quarterly at care conferences. The DNR form would be placed in front of the physical chart in the sleeve. Staff would obtain the DNR order and if hospitalized , send a copy of the DNR order. Further review of the plan of care revealed no documentation if the resident had chosen DNRCC (Do Not Resuscitate Comfort Care) or DNRCCA (Do Not Resuscitate Comfort Care Arrest).Review of a quarterly care conference note dated [DATE] revealed the resident had chosen a full code status. Review of the signed paper DNR Order form dated [DATE] revealed the box for DNR Comfort Care-Arrest (DNRCCA) had been checked.Review of the quarterly care conference progress notes dated [DATE] and [DATE] revealed Resident #8 had chosen a DNRCC code status. Review of an electronic physician order dated [DATE] revealed the resident had chosen a DNRCC code status. Further review of the electronic medical record revealed the resident's code status was documented as DNRCC. Interview on [DATE] at 11:25 A.M., Registered Nurse (RN) #377 revealed she would check for a resident's code status in the electronic medical record or the physical chart. RN #377 revealed the best place to check would be in the front of the physical chart as it had a copy of the DNR form. RN #377 revealed Resident #8's code status was DNRCC. RN #377 was then asked to review the resident's signed DNR form in the physical chart. RN #377 verified the code status had not matched in the paper medical record and the electronic medical record. RN #377 verified the signed DNR order form was for a DNRCCA code status and the electronic physician order was for a DNRCC code status. Review of the facility policy DNR Status, dated [DATE], revealed a DNR code status should be obtained in writing and faxed to the primary physicians as soon as possible. Once the DNR Form was signed and returned by physician, the charge nurse would write corresponding telephone order in resident's chart. The medical records technician would monitor DNR Code to ensure they were complete and correct according to the signed document. If a discrepancy was found, the medical records technician would inform the charge nurse and ensure the correct actions were taken to correct the discrepancy.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, observation, staff interview, and policy review, the facility failed to ensure proper use and monitoring of a physical restraint. This affected one (#10) of one resident reviewed for restraints. The facility identified one resident with a restraint. The facility census was 86. Findings include:Review of the medical record for Resident #10 revealed an admission date of 05/03/24. Diagnoses included Parkinson's disease, progressive multiple sclerosis, dementia, type two diabetes mellitus, and dysphagia. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had impaired cognition and was never understood. Further review of the MDS revealed the resident required physical restraints used daily as a limb restraint in bed, in chair, and out of bed. The resident was dependent on staff for activities of daily living. Review of the plan of care initiated 05/10/24 revealed the resident had a restraint and used arm protection such as socks, gloves, or sleeves to prevent self-harm from chewing or biting her arm related to decreased safety awareness and dementia. Interventions included to discuss and record with family and caregivers the benefits and risks of the restraint, when the restraint should and would be applied, routines while restrained, and any concerns or issues regarding restraint use. Staff were to ensure there was a valid consent in the medical record prior to initiating the restraint. Further interventions included to evaluate the restraint use quarterly and as needed, evaluate and record continuing risk/benefits, alternatives to the restraint, the need for ongoing use and the reason for restraint use. Staff were to monitor/document/report to the physician as needed changes regarding effectiveness of restraint, less restrictive device if appropriate, and any negative or adverse effects notes including decline in mood, changes in behavior, decreases in activities of daily living performance, decline in cognitive ability or communication, contracture formation, skin breakdown, sign/symptoms of delirium, falls/accidents/injuries, agitation, and weakness. Staff were also to provide the resident with opportunities for restraint-free time daily. Review of a physician order dated 05/03/24 revealed an order to monitor and document incidents of self-injurious behavior such as biting self, scratching self, etc. twice daily for dementia. Review of a physician order dated 12/13/24 revealed the resident was admitted to hospice with a diagnosis of senile degeneration of the brain. Review of a physician order dated 01/07/25 revealed an order for the resident to wear gloves or socks and geri-sleeves (fabric skin protector) to maintain skin integrity two times a day for itching. There were no physician orders for when and how long the restraints should be applied. There were no physician orders for when and how often the restraints should be removed.Review of a restraint consent form dated 05/06/24 revealed the resident's representative was informed of the risks/benefits of the restraint use on 06/04/24. Review of a restraint progress note form initiated 05/10/24 and signed monthly by the nurse practitioner revealed the resident required use of special arm coverage which could be classified as a physical restraint due to limiting access to her own body. The resident was noted with decreased awareness of safety needs related to confusion and memory impairment. The resident's Brief Interview for Mental Status (BIMS) score was zero placing her in the severe cognitive impairment category. Further review of the progress note revealed the resident bites and chews on the skin of her arm causing harm to herself. The resident had episodes of anxiety and restlessness. The resident had diagnoses including Alzheimer's dementia, anxiety, and dermatitis. Continued review of the progress note revealed the resident's representative had been educated to the risks/benefits of the restraint and agreed it was the least restrictive device and consented to use of the device. Nursing was to perform skin integrity checks every shift. Use of the device would be reevaluated regularly. Review of behavior task charting from 11/01/25 through 02/25/26 completed by the certified nursing assistants revealed documentation of behavioral symptoms not directed at others occurred on 12/10/25, 12/18/25, 01/24/26, 01/26/26, and 02/06/26. There was no further (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation describing the type of behavior. Review of the treatment administration records and nurse's notes from 09/06/25 through 02/23/26 revealed no documentation regarding when or how long the restraints should be used. There was no documentation of when or how often the restraints should be removed. There was no documentation of daily skin checks while the resident was wearing the restraints. There was no documentation of how often the resident exhibited biting behaviors. Review of a nurse's note dated 01/03/25 at 8:41 P.M. revealed the resident had increased vocalization and was biting bilateral upper extremities. Review of a nurse's note dated 11/09/25 at 11:33 A.M. revealed the resident attempted to self-remove the arm covering with her teeth and laughed when they were reapplied. Further review of the nurse's notes from 12/01/25 through 02/23/26 revealed no documentation of the resident having biting behaviors.Review of a weekly skin assessment dated [DATE] revealed Resident #10 had no skin breakdown. Observation on 02/24/26 at 7:36 A.M., 1:24 P.M., 2:05 P.M. and 2:20 P.M. revealed the resident had socks covering her hands. The resident was observed sleeping most of the time and there were no observations of the resident attempting to bite her hands. Further observation on 02/25/26 at 8:51 A.M. revealed Resident #10 was sitting in her wheelchair in the dining room with a blanket and socks covering her hands. The resident eyes were open, and the resident made no attempts to bite her hands. Licensed Practical Nurse (LPN) #336 was asked by the surveyor to remove the socks from the resident's hands for a skin inspection. The resident's skin was clean, dry, and free of skin breakdown. Continued observations on 02/25/26 at 12:07 P.M. in the dining room revealed staff attempted to wake the resident for lunch. The resident had the sock restraints on her hands and made no attempts to bite herself. Interview on 02/24/26 at 2:21 P.M. with Registered Nurse (RN) #377 revealed the resident wore socks on her hands to prevent her from biting herself. RN #377 revealed she checked the resident's skin underneath the socks on her hands at least once per shift. RN #377 revealed there was no documentation for the skin checks for the resident's hands. RN #377 revealed they would only document if there was a problem. Interview on 02/25/26 at 8:51 A.M., LPN #336 revealed the resident wore the sock restraints on her hands to prevent her from biting herself. LPN #336 revealed he was not removing the socks to check the resident's skin. LPN #336 revealed the nursing assistants may be removing the socks when they change her. Interview on 02/25/26 at 10:49 A.M. with the Director of Nursing (DON) who also serves as the facility Nurse Practitioner (NP) #411 revealed the resident had itching and took medication for the itching. NP #411 revealed the resident came from another facility with orders for the restraint for her hands and her representative wanted the restraint to remain in place. The DON verified the physician order for the restraint had not specified a specific medical reason for the need for the restraint. The DON further verified there was no documentation how often the resident was required to wear the restraint each day and no documentation when and how often the restraint should be removed. The DON revealed the facility used the restraint protocol. Further interview on 02/26/26 at 8:50 A.M., the DON presented documentation dated 01/05/25 noting the resident had bitten herself. The DON verified she had no documentation of the resident biting herself after this date and would continue to look for the documentation. The DON revealed the resident typically bit herself and staff were not documenting her behaviors. The DON verified the facility had no documentation a less restrictive intervention was attempted prior to using the physical restraint on the resident's hands and no further restraint reductions had been attempted. The DON revealed the resident had declined recently and now was a good time to reevaluate the need for the restraint to her hands. Review of the facility Guidelines for Restraint Use, dated 02/23/07 revealed the facility would identify a specific medical symptom for restraint use and identify the underlying cause of the medical symptom. The facility would rule out other possible interventions. The facility would ensure a physician order specifying the type/reason/duration of the restraint and the physician would reevaluate every 30 days. The comprehensive plan of care would specify at a minimum the type of restraint used, when the restraint would be used and when the restraint should be released. The resident would be monitored every 30 minutes while restrained. Also, the resident would be reassessed and reevaluated for reduction/elimination of the restraint.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, review of care conference meeting documentation, resident and family interview, staff interview, and policy review, the facility failed to ensure residents and resident representatives were invited to care conference meetings. This affected two (#8, #25) of two residents reviewed for care planning. The facility census was 86. Findings include:1.Review of the medical record revealed Resident #8 had an admission date of 09/04/25. Diagnoses included Parkinsonism, dementia, type two diabetes mellitus, hypertension, depression, and anxiety. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had moderate cognitive impairment. Review of the quarterly care conference meeting notes dated 11/26/25 and 02/19/26 revealed the resident was not present at the meetings. There was no documentation the resident had been given an invitation to the meeting and no documentation the resident had refused to attend the meeting. Interview on 02/23/26 at 3:13 P.M., Resident #8 revealed she was not invited to attend her care conference meetings. Interview on 02/25/26 at 11:47 A.M., Social Worker (SW) #343 revealed she coordinated the resident care plan meetings. SW #343 revealed she would send a letter to resident families regarding the planned meeting time and would provide an invitation to the resident for the meeting. SW #343 revealed she had no documentation Resident #8 had been invited to her care plan meetings. 2. Review of Resident #25's medical record revealed an admission date of 08/06/24. Diagnosis included dementia, chronic obstructive pulmonary disease, emphysema, and congestive heart failure. Review of Resident #25's quarterly MDS dated [DATE] revealed the resident was a [AGE] year old male and had a low cognitive function. Interview with Resident #25's family on 02/23/26 at 1:48 P.M. revealed they had not been invited to a care conference for a long period of time. Review of Resident #25's Care Conference note dated 12/11/25 revealed nursing, dietary, social worker, and activities were in attendance at the meeting. No family was in attendance. Review of Resident #25's social service notes dated 06/01/25 through 02/24/26 revealed it was absent of documentation regarding inviting family to care plan conferences. Interview with Licensed Social Worker (LSW) #343 on 02/25/26 at 1:33 P.M. revealed she failed to document when families were invited to care conferences. The LSW verified the family of Resident #25 failed to be invited to meetings. Review of the facility policy titled Resident Participation - Assessment/Care Plan undated revealed an Interdisciplinary Care Conference will take place within 21 days of admission to facility, and then quarterly and as needed thereafter. Care plan meetings are scheduled at the best time of the day for the resident and family when possible. The social services director or designee is responsible for (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notifying the resident/representative. Notices include the date, time and location of the conference, the name of each person contact and the date he or she was contacted, the method of contact, input from the resident representative if the are not able to attend, and refusal of participation, if applicable.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and review of the facility policy, the facility failed to follow the bowel protocol. This affected one resident (#95) reviewed for bowel movements. The facility census was 86. Findings include: Review of the medical record for Resident #95 revealed an admission for date 02/12/26. Diagnoses included Alzheimer's, carotid stenosis, anxiety, heart disease, history of recent fall with nondisplaced fracture of the clavicle, and Meniere's disease. Review of the admission assessment dated [DATE] for Resident #95 revealed he was cognitively impaired. Review of the current physicians orders for 02/26 for Resident #95 revealed he was prescribed Tramadol 50 milligrams (mg) for pain, Miralax 17 grams (g) daily (used for constipation prevention), Colace 100 mg twice daily (used for constipation prevention), Milk of Magnesia (MOM) 30 milliliters (ml) as needed daily (used for constipation prevention), and Bisacodyl rectal suppository 10 mg every 24 hours as needed for constipation. Further review of the physician's orders revealed the Bisacodyl 10 mg rectal suppository was ordered on 02/24/26. Review of the bowel movement log for Resident #95 from admission [DATE]) to current revealed no documented bowel movements for six days from 02/18/26 through 02/23/26. Review of the Medication Administration Record (MAR) for 02/26 for Resident #95 revealed an order for MOM 30 mls was in place since 2025 for administration as needed, however, no MOM was administered for no bowel movement for six days. Interview on 02/26/2026 at 7:36 A.M. with the Director of Nursing (DON) stated the facilities bowel program is MOM daily after three days of no bowel movement, and for any resident that is already on bowel aides, MOM 30 mls will be started six days after no bowel movement. The DON verified Resident #95 had no bowel movement for six days and MOM 30 mls was not administered per facility bowel protocol. Review of the facility policy titled, Routine Bowel Program, undated, revealed all resident records will be reviewed daily for adequate bowel elimination and will receive appropriate interventions and/or medications as ordered by their physician to assist the process if/when needed. Each nurse is to ensure that bowel movements (BM) are recorded each shift every day for residents under his/her care. If a resident/patient has a noted absence of BM for three days, the protocol below will be initiated: Milk of Magnesia 30 milliliters (ml) will be administered, if no BM in 24 hours, then repeat dose may be administered every 24 hours, unless otherwise ordered by the physician. If a resident has not had a BM after six days of initiated bowel protocol the charge nurse will notify medical provider for further instructions. If a resident is receiving a routine bowel aid and has not produced a BM for six days, the charge nurse may begin the above protocol. The charge nurse shall notify the appropriate medical provider for further instructions.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on record review, staff interview, policy review, and review of the facility's hemodialysis center contract, the facility failed to ensure consistent communication occurred between the facility and the dialysis center for residents who received hemodialysis (HD). This affected one (#12) of one resident in the facility who received hemodialysis. The facility census was 86.Findings include: Review of the medical record for Resident #12 revealed an admission date of 11/21/23 with diagnoses of end stage renal disease and dependence on renal dialysis. Review of the quarterly Minimum Data Set (MDS) assessment, dated 01/29/26, revealed Resident #12 had impaired cognition and received dialysis. Review of the care plan, initiated 12/18/23, revealed Resident #12 needed hemodialysis related to renal failure. No interventions were in place regarding coordination of care with the hemodialysis clinic. Review of the physician order dated 12/01/24 revealed Resident #12 went to hemodialysis offsite three times weekly on Mondays, Wednesdays, and Fridays. Interview on 02/25/26 at 10:34 A.M. with Licensed Practical Nurse (LPN) #373 and concurrent review of a facility's dialysis communication form, titled Outpatient Dialysis Assessment, revealed the facility completed the top portion (resident vital signs) and sent the form with Resident #12 to the HD clinic. LPN #373 stated the HD Clinic completed the bottom portion of the form and returned it with Resident #12. Review of Resident #12's Outpatient Dialysis Assessment forms, dated 01/26/26 through 02/13/26, revealed the facility did not complete the top portion on 01/26/26, 01/28/26, 01/30/26, and 02/11/26; the HD clinic did not complete the bottom portion on 02/13/26; and no form was available for 02/02/26 and 02/04/26. Interview on 02/25/26 at 9:23 A.M. with the Director of Nursing (DON) confirmed the forms dated 01/26/26, 01/28/26, 01/30/26, 02/11/26, and 02/13/26 were incomplete. A request was made for the facility to provide any additional forms from 01/26/26 through 02/25/26. Review of three additional Outpatient Dialysis Assessment forms, provided by the facility, dated 02/18/26, 02/23/26, and 02/25/26, revealed the facility did not complete the top portion on 02/18/26, and no form was provided for 02/16/26 and 02/20/26. Review of the facility's policy, Hemodialysis Care, revised September 2010, revealed the general medical nurse should keep record of the dialysis log containing pertinent information from dialysis center. Review of the facility's contract with the hemodialysis center for Resident #12 revealed the facility shall ensure all appropriate medical, social, administration and any other pertinent information that will facilitate the adequate coordination of care for the resident accompany the designated resident at the time of transfer to the HD Center.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365498	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ottawa CO Riverview Nursing Ho	8180 W State Rt 163 Oak Harbor, OH 43449

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, staff interview, record review, and policy review, the facility failed to ensure licensed nurses applied lidocaine patches for pain. This affected one (#57) of one resident reviewed for pain management. The facility census was 86.Findings include:Review of the medical record for Resident #57 revealed an admission date of 12/01/25 with diagnoses of pain in left knee, pain in right knee, osteoarthritis, and anxiety, Review of the comprehensive Minimum Data Set (MDS) assessment, dated 12/07/25, revealed Resident #57 had impaired cognition and was dependent on staff for chair to bed transfers. Review of the current physician order, dated 01/27/26, Resident #57 revealed Resident #57 received Lidocaine External Patch 4% applied to bilateral knees topically one time a day for osteoarthritis. Interview and observation on 02/23/26 at approximately 11:30 A.M. revealed Resident #57 dressed and in her wheelchair. Resident #57 stated she had pain in both of her knees and complained about the pain patches on her knee rolling up under her pants. Resident #57 proceeded to pull up the left leg of her pants and show the Lidocaine patch was rolled up and was above her knee. Resident #57 pulled off the patch and began unrolling it. Further observation revealed the pain patch was dated 02/23/26 and was initialed by Licensed Practical Nurse (LPN) #373. Continued interview with Resident #57 on 02/23/26 at approximately 11:40 A.M. and concurrent interview with Certified Nursing Assistant (CNA) #325 revealed CNA #325 applied the Lidocaine patches to Resident #57 when CNA #325 dressed Resident #57 earlier in the morning. CNA #325 stated the nurse left the dated and initialed Lidocaine patches at bedside and CNA #325 applied them after providing personal care and before getting Resident #57 dressed. Interview on 02/23/26 at 12:45 P.M. with LPN #373 confirmed she did not apply Resident #57's Lidocaine patches to Resident #57's knees on 02/23/26 because it was a very busy morning. Review of the policy Administering Medications, revised 04/2019, revealed only persons licensed or permitted by this state to prepare, administer and document the administration of medications may do so.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, review of medication administration records, review of physician orders, review of pharmacy guidelines, observation, staff interview, and policy review, the facility failed to ensure a resident was free from a significant medication error. This affected one (#67) of three residents observed for medication administration. The facility census was 86. Findings include:Review of the medical record for Resident #67 revealed an admission date of 11/06/23. Diagnoses included Parkinson's disease, dysphagia, hypokalemia, cardiomegaly, hypertension, hemiparesis and hemiplegia following cerebral infarction.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had mild cognitive impairment.Review of a physician order dated 10/23/25 revealed Resident #67 had orders for potassium chloride extended release 20 milliequivalents (MEQ), two tablets by mouth daily for hypokalemia. There were no physician orders to crush the resident's medications. Review of the Medication Administration Record (MAR) from 02/01/25 through 02/24/25 revealed Licensed Practical Nurse (LPN) #405 had administered Resident #67's two tablets of potassium chloride extended release 20 MEQ on 02/01/25, 02/04/25, 02/05/25, 02/14/25, 02/15/25, 02/19/25, 02/20/25, 02/23/25, and on 02/24/25.Review of the Resident #67's progress notes from 02/01/25 through 02/24/25 revealed no documentation the resident had a change in condition. Observation on 02/25/26 at 7:34 A.M., of medication administration for Resident #67 with Licensed Practical Nurse (LPN) #405 revealed LPN #405 placed senna 8.6 milligrams (mg), vitamin D 25 micrograms (mcg) two tablets, amlodipine 10 mg, Lasix 40 mg, one multivitamin, and two tablets of potassium 20 MEQ in a small plastic sleeve and then placed the medications in the medication crusher. LPN #405 was asked by the surveyor if she was going to crush the resident's potassium. LPN #405 revealed she always crushed the resident's potassium along with his other medications because he had difficulty swallowing them. LPN #405 then revealed the only medication she would not crush for the resident was his omeprazole because it was a capsule. After surveyor intervention the resident's potassium was not crushed. LPN #405 then administered the crushed medications along with two whole tablets of potassium chloride extended release 20 MEQ and one capsule of omeprazole 20 mg in applesauce to the resident. Further observation revealed Resident #67 had difficulty swallowing the whole medications requiring several additional spoonfuls of applesauce to swallow the medication. Interview on 02/25/26 at 4:48 P.M., Registered Nurse (RN) #345 verified nurses should not crush potassium. Further interview on 02/26/25 at 9:05 A.M., RN #345 verified LPN #405 had administered medications including potassium for Resident #67 nine times from 02/01/25 through 02/25/26. Interview on 02/26/26 at 1:33 P.M., LPN #335 revealed Resident #67 was able to take his medication whole in pudding and the resident had no problems taking medications whole. Interview on 02/26/26 at 8:35 A.M., Nurse Practitioner (NP) #411 verified she had not been notified Resident #67 had difficulty swallowing medications. Review of the facility pharmacy document dated 2025 of a list of Do Not Crush Medications revealed potassium chloride extended-release medication should not be crushed. Review of the facility policy Crushing Medications, revealed a medication would be crushed only when it was deemed appropriate per specific medication guidelines, consistent with physician orders. Staff would refer to the pharmacy provider forms for medications that should not be crushed. Nurses administering medications would verify the facility may crush medication order was present in the resident chart.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, family interview, and facility policy review the facility failed to arrange routine dental care visits for one (#25) of two residents reviewed for dental care. The facility census was 86.Findings include:Review of Resident #25's medical record revealed an admission date of 08/06/24. Diagnoses included dementia, chronic obstructive pulmonary disease, emphysema, and coronary artery disease. Review of Resident #25's quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident was a [AGE] year old male with a low cognitive function. The resident was dependent on staff for oral hygiene care. Review of Resident #25's care plan revealed he was at risk for altered oral/dental status related to cognitive loss and required assistance with dental care. Interventions were to have dental exams as warranted or desired by the resident. Review of Resident #25's outside services form revealed on 06/25/25 his family gave consent for the resident to see dental services for preventative dental care. Review of Resident #25's medical record found the resident had received no dental care since the consent was signed. Interview with Resident #25's family on 02/23/26 at 1:48 P.M. revealed they had requested dental care for the resident and the facility failed arrange the services. Interview with Licensed Social Worker (LSW) # 343 on 02/25/2026 at 1:33 P.M. revealed the facility had failed to arrange for preventative dental appointments for Resident #25 per family request. Review of the facility policy titled Dental dated 01/06/21 revealed the dental healthcare provider works with social services to coordinate dental visits. Social services was to email add on needs for dental services to the dental provider.