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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365620	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Riverview.	7743 County Road 1 South Point, OH 45680

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 - Minimal harm or potential for 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** 07316 Based on medical record review and staff interview, the facility failed to ensure the resident environment remained as free of accident hazards as was possible and failed to ensure a residents received adequate supervision to prevent accidents. This affected one (Resident #87) of three residents reviewed for wandering behavior. The facility census was 89. Findings include: Review of the medical record for Resident #87 revealed an admitted [DATE] with diagnoses including dementia, dysphagia (difficulty swallowing), and congestive heart failure. Review of the plan of care for Resident #87 dated 04/26/21 revealed the resident had exit seeking behavior and was an elopement risk. The resident wandered about the facility in her wheelchair looking for a way home. Interventions included the use of the alert bracelet to her ankle and to calmly redirect to an appropriate area. Review of the physician's orders for Resident #87 revealed an order dated 04/17/23 for a secure bracelet for the resident's ankle to prevent elopement form the facility and order dated 05/26/23 for a regular, soft and bite sized texture diet with minced meats. Interview on 06/24/24 at 1:17 P.M. with Licensed Practical (LPN) #100 confirmed she worked over until 2:00 A.M. on 05/20/24 which was the night Resident #87 was found in the unlocked facility kitchen unattended. LPN #100 confirmed on 05/20/24 around 1:50 A.M. she asked Nursing Assistant (NA) #115 if he had seen the resident, but the aide had not seen Resident #87. On 05/20/24 at approximately 2:00 A.M. NA #115 found Resident #87 in the kitchen with an opened bag of potato chips on her lap. LPN #100 confirmed the kitchen was usually locked and she was unsure why it had been left unlocked. LPN #100 confirmed she reported the incident to Registered Nurse (RN) #110 right after it happened. LPN #100 confirmed RN #100 told her that because Resident #87 did not leave the building, no documentation was necessary. (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 - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/24/24 at 1:53 P.M. with NA #115 confirmed he worked on night shift on the night Resident #87 was found in the unattended facility kitchen. NA #115 stated Resident #87 was a wanderer and he and he went to look for her after he had not seen her for about 10 minutes. NA #115 confirmed he found Resident #87 eating potato chips in the unlocked and unattended kitchen. NA #115 confirmed when he found Resident #87, she had already consumed a whole snack size bag of baked chips when staff removed the resident from the kitchen. NA #115 further confirmed the kitchen was normally locked and he did not know how it was left unlocked. Interview on 06/24/24 at 1:50 P.M. with the Dietician confirmed Resident #87 was on a diet where all foods were to be soft and bite sized, except meats which were to be minced and moist. The Dietitian confirmed Resident #87 had dysphagia and should not eat potato chips because they not considered a safe texture in keeping with the resident's diet. Interview with on 06/24/24 at 1:35 P.M. with RN #100 confirmed LPN #100 called her on 05/20/24 and told her that Resident #87 had been gone for about 15 minutes when she was found in the unlocked and unattended facility kitchen. RN #100 stated she did not remember being told that she ate anything. RN #100 confirmed the kitchen is normally locked when unattended and residents are not normally allowed in the kitchen. RN #100 confirmed Resident #87 could have gotten hurt if she would have turned the stove on, got out a knife, or ate something not on her diet. RN #100 stated she never told LPN #100 not to document the incident. Interview on 06/24/24 at 2:40 P.M. with the Director of Nursing (DON) confirmed one nurse on night shift had a key to the kitchen and must have went in and failed to lock the kitchen. The DON confirmed Resident #87 had dysphagia and was not safe to eat potato chips, and staff had not informed her Resident #87 had eaten chips when she was found unattended in the facility kitchen on 05/20/24. This deficiency represents noncompliance investigated under Complaint Number OH00154534.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365620	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/27/2024
NAME OF PROVIDER OR SUPPLIER Legacy Riverview.		STREET ADDRESS, CITY, STATE, ZIP CODE 7743 County Road 1 South Point, OH 45680	

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07316 Based on medical record review and staff interview, the facility failed to ensure the resident environment remained as free of accident hazards as was possible and failed to ensure a residents received adequate supervision to prevent accidents. This affected one (Resident #87) of three residents reviewed for wandering behavior. The facility census was 89. Findings include: Review of the medical record for Resident #87 revealed an admitted [DATE] with diagnoses including dementia, dysphagia (difficulty swallowing), and congestive heart failure. Review of the plan of care for Resident #87 dated 04/26/21 revealed the resident had exit seeking behavior and was an elopement risk. The resident wandered about the facility in her wheelchair looking for a way home. Interventions included the use of the alert bracelet to her ankle and to calmly redirect to an appropriate area. Review of the physician's orders for Resident #87 revealed an order dated 04/17/23 for a secure bracelet for the resident's ankle to prevent elopement form the facility and order dated 05/26/23 for a regular, soft and bite sized texture diet with minced meats. Interview on 06/24/24 at 1:17 P.M. with Licensed Practical (LPN) #100 confirmed she worked over until 2:00 A.M. on 05/20/24 which was the night Resident #87 was found in the unlocked facility kitchen unattended. LPN #100 confirmed on 05/20/24 around 1:50 A.M. she asked Nursing Assistant (NA) #115 if he had seen the resident, but the aide had not seen Resident #87. On 05/20/24 at approximately 2:00 A.M. NA #115 found Resident #87 in the kitchen with an opened bag of potato chips on her lap. LPN #100 confirmed the kitchen was usually locked and she was unsure why it had been left unlocked. LPN #100 confirmed she reported the incident to Registered Nurse (RN) #110 right after it happened. LPN #100 confirmed RN #100 told her that because Resident #87 did not leave the building, no documentation was necessary. Interview on 06/24/24 at 1:53 P.M. with NA #115 confirmed he worked on night shift on the night Resident #87 was found in the unattended facility kitchen. NA #115 stated Resident #87 was a wanderer and he and he went to look for her after he had not seen her for about 10 minutes. NA #115 confirmed he found Resident #87 eating potato chips in the unlocked and unattended kitchen. NA #115 confirmed when he found Resident #87, she had already consumed a whole snack size bag of baked chips when staff removed the resident from the kitchen. NA #115 further confirmed the kitchen was normally locked and he did not know how it was left unlocked. Interview on 06/24/24 at 1:50 P.M. with the Dietician confirmed Resident #87 was on a diet where all foods were to be soft and bite sized, except meats which were to be minced and moist. The Dietitian confirmed Resident #87 had dysphagia and should not eat potato chips because they not considered a safe texture in keeping with the resident's diet. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with on 06/24/24 at 1:35 P.M. with RN #100 confirmed LPN #100 called her on 05/20/24 and told her that Resident #87 had been gone for about 15 minutes when she was found in the unlocked and unattended facility kitchen. RN #100 stated she did not remember being told that she ate anything. RN #100 confirmed the kitchen is normally locked when unattended and residents are not normally allowed in the kitchen. RN #100 confirmed Resident #87 could have gotten hurt if she would have turned the stove on, got out a knife, or ate something not on her diet. RN #100 stated she never told LPN #100 not to document the incident. Interview on 06/24/24 at 2:40 P.M. with the Director of Nursing (DON) confirmed one nurse on night shift had a key to the kitchen and must have went in and failed to lock the kitchen. The DON confirmed Resident #87 had dysphagia and was not safe to eat potato chips, and staff had not informed her Resident #87 had eaten chips when she was found unattended in the facility kitchen on 05/20/24. The DON confirmed the incident on 05/20/24 involving Resident #87 should have been documented in the resident's medical record. This deficiency represents noncompliance investigated under Complaint Number OH00154534.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34299 Based on medical record review, resident interview, staff interview and review of the facility policy, the facility policy failed to notify local health department and visitors to the facility of an outbreak of a stomach virus which infected residents and staff. This affected 19 of 19 residents reviewed for stomach virus symptoms. The facility census was 89 residents. Findings include: Review of the medical record for Resident #11 revealed an admitted [DATE] with diagnoses including cellulitis in left lower extremity, diabetes mellitus type two, depression, morbid obesity, and gastrointestinal reflux disease. Review of the nursing progress notes for Resident #11 dated 06/18/24 to 06/26/24 revealed they did not include information regarding a stomach virus or documentation regarding notification to resident's representatives of an outbreak of a stomach virus. Review of the medical records for Residents #2, #18 and #38 revealed the residents had nausea, vomiting and or diarrhea from 06/15/24 through 06/19/24. There was no documentation regarding resident representative notification of an outbreak of stomach virus. Interview on 06/26/24 at 10:06 A.M. with Resident #2 confirmed she had been sick a couple of weeks ago along with other residents. Resident #2 stated her symptoms included nausea, vomiting and diarrhea. Interview on 06/26/24 at 10:03 A.M. with Resident #18 confirmed she had been sick a couple of weeks ago with nausea, vomiting and diarrhea. Interview on 06/27/24 at 9:15 A. M. with Licensed Practical Nurse (LPN) #156 confirmed she had a stomach virus a couple of weeks ago and she had to call off work due to her symptoms. Interview on 06/27/24 at 9:18 A.M. with State tested Nursing Assistant (STNA) #145 confirmed she had a stomach virus a couple weeks ago and she had to call off work due to her symptoms. Interview on 06/27/24 at 9:22 A.M. with STNA #114 confirmed she had a stomach virus a couple weeks ago and was sent home from work when she developed symptoms. Interview on 06/26/24 at 2:41 P.M. with the Director of Nursing (DON) confirmed the facility had an outbreak of a stomach virus in early June 2024 which infected 19 residents and eight staff members. The DON further confirmed the facility did not notify the local health department of the outbreak of the virus with symptoms including nausea, vomiting and diarrhea, nor had the facility notified visitors and resident representatives of the outbreak. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled Outbreak Prevention and Intervention dated 11/23/23 revealed outbreak measures would be instituted whenever there was an incidence of infections above what was normally expected considering seasonal variation. Appropriate notifications would be issued to the medical director, the attending physician, administrator, all departments, and family members at a minimum and to appropriate state and local officials. The facility should determine that an outbreak existed when a commonality of symptoms was evident among residents and or staff with common person, place or time. The facility should educate the staff, residents and visitors of their individual responsibilities and importance of compliance with any isolation requirements. This deficiency represents noncompliance investigated under Complaint Number OH00155114.