

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

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>365620                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                 | (X3) DATE SURVEY<br>COMPLETED<br><br>09/25/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Riverview Post Acute                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>7743 County Road 1<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                          |                                                 |
| F 0656<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on staff interview, policy review, observation, and medical record review, the facility failed to develop a care for the resident's care and services for the diagnosis of seizure disorder. This affected one (#2) of 21 residents reviewed for care plans. The facility census was 79. Findings include: Review of the medical record for Resident #2 revealed an admission date of 06/05/25. Diagnoses included epilepsy and vascular dementia. Review of the physician orders dated 09/2025 revealed an order for Levetiracetam (anti-convulsant medication) 500 milligrams (mg) by mouth daily for treatment of seizure disorder and for Resident #2 to wear soft side helmet to protect the head if resident falls. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 had cognitive impairment with physical and verbal behaviors toward others that put the resident at significant risk for physical illness or injury, significantly interfered with resident care, intruded on privacy of others, and significantly disrupted care or the living environment of others. Review of the plan of care initiated on 06/09/25 and last revised on 09/24/25 revealed no plan of care addressing seizure disorder. Observations of Resident #2 on 09/23/25 at 10:06 A.M. and 09/24/25 at 3:12 P.M. revealed no signs and symptoms of seizure activity. Resident #2 was wearing a soft helmet. An interview on 09/25/25 at 12:45 P.M. with Certified Nursing Assistant (CNA) #150 revealed the CNA was not aware Resident #2 had a seizure diagnosis. CNA #150 confirmed there was not any instructions in the nursing's kardex or plan of care to address Resident #2 seizure disorder and what to do if resident had a seizure. An interview on 09/25/25 at 12:49 P.M. with Licensed Practical Nurse (LPN) #174 revealed Resident #2 had not had any recent seizure activity. An interview on 09/25/25 at 12:54 P.M. with Unit Manager #159 confirmed Resident #2 had a diagnosis of seizure disorder, received medication for seizure disorder and there was not a plan of care addressing Resident #2 seizure disorder. Review of the facility policy titled Seizures and Epilepsy-Clinical Protocol dated 11/2018 revealed the nursing staff should assess, document and report the following: vital signs, neurological assessment, change in level of consciousness, any seizure activity in detail (location duration, severity and reoccurrence), any injury occurring with a seizure, whether the resident has a known seizure disorder or history of actual seizure activity, date of most recent actual seizure activity, how current seizure activity relates to usual patterns and last blood level of any anti-convulsant medication being administered.</p> |                                                                                          |                                                 |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER<br>REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0677<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews, record reviews, and review of facility policy, the facility failed to ensure a resident who was dependent on staff for Activities of Daily Living (ADLs) received timely and appropriate nail care. This affected one (#6) of six residents reviewed for ADLs. The facility census was 79. Findings include:Record review for Resident #6 revealed the resident was admitted to the facility on [DATE] and had diagnoses which included diabetes mellitus, heart failure, muscle wasting and atrophy, and vascular dementia. Review of the care plan, dated 02/21/24, revealed the resident had an ADL self-care/mobility/functional ability performance deficit. Interventions included nail care as needed. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #6 had impaired cognition and was dependent on staff with personal hygiene and bathing. Observations on 09/22/25 at 12:50 P.M. and 09/23/25 at 9:45 A.M. and 3:25 P.M. revealed Resident #6 was lying in bed. The resident's fingernails were extremely long and had dark-colored debris caked underneath them. Observation and interview with Registered Nurse (RN) #117 on 09/23/25 at 4:15 P.M. confirmed Resident #6's fingernails were extremely long with dark-colored debris caked underneath them and were in need of being trimmed and cleaned. RN #117 confirmed she was going to get nail clippers and was coming back to trim and clean the resident's nails. Review of the facility policy titled Fingernails/Toenails, Care of revised 02/2018 revealed the purpose of the procedure was to clean the nail bed, to keep the nails trimmed, and to prevent infections. Nail care included daily cleaning and regular trimming. This deficiency represents non-compliance investigated under Master Complaint Number 2608350 and Complaint Number OH00166779 (1282675). |                                                                                          |                                                 |

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| <p>F 0699</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Provide care or services that was trauma informed and/or culturally competent.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record reviews, interviews, and review of facility policy, the facility failed to ensure residents with Post Traumatic Stress Disorder (PTSD) received timely assessment and care to prevent re-triggering of traumatic events. This affected two (#10 and #12) of four residents reviewed for mood and behavior. The facility census was 79. Findings include: 1. Record review for Resident #10 revealed the resident was admitted to the facility on [DATE]. Diagnoses included PTSD.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #10 had mildly impaired cognition.</p> <p>Record review revealed there was not an assessment or plan of care available which identified the cause of the resident's PTSD, the potential triggers of the resident's PTSD, or interventions to prevent the retriggering of the resident's PTSD.</p> <p>Interview on 09/25/25 at 3:10 P.M. with Social Services Assistant (SSA) #201 confirmed Resident #10 did not have an assessment or plan of care in place to address the resident's PTSD diagnosis prior to 09/22/25.</p> <p>2. Record review for Resident #12 revealed the resident was admitted to the facility on [DATE] and had diagnoses which included PTSD.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #12 had intact cognition.</p> <p>Record review revealed there was not an assessment or plan of care available which identified the cause of the residents PTSD, the potential triggers of the residents PTSD, or interventions to prevent the retriggering of the residents PTSD.</p> <p>Interview with the Director of Nursing on 09/24/2025 at 2:47 P.M. verified no trauma assessment or care plan addressing PTSD was initiated until 09/23/25 for Resident #12.</p> <p>Review of the facility policy titled Trauma Informed Care and Culturally Competent Care revised 08/2022 revealed the purpose was to address the needs of trauma survivors by minimizing triggers and/or re-traumatization. Assessment involved an in-depth process of evaluating the presence of symptoms, their relationship to trauma, as well as the identification of triggers. Develop an individualized care plan that address the past trauma in collaboration with the resident and family, as appropriate.</p> |                                                                                          |                                                 |