

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365877	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/11/2024
NAME OF PROVIDER OR SUPPLIER  Riverside Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1390 King Tree Drive Dayton, OH 45405	

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)
<p>F 0603</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from separation (from other residents, his/her room, or confinement to his/her room).</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36303</p> <p>Based on medical record review, staff interview, and review of facility policy, the facility failed to ensure a resident met criteria for admission to the facility's secure unit and was in the least restrictive environment available. This affected one (#6) of three residents reviewed who resided in the secure or locked unit. The census was 173.</p> <p>Findings include:</p> <p>Review of Resident #6's closed medical record revealed an admitted [DATE]. Diagnoses listed include anxiety disorder, major depressive disorder, hypokalemia, and hypertension. Resident #6 was transferred to a local hospital on 04/06/24 for stroke like symptoms and had not returned to the facility.</p> <p>Review of an admission Minimum Data Set (MDS) dated [DATE] revealed Resident #6 was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of a possible 15. Resident #6 was not having hallucinations or delusions, was not verbally of physically aggressive towards others, and had not wandered.</p> <p>Review of behavioral hospital documentation revealed Resident #6 was admitted from a local hospital on 01/17/24 after being found laying face down on her floor by neighbors. Resident #6 was psychotic and having delusions. Resident #6 was treated for nontraumatic rhabdomyolysis, severe hypokalemia, and starvation ketosis while at the local hospital. Review of discharge instructions dated 02/09/24 revealed Resident #6 was at her baseline as evidenced by decrease in psychotic and delusional behaviors. Resident #6 had been cooperative with care and denies any paranoid ideation's or delusional thoughts and has been medication compliant.</p> <p>Further review of Resident #6's closed medical record revealed she was admitted to a secured unit of the facility on 02/09/24 and remained there during her stay until transfer 04/06/24. Resident #6 was documented as being her own representative.</p> <p>Review of physician orders revealed and order dated 02/13/24 for may be on secured unit related to poor safety awareness and impaired cognition.</p> <p>(continued on next page)</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0603</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further review of Resident #6's closed medical record revealed no documentation of any hallucinations, delusions, wandering, or exit seeking behavior while at the facility from 02/09/24 to 04/06/24. Resident #6 was documented as being pleasant and cooperative with care and medications. There was no documentation by a physician of Resident #6's benefit from a secured unit environment. No documentation of Resident #6 signing a consent to be in the facility's secured unit was found.</p> <p>Review of a psychiatric consult dated 04/04/24 revealed Resident #6 was alert and oriented, engaged, and cooperative. Resident #6 denied any hallucinations, suicidal ideation's, or homicidal ideation's. Nursing staff deny any concerns and state resident is compliant with care and medications. Nursing staff state patient is at baseline. Resident #6 was documented as not having any psychosis or disturbance of perception. Resident #6's insight and judgment was fair.</p> <p>Interview with the Administrator and Registered Nurse (RN) #120 on 04/10/24 at 12:45 P.M. confirmed Resident #6 did not have an assigned guardian and the resident was alert and oriented. The Administrator and RN #120 confirmed that Resident #6 had not displayed any behaviors that would warrant residing in the secure unit. The Administrator and RN #120 confirmed a physician had not documented a benefit to Resident #6 residing in the secure unit. RN #120 confirmed Resident #6's psychiatric consult dated 04/04/24 was negative for any acute psychosis. RN #120 confirmed a psychiatric consult was not conducted when Resident #6 was first admitted to the secure unit.</p> <p>Review of the facility's undated policy titled Secured (Locked) Unit the secured of locked unit is a unit that is separated from the other units without free access to move between unit by residents and used for those residents with limited cognitive or reasoning abilities who lack the capacity for re-direction, re-learning including those with late stage Alzheimer's, related dementia's, and mental illness. Confused or wandering does not meet criteria for placing a resident on a secured unit. A resident will be admitted to a locked or secured unit based on a mental and physical assessment that has documentation that the resident would benefit from such an environment. The interdisciplinary team (IDT) will provide documentation the secure unit is the least restrictive approach that is reasonable to protect the resident and assure his/her safety. The physician is aware and had provided documentation and order that the resident would benefit from such an environment.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00152759.</p>		