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Form Approved OMB
No. 0938-0391

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 07/31/2024
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)
F 0689 Level of Harm - 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** 48570 Based on medical record review, review of the facility investigation, resident interview, staff interview, and review of the facility policy, the facility failed to provide appropriate supervision and assistance with resident transfers which resulted in Actual Harm on 06/03/24 when Resident #66 was transferred out of a shower chair into bed by two staff members without the use of a Hoyer lift as ordered, resulting in the resident sustaining a fracture to the left humerus during the transfer. This affected one (Resident #66) of three residents reviewed for accidents. The facility census was 169 residents. Findings include: Review of the medical record for Resident #66 revealed an admitted [DATE] with a diagnosis of hemiplegia and hemiparesis following cerebral infarction. Review of the care plan for Resident #66 dated 11/10/23 revealed staff should use a Hoyer lift for all transfers with the assistance of two staff. Review of physician's orders for Resident #66 revealed an order dated 02/12/24 for the resident to transfer using Hoyer lift with the assistance of two staff. Review of the Minimum Data Set (MDS) assessment for Resident #66 dated 04/19/24 revealed the resident was cognitively intact, had impairment on one side of her upper and lower extremities, required supervision assistance with eating and was dependent on staff assistance for oral hygiene, toileting hygiene, bathing, dressing, personal hygiene, bed mobility, transfers, and wheelchair mobility. Review of the progress note for Resident #66 dated 06/03/24 timed at 4:00 P.M. revealed the nurse informed the attending physician's office the resident was complaining of pain to the left shoulder and elbow. The nurse practitioner (NP) ordered a stat x-ray to the resident's left arm. Review of the progress note for Resident #66 dated 06/03/24 timed at 6:30 P.M. revealed a State tested Nursing Assistant (STNA) stated after the resident received her shower, the STNA and another aide were repositioning the resident while in the shower chair the resident's buttock had gotten stuck in the hole in the center of the shower chair. The STNA had then put her arm around the resident's chest to get her centered and then the two aides manually transferred Resident #66 from the shower chair to her bed. (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 - Actual harm Residents Affected - Few	Review of progress note for Resident #66 dated 06/03/24 timed at 8:29 P.M. revealed the x-ray to the resident's left arm showed an irregularity of the proximal humerus which might represent an acute nondisplaced fracture versus prior trauma. Review of progress note for Resident #66 dated 06/03/24 timed at 9:55 P.M. revealed the nurse spoke with the on-call physician and received an order for the resident to follow up with an orthopedic doctor and to wear a sling due to left humerus fracture. Review of investigation file for Resident #66 regarding the incident dated 06/03/24 revealed on 06/03/24 at 4:00 P.M. when two STNAs transferred the resident to bed without use of a Hoyer lift the resident reported she heard a pop to her left arm and shoulder area. Review of the witness statement per STNA #187 dated 06/03/24 revealed Resident #66 was in her shower chair and began to complain the shower chair was cutting into her butt, so she pushed the resident to her room in the shower chair. Further review of the statement revealed the Hoyer lift was not working, so STNAs #187 and #188 manually transferred the resident to bed. Then Resident #66 complained of hearing a pop to her left shoulder area. Review of the witness statement from STNA #188 dated 06/03/24 revealed STNA #187 and #188 transferred Resident #66 from the shower chair to the bed with STNA #188 holding the resident's legs and STNA #187 holding the resident's chest. Interview on 07/24/24 at 1:06 P.M. with Resident #66 confirmed she had a broken left upper arm that occurred after two STNAs failed to use a Hoyer lift last month to transfer her. Interview confirmed the Hoyer battery was dead when they attempted to use it, so they picked the resident up and put her in bed. Resident #66 further confirmed during the transfer she told the aides she heard and felt something pop in her left arm. Interview on 07/25/24 at 3:15 P.M. with STNA #188 confirmed on 06/03/24 she assisted STNA #187 with a transfer of Resident #66 from the shower chair to the bed. STNA #188 confirmed they were supposed to use a Hoyer lift to transfer the resident, but the lift wasn't working so they manually transferred the resident. STNA #188 confirmed she picked up the resident by her legs and STNA #187 picked up the resident by her chest. STNA #188 confirmed Resident #66 reported she heard a pop in her left shoulder area during the transfer. Interview on 07/25/24 at 4:11 P.M. with the Director of Nursing (DON) confirmed STNAs #187 and STNA #188 manually transferred Resident #66 from the shower chair to the bed 06/03/24 at 4:00 P.M. when the Hoyer lift was not working. The DON confirmed Resident #66 had a physician's order to be transferred via Hoyer lift only. The DON confirmed Resident #66 sustained a fracture to the left humerus during the manual transfer on 06/03/24. Interview on 07/31/24 at 2:02 P.M. with the Administrator confirmed he was not aware of the manual transfer of Resident #66 on 06/03/24 in which the resident sustained a broken humerus. Review of the facility policy titled Mechanical Lifts and Transfer undated revealed safety was a primary concern for residents, staff and visitors. The use of mechanical lifts required a competent and skilled user and required the use of two employees to perform the lift safely, for both the resident and the employees. (continued on next page)

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	365877	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Nursing and Rehabilitation Center	1390 King Tree Drive Dayton, OH 45405

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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 0689 Level of Harm - Actual harm Residents Affected - Few	This deficiency represents noncompliance investigated under Complaint Number OH00155630.

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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 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** 48570 Based on medical record review, staff interview and review of the facility policy, the facility failed to ensure residents were free of significant medication errors. This affected one (Resident #169) of three residents reviewed for medication administration. The facility census was 169 residents. Findings include: Review of the medical record for Resident #169 revealed an admitted [DATE] with diagnoses of chronic obstructive pulmonary disease and pressure ulcer of sacral region. Review of the preadmission paperwork from Resident #169's prior skilled nursing facility dated 07/18/24 revealed the resident was to receive the following medications: aspirin 81 milligrams (mg) once daily, lisinopril 10 mg at bedtime for hypertension, hold if systolic blood pressure was less than 110 or if pulse was less than 60, methocarbamol 750 mg every six hours. Review of the admitting physician's orders for Resident #169 dated 07/18/24 and transcribed from the preadmission paperwork provided by the resident's previous facility revealed the order for aspirin was omitted and was not transcribed. The lisinopril order did not include the parameters to hold the medication for systolic blood pressure less than 110 or pulse less than 60. The methocarbamol order was transcribed as being given as needed every six hours instead of being given routinely every six hours. Review of the Medication Administration Record (MAR) for Resident #169 dated July 2024 revealed the resident did not receive aspirin 81 mg from 07/18/24 through 07/31/24. Lisinopril was administered from 07/18/24 to 07/24/24 but did include a blood pressure and/or pulse check prior to administration. The parameters to hold lisinopril for systolic blood pressure less than 110 or pulse less than sixty were added on 07/25/24. Methocarbamol was given as needed and not every six hours as ordered from 07/18/24 to 07/31/24. Interview on 07/31/24 at 10:20 A.M with Licensed Practical Nurse (LPN) #171 confirmed Resident #169 had an order for aspirin 81 mg once daily that was omitted on admission. Interview further confirmed the parameters to hold lisinopril were not transcribed upon admission but were added on 07/25/24. LPN #171 further confirmed methocarbamol was transcribed as an as needed medication but was supposed to be given every six hours routinely. LPN #171 confirmed Resident #169's medical record did not include documentation the physician was notified of the orders and/or that the physician had ordered any changes to the medications received in the admission orders from the prior skilled nursing facility. Interview on 07/31/24 at 12:58 P.M. with LPN #234 confirmed he completed the admission orders for Resident #169 based on the orders sent to the facility from the prior skilled nursing facility order summary. Interview confirmed he called the physician prior to admission to confirm the orders and the physician had made no changes. LPN #234 confirmed he thought he had transcribed the admission orders correctly but confirmed he made the following errors: the order for the aspirin was omitted, the parameters for lisinopril administration were not entered, methocarbamol was transcribed as an as needed medication instead of a routine medication. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Medication Administration revealed medications should be administered only as prescribed by the provider. This deficiency represents noncompliance investigated under Complaint Number OH00156006.