STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365877	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Nursing and Rehabilitation Center	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 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** 34291 Based on observation, record review, interview and policy review, the facility failed to ensure a resident was able to use his electric wheelchair and failed to ensure a resident could leave the building unattended. This affected one (Resident #173) of one resident reviewed for resident rights. The facility census was 170. Findings include: 1a. Record review revealed Resident #173 was admitted on [DATE]. Medical diagnoses included a stroke with left sided weakness. Resident #173 was his own person. Review of the quarterly Minimum Data Set (MDS) assessment, dated 08/01/24, revealed Resident #173 was cognitively intact. He needed set-up or clean-up assistance for eating, dependent or toileting, partial/moderate assistance for bed mobility and transfers. He had no behaviors. Review of a progress note dated 07/26/23 revealed Resident #173 was observed on multiple occasions driving his electric wheelchair to unauthorized areas on facility grounds including driveways, shipping and receiving area, rummaging through shed, and employee parking lot. It was also reported by dietary staff that resident was chasing an employee while seated in his electric wheelchair in the parking lot with a reacher stick in an attempt to strike her physically with the reacher stick. Resident #173 was advised of safety risk related to being in unauthorized areas. He verbalized understanding of safety education presented, but continued to demonstrate behaviors of non-compliance as evidenced by continuing to enter unauthorized areas. A meeting was held with Resident #173. Present in the meeting were the Director of Nursing (DON), Assistant Director of Nursing (ADON), the Executive Director, and Regional Clinical Director. Resident #174 was again provided education and risk related to potential safety concerns and advised of interventions to be implemented if he is not in agreement to adhering to safety contract. Resident #173 verbalized understanding of information presented as evidence of teach-back method. Patient #173 was able to state in his own words what he needs to do to remain safe in and outside of the facility. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Self-Reported Incident (SRI) dated 08/30/23 at 6:00 P.M. documented Resident #125 was being loud in the dining room. Resident #173 approached Resident #125 in his motorized scooter and rolled onto her foot. Resident #125's hand struck Resident #173's ear, causing a small scratch. The residents were immediately separated. Head to toe assessments completed on both with no concerns noted. There were no witnesses to the incident. Social services met with residents and both residents stated they felt safe in the facility. No negative psychosocial effects noted. Notifications were made to Medical Director, Police Department and Family Representative. Review of a witness statement by State tested Nursing Aide (STNA) #374, written on 08/30/23, revealed she was supervising the dining room for this meal and Resident #173 approached Resident #125 who put her hand out to stop him and said stop coming towards me and Resident #173 proceeded to run into Resident #125. Review of witness statement by Licensed Practical Nurse (LPN) #359, written on 08/30/24, revealed when she came into the dining room, Resident #173 had Resident #125 pinned against the wall with his motorized wheelchair and Resident #125 said get off my foot. Review of statement from Resident #125, dated 08/31/23, revealed Resident #173 told her to shut up and she said I don't know how to Resident #125 was walking back to the her table and Resident #173 approached her in his wheelchair and she motioned with her hands to stay away. Resident #173 intentionally ran over the resident and had Resident #125 pinned up against the wall in the dining room. Then in another paragraph Resident #125 said Resident #173 rolled onto her foot and stopped and that was when Resident #125 starting punching Resident #173 to get off of her foot. Review of statement from Resident #173, dated 08/31/23, revealed Resident #125 was yelling and screaming at everyone in the dining room and he approached Resident #125 to speak to her. Resident #125 grabbed his shirt and during the struggle the power chair rolled over Resident #125's foot. Review of a progress note dated 08/31/23 revealed Resident #173 was discussed in clinical meeting on this date for alleged allegation of resident to resident abuse. Resident #173 had misjudgment of use of the power chair. Resident #173's power chair was removed and manual wheelchair provided at this time for mobility. Resident #173 was offered other acceptable areas to have a quiet environment during meals. Resident #173 verbalized understanding at this time no further concerns noted. Review of the care plan, revised on 06/24/24, revealed Resident #173 was at risk for behaviors as evidenced by refusals of care, calling 911, refusing medications, physical and verbal aggression, sexually inappropriate, intrusive, threatening to harm staff, and embellishes that leads to allegations. Review of the progress notes and physician progress notes from 05/10/24 through 09/04/24 revealed no documentation of any behaviors by facility staff or the physician. Review of a care conference dated 08/20/24 revealed Resident #173 requested to get his motorized wheelchair back and the request was denied. There was no reason for the denial documeted. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/04/24 at 1:27 P.M., Resident #173 stated over a year ago he accidentally ran over Resident #125's foot with his motorized wheelchair. He has asked Licensed Social Worker (LSW) #338 several times to get his wheelchair back and the answer is no he can't have it back. He stated he apologized to Resident #125 right after it happened and she has forgiven him and they get along fine. During an interview on 09/04/24 at 3:54 P.M., Physical Therapy Assistant #217 on said Resident #173's motorized wheelchair was in the therapy room. She stated the incident with Resident #173's motorized wheelchair had been months ago, and he purposefully ran over a resident. During an interview on 09/05/24 at 11:27 A.M., the Administrator stated the motorized wheelchair had been taken away from Resident #173 because the resident purposefully ran over Resident #125's foot over a year ago and used it as a weapon. He stated he was changed into a manual wheelchair at that time and there hasn't been any behaviors since then except the resident wanted the battery changed in his motorized wheelchair and became verbally aggressive with the person who was changing the battery. When asked if Resident #173 had been reassessed to have his motorized wheelchair back he stated he would check, but he never came back with any documented assessments. During an interview on 09/05/24 at 2:13 P.M., LSW #338 stated Resident #173 asks every couple of months for his wheelchair back and the answer has been no, due to continuous behavior. When asked about the documentation of these behaviors, LSW #338 stated she doesn't record all of those behaviors in the medical record. She stated Resident #173 propels backwards in his manual wheelchair, doesn't take direction, inserts himself into other situations, is verbally aggressive, doesn't take responsibility for what he does, and he wants what he wants when he wants it and he isn't in that place where he can have that. She stated the resident hates not having his motorized wheelchair. Review of the policy titled Resident Rights, undated, revealed it is the policy of this facility to provide resident centered care that meets the psychosocial, physical, and emotional needs and concerns of the residents. Safety of residents, visitors and employees is a top priority of care. 1b. Review of physician orders dated 04/24/24 revealed Resident #173 may go out on supervised leave of absence (LOA). Review of a progress note dated 06/25/24 revealed the nurse was alerted by the receptionist that Resident #173 was outside on the front porch of the facility and refusing to come back into the building. Upon further investigation, it was determined Resident #173 was not signed out by a responsible party, even though Resident #173 was his own person. The nurse, along with an aide, approached Resident #173 and attempted to encourage resident to return inside of building. Resident #173 stated he was not coming in, to give him 15 minutes, he just wanted to sit outside. In an attempt to prevent escalation the aide remained outside with resident until he was willing to return inside the building. Resident #173 was educated on the importance of following Leave of Absence (LOA) guidelines as it ensures resident safety. Resident verbalized understanding and stated it would not happen again. The Director of Nursing and building Administrator were notified of the incident. Interview with Resident #173 on 09/04/24 at 1:27 P.M. revealed he wasn't able to go out the front door without supervision. He stated he didn't sign out of the facility one time and had to have a staff member go out front with him if he wanted to go out. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing (DON) on 09/05/24 at 1:38 P.M. revealed Resident #173 didn't sign out one time on 06/25/24 and wouldn't come back into the facility when asked to. She met with the physician and Interdisciplinary Team (IDT) and it was decided to make him supervision with leave of absence out the front door. She stated he could go out on the locked patio if he wanted. She stated there were issues when he had his motorized wheelchair, he would go in the back of the facility where there is a steep hill and he could get hit. She stated he hasn't had his motorized wheelchair since 08/31/23 and the orders went into effect on 04/24/24 because of the motorized wheelchair. During an interview on 09/05/24 at 1:40 P.M., Receptionist #289 said Resident #173 was not allowed to go out the front door without a staff member and she didn't know why. Review of the policy titled Resident Leave of Absence, undated, revealed a resident who is cognitively intact with independent decision making with a physician's order may sign themselves out for a LOA. In the event the resident exits the facility without signing out on the log, the facility will initiate an investigation in an attempt to locate the resident. Upon the resident return to the facility, appropriate re-education for the leave of absence procedure will be completed. This is an incidental deficiency discovered during the course of this complaint investigation.

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34291 Based on observation, record review, interview and policy review, the facility failed to ensure the residents were treated with dignity and respect. This affected three (Residents #153, #143 and #39) of three residents reviewed for dignity and respect. The facility census was 170. Findings include: 1. Record review revealed Resident #153 was admitted on [DATE]. Medical diagnoses included peripheral autonomic neuropathy and heart failure. Review of the quarterly Minimum Data Set (MDS) assessment, dated 08/14/24, revealed she was cognitively intact. Review of functional status revealed she was set-up or clean-up assistance for eating, supervision or touching assistance for toileting, bed mobility, and for transfers. During an observation on 08/28/24 at 1:10 P.M., Resident #153 came to the nursing station and asked Licensed Practical Nurse (LPN) #363 for a bottle of shampoo out of the shower room. The nurse told the resident to go back to her room and she would get the shampoo when she could, and stated there wasn't any staff member available to wash her anyway. During an interview on 09/03/24 at 10:31 A.M Resident #153 stated LPN #363 doesn't like to be bothered. She stated she is told a lot to go back to her room and she doesn't like it. During an interview on 09/03/24 at 10:27 A.M., LPN #363 stated she told the resident to go back to her room, but didn't know why she told her that. 2. Record review revealed Resident #143 was admitted on [DATE]. Medical diagnoses included paranoid schizophrenia. Review of the quarterly MDS assessment, dated 06/12/24, revealed Resident #143 was moderately cognitively impaired. She required setup or clean-up assistance for eating, toileting, bed mobility, and transfers. During an observation on 08/28/24 at 3:20 P.M., Resident #143 requested ice water. LPN #229 said ice water would be passed at 5:00 P.M. at 9:00 P.M. During an interview on 09/03/24 at 10:35 A.M., Resident #143 stated the room containing ice water was locked and she wasn't able to help herself to ice water. She stated the staff make you wait till scheduled times to get ice water and she didn't like it. During an interview on 09/03/24 at 3:47 P.M., LPN #229 stated ice water was to passed at 5:00 P.M. and at 9:00 P.M. and this was the facility policy. She said asking for ice water was a behavior of the resident. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #143's care plan revealed no documentation related to the resident having a behavior of asking for ice water. 3. Record review revealed Resident #39 was admitted on [DATE]. Medical diagnoses included dementia, arthritis, and schizophrenic. Review of the annual MDS assessment, dated 08/22/24 revealed Resident #39 was rarely or never understood. He required supervision/touching assistance for eating, bed mobility, and transfers. He was dependent for toileting. During an observation on 09/04/24 at 2:26 P.M., Resident #39 was being led through the dining are by the left wrist by State tested Nursing Aide (STNA) #264. During an interview on 09/04/24 at 2:30 P.M., STNA #264 stated she was holding the resident by the wrist to ambulate because he was a slow walker. She stated she didn't mean any ill intent, but that's the way she walked the residents, by the wrist. She admitted it could be a dignity and respect issue. Review of the policy titled Resident Rights, undated, revealed the definition of dignity is a state worthy of honor or respect; includes but not limited to speaking respectfully to resident, The residents have a right to be treated with respect. This deficiency represents non-compliance investigated under Complaint Numbers OH00157418, OH00156598, and OH00156581.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34291 Based on observation, medical record review, staff and resident interview the facility failed to ensure choices were respected. This affected one (Resident #27) of one resident reviewed for choices. The facility census was 170. Findings include: Record review revealed Resident #27 was admitted on [DATE]. Her medical diagnoses included chronic obstructive pulmonary disease, renal failure, and diabetes. Review of the quarterly Minimum Data Set (MDS) assessment, dated 07/20/24, revealed Resident #27 was cognitively intact. She required supervision/touching assistance for eating, substantial/maximal assistance for bed mobility, transfers and toileting. During an observation on 09/05/24 at 6:48 A.M., Resident #27 was asleep with her head on the dining room table with her pillow under her head. During an interview on 09/05/24 at 6:49 A.M., State tested Nurse Aide (STNA) #283 stated she got the resident up at about 6:00 A.M. because she is on the list of residents who need to get up before first shift comes to work. She stated the resident hated to get early because she isn't a morning person, but she was on the list to get out of bed on second shift per the supervisor. During an observation on 09/05/24 at 9:16 A.M., Resident #27 was still asleep at the dining room table. During an interview on 09/05/24 at 9:29 A.M., Resident #27 stated she hated to get up early, but the staff get her up early every day. This was an incidental deficiency discovered during the course of this complaint investigation.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 34291 Based on observation and interview, the facility failed to provide a homelike environment. This affected seven (Residents #34, #170, #153, #136, #10, #131, and #171) of seven residents reviewed for homelike environment. The census was 170. Findings include: 1. During an observation on 08/28/24 at 12:45 P.M., Resident #34;s room had an outlet behind the head of the bed that was dangling on the wall. During an interview at the time of the observation, Resident #34 stated she reported it to the maintenance man and he didn't come and fix it. During an interview on on 08/28/24 at 3:00 P.M., Maintenance Man (MM) #252 confirmed the resident told him about the dangling outlet and he had not fixed it yet. 2. During an observation on 08/28/24 at 1:03 P.M., Resident #170's had a brown substance on the floor, the top of the heater was rusted, the wall in the bathroom had holes by the paper towel holder and a light bulb was out. The paint on the ceiling was peeling. 3. During an observation on 08/28/24 at 1:10 P.M., Resident #153's room had scuff marks by the right side of her bed and the window blind was torn. 4. During an observation on 08/28/24 at 1:15 P.M., Resident #136's room had torn window blinds, the walls were scuffed up, the light behind his bed had a light bulb missing and there was no covering to the lights. The covering to the heater next to the bed was coming off. 5. During an observation on 08/28/24 at 1:20 P.M., Resident #10's window blinds were broken, the walls behind the bed were scuffed and the molding behind the bed was off the wall. 6. During an observation on 08/28/24 at 1:25 P.M., Resident #131's window blinds were torn. 7. During an observation on 09/03/24 at 9:50 A.M., Resident #171's room had a light out on the vanity, a yellow circle on the ceiling in the bathroom and a yellowish brown substance in the corners of the bathroom. The toilet has a big area of rust inside the bowl. During an interview on to the above mentioned rooms on 08/28/24 at 3:00 P.M., MM #252 confirmed all of the issues in the above mentioned rooms. and thought his assistant was working on all of the problems in the rooms. This deficiency represents non-compliance investigated under Complaint Number OH00157011 and OH00156598.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34291 Based on observation, record review, interview and policy review, the facility failed to ensure a resident cleansed in the proper manner after he was incontinent. This affected one (Resident #137) of three residents reviewed for incontinence. The facility census was 170. Findings include: Record review revealed Resident #137 was admitted on [DATE]. Medical diagnoses included cerebrovascular disease, diabetes and non-Alzheimer's disease. Review of the quarterly Minimum Data Set (MDS) assessment, dated 08/06/24, revealed Resident #137 was severely cognitively impaired. He was dependent for eating, toileting, bed mobility and transfers was not assessed on this assessment. He was always incontinent for bowel and bladder. During observation on 08/28/24 at 7:44 A.M., State tested Nurse Aide (STNA) #309 performed incontinent care on Resident #135. STNA #309 pulled down the incontinent brief and washed down each side of the perineum. She turned him over and situated the clean incontinent brief. She didn't cleanse the penis, the scrotum or his buttocks. The incontinent brief was wet. During an interview on 08/28/24 at 7:51 A.M., STNA #309 stated she didn't know what the policy was for incontinence care. She stated she only cleansed the resident generally because hospice was coming into the facility to shower the resident. Review of the medical record revealed Hospice was not scheduled to visit the resident until 08/29/24. Review of the policy titled Perineal Care-Male, undated, stated to use soap and water to wash perineal area starting with urethra and working outward. Retract foreskin of the uncircumcised male. Wash and rinse urethral area using a circular motion. Continue to wash the perineal area including the penis, scrotum and inner thighs.Thoroughly rinse perineal area in same order, using fresh water and clean washcloth, or using disposable perineum wipes. Gently dry perineum following same sequence. Reposition foreskin of uncircumcised male. Ask the resident to turn on his side with his upper leg slightly bent, if able. Using a clean washcloth, apply soap or skin cleansing agent; use disposable perineum wipes if available. Wash and rinse the rectal area thoroughly, including the area under the scrotum, the anus, and the buttocks. Dry area thoroughly. This was a incidental deficiency discovered during the course of this complaint investigation.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34291 Based on observation, record review, interview and policy review, the facility failed to ensure a resident was medicated for pain during a dressing change. This affected one (Resident #50) of three residents reviewed for pressure ulcers. The facility identified four residents with pressures ulcers in the facility. Th census was 170. Findings include: Record review revealed Resident #50 was admitted on [DATE]. His medical diagnoses included Parkinson's disease, and renal disease. Review of the quarterly Minimum Data Set (MDS) assessment, dated 08/13/24, revealed Resident #50 was moderately cognitively impaired. He was impaired for his upper and lower extremities. He was dependent for toileting and bed mobility. He was a Hoyer lift for transfers. During an observation on 09/04/24 at 12:48 P.M., Licensed Practical Nurse (LPN) #275 completed a dressing change to the resident's left heel with assistance from the Director of Nursing (DON). LPN #275 tried to reposition the resident in the chair and he said I am hurting. LPN #275 proceeded to wash her hands, don a gown and cleanse the wound. Resident #50 again said I am hurting. The DON said the nurse would medicate him after the dressing change. The nurse proceeded with the dressing and Resident #50 again said I am hurting. LPN #275 said she would medicate him for the pain, but never assessed his pain location or intensity. During an interview on 09/04/24 at 1:01 P.M., Resident #50 said the pain was in his left heel and his sides. He rated his pain a ten on a one to ten pain scale. During an interview on 09/04/24 at 1:03 P.M., LPN #275 said not assessing the resident's pain or medicating him prior to the dressing change was an accident and she was nervous. Review of the policy titled Pain Management and Assessment, undated, stated it is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. The purpose of this policy is to provide guidance to the clinical staff to support the intent of S483.25(k) that based on the comprehensive assessment of a resident, the facility must ensure that residents receive the treatment and care in accordance with professional standards of practice, the comprehensive care plan, and the resident's choices, related to pain management. There is no objective test that can measure pain. The clinician must accept the resident's report of pain. Clinical observations clarify information from the resident. Site of discomfort may direct the nurse to specific types of pain-relief measures. The policy directed to use the pain scale to assess pain. This is an incidental deficiency discovered during the course of this complaint investigation.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. 34291 Based on observation, interview and policy review, the facility failed to ensure a refrigerator was provided for residents to use if they wished. This affected six (Residents #71, #43, #69, #173, #88 and #90) of six residents reviewed for the storage of resident food. The census was 170. Findings include: During an interview on 09/04/24 at 1:11 P.M., Resident #88 stated her family brought in a bottle of homemade lemonade. She asked the kitchen if they could keep it cold for her and they said yes. She stated an aide brought the lemonade back to her and yelled at her because the lemonade was in the kitchen. She said she had to throw out the lemonade. She stated there wasn't a place to store something cold for the residents. During an interview on 09/04/24 at 1:24 P.M., Resident #173 stated there was a refrigerator at the nursing station, but there was limited space for resident's food and the residents aren't permitted to have appliances in their rooms. During an interview on 09/04/24 at 2:35 P.M., Resident #71 stated she had bottles of soda sitting in her room. She stated the facility doesn't provide a refrigerator to store any items for the residents. During an observation on 09/04/24 at 3:30 P.M., the refrigerator on the 100 hall contained meals, soda and condiments in it. Nothing was labeled or dated. During an interview on 09/04/24 at 3:50 P.M., Dietary Manager (DM) #214 stated the facility doesn't store anything that comes in from the outside, because the facility doesn't know what it is. There are refrigerators on the units but the resident's food wasn't stored in those. During an interview on 09/05/24 at 8:39 A.M., Resident #69 stated he asked the Administrator if there was a refrigerator to put food in and he said yes. He said when he asked the staff they told him there wasn't enough room in the refrigerator for his food. The staff member also told him it was for the staff to use and he had to stop buying food because there isn't enough room to store it. During an interview on 09/05/24 at 8:44 A.M., Resident #90 stated he could have something stored that was cold if there was enough space in the refrigerator. He stated the staff doesn't like the residents to put cold food in the refrigerator. During an interview on 09/05/24 at 8:50 A.M., Resident #43 stated there wasn't a refrigerator for residents to keep food or drinks in. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365877	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Nursing and Rehabilitation Center	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 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the policy titled Storage of Resident Food, undated, stated it is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. Residents have the option of bringing food into the facility or have family or friends bring food into the facility as long as safe storage guidelines are followed to protect the resident and other residents in the facility. Safety for all residents is a priority for food handling, including when residents have their own food brought into the facility. This policy does not infer that residents need to or are required to supplement their nutritional needs, but that food is recognized for its social, psychological and emotional health as well as nutritional and health benefits. The facility recognizes and supports resident's need and right to bring in food from outside sources but still maintain safety and sanitary conditions for storage and consumption. The amount of food brought into the facility will be based on storage availability. The facility will provide properly sealed storage containers as needed. This deficiency represents non-compliance investigated under Complaint Number OH00157418.