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	10/07/2024

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** 43062 Based on observation, staff interview, record review, and facility policy review, the facility failed to treat residents with dignity and respect. This affected two (#70 and #73) out of three residents reviewed. The facility census was 172. Findings include: 1) Review of medical record for Resident #70 revealed an admitted d of [DATE] and expired at the facility with hospice services in place on [DATE]. Diagnoses included, amnesia, malignant neoplasm of bone, chronic hepatitis, essential primary hypertension, chronic kidney disease, hydronephrosis, anemia, gout, vascular dementia, anxiety, gastro-esophageal reflux disease (GERD), and dysphasia. Review of the Minimum Data Set (MDS) assessment for Resident #70, dated [DATE], revealed the resident was severely cognitively impaired. Resident #70 was dependent on staff for activities of daily living (ADLs). Observation of Resident #70 on [DATE] at 9:59 A.M. revealed the resident was seated in a wheelchair at a table in the common area for other residents. Resident #70 was only wearing a hospital type gown that was hanging off his shoulders with part of his upper chest exposed. Resident #70's soiled wheelchair cushion was lying on the floor under the foot pedals of the wheelchair. Resident #70 had an new incontinence brief hanging from one arm of the wheelchair and a pair of pants with a shirt on the other handle. Resident #70 was not wearing any shoes or socks. STNA #206 was seated across from him and entering information on a tablet. Interview with Registered Nurse (RN) #201 verified the resident was seated in the common area with his gown hanging from his shoulder and exposing his chest , the new incontinent brief and clothes hanging from the handles and no shoes or socks in place. RN #201 verified Resident #70's soiled wheelchair cushion was on the floor in front of Resident #70's foot. Observation at the same time, revealed RN #201 picked up the wheelchair cushion identified the food and debris splattered all over the wheelchair cushion and placed the cushion back on the floor. RN #201 indicated she wouldn't want to sit in a common area with only a hospital type gown on, no shoes or socks on and an incontinence brief hanging from the handle. She questioned State tested Nurse Aide (STNA) # 206 why Resident #70 was in the common room area. (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	Interview with STNA #206 on [DATE] at 10:01 A.M., revealed Resident #70 was seated in the common area because he was waiting on shower from the shower aide. STNA #206 stated she placed Resident #70 in the common area to help the shower aide. STNA #206 indicated she would not want to be in common area with an incontinent brief and clothes hanging from the wheelchair; however, it was more convenient for the staff to complete showers this way. 2) Review of the medical records for Resident #73 revealed an admitted [DATE]. Diagnoses included unspecified intellectual disabilities (ID), psychosis, major depressive disorder, encephalopathy, anxiety disorder, schizophrenia, dysphasia, bipolar disorder, hyperlipidemia, and insomnia. Review of the MDS assessment, dated [DATE], revealed Resident #73 had impaired cognition. Resident #73 was dependent on staff for ADLs and supervision for eating. Review of care plans for Resident #73's revealed the resident had behavioral problems including eating non-edible items. The interventions listed included, approach and speak in a calm manner, intervene as necessary to protect the rights and safety of others, and intervene as necessary. Observation of Resident #73 on [DATE] at 9:51 A.M. revealed Resident #73 was walking down the hallway, directly past several staff members with a non-skid sock hanging from his mouth and he was chewing and appeared to be eating the sock. Interview with Registered Nurse (RN) #201 verified Resident #73 had a non-skid sock hanging from his mouth as he walked past several staff members in the hallway. RN #201 stated this was just something Resident #73 does. RN #201 stated Resident #73 should have been redirected by staff regarding the non-skid sock being in his mouth. Review of the facility policy titled, Resident Rights, undated, confirmed the facility policy is to provide Residents with centered care that meets the psychosocial physical and emotional needs and concerns of the residents. The purpose of the policy to is to guide employees in the general principles of dignity and respect of caring for residents. Further review of the policy revealed, the Residents will be treated with dignity and respect related to care needs. This deficiency represents non-compliance investigated under Complaint Number OH00158218 and OH00158074. This is an example of continued non-compliance from the survey dated [DATE].

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43062 Based on record review, staff interview, and facility policy review, the facility failed to ensure a resident's guardian and physician were notified timely following a change in condition. This affected one (#10) out of three residents reviewed. The facility census was 172. Findings include: Review of medical record for Resident #10 revealed the resident was admitted to the facility on [DATE]. Diagnoses included diabetes mellitus, hypertension, squamous cell carcinoma, schizoaffective disorder, chronic obstructive pulmonary disease (COPD), anxiety disorder, conversion disorder, insomnia, dysphasia, bipolar disorder, osteoarthritis, and major depressive disorder. The resident had a guardian on file. Review of the most recent Minimum Data Set (MDS) assessment for Resident #10, dated 07/18/24, revealed the resident mildly cognitively impaired. Resident #10 required supervision for activities of daily living (ADLs). Review of a census record for Resident #149, revealed the resident was moved to Resident #10's room on 09/06/24. Review of medical record for Resident #10, revealed no documented evidence that Resident #10's guardian was notified when Resident #10 received a roommate. Review of a nurse's progress notes for Resident #10 dated 09/23/24 at 10:44 P.M., revealed Resident #10 arrived back to the facility from the hospital and one-on-one (1:1) supervision was initiated and the resident reported a sexual assault. Review of a nurse's progress for Resident #10 dated 09/24/24, revealed the resident remains on 1:1 supervision and the resident's guardian was in to speak with the resident. Review of nurse's progress note for Resident #10 dated 09/25/24 and recorded as a late entry for 09/23/24 revealed Resident #10 approached the nurse around on 09/23/24 around 9:45 A.M. and reported she was going out. The nurse confirmed she did not have an appointment, and Emergency Medical Transport (EMT) arrived at the facility. The EMT reported to the nurse that Resident #10 called 911 herself because her stomach hurt, and she may be pregnant with a fetus. Resident #10 was transferred to the hospital. There was no documented evidence the resident's physician and the guardian was notified. Review of a nurse's progress note for Resident #10 dated 09/26/24 and recorded as a late entry for 09/25/24 at 3:00 P.M., revealed the facility discontinued the 1:1 sitter for Resident #10 for the psychosocial monitoring related to the sexual abuse allegation that occurred on 09/23/24. There was no documented evidence the resident's guardian was notified. Interview with Licensed Practical Nurse (LPN) #331 on 09/26/24 at 8:50 A.M. revealed Resident #10 was no longer ordered to be a 1:1 supervision. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #10's guardian on 09/26/24 at 1:01 P.M., indicated she was upset related to the lack of communication by the facility. Resident #10's guardian stated she was never notified by the facility when Resident #10 received a roommate on 09/06/24 and when the resident was sent to the hospital on 09/23/24. Resident #10's guardian stated she was not aware of the resident going to hospital emergency room (ER) until the ER contacted her for permission to treat Resident #10. Resident #10's Guardian stated she also found out about the new roommate when she visited Resident #10 while at the hospital. Resident #10's guardian stated she was told by the staff that Resident #10 would remain on a 1:1 observation until the guardian could find the resident a new facility. Resident #10's guardian indicated she was not aware of the 1:1 supervision ended for the resident. Observation of Resident #10 on 09/26/24 at 1:27 P.M., revealed the resident was in her room and not on a 1:1 supervision. Interview with LPN #331 at the same time, indicated she was the nurse for Resident #10 and was informed during their morning report that Resident #10 was no longer to be on a 1:1. LPN #331 verified Resident #331 was not on 1:1 observation. Interview with the Director of Nursing (DON) on 09/30/24 at 5:07 A.M. verified there was no documented evidence of Resident #10's guardian being notified when Resident #10 received Resident #140 as a roommate on 09/06/24. The DON verified there was no documented evidence the Guardian was notified when Resident #10 went to theER on [DATE]. Review of the facility policy, Resident Room Change Policy, undated, revealed Social Services will complete the notification of room change and new roommate notification forms. The facility social worker will discuss room changes with both residents and resident representatives and document the discussion. Social Service will make routine visits after a room change to ensure both residents are adjusting positively to the new situation. Review of the facility policy titled, Notification of Change in Condition, undated, revealed the facility must inform the resident, consult with the resident's physician, and notify the resident's representative, authorized family member, or legal guardian where there is a change of condition. The notification of change included, accidents, change in a resident's physical, mental, or psychosocial condition, new treatments, discontinuation of treatments, transfer or discharge, and change of room or roommate assignment.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43062 Based on observation, staff interview, and record review, the facility failed to provide a safe, clean, and homelike environment. This affected four (#10, #128, #138, and #149) out of the five residents reviewed. The facility census was 172. Findings include, 1) Review of medical record for Resident #10 revealed the resident was admitted on [DATE]. Diagnoses included diabetes mellitus, hypertension, squamous cell carcinoma, schizoaffective disorder, chronic obstructive pulmonary disease (COPD), anxiety disorder, conversion disorder, dysphasia, bipolar disorder, osteoarthritis, and major depressive disorder. Review of the most recent Minimum Data Set (MDS) assessment for Resident #10, dated 07/18/24, revealed she was mildly cognitively impaired. Resident #10 required supervision for activities of daily living (ADLs). Observation of Resident #10's on 09/24/24 at 8:50 A.M., revealed the resident was lying in bed. There was an oxygen concentrator across the room with an attached nasal cannula laying across the floor and not on the resident. There was a pair of dirty pants and a soiled incontinence brief with gnats flying around the soiled brief lying on the floor near the end of the nasal cannula. Interview with Licensed Practical Nurse (LPN) #331 on 09/24/24 at 8:50 A.M. verified Resident #10 's oxygen nasal cannula was lying on the floor, a dirty pair of dirty pants and a soiled incontinence brief lying on the with gnats flying around the brief. 2) Record review for Resident #128 revealed he was admitted to the facility on [DATE]. Diagnoses included dementia, polyneuropathy, schizoaffective disorder, COPD, diabetes mellitus (DM) 2, anxiety disorder, and edema. Review of the MDS assessment, dated 07/30/24, revealed Resident #128 had impaired cognition. Resident #128 required supervision for ADLs. Observation of Resident #128's room on 10/01/24 at 12:38 P.M., revealed the resident's bed did not have any sheets on it and the mattress was dirty and the outer lining was shredded with holes in it. There were numerous gnats flying around and crawling on the mattress. There was a 12-inch gap between the mattress and the headboard. There was a metal box hanging from the wall with exposed wiring behind the box. Interview with LPN #525 at the same time verified the condition of Resident #128's bed and the room. LPN #525 stated Resident #128 is incontinent, and his legs wept fluids from a cellulitis infection. 3) Review of medical record for Resident #149 revealed the resident was admitted on [DATE]. Diagnoses included thyroid disorder, schizophrenia, bipolar disorder, anxiety disorder, anemia, dysphasia, dementia, schizoaffective disorder, and essential primary hypertension. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the MDS assessment for Resident #149 on 08/02/24, revealed she was cognitively intact. Resident #149 required supervision for ADLs. Observation of Resident #149's room on 09/30/24 at 12:20 P.M., revealed the toilet was clogged with waste and toilet paper in the bowl and a plunger sitting next to the toilet. There was a window unit air conditioner in place and the thermostat control panel was missing with exposed wires Interview with Resident #149 at the same time, indicated her toilet had been stopped up and she had tried to plunge it several times. Interview with the Administrator on 09/30/24 at 12:24 P.M. verified the window unit air conditioners thermostat panel was missing with exposed wires. The Administrator reported the toilet was working as he attempted to flush the toilet. When the toilet didn't flush, the Administrator reached for the plunger and started using the plunger to get the toilet to flush. The toilet never flushed. 4) Review of medical record for Resident #138 revealed the resident was admitted on [DATE]. Diagnoses included schizophrenia, anxiety disorder, major depressive disorder, COPD, anemia, and pseudobulbar affect. Review of the MDS assessment for Resident #138, dated 08/31/24, revealed she had impaired cognition. Resident #138 required supervision for ADLs. An observation of Resident #138's room on 09/30/24 at 12:27 P.M. revealed the resident's foot board had fallen off the bed and was lying on her floor. Interview with LPN #209 on 09/30/24 at 12:28 P.M., verified the foot board had fallen off Resident #138's bed and was lying on the floor. This deficiency represents non-compliance investigated under Complaint Number OH00158218 and OH00158074. This is an example of continued non-compliance from the survey dated 09/05/24.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43062 Based on observations, staff interviews, and facility policy review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety. This affected one (#68) of the five residents reviewed for dining. The facility census was 172. Findings include: Record review for Resident #68 revealed she was admitted on [DATE]. Diagnoses included anemia, hypothyroidism, hyperlipidemia, major depressive disorder, anxiety, Alzheimer's disease, insomnia, sleep antenna, essential primary hypertension, and dysphasia. Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #68 had impaired cognition. Resident #68 required supervision from staff with eating. Observation of the main dining room on 10/01/24 at 12:39 P.M. revealed State tested Nursing Assistant (STNA) #348 deliver a food tray to Resident #68. STNA #328 removed her N-95 respirator and used her teeth to open a package of ranch dressing for Resident #68. STNA #328 handed the package of ranch dressing to Resident #68, who squeezed the dressing packet onto her salad. Interview with STNA #348 on 10/01/24 at 12:40 P.M. verified she pulled her N-95 respirator down, used her teeth to open a ranch dressing packet then handed the dressing packet to Resident #68 to put on her salad. Review of a facility policy titled Infection Prevention Program undated, revealed residents had a right to reside in a safe environment that promotes health and reduces the risk of acquiring infections.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43062 Based on observations, staff interviews, record review, review of facility policy and review of online resources from the Centers for Disease Control (CDC), the facility failed to provide a safe and sanitary environment. This had the potential to affect all 44 Residents (#128, #129, #130, #131, #132, #133, #134, #135, #136, #137, #138, #139, #140, #141, #142, #143, #144, #145, #146, #147, #148, #149, #150, #151, #152, #153, #154, #155, #156, #157, #158, #159, #160, #161, #162, #163, #164, #165, #166, #167, #168, #169, #170, and #171) who resided on the 200-hall (East). The facility census was 172. Findings include: Review of medical record for Resident #128 revealed the resident was admitted on [DATE]. Diagnoses included dementia, polyneuropathy, schizoaffective disorder, chronic obstructive pulmonary disease (COPD), diabetes mellitus, anxiety disorder, and edema. Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #128 had impaired cognition. Resident #128 required supervision from staff with transfers and ambulation. Review of the care plan revised on 05/08/24 revealed Resident#128 had impaired skin integrity related to incontinence and infection-cellulitis, a behavior problem related to refusing care, being non-compliant with treatments and required an enhanced barrier precaution related to seeping /drainage. Interventions included for staff to intervene with behaviors to protect the rights and safety of others, administer treatments per medical providers orders, utilize EBP with utilization of the appropriate personnel protective equipment (PPE) during high contact care related to chronic seeping of the resident's bilateral lower extremities and the resident was not isolated to his room and allowed to freely move about the facility Review of the physician orders for Resident #128 dated 05/17/24, revealed the resident was ordered to have Enhanced Barrier Precautions (EBP) related to chronic seeping bilateral lower extremities. The resident was ordered to have bilateral legs washed and four-layer compression wraps and tubi-grip applied every three days and as needed (PRN). Orders dated 09/25/24 revealed the resident was ordered Doxycycline (antibiotic) 100 milligrams (mg) twice daily for 10 days for cellulitis infection. Observation of the 200-hall (East) on 09/25/24 at 11:15 A.M., revealed Resident #128 was seated in a portable chair in common area for residents with no socks in place and a large puddle of fluids under the chair. Observation revealed a wet [NAME] steps in the hallway leading from the resident's room to where he was seated. A wet floor sign was observed near Resident #128. There were numerous residents walking in/around the area. Interview with Resident #128's Guardian on 09/26/24 at 1:01 P.M., revealed Resident #128's legs would not be bandaged, and his legs would seep fluid all over the floor and leave puddles of fluid where he walked. Resident #128's Guardian stated Resident #128 had cellulitis infection in his legs and the resident would take the bandages off and let his legs seep everywhere. Resident #128's guardian stated Resident #128 could not sleep in his bed because his bed was broken. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation of the 200-hall (East) on 09/26/24 at 4:49 A.M., revealed Resident #128 walking in the hallway with clear fluids seeping from his legs and a trail of seeping fluids from his room to the common area near the nurse's station. STNA #357 was attempting to clean up the trail of fluids with a bath blanket; however, she was creating more wet footprints from the fluids. STNA #357 indicated Resident #128's legs wept fluids and the resident would leave puddles on the floor and the other residents would walk through the puddles. Observation of the 200-hall (East) on 09/30/24 at 12:15 P.M., revealed wet footprints down the hallway approximately 25 feet ending at Resident #128's room. STNA #205 verified the trail of wet footprints, and the trail ended at Resident #128's room. STNA #205 stated Resident #128 had an infection in his legs, and it caused them to leak puddles on the floor and the other residents had to walks through the puddles. Interview with the Administrator on 09/30/24 at 12:25 P.M. verified Resident #128 was seated in the common area near the nurse's station and his legs were seeping fluid on to the floor and there was a trail of fluid leading to the resident's room. Interview with the Director of Nursing (DON) on 09/30/24 at 5:07 P.M. revealed the staff attempted to keep Resident #128's legs bandaged. The DON stated the facility had tried different types of wraps. The DON stated Resident #128 would unwrap his legs which caused his legs to seep, and the resident would leave puddles on the floor where the resident walked or sat. The DON verified Resident #128 had cellulitis - infection in his legs and they should always be bandaged to prevent the seeping. Review of the facility policy titled, Infection Prevention Program, undated revealed the residents of the facility have the right to reside in a safe environment that promotes health and reduces the risk of acquired infections. Further review of the policy revealed the facility will monitor the occurrences of infection and implement appropriate control measures. Review of online resources from the CDC (https://www.cdc.gov/infection-control/hcp/environmental-control/index.html), titled Guidelines for Environmental Infection Control in Health-Care Facilities and Cleaning Strategies for Spills of Blood and Body Substances, updated July 2019, revealed to keep housekeeping surfaces (e.g., floors, walls, and tabletops) visibly clean on a regular basis and clean up spills promptly using a one-step process and an Environment Protection Agency (EPA)-registered hospital disinfectant/detergent designed for general housekeeping purposes in patient-care areas when uncertainty exists as to the nature of the soil on these surfaces [e.g., blood or body fluid contamination versus routine dust or dirt or uncertainty exists regarding the presence or absence of multi-drug resistant organisms (MDRO) on such surfaces. Prompt removal and surface disinfection of an area contaminated by either blood or body substance are sound infection control practices and Occupational Safety and Health Administration (OSHA) requirements. This deficiency represents non-compliance investigated under Complaint Number OH00158218 and OH00158074.