

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

Printed: 07/18/2026
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 09/02/2025
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 - Immediate jeopardy to resident health or safety 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** Based on review of medical records, interviews with staff, residents, and family, review of video footage from electronic monitoring device, and policy review, the facility failed to provide adequate supervision to prevent two cognitively impaired residents (#49 and #160) from continuing to engage in sexually aggressive behaviors in the female resident's room (#160). This resulted in Immediate Jeopardy and the potential for serious, physical, mental, and/or psychosocial negative outcomes for two residents (#49 and #160) when the facility failed to supervise and intervene to prevent Resident #49 from entering Resident #160's room and engaging in sexual activity. On 04/28/25, Resident #49 entered Resident #160's room numerous times throughout the day. Resident #49 was observed touching Resident #160's breast outside the shirt and kissing her lips. After numerous times of Resident #49 entering and leaving Resident #160's room, the residents were observed engaging in oral sex on each other. At no time was staff observed checking on the residents or redirecting Resident #49 out of Resident #160's room from 9:42 A.M. to 3:28 P.M. At approximately 3:28 P.M., Licensed Practical Nurse (LPN) #491 and Certified Nursing Assistant (CNA) #436 walked into Resident #160's room where they found Resident #160 on her bed with her pants and depends on the ground and Resident #49 standing in front of her. Resident #49 was redirected out of the room. The facility failed to complete an investigation, failed to complete a Self-Reported Incident (SRI), and failed to initiate/update residents' care plans to address the sexually inappropriate behavior. This affected two (#49 and #160) of two residents reviewed for supervision. The facility census was 164. On 08/13/25 at 4:46 P.M., Regional Director of Operations (RDO) #750, the Director of Nursing (DON), and Divisional Director of Clinical Operations (DDCO) #751 were notified Immediate Jeopardy began on 04/28/25 when Resident #49 entered Resident #160's room at 9:42 A.M. and was observed touching her breast and kissing her lips. After numerous times of Resident #49 entering and leaving Resident #160's room, the residents were observed engaging in oral sex on each other. At no time was staff observed checking on the residents or redirecting Resident #49 out of Resident #160's room from 9:42 A.M. to 3:28 P.M. At approximately 3:28 P.M., Licensed LPN #491 and CNA #436 walked into Resident #160's room where they found Resident #160 on her bed with her pants and depends on the ground and Resident #49 standing in front of her. Resident #49 was redirected out of the room. The Immediate Jeopardy was removed on 08/14/25 when the facility implemented following corrective actions: On 04/28/25 at 3:28 P.M., CNA #436 was completing room rounds and went into Resident #160's room. Resident #160 was in bed with her pants to her knees. Resident #49 was in the room with clothes on. On 04/28/25 at 3:45 P.M., the [NAME] Unit Manager (UM) [LPN #406] called Resident #160's daughter and informed her of Resident #49 being in Resident #160's room and Resident #160 having her pants around her knees. On 04/28/25 at 5:30 P.M., the DON and the Administrator called Resident #160's daughter to ask if she could look at the video in the room. The daughter stated she had already looked at it and there was nothing on it. On 08/08/25 at 1:24 P.M., Resident #160's daughter sent a text message to [NAME] UM LPN #406 informing her that she finally looked at the video and Resident #160 had been assaulted several times on 4/28/25 by another resident. On 08/08/25 at 1:26 P.M., (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	[NAME] UM LPN #406 notified the Administrator and the DON of an allegation of resident-to-resident sexual abuse. On 08/08/25 at 1:30 P.M., the DON notified Division Director of Risk Management (DDRM) #725 and RDO #750 of an allegation of resident-to-resident sexual abuse. On 08/08/25 at 1:35 P.M., the Administrator submitted a Self-reported Incident (SRI) with the State Agency (SA). On 08/08/25 at 2:00 P.M., the family of Resident #49, who no longer resides at the facility, was made aware of the allegation of resident-to-resident sexual abuse. Resident #49 was transferred on 08/06/25 per family's request to be closer to family. On 08/08/25 at 2:15 P.M., [NAME] UM LPN #406 called the police to report the allegation of resident-to-resident sexual abuse. On 8/08/25 at 2:25 P.M., the DON called Resident #160's daughter and asked what was on the video. The daughter stated, my mom was being assaulted. The DON requested to see the video. The daughter stated that she couldn't come up today but would meet the DON on 8/09/25 at 1:00 P.M. The daughter refused to have Resident #160 sent to hospital for an examination. On 08/08/25 at 2:30 P.M., [NAME] UM LPN #406 notified Nurse Practitioner (NP) #800 of the allegation of resident-to-resident sexual abuse involving Resident #160. No new orders were given. On 08/08/25 at 2:37 P.M., DDRM #725 notified the current facility of Resident #49 of resident-to-resident sexual abuse allegation. On 08/08/25 at 2:45 P.M., [NAME] UM LPN #406 completed a skin assessment on Resident #160 with no concerns noted. On 08/08/25 at 4:00 P.M., the local Sheriff's Department arrived at the facility and took a report and informed the DON to please call them when Resident #160's daughter arrives on 08/09/25 as they would like to come to the facility and see the video. On 08/09/25 at 2:00 P.M., the DON called Resident #160's daughter to ask about her whereabouts. Resident #160's daughter informed the DON that she would not be able to come to the facility today, but she would try to make it sometime next week. On 08/11/25 at 4:00 P.M., Resident #160 was placed on 1:1 supervision until the physician deems it is not needed and discontinues the order. On 08/13/25 from 5:00 P.M. to 8:00 P.M., the DON interviewed staff regarding knowledge of any residents that have a sexual relationship and or any inappropriate sexual behaviors. Any resident found to be having sexual relations with other residents would be reviewed by the physician and Interdisciplinary Team (IDT) to discuss the risks/benefits of sexual behavior and this would be discussed with the resident's guardian/representative and a plan of care would be developed. There were no other residents that were identified to be having a sexual relationship and there were no additional resident-to-resident sexual occurrences found. The DON reviewed all residents' charts with no findings. On 08/13/25 from 6:00 P.M. to 9:00 P.M., the DON educated 155 staff members on the facility's abuse and neglect policy which included: (a) What constitutes abuse and types of abuse and neglect; (b) Identification of signs and symptoms in residents and staff of potential abuse and abusers; (c) Actions to take when abuse is witnessed, suspected, or alleged; (d) Timely and appropriate reporting of witnessed, suspected, or alleged abuse to all responsible parties per facility policy; (e) Protection of resident while conducting a thorough investigation of alleged abuse; (f) Proper assessment of residents who have been or suspected to be abused; (g) Prevention of future incidents of abuse from occurring; (h) Sexual activity between residents including what constitutes sexual abuse per Centers for Medicare and Medicaid Services (CMS) guidelines and what to do when you identify inappropriate sexual behaviors including reporting to your supervisor, DON, or Administrator and holding a meeting with physicians, IDT and family to develop a plan of care for the resident. Staff were also educated on supervision of residents using the policy titled Unit Supervision with emphasis on rounding and checking on residents every two hours. Staff was educated in person, via OnShift software and via phone calls. On 08/13/25 from 6:00 P.M. to 8:00 P.M., the DON started additional skin checks on all residents and completed interviews with residents who have a BIMS of 13 or higher. On 08/13/25, Minimum Data Set (MDS) Nurse #426 updated Resident #160's care plan to reflect sexual behaviors. On 08/13/25 at 8:30 P.M., the Administrator held an ad hoc Quality Assurance/Performance Improvement (QAPI) meeting to discuss the Immediate Jeopardy and abatement plan, the facility's abuse policy, and the resident-to-resident sexual abuse allegation and unit supervision. Staff present included the Administrator, the DON, the (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	leave the room. LPN #491 explained she educated both residents and completed a head-to-toe assessment on Resident #160 with no negative findings. LPN #491 stated she tried to ensure Resident #160 and Resident #49 were separated the rest of the shift. Interview on 08/14/25 at 1:55 P.M. with UM/LPN #406 revealed LPN #491 reported Resident #49 was found in Resident #160's room. Resident #160 was found with no pants or depends on, sitting on her bed. Resident #49 was fully clothed and asked to leave the room. UM/LPN #406 reported she reached out to Resident #160's daughter and informed her of the incident. UM/LPN #406 stated both residents had progressive dementia and appeared that they didn't know who each other were. UM/LPN #406 stated the previous Administrator at the time of the incident did not feel it was necessary to complete an SRI for the incident. UM/LPN #406 also stated an incident report was not completed. Interview on 08/14/25 at 3:22 P.M. with MD #801 verified Resident #160 had memory loss and some cognitive and behavioral issues. MD #801 reported Resident #49 had vascular dementia and post-traumatic stress disorder (PTSD). MD #801 stated Resident #49 had memory loss as well. MD #801 stated both residents had memory issues and could not state if she felt that either resident could give consent to sexual activity. Interview on 08/14/25 at 3:52 P.M. with CNA #436 reported on 04/28/25 she came onto shift at 3:00 P.M., and Resident #49 and Resident #160 were in the common area watching television. About 15-20 minutes later, CNA #436 walked by, and both residents were gone. CNA #436 stated she saw Resident #160's door was closed to her room, which wasn't unusual, but she had a gut feeling to go in and check. CNA #436 knocked on her door and went in and found Resident #160 on her bed with her pants halfway down her legs, and Resident #49 standing in front of her fully clothed. CNA #436 stated Resident #49 was asked to leave the room. CNA #436 explained Resident #160 became aggressive and started calling her names. CNA #436 reported neither resident was placed on a 1:1. Review of the facility policy titled, Unit Supervision, revealed the policy of the facility was to provide resident centered care that met the psychosocial, physical, and emotional needs and concerns of the residents. Safety was a primary concern for the residents, staff, and visitors. The Unit Supervisor was a licensed nurse with the skills and competency to safely and appropriately monitor and delegate tasks to others and perform duties consistent with safe and effective care and treatment of the assigned residents. Supervision responsibilities were assigned by the DON or designee to provide for the care and treatment of the residents, direct services of on-duty staff, and assume responsibility for a safe environment during the time the nurse was working the shift for the specific unit the nurse was assigned. This deficiency represents non-compliance investigated under Complaint Numbers 1259562 and 2585469.		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of documentation from an employment agency, review of documentation from Board of Executives of Long-Term Services and Supports (BELTSS), interview with Board Administrator at BELTSS, and staff interview, the facility failed to ensure Administrator had a valid Nursing Home Administrator (NHA) license. This had the potential to affect all the residents. The facility census was 164. Interview on 08/05/25 at 10:09 A.M. with Regional Director of Operations (RDO) #750 confirmed the facility had employed interim NHA #630 from 05/12/25 through 06/10/25. RDO #750 stated interim NHA #630 had been hired through an employment agency and provided documentation interim #630 had an active NHA license. Interview on 08/06/25 at 4:15 P.M. with Board Administrator #635 stated BELTSS was notified of a concern about the validity of interim NHA #630's license. Board Administrator #635 stated after an investigation it was determined that interim NHA #630 had used the license number for NHA ##700 to obtain a position as a NHA. Board Administrator #635 stated interim NHA #630 and NHA #700 had similar names but different Social Security Numbers, addresses, and date of birth s. Board Administrator #635 confirmed interim NHA #630 did not have a valid NHA license. Review of the documentation from the employment agency provided to the facility revealed interim NHA #630's date of birth was 10/23/73 and resided in Cincinnati. Review of the documentation revealed interim NHA #630 had used NHA license number 7258. Review of documentation from BELTSS revealed NHA #700 had an active license of number 7258, a date of birth of [DATE] and resided in Englewood. Review of BELTSS documentation revealed interim NHA #630 was registered as an Administrator in Training and did not have an active NHA license. This deficiency represents non-compliance investigated under Complaint Number 2578224.		

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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident has the right to receive notices in a format and a language he or she understands. Based on review of the Resident Council Minutes, and staff and resident interviews, the facility failed to ensure the residents had access to the state and local advocacy organizations. This affected three residents (#117, #59 and #128) and all residents residing on the South and [NAME] units. The census was 164. Review of the monthly Resident Council Minutes from 08/15/24 through 07/07/25 revealed there was no evidence the state or local advocacy group contacts were reviewed at monthly Resident Council meetings. Observation on 08/07/25 at 2:30 P.M. of secured [NAME] and South units revealed no evidence of postings or available documents of state or local advocacy group contacts. Interviews with Residents #128, #59 and #117 during a surveyor led Resident Council Meeting on 08/05/25 at 2:06 P.M. revealed they did not know of any contact information of state or local advocacy groups. The residents stated in monthly Resident Council meetings, the state or local advocacy groups were not reviewed. The residents stated they would like to know the contact information and, in the past, had to ask staff for the contact information, which made them feel uncomfortable due to possible retaliation. Interview on 08/05/25 at 2:44 P.M. the Administrator confirmed the contact information of state or local advocacy groups were not documented on the monthly Resident Council meeting. The Administrator verified the contact information of state or local advocacy groups should be posted and available to residents on the secured units. Interview on 08/05/25 at 2:34 P.M. the Director of Nursing (DON) verified the contact information of state or local advocacy groups were not available on the secured [NAME] and South units.		

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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** Based on observations and staff and resident interviews, the facility failed to ensure a clean, comfortable, and homelike environment. This affected five (Residents #14, #36, #20, #65, and #112) of nine residents reviewed for environment. The facility census was 164.1. Review of the medical record for Resident #14 revealed an admission date of 11/25/24 with medical diagnoses of Parkinson's disease, schizophrenia, bipolar disorder, and hypertension. Review of the medical record for Resident #14 revealed a quarterly Minimum Data Set (MDS) assessment, dated 06/16/25, which indicated Resident #14 was cognitively intact and required supervision with toilet hygiene, bed mobility, and transfers, and partial/moderate staff assistance with bathing. Observation and interview on 08/05/25 at 7:25 A.M. revealed water leaking from the toilet in Resident #14's bathroom onto the bathroom floor, floor in the room outside of bathroom, and to the threshold of the room to the hallway. Resident #14 stated the toilet had been leaking for several weeks and staff were aware. Interview on 08/05/25 at 7:35 A.M. with Housekeeping #609 confirmed the toilet in Resident #14's room was leaking water onto the bathroom floor, floor in the room outside the bathroom, and to the threshold of the room to the hallway. Housekeeping #609 confirmed the toilet had been leaking for &ldquo;a while&rdquo; and stated he would clean up the water right away. 2. Observations of the [NAME] Unit on 08/04/25 at 9:30 A.M. revealed the unit smelled like urine. At 2:06 P.M. the unit still smelled of urine. Observations on 08/06/25 at 7:40 A.M. and 12:02 P.M. the [NAME] Unit still smelled of urine. Observation of 08/07/25 at 9:00 A.M. the [NAME] Unit still smelled of urine. Interview with Housekeeping #602 on 08/07/25 at 9:07 A.M. confirmed the [NAME] unit smelled of urine. 3. Observation of the bathroom for Resident #36 on 08/04/25 at 11:57 A.M. revealed the light was hanging off the medicine cabinet with light socket exposed. The handle going into the bathroom was jiggly and about to fall off the door. Interview and observation of Resident #20's room on 08/04/25 at 12:42 P.M. revealed his room was dark and the lights were burned out in his overhead light. He had no lights in his room. The string to the light was short and the resident couldn't reach it. The resident stated the lights have been burned out for some time now and his string was not long enough for him to reach it. Interview and observation of Resident #65's room on 08/05/25 at 7:36 A.M. revealed the string to his light on the back wall behind his bed was short and the resident could not reach it because he was bed bound. There were gouges out of the wall behind his bed and to the side of it. There were missing hooks off his privacy curtain and the curtain is hanging in that area. The resident stated he doesn't get out of bed, and he isn't able to reach his light to be able to turn his light on and off from his bed (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Riverside Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1390 King Tree Drive Dayton, OH 45405	
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	because the cord wasn't long enough. Interview with the Maintenance Director #499 on 08/07/25 at 2:57 P.M. toured the above-mentioned rooms and confirmed the problems in the rooms. 4. Review of the medical record for Resident #112 revealed an admission date of 02/19/24. Diagnoses included dementia, anxiety disorder, and cerebrovascular accident. Review of the MDS assessment dated [DATE] revealed Resident #112 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of nine. This resident was assessed to require setup with eating, substantial assistance with toileting, bathing, and dressing, and supervision with transfers. Observation on 08/04/25 at 1:38 P.M. revealed five gashes about 12 inches in length behind the headboard of Resident #112's bed. Interview on 08/07/25 at 9:10 A.M. with Maintenance Director #499 verified the gashes behind the headboard of Resident #112's bed. This deficiency represents non-compliance investigated under Complaint Numbers 1259570 and 2573764.		

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on review of the Resident Council Minutes, staff and resident interviews, and policy review, the facility failed to ensure concerns were addressed in a timely manner or resolved. This affected three residents (#117, #59 and #128) of three residents reviewed for Resident Council Meetings. The census was 164. Review of the monthly Resident Council Minutes from 08/15/24 through 07/07/25 revealed the following concerns: 08/15/24 missing clothing, multiple food concerns by individual residents.10/07/24 call light response, missing clothing.11/18/24 multiple food concerns by multiple residents.12/10/24 multiple food concerns by multiple residents.03/03/25 food condiments missing, multiple food concerns by multiple residents, missing clothing.04/07/25 missing clothing, call light response time.05/12/25 missing clothing concerns by multiple residents, multiple food concerns by multiple residents.06/02/25 multiple food concerns by multiple residents, missing clothing.07/07/25 food condiments, multiple food concerns by multiple residents, missing clothing. Review of Grievance Logs revealed:September 2024 Log had no follow up on food concerns to the August meeting.November 2024 Log had no follow up to the call light response and missing clothing to the October meeting.December 20 Log had no follow up on food concerns to the November meeting.January 2025 Log had no follow up on food concerns to the December meeting.April 2025 Log had no follow up on food condiments missing and multiple food concerns by multiple residents to the March meeting. May 2025 Log had no follow up on call light response time to the April meeting.June 2025 Log had no follow up on missing clothing concerns by multiple residents, multiple food concerns by multiple residents to the May meeting.July 2025 Log had no follow up on multiple food concerns by multiple residents, missing clothing to the June 2025 meeting. Interview with Residents #128, #59, and #117 during a surveyor led Resident Council Meeting on 08/05/25 at 2:06 P.M. revealed the residents didn't feel like complaints were getting addressed in a timely manner by the administration. They revealed the concerns of food service, food condiments, and missing clothing had been going on for months with no resolution. The concerns were not just repeated by the same residents at each of the meetings but by multiple residents. The call lights are not being answered in a timely manner which has been going on for months with no resolution. The residents stated they felt like they were not being heard by the administration regarding their concerns regarding the food services and laundry services. Interview with Activities Director (AD) #418 on 08/05/25 at 11:50 A.M. verified the residents' concerns discussed in the meeting were verbally relayed to the respective department heads and a resolution was not discussed at the next resident council meeting. She stated she had no evidence the concerns had been addressed by the department head to resolve the residents' issues. Interview on 08/05/25 at 2:44 P.M. the Administrator confirmed there were months in which residents' concerns resolutions were not addressed and listed on the grievance log. The Administrator stated the concerns from Resident Council should be listed in the Grievance Log to show the residents' concerns have been resolved. Review of the policy titled, Resident Council, undated, revealed the Activity Director is designated the liaison to the Resident Council and provides assistance to the council such as correspondence. The facility documents the resident council meeting on the Resident Council Minutes form. Any concerns at the meeting should be documented on the Concern Form and distributed to the appropriate Department Head. The facility follows the Resident Grievance Procedure for any concerns identified.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of medical records and staff interviews, the facility failed to timely report an allegation of resident to resident sexual abuse to the State Agency (SA). This affected two (#49 and #160) residents of ten reviewed for abuse. The facility census was 164. Review of the medical record for Resident #160 revealed an admission date of 06/01/22. Diagnoses included chronic obstructive pulmonary disease (COPD), major depressive disorder, dementia, and anxiety disorder. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #160 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of four. This resident was assessed to require setup with eating, supervision with toileting and transfers, and partial assistance with dressing. Review of the care plan for Resident #160 revealed she was not care planned for sexually inappropriate behaviors. Review of the progress note dated 04/28/25 at 4:25 P.M. revealed Licensed Practical Nurse (LPN) #491 knocked on Resident #160's room with no answer. LPN #491 entered the room and observed Resident #160 on her bed with her pants and underwear on the ground. Resident #49 was standing in front of her fully clothed. LPN #491 educated Resident #49 that he was not supposed to be in her room and walked him to the common area. A skin assessment was completed on Resident #160 with no negative findings noted. Resident #160 was assisted with getting dressed and taken to the common area. Review of the progress note dated 05/01/25 at 9:58 A.M. revealed Social Services Director (SSD) #447 documented Resident #160 was allegedly attempting to solicit Resident #49 to physically engage. Guardian was notified. Due to cognition concerns, facility recognized resident rights to consensual contact, but due to resident cognition/memory concerns, interventions were put into place. Social services will continue to follow up as needed. Review of the medical record for Resident #49 revealed an admission date of 03/21/23. Diagnoses included dementia, mood disorder, post-traumatic stress disorder (PTSD), and major depressive disorder. Review of the quarterly MDS assessment dated [DATE] revealed Resident #49 had severe cognitive impairment as evidenced by a BIMS score of seven. This resident was assessed to require setup with eating, supervision with toileting, dressing, and transfers. Review of the care plan dated 07/17/25 revealed Resident #49 was not care planned for inappropriate sexual behaviors. Review of the progress note dated 05/01/25 at 10:05 A.M. revealed Social Services Director (SSD) #447 documented Resident #49 was allegedly attempting to solicit Resident #160 to physically engage. Guardian was notified. Due to cognition concerns, facility recognized resident rights to consensual contact, but due to resident cognition/memory concerns, interventions were put into place. Review of the facility investigation revealed the facility did not provide proof of completing an investigation for possible sexual abuse. Interview on 08/06/25 at 11:53 A.M. with the Director of Nursing (DON) revealed Resident #49 was found in Resident #160's room on 04/28/25 after 3:00 P.M. by LPN #491 and Certified Nurse Aide (CNA) #436. The DON stated Resident #160 was found on her bed with no pants or depends on, and Resident #49 was standing at the end of the bed. The DON explained Resident #49 could not recall why he was in the room. The DON stated the facility completed an investigation but failed to give it this surveyor. The DON also stated both residents had very low cognition. The DON reported the daughter of Resident #160 reported that she didn't see anything on the camera, so they did not report it to the Ohio Department of Health (ODH). Interview on 08/14/25 at 1:55 P.M. with Unit Manager (UM)/LPN #406 revealed LPN #491 reported Resident #49 was found in Resident #160's room. Resident #160 was found with no pants or depends on sitting on her bed. Resident #49 was fully clothed and asked to leave the room. UM/LPN #406 reported she reached out to Resident #160's daughter and informed her of the incident. UM/LPN #406 stated both residents had progressive dementia and appeared that they didn't know who each other were. UM/LPN #406 stated the previous Administrator at the time of the incident did not feel it was necessary to complete a SRI (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for the incident. UM/LPN #406 also stated an incident report was not completed. This deficiency represents non-compliance investigated under Complaint Numbers 1259568 and 1259561.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of medical records and staff interviews, the facility failed to timely investigate an allegation of resident to resident sexual abuse. This affected two (#49 and #160) residents of ten reviewed for abuse. The facility census was 164. Review of the medical record for Resident #160 revealed an admission date of 06/01/22. Diagnoses included chronic obstructive pulmonary disease (COPD), major depressive disorder, dementia, and anxiety disorder. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #160 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of four. This resident was assessed to require setup with eating, supervision with toileting and transfers, and partial assistance with dressing. Review of the care plan for Resident #160 revealed she was not care planned for sexually inappropriate behaviors. Review of the progress note dated 04/28/25 at 4:25 P.M. revealed Licensed Practical Nurse (LPN) #491 knocked on Resident #160's room with no answer. LPN #491 entered the room and observed Resident #160 on her bed with her pants and underwear on the ground. Resident #49 was standing in front of her fully clothed. LPN #491 educated Resident #49 that he was not supposed to be in her room and walked him to the common area. A skin assessment was completed on Resident #160 with no negative findings noted. Resident #160 was assisted with getting dressed and taken to the common area. Review of the progress note dated 05/01/25 at 9:58 A.M. revealed Social Services Director (SSD) #447 documented Resident #160 was allegedly attempting to solicit Resident #49 to physically engage. Guardian was notified. Due to cognition concerns, facility recognized resident rights to consensual contact, but due to resident cognition/memory concerns, interventions were put into place. Social services will continue to follow up as needed. Review of the medical record for Resident #49 revealed an admission date of 03/21/23. Diagnoses included dementia, mood disorder, post-traumatic stress disorder (PTSD), and major depressive disorder. Review of the MDS assessment dated [DATE] revealed Resident #49 had severe cognitive impairment as evidenced by a BIMS score of seven. This resident was assessed to require setup with eating, supervision with toileting, dressing, and transfers. Review of the care plan dated 07/17/25 revealed Resident #49 was not care planned for inappropriate sexual behaviors. Review of the progress note dated 05/01/25 at 10:05 A.M. revealed Social Services Director (SSD) #447 documented Resident #49 was allegedly attempting to solicit Resident #160 to physically engage. Guardian was notified. Due to cognition concerns, facility recognized resident rights to consensual contact, but due to resident cognition/memory concerns, interventions were put into place. Review of the facility investigation revealed the facility did not provide proof of completing an investigation for possible sexual abuse. Interview on 08/06/25 at 11:53 A.M. with the Director of Nursing (DON) reported Resident #49 was found in Resident #160's room on 04/28/25 after 3:00 P.M. by LPN #491 and Certified Nurse Aide (CNA) #436. The DON stated Resident #160 was found on her bed with no pants or depends on, and Resident #49 was standing at the end of the bed. The DON explained Resident #49 could not recall why he was in the room. The DON stated the facility completed an investigation but failed to give it this surveyor. The DON also stated both residents had very low cognition. The DON reported the daughter of Resident #160 reported that she didn't see anything on the camera, so they did not report it to the Ohio Department of Health (ODH). Interview on 08/14/25 at 1:55 P.M. with Unit Manager (UM)/LPN #406 revealed LPN #491 reported Resident #49 was found in Resident #160's room. Resident #160 was found with no pants or depends on sitting on her bed. Resident #49 was fully clothed and asked to leave the room. UM/LPN #406 reported she reached out to Resident #160's daughter and informed her of the incident. UM/LPN #406 stated both residents had progressive dementia and appeared that they didn't know who each other were. UM/LPN #406 stated the previous Administrator at the time of the incident did not feel it was necessary to complete a SRI for the incident. UM/LPN #406 also stated an incident report was not completed. This deficiency represents non-compliance investigated under Complaint Numbers 1259568 and 1259561.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on medical record review, staff interview, and policy review, the facility failed to ensure a Pre-admission Screening and Resident Review (PASARR) was completed accurately upon admission. This affected one (#07) resident out of two residents reviewed for PASARR. The facility census was 164. Review of the medical record for Resident #07 revealed an admission date of 10/18/24 with medical diagnoses of diabetes mellitus, hypertension, post traumatic stress disorder (PTSD), bipolar disorder, and chronic kidney disease. Review of the medical record for Resident #07 revealed a quarterly Minimum Data Set (MDS) assessment, dated 06/09/25, which indicated Resident #07 was cognitively intact and required partial/moderate staff assistance with toilet hygiene, supervision with bed mobility and transfers, and set-up assistance with eating and bathing. Review of the medical record for Resident #07 revealed a PASARR dated 10/10/24 which revealed a diagnosis of panic or other severe anxiety disorder was documented. Review of the PASARR revealed no other mental health diagnoses were indicated. Review of PASARR notice dated 10/10/24 revealed there were no indications of serious mental health illness and/or developmental disability. Interview on 08/07/25 at 1:32 P.M. with the Administrator stated the Social Service department are to review all resident PASARRs upon admission to ensure all mental health medical diagnoses were included. The Administrator confirmed the PASARR for Resident #07 did not have documentation to support bipolar disorder. Review of the facility policy titled, Pre-admission Screening and Resident Review, stated a PASARR is a mandate of Omnibus Budget Reconciliation Act (OBRA) 1987 Nursing Home Reform Act while requires states to identify and evaluate all individuals admitted to Medicaid certified nursing facilities for evidence of Severe Mental Illness (SMI), Intellectual or Development Disabilities (ID/DD) or related condition to ensure needs are met in most appropriate setting. This prohibits nursing facilities from admitting or retaining an individual with SMI or ID/DD unless the individual requires level of services of a nursing facility (NF), receives adequate services to meet needs and is in the least restrictive setting. The policy stated all individuals must be screened for indications of serious mental illness and ID/DD unless they meet the requirements for a hospital discharge exemption regardless of pay type. The policy stated any new admission with inaccurate information (clean Level 1 and needs Level 2) will have a Resident Review initiated immediately by the social service or designee as assigned by the Executive Director.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interviews, and policy review, the facility failed to develop comprehensive care plans in a timely manner. This affected two (Residents #160 and #49) of 32 residents sampled for care plans. The census was 165. 1. Review of the medical record for Resident #160 revealed an admission date of 06/01/22. Diagnoses included chronic obstructive pulmonary disease (COPD), major depressive disorder, dementia, and anxiety disorder. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #160 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of four. This resident was assessed to require setup with eating, supervision with toileting and transfers, and partial assistance with dressing. Review of the care plan for Resident #160 revealed she was not care planned for sexually inappropriate behaviors. Review of the progress note dated 04/28/25 at 4:25 P.M. revealed Licensed Practical Nurse (LPN) #491 knocked on Resident #160's room with no answer. LPN #491 entered the room and observed Resident #160 on her bed with her pants and underwear on the ground. Resident #49 was standing in front of her fully clothed. LPN #491 educated Resident #49 that he was not supposed to be in her room and walked him to the common area. A skin assessment was completed on Resident #160 with no negative findings noted. Resident #160 was assisted with getting dressed and taken to the common area. Review of the progress note dated 05/01/25 at 9:58 A.M. revealed Social Services Director (SSD) #447 documented Resident #160 was allegedly attempting to solicit Resident #49 to physically engage. Guardian was notified. Due to cognition concerns, facility recognized resident rights to consensual contact, but due to resident cognition/memory concerns, interventions were put into place. Social services will continue to follow up as needed. Interview on 08/07/25 10:26 AM with MDS Nurse #426 verified Resident #49 was not care planned for inappropriate sexual behaviors. 2. Review of the medical record for Resident #49 revealed an admission date of 03/21/23. Diagnoses included dementia, mood disorder, post-traumatic stress disorder (PTSD), and major depressive disorder. Review of the MDS assessment dated [DATE] revealed Resident #49 had severe cognitive impairment as evidenced by a BIMS score of seven. This resident was assessed to require setup with eating, supervision with toileting, dressing, and transfers. Review of the care plan dated 07/17/25 revealed Resident #49 was not care planned for inappropriate sexual behaviors. Review of the progress note dated 05/01/25 at 10:05 A.M. revealed Social Services Director (SSD) (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#447 documented Resident #49 was allegedly attempting to solicit Resident #160 to physically engage. Guardian was notified. Due to cognition concerns, facility recognized resident rights to consensual contact, but due to resident cognition/memory concerns, interventions were put into place. Review of the facility investigation revealed the facility did not provide proof of completing an investigation for possible sexual abuse. Interview on 08/06/25 at 11:53 A.M. with the Director of Nursing (DON) reported Resident #49 was found in Resident #160's room on 04/28/25 after 3:00 P.M. by LPN #491 and Certified Nurse Aide (CNA) #436. The DON stated Resident #160 was found on her bed with no pants or depends on, and Resident #49 was standing at the end of the bed. The DON explained Resident #49 could not recall why he was in the room. The DON stated the facility completed an investigation but failed to give it this surveyor. The DON also stated both residents had very low cognition. The DON reported the daughter of Resident #160 reported that she didn't see anything on the camera, so they did not report it to the Ohio Department of Health (ODH). Interview on 08/07/25 10:24 AM with MDS Nurse #426 verified there was no care plan for Resident #160 for inappropriate sexual behaviors. Interview on 08/14/25 at 1:55 P.M. with Unit Manager (UM)/LPN #406 revealed LPN #491 reported Resident #49 was found in Resident #160's room. Resident #160 was found with no pants or depends on sitting on her bed. Resident #49 was fully clothed and asked to leave the room. UM/LPN #406 reported she reached out to Resident #160's daughter and informed her of the incident. UM/LPN #406 stated both residents had progressive dementia and appeared that they didn't know who each other were. UM/LPN #406 stated the previous Administrator at the time of the incident did not feel it was necessary to complete a SRI for the incident. UM/LPN #406 also stated an incident report was not completed. Review of the policy titled Plan of Care Overview not dated, 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 is a primary concern for our residents, staff and visitors. The purpose of the policy is to provide guidance to the facility to support the inclusion of the resident or resident representative in all aspects of person-centered care planning and that this planning includes the provision of services to enable the resident to live with dignity and supports the resident's goals, choices, and preferences including, but not limited to, goals related to the their daily routines and goals to potentially return to a community setting.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical review, staff interview, and policy review, the facility failed to monitor a resident's weight as ordered. This affected one (#01) resident out of four residents reviewed for nutritional status. The facility census was 164. Review of the medical record for Resident #01 revealed an admission date of 07/09/19 with medical diagnoses of left hemiplegia, chronic obstructive pulmonary disease, left above the knee amputation (AKA), hypertensive heart and chronic kidney disease. Review of the medical record revealed Resident #01 had discharged to the hospital on [DATE] and readmitted to the facility 07/08/25. Review of the medical record for Resident #01 revealed a quarterly Minimum Data Set (MDS) assessment, dated 07/18/25, which indicated Resident #01 was cognitively intact and was dependent upon staff for toilet hygiene, bathing, and bed mobility. Review of the MDS revealed Resident #01 did not transfer and did not indicate any weight loss. Review of the medical record for Resident #01 revealed a physician order dated 07/16/25 for weight to be obtained for four weeks upon admission and an order dated 08/03/25 for monthly weights. Review of the medical record for Resident #01 revealed no documentation to support the facility obtained weights 07/16/25, 07/23/25, 07/30/25, and 08/03/25. Review of the medical record revealed the last weight documented was on 06/20/25 at 158 pounds. Review of the medical record for Resident #01 revealed a weight entry note dated 08/03/25 at 12:14 P.M. which stated, unable to obtain weight. Interview on 08/07/25 at 9:26 A.M. with Dietician #710 stated Resident #01 was at risk for weight loss due to multiple medical conditions and pressure ulcers. Dietician #710 stated Resident #01's weights were not obtained in July or August 2023 due to the Hoyer (mechanical) lift weight broken and staff did not have a way to weight Resident #01. Review of the facility policy titled, Resident Height and Weight, stated staff are to obtain weekly weight times four weeks for baseline and for stable residents will be weighted monthly thereafter, unless physician or diagnosis indicates otherwise		

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 09/02/2025
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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and policy review, the facility failed to ensure enteral feeding supplies were replaced according to professional standards. This affected one (Resident #11) of two residents sampled for enteral feedings. The census was 164. Review of the medical record revealed Resident #11 was admitted to the facility on [DATE]. Diagnoses included Parkinson's disease, unspecified major depressive disorder, unspecified moderate dementia with psychotic disturbance, and generalized anxiety disorder. Review of the Minimum Data Set (MDS) dated [DATE] revealed Resident #11 had severely impaired dementia, had self-directed behaviors, did not wander, and did not reject care. Review of the care plan dated 02/24/23 revealed Resident #11 had g-tube status. Interventions included administer medications via g-tube per orders, administer flushes as per protocol, enhanced barrier precautions, check for placement and residuals, and provide tube feeding as ordered. Review of the medical record revealed Resident #11 had physician orders dated 07/27/25 for Jevity 1.5 at 70 milliliters (ml) per hour for eight hours nocturnally from 9:00 P.M. to 5:00 A.M. for a total of 560 ml's per eight hours daily. Observation on 08/07/25 at 2:10 P.M. revealed a Kangaroo pump bag was hanging at bedside and contained a brown liquid that was labeled Jevity 1.5 and was dated 08/05/25. Interview on 08/07/25 at 2:34 P.M. Licensed Practical Nurse (LPN) #434 verified the tube feeding bag hanging at Resident #11's bedside was dated 08/05/25. LPN #434 stated unused tube feeding solution should be discarded 24-hours after opening. Review of policy titled, Enteral General Nutritional (tube feeding) Guidelines, not dated, revealed staff changed syringes, tubing, and bottles used for tube feeding daily and labeled and dated items.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on medical record review, Nurse Practitioner (NP) interview, and policy review, the facility failed to administer medication as ordered which resulted in a significant medication error. This affected one (#02) resident out four residents reviewed for medication administration. The facility census was 164. Review of the medical record for Resident #02 revealed an admission date of 02/09/23 with medical diagnoses of right hemiplegia, chronic obstructive pulmonary disease, end stage renal disease, dependence on dialysis, and bipolar disorder. Review of the medical record for Resident #02 revealed a Minimum Data Set (MDS) assessment, dated 07/07/25, which indicated Resident #02 was cognitively intact and was dependent upon staff for toilet hygiene, showers/bathes, transfers and bed mobility. Review of the medical record for Resident #02 revealed a physician order dated 11/30/24 for Midodrine (hypotension medication) oral tablet 2.5 milligram (mg) one tablet by mouth every eight hours as needed for hypotension. Hold if systolic blood pressure (SBP) is greater than 110 and administer if SBP is less than 110. Review of the medical record for Resident #02 revealed a blood pressure reading on 06/03/25 of 97 (SBP)/50 diastolic blood pressure (DPB) milliliters in mercury (mmHg). Review of the medical record revealed pre-dialysis assessments on 07/24/25 with a documented blood pressure of 105/78 mmHg, on 07/31/25 with documented blood pressure of 106/64 mmHg, and on 08/05/25 with a documented blood pressure of 104/67 mmHg. Review of the medical record for Resident #02 revealed the Medication Administration Records (MAR) for June, July and August 2025 did not have documentation to support Midodrine was administered on 06/03/25, 07/24/25, 07/31/25, and 08/05/25. Interview on 08/07/25 at 10:23 A.M. with NP #800 stated the order was supposed to be entered to administer Midodrine 2.5 mg one tablet every eight hours for hypotension and to hold if SBP is greater than 110 and to administer if SBP less than 110. NP #800 stated Resident #02 should have her blood pressure checked three times per day for the facility to monitor her for possible Midodrine administration. NP #800 also stated the facility staff should have administered Midodrine as ordered prior to dialysis. NP #800 confirmed the facility had not administered Midodrine as ordered on 06/03/25, 07/24/25, 07/31/25, and 08/05/25. Review of the facility policy titled, Medication Administration, revealed the facility is to provide resident centered care the meets the psychosocial, physician, and emotional needs and concerns of the residents. The policy continued to state staff are to administer medication only as prescribed by the provider. This deficiency represents non-compliance investigated under Complaint Number 1259566.		