STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366130	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Landing Nursing and Rehabilitation	856 South Riverside Drive McConnelsville, OH 43756

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** 47985 Based on observation, record review, facility policy review and interview, the facility failed to provide care in a dignified manner for Resident #3 related to the use of a urinary catheter. This affected one resident (#3) of two residents reviewed for catheters. The facility census was 46. Findings included: Record review revealed Resident #3 admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, hypertensive heart and chronic kidney disease with heart failure, type II diabetes, and neuromuscular dysfunction of bladder. Review of the resident's physician's orders revealed an order (dated 03/18/23) for Resident #3 to monitor and maintain 16 French 10 cubic centimeter (cc) indwelling catheter related to neurogenic bladder. On 04/23/24 at 8:45 A.M. Resident #3 was observed laying in bed and his urinary catheter bag was hanging from a lower bar of the bed, uncovered and half full of yellow urine which was visible from the hallway. Interview with Resident #3 at the time of the observation revealed it was concerning to him the catheter bag was not covered because it was supposed to be placed in a black bag. The resident stated staff only used the black bag when he was in his wheelchair. Resident #3 stated it was embarrassing to have his catheter bag uncovered. Observation on 04/24/24 at 9:43 A.M. revealed Resident #3 was resting in his bed with his catheter bag hanging from a lower bar of the bed, uncovered and with a small amount of yellow urine visible from the hallway. On 04/29/24 at 8:27 A.M. Resident #3 was observed resting in bed with his catheter bag hanging from a lower bar of the bed, uncovered and half full of yellow urine and visible from the hallway. State tested Nursing Assistant (STNA) #332 confirmed Resident #3 did not have a dignity cover on his catheter bag at that time. Observation of 05/01/24 at 8:51 A.M. revealed Resident #3 resting in bed, his catheter was uncovered, half full of yellow urine, and visible from the hallway. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366130	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/07/2024
NAME OF PROVIDER OR SUPPLIER Riverside Landing Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 856 South Riverside Drive McConnelsville, OH 43756	

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an undated policy titled Foley Catheter Care revealed staff should place the place Foley catheter drainage bag inside of a Foley catheter privacy bag.

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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 - Few	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** 47985 Based on observation, record review, facility policy review and interview, the facility failed to ensure residents were provided a clean, comfortable and homelike environment. This affected three residents (#3, #17, and #23) of three residents reviewed for environment. The facility census was 46. Findings included: 1. Record review revealed Resident #3 admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, hypertensive heart and chronic kidney disease with heart failure, type II diabetes, and neuromuscular dysfunction of bladder. On 04/23/24 at 8:40 A.M. interview with Resident #3 revealed concerns related to the condition of his room. The resident revealed he could not recall his floors being stripped or waxed since he had been in the room and thought the floors looked dirty and scuffed up. Observation of the floors at the time of the interview revealed the floors had several black scuffs from Resident #3's bedside to the doorway along with small amounts of debris on the floor and dark stains. On 04/30/24 at 4:24 P.M. during a tour with Maintenance Director (MD) #358, MD #358 confirmed Resident #3's floors in his room needed to be cleaned, stripped and waxed. Interview on 04/30/24 at 4:41 P.M. with Housekeeping Director #305 revealed due to short staffing, the facility had not been able to keep up with stripping and waxing floors but stated they had been working on getting caught up. Review of a policy titled Housekeeping Policy/Procedure dated 12/28/13 revealed the facility should be maintained and cleaned to meet a homelike environment for the residents. 2. Record review revealed Resident #23 admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, acute respiratory failure with hypoxia, hemiplegia, and depression. Observation on 04/22/24 at 11:46 A.M. revealed a crack in the floor under Resident #23's bed filled with a large amount of dark brown and black unidentifiable substance. On 04/30/24 at 4:24 P.M. during a tour with Maintenance Director (MD) #358, MD #358 confirmed the flooring in Resident #23's room was separating and accumulating a dark brown and black substance. Interview on 04/30/24 at 4:41 P.M. with Housekeeping Director #305 revealed due to short staffing, the facility had not been able to keep up with stripping and waxing floors but stated they had been working on getting caught up. Review of a policy titled Housekeeping Policy/Procedure dated 12/28/13 revealed the facility should be maintained and cleaned to meet a homelike environment for the residents. (continued on next page)

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Riverside Landing Nursing and Rehabilitation	856 South Riverside Drive McConnelsville, OH 43756

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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 - Few	3. Record review revealed Resident #17 admitted to the facility on [DATE] with diagnoses including senile degeneration of brain, dementia with behaviors, type II diabetes, and osteoarthritis. Observations made on 04/30/24 at 4:24 P.M. during a tour with Maintenance Director (MD) #358 revealed Resident #17's room had a faux leather recliner with the top layer of fabric peeling off scattered across the chair. MD #358 confirmed Resident #17's recliner was in disrepair and did not make the room feel home-like. Review of a policy titled Housekeeping Policy/Procedure dated 12/28/13 revealed the facility should be maintained and cleaned to meet a homelike environment for the residents.

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985 Based on record review, facility self-reported incident (SRI) review, policy review and interview, the facility failed to ensure residents were free from abuse. This affected five residents (#2, #6, #17, #20, and #21) of seven residents reviewed for abuse. The facility census was 46. Findings included: 1. Record review revealed Resident #2 admitted to the facility on [DATE] with diagnoses including traumatic hemorrhage of cerebrum, spastic hemiplegia affecting left nondominant side, type II diabetes, bipolar disorder, panic disorder, and anxiety disorder. Review of a personal witness statement by Licensed Practical Nurse (LPN) #328 dated 12/14/23 revealed LPN #328 was sitting in the nurse's station charting when she heard screaming from the dining room. She went to the dining room, and Resident #2 stated she had screamed due to another resident slapping her in the mouth, there was no swelling or redness noted. LPN #328 stated another male resident was in the dining area and witnessed Resident #2 getting slapped. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 had mild cognitive impairment, had physical and verbal behaviors daily, and required maximum assistance for bed mobility and transfers. Review of SRI tracking number 246210 dated 04/10/24 revealed a staff member observed a male resident [Resident #31] grabbing Resident #2's breast. Resident #2 had denied incident occurred. Review of a witness statement from Activity Director #363 dated 04/10/24 revealed she witnessed a male resident [Resident #31] inappropriately touch a female resident [Resident #2], immediately separated the residents, and reported the incident to the Administrator. Interview on 04/24/24 at 3:31 P.M. with the Administrator confirmed a male resident [Resident #31] grabbed Resident #2. Interview on 04/25/24 at 8:49 A.M. with Resident #2 revealed she recalled a male resident touching her inappropriately in the beginning of April. Resident #2 stated the male still resides in the facility, and staff did not do anything to keep the incident from reoccurring. Resident #2 stated the incident made her uncomfortable, sad, and made her feel unsafe. Resident #2 stated she does see the male resident, and he tries to talk to her, but she tells him to leave her alone. 2. Record review revealed Resident #6 admitted to the facility on [DATE] with diagnoses including dementia, chronic pulmonary obstructive disease, hypertension, anxiety disorder, major depressive disorder, and mild cognitive impairment. Review of the quarterly MDS assessment completed on 03/23/24 revealed Resident #6 had severely impaired cognition and required maximum to dependent assistance from staff for activities of daily living. (continued on next page)

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a progress note dated 03/06/24 at 4:47 P.M. by the Administrator revealed Resident #6's family and nurse practitioner were made aware of resident-to-resident contact. Review of a progress note dated 03/06/24 at 7:36 P.M. by Licensed Practical Nurse (LPN) #361 revealed Resident #6 had no skin issues noted. Review of SRI tracking number 244923 completed on 03/06/24 revealed a male resident [Resident #23] touched Resident #6's breast. The facility determined sexual abuse was unsubstantiated due to no harm occurring to Resident #6 since she was cognitively impaired. Review of a witness statement completed by the Administrator and witnessed by Social Services Designee (SSD) #347 revealed the Administrator interviewed Resident #23 who admitted to touching the breasts of two differed residents, including Resident #6. Review of a witness statement by the Administrator and witnessed by SSD #347 dated 03/06/24 revealed Resident #6 was interviewed and did not recall the incident, did not appear to be in any distress or anguish, and had a smile on her face. Review of a progress note from 03/07/24 at 12:21 P.M. by SSD #347 revealed a follow up was completed with Resident #6 who was pleasantly confused per baseline, did not demonstrate fear or behaviors that would indicate mental anguish. Interview on 04/25/24 at 3:17 P.M. with SSD #347 revealed if Resident #6 was alert and oriented, using reasonable person concept, she believes Resident #6 would be upset. SSD #347 stated there were no interventions in place to prevent incident from reoccurring, but the staff do try to redirect Resident #23 approach Resident #6. Interview on 04/29/24 at 3:52 P.M. with Resident #6's representative (RP) #101 revealed she was notified Resident #6 was okay, but someone had touched her breast. RP stated she told the facility to keep the other resident away from Resident #6, and if she was aware of what happened, Resident #6 would smack the other resident and tell him to get away. RP #101 stated Resident #6 was a Christian, was married to one man and would be upset if she knew what occurred. Interview on 04/30/24 at 8:43 A.M. with Administrator revealed Resident #23's inappropriate behaviors towards female residents initially began in February 2024. Administrator confirmed the intervention for the incident on 03/06/24 was to implement 15-minute checks and confirmed on 03/08/24 15 minute-checks were not completed between 7 A.M. and 2 P.M. The Administrator confirmed 15-minute checks stopped on 03/11/24. Interview on 05/01/24 at 8:25 A.M. with State tested Nursing Assistant (STNA) #351 revealed she was aware of an incident where Resident #23 attempted to touch Resident #6's breast, but it was reported. STNA #351 stated Resident #23 is alert and oriented but will pretend he doesn't know what happened and increased supervision should have been started sooner than it did. 3. Record review revealed Resident #17 admitted to the facility on [DATE] with diagnoses including senile degeneration of the brain, dementia with behaviors, major depressive disorder, and anxiety disorder. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Riverside Landing Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 856 South Riverside Drive McConnelsville, OH 43756	

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the quarterly MDS assessment completed on 02/05/24 revealed Resident #17 had severely impaired cognitive function, had delusions, physical behaviors four to six days a week, verbal behaviors one to three days a week, wandered daily, and required maximum assist to dependent assistance from staff for activities of daily living (ADL). Review of a progress note dated 04/09/24 at 7:15 P.M. by LPN #361 revealed male resident [Resident #23] made contact with Resident #17, and holding hands was noted. A skin assessment was completed, and the physician and family were updated. Review of SRI tracking number 246138 completed on 04/09/24 revealed Resident #23 was kissing Resident #17 on the lips and holding her hands. The Administrator spoke with both residents who were unable to recall the incident. Review of a witness statement dated 04/09/24 by STNA #313 revealed Resident #23 was kissing Resident #17 on the lips, and they were holding hands. STNA #313 reported the incident immediately after separating the residents. Review of a witness statement completed on 04/09/24 by LPN #359 revealed she was called to the hallway due to a resident [Resident #23] kissing another resident [Resident #17], the residents were separated, assessments were completed per facility policy, physician, administrator and Assistant Director of Nursing (ADON) were notified. Resident #23 recalled the incident directly after it occurred and confessed to kissing Resident #17. Resident #23 was placed on 15-minute checks from 04/09/24 through 04/16/24. Interview on 04/25/24 at 9:38 A.M. with STNA #313 revealed she did not believe Resident #17 had the ability to provide consent for intimate interactions with others. Interview on 04/25/24 at 3:17 P.M. with SSD #347 revealed she did not have any concerns related to Resident #17's room being directly across the hall from Resident #23's. SSD #347 stated she did not believe Resident #17 could give consent for a relationship but Resident #17 did not have adverse reactions. Interview on 04/29/24 at 4:43 P.M. with Resident #17's RP #102 revealed he was not notified of any incident occurring and he did not believe Resident #17 was able to consent to any type of relationship. RP #102 stated Resident #17 would not have approved of that interaction, would have been angry, and told the guy to get away. Interview on 04/29/24 at 3:20 P.M. with STNA #332 revealed Resident #17 cannot give consent to intimate interactions with other residents. Interview on 04/29/24 at 5:16 P.M. with STNA #313 revealed she observed Resident #17 with Resident #23, holding one of his hands and the other arm wrapped in an embrace as they kissed in the hallway. STNA #313 stated Resident #17 did not appear to be in distress. Interview on 04/30/24 at 8:43 A.M. with Administrator revealed Resident #23 initially began having sexually inappropriate behaviors in February 2024 with hand holding and attempts to kiss residents. Medications were started at that time as an intervention, then after an incident on 03/06/24 15-minute checks were started then stopped on 03/11/24. After a third incident on 04/09/24, 15-minute checks were started again, and a discharge notice was issued which was currently being appealed. (continued on next page)

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 05/01/24 at 8:25 A.M. with STNA #351 revealed she had seen Resident #23 attempt to kiss Resident #17 multiple times but was not at the facility when events occurred. STNA #351 stated Resident #23 was alert and oriented but liked to pretend he was confused, and she was concerned since Resident #17's room was directly across from Resident #23's. STNA #351 stated Resident #17 would not be able to yell out for help if needed. STNA #351 stated Resident #17 would be upset related to incident of kissing with Resident #23 if she was aware using reasonable person concept. 4. Record review revealed Resident #20 admitted to the facility on [DATE] with diagnoses including sepsis, pneumonia, acute respiratory failure, type II diabetes, schizoaffective disorder, and anxiety disorder. Review of a care plan completed on 12/06/23 revealed Resident #20 had an alteration in cognitive function related to schizoaffective disorder. Review of the MDS assessment completed on 04/02/24 revealed Resident #20 had a Brief Interview for Mental Status BIMS of 12 out of 15, indicating moderate cognitive impairment. Review of a Medication Administration Record (MAR) for April 2024 revealed Resident #20 was given an as needed order for hydroxyzine HCl oral tablet 25 milligrams (antihistamine used to treat anxiety) give 25 milligrams by mouth every eight hours as needed for anxiety. Hydroxyzine was first administered on 04/28/24. Review of a progress note dated 04/27/24 at 3:00 P.M. by LPN #368 revealed Resident #20 was placed on 15-minute checks for 72 hours related to sexual behaviors towards another resident. Review of a BIMS evaluation for Resident #20 dated 04/27/24 at 3:34 P.M. by LPN #327 revealed a score of two out of 15, indicating severe cognitive impairment. Interview on 04/29/24 at 1:05 P.M. with LPN #368 revealed Residents #20 and #23 were placed on 15-minute checks due to Resident #23 kissing Resident #20 on the cheek. Interview on 04/29/24 at 2:26 P.M. with the Administrator revealed Resident #23 had an alarm placed on his door, was placed on 15-minute checks, and was on a different hallway than Resident #20. Interview on 04/29/24 at 3:20 P.M. with STNA #332 revealed Resident #20 was not able to give consent for intimate touching or kissing. STNA #332 stated Resident #20 had increased behaviors since 04/26/24 including anger outbursts and not letting anyone touch her, which was unusual, but the nurse had stated, her dementia was kicking in. Interview on 04/30/24 at 2:49 P.M. with Regional Quality Assurance (QA) Nurse #334 revealed an order for Resident #23 to be placed on one-to-one supervision while he was out of his room was in place since there was now an alarm on his door. 32801 5. Record review revealed Resident #21 was admitted to the facility on [DATE] with diagnoses including anxiety disorder, depression, and intellectual disabilities. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #21's nursing note dated 03/06/24 revealed the resident had reported that male resident [Resident #23] had inappropriately touched her. Education was provided to both residents. Review of Resident #21's plan of care dated 03/06/24 revealed on 03/06/24 a male resident [Resident #23] had touched the resident inappropriately. The residents BIMS was eight out 15 at the time of the incident, indicating moderate cognitive impairment. The intervention included notifying the family and physician, separating residents immediately, and staff were to give the resident time to discuss the incident. Review of SRI tracking number 244923 dated 03/06/24 revealed Resident #6 and Resident #21 were sexually abused by a male resident [Resident #23]. Residents #21 and #23 were able to provide meaningful information, however Resident #6 was not able to provide meaningful information when interviewed. Resident #21 had requested to speak to the Administrator on 03/06/24 at 4:15 P.M. Resident #21 reported Resident #23 had touched her breast when she was sitting in the common area. Resident #23 confirmed he touched Resident #6 and #21's breast. Resident #23 had dementia and was not always cognitively intact. Resident #23 voiced understanding of keeping hands to himself and accepted the education on what was appropriate/inappropriate. The incident was not observed by staff. The facility reported the allegation was unsubstantiated due to the evidence being inconclusive. Review of the facility investigation for SRI tracking number 244923 revealed Resident #21 told two staff members that Resident #23 had grabbed her breast, without consent. Resident #21 and pointed the resident [Resident #23] out to a staff member and stated he had done it twice, and she didn't want him to grab her. Review of Resident #21's typed statement dated 03/07/24 revealed SSD #347 interviewed the resident on 03/06/24. The resident reported on 03/06/24 a man [Resident #23] grabbed and pinched her breast on the outside of her clothing in the dining room with other residents present. The resident reported it was uncalled for, and she was unsure why he did it. The resident seemed to have minimal mental anguish and stated she felt safe if he was not around. SSD #347 offered counseling services to help her deal with this new trauma to which the resident declined. The resident was comfortable coming to administration if something changed, and she wished to speak with someone regarding the incident. Review of Resident #23's typed statement by the Administrator and witnessed by SSD #347 dated 03/06/24 revealed the resident reported there were two different occurrences that took place yesterday with two residents. The resident admitted to touching the breasts of two female residents [Resident #6 and Resident #21]. Resident #23 asked for an increase in Tagamet (antihistamine and antacid) yesterday per psych. The resident doesn't seem to fully comprehend the severity of his actions. The resident has a diagnosis of vascular dementia. Review of Resident #6's typed statement typed by the Administrator dated 03/06/24 revealed the resident did not recall the incident that took place yesterday. The resident did not appear to be in any distress or anguish from the incident. Review of the census sheet dated 03/06/24 revealed head to toe assessments were completed on six residents that were not able to be interviewed, and the 35 residents that were interviewed and felt safe. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 04/23/24 at 2:24 P.M., with Resident #21 revealed a man named maybe (name given) touched her breast and attempted to touch her private areas below her waistline. Resident #21 confirmed she felt the resident had sexually abused her and it bothered her. Resident #21 reported she feared him, and he still resided in the building. Review of the facilities policy titled Abuse, Neglect, Exploitation of Residents and Misappropriation of Property, dated 05/2018, revealed it was the goal of the facility that its residents would be protected from sexual abuse. Residents would not be subjected to abuse by anyone.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985 Based on record review, observations, interview and facility policy review, the facility failed to ensure Resident #1 was free of restraints. This affected one resident (#1) of one resident reviewed for restraints. The facility census was 46. Findings included: Record review revealed Resident #1 admitted to the facility on [DATE] with diagnoses including intracranial injury with loss of consciousness greater than 24 hours with return to pre-existing conscious level, hemiplegia affecting right dominant side, and type II diabetes. Observation on 04/22/24 at 9:44 A.M. revealed Resident #1 in his motorized wheelchair with a seatbelt on. Observation on 04/24/24 at 11:31 A.M. revealed Resident #1 in his wheelchair with a seatbelt on. Interview on 04/24/24 at 2:34 P.M. with Licensed Practical Nurse (LPN) #327 revealed the facility did not have anyone with restraints in place, and the only type of assessments in place would be paperwork for bed rails. LPN #327 confirmed Resident #1 had a seatbelt on while in his wheelchair. Interview on 04/24/24 at 2:39 P.M. with LPN #361 revealed the seatbelt for Resident #1 was not considered a restraint since he is able to release it himself. LPN #361 confirmed there were no orders or assessments for a seatbelt to Resident #1's wheelchair. Review of an undated policy titled Restraint Management and Reduction revealed when a resident is admitted to the facility with a restraint order, the nurse completes a restraint assessment, establishes a plan, obtains a physician's order, obtains consent, and updates the care plan prior to implementing the plan. The physician's order for restraint use must specify the type, medical diagnosis, timeframe, parameters for use, and frequency of checking and removing. The facility is responsible for obtaining the informed consent from the responsible party and must document information regarding the restraint in the medical record.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Landing Nursing and Rehabilitation	856 South Riverside Drive McConnelsville, OH 43756

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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 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 49739

Based on record review, review of facility self-reported incidents (SRI's), staff interview, and review of the facility policy, the facility failed to report allegations of abuse to the state agency in a timely manner for Residents #8 and #2, and an injury of unknown origin for Resident #17. This affected three (#8, #2, and #17) of six residents reviewed for abuse. The facility census was 46.

Findings include:

1. A review of Resident #8's medical record revealed he was admitted to the facility on [DATE] with diagnoses including paraplegia; unspecified psychosis not due to a substance or known physiological condition; anxiety disorder; depression; panic disorder; abnormal posture; muscle wasting and atrophy; muscle weakness; and generalized anxiety disorder.

Review of SRI tracking number 244564 and the facilities investigation dated 02/26/24 revealed the incident was discovered on 02/25/24 that there was a physical altercation between Resident #8 and another male resident. The SRI was not reported to the state agency until 02/26/24.

Further review of the staff statements dated 02/25/24 revealed the incident occurred on 02/24/24 at 3:30 P. M.

Review of the staff education dated 02/26/24 revealed staff were educated on the abuse policy and reporting abuse timely to the direct supervisor. The education was provided by the Administrator and Assistant Director of Nursing (ADON) #361. There was no evidence the Administrator was educated on reporting the abuse timely to the state agency per the facilities policy.

Interview on 04/30/24 at 4:12 P.M., with the Administrator confirmed the SRI was reported late to the state agency. The Administrator reported she had educated staff on reporting abuse timely. The incident happened on 02/24/24, the investigation started on 02/25/24, however the incident was not reported to the state agency until 02/26/24.

Review of the facilities Abuse policy, dated 05/2018, revealed all allegations of abuse or serious bodily injury would be reported to the state agency as soon as possible, but no more than two hours after the alleged incident was discovered. Reports of all allegations not involving abuse or serious bodily injury must not exceed 24 hours.

47985

2. Record review revealed Resident #2 admitted to the facility on [DATE] with diagnoses including traumatic hemorrhage of cerebrum, spastic hemiplegia affecting left nondominant side, type II diabetes, bipolar disorder, panic disorder, and anxiety disorder.

Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 had mild cognitive impairment, had physical and verbal behaviors daily, and required maximum assistance for bed mobility and transfers.

(continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a personal witness statement by Licensed Practical Nurse (LPN) #328 dated 12/14/23 revealed LPN #328 was sitting in the nurse's station charting when she heard screaming from the dining room, she went to the dining room, and Resident #2 stated she had screamed due to another resident slapping her in the mouth, there was no swelling or redness noted. LPN #328 stated another male resident was in the dining area and witnessed Resident #2 getting slapped. Interview on 04/24/24 at 3:31 P.M. with the Administrator confirmed a male resident slapped Resident #2 but it was not reported because there was no harm to either resident. 3. Record review revealed Resident #17 admitted to the facility on [DATE] with diagnoses including senile degeneration of the brain, dementia with behaviors, major depressive disorder, and anxiety disorder. Review of the quarterly MDS assessment completed on 02/05/24 revealed Resident #17 had severely impaired cognitive function, had delusions, physical behaviors four to six days a week, verbal behaviors one to three days a week, wandered daily, and required maximum assist to dependent assistance from staff for activities of daily living (ADL). Review of a nursing note on 04/11/24 at 3:47 P.M. by LPN #361 revealed staff reported the top of Resident #17's left hand was swollen and red. Resident #17 was unable to explain what happened but upon palpation Resident #17 complained of pain with range of motion and was unable to make a fist without pain. Hospice was notified and gave a new order for an x-ray. Review of a nursing note dated 04/11/24 at 3:54 P.M. by LPN #361 revealed a mobile x-ray company was called for an x-ray to left hand for Resident #17. Review of a nursing note dated 04/12/24 at 1:08 P.M. by LPN #320 revealed the x-ray results were received for Resident #17's left hand, the on-call physician was notified and gave a new order for the resident to be sent to the hospital to get a splint. Review of a nursing note on 04/12/24 at 1:23 P.M. by LPN #320 revealed Resident #17's family was notified of a fracture of the left hand and recommendation to be sent to the hospital to get a splint. Interview on 04/30/24 at 8:43 A.M. with the Administrator confirmed Resident #17's injury of unknown origin was not reported to the state agency. The Administrator stated an investigation was completed and it was determined Resident #17 likely got her hand stuck in her wheelchair. Administrator stated they made the determination due to Resident #17 always having a tight grip on her wheels. The Administrator confirmed the injury was not observed and Resident #17 was unable to explain what happened. Review of the policy titled, Abuse, Neglect, and Exploitation of Residents and Misappropriation of Property, dated May 2018, revealed injuries of unknown source occur when the source of the injury was not observed by any person, the source of the injury could not be explained by the resident and the injury is suspicious because of the extent of the injury or the location of the injury.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review and staff interview, the facility failed to ensure Minimum Data Set (MDS) assessments were completed accurately to reflect a resident's dental status, vision status, proper diagnoses, and medications received. This affected three residents (#8, #23, and #31) of 22 residents reviewed for assessments. Findings include: 1. Review of Resident #31's medical record revealed she was admitted to the facility on [DATE] with diagnoses including vascular dementia and hemiplegia and hemiparesis following a stroke (CVA) affecting his right dominant side. Review of Resident #31's physician's orders revealed the resident was receiving Atorvastatin (medication used to lower blood cholesterol levels) 80 milligrams (mg) by mouth (po) every night at bedtime for hyperlipidemia (high cholesterol in the blood). The Atorvastatin had been in place since 03/15/23. The resident also used Plavix (an anti-platelet) 75 mg po every morning for a CVA. The resident's physician's orders did not reveal the use of an anticoagulant. Review of Resident #31's quarterly MDS assessment dated [DATE] revealed not all of the resident's diagnoses were properly coded on the MDS assessment. Section (I.) that documented the resident's diagnoses had a place for the assessor to identify the resident as having hyperlipidemia. The box was not checked to reflect that as one of the resident's diagnoses despite the resident being on Atorvastatin and receiving that medication during the seven-day assessment period. Section (N.), that documented medication classifications the resident had received during the seven-day assessment period, was also not completed accurately. The resident was indicated to have received an anticoagulant despite an anticoagulant not being received during that time. Findings were verified by Registered Nurse (RN) #310, who was the facility's MDS Coordinator. On 04/29/24 at 10:06 A.M., an interview with RN #310 confirmed she did not include the diagnosis of hyperlipidemia on Resident #31's quarterly MDS assessment completed on 04/15/24 despite the resident receiving Atorvastatin every night at bedtime for hyperlipidemia and had been during the seven-day assessment period. She also confirmed Resident #31 being marked as having received an anticoagulant was in error as the resident only received Plavix, which was an anti-platelet. 47985 2. Record review revealed Resident #23 admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, acute respiratory failure with hypoxia, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, and dementia. Review of a quarterly MDS assessment dated [DATE] revealed Resident #23 had intact cognition, had adequate hearing, and adequate vision. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a care plan dated 10/31/23 revealed Resident #23 had an alteration in visual function related to wearing glasses. Goals included having no injuries, feeling safe and secure in the environment, and maintaining current visual function. Interventions included ensuring eyeglasses were clean, in good repair, and appropriately worn by the resident, and scheduling eye exams as necessary. Interview on 04/22/24 at 11:42 A.M. with Resident #23 revealed his vision was impaired and he could hardly read the words on the television. Resident #23 stated he had asked for an appointment but did not receive one. Interview on 04/23/24 at 4:14 P.M. with Resident #23 revealed he still has glasses, but they do not work very well. Interview on 04/25/24 at 3:17 P.M. with Social Services Designee (SSD) #347 revealed she completed section B of the MDS which evaluates residents' ability to communicate. SSD #347 stated she does not ask residents questions or ask them to read anything to determine their visual function. SSD #347 stated she uses observations to determine how to code the MDS for communication, or she will pull the information from the previously completed MDS. SSD #347 stated she was unaware Resident #23 needed new glasses because she did not think it looked like he was struggling to see. Review of Section B of the Resident Assessment Instrument 3.0 Manual revealed steps for assessing a residents' vision include asking family, caregivers, or direct care staff over all shifts if possible about the resident's usual vision patterns during the seven-day look back period; then ask the resident about their visual habits; to test the accuracy of findings, ensure the resident's customary visual appliance for close vision is in place, ensure adequate lighting, ask the resident to look at regular-sized print in a book or newspaper then ask them to read aloud. 32801 3. A review of Resident #8's medical record revealed he was admitted to the facility on [DATE] with diagnoses including paraplegia; unspecified psychosis not due to a substance or known physiological condition; anxiety disorder; depression; panic disorder; abnormal posture; muscle wasting and atrophy; muscle weakness; and generalized anxiety disorder. Review of Resident #8's dental plan of care dated 05/16/22 revealed the resident had dental caries and abscess teeth. Interventions included to coordinate arrangement for dental care, monitor for any dental problems needing attention, and providing mouth care. Review of Resident #8's significant change MDS assessment dated [DATE] revealed the resident has no dental issues. Review of Resident #8's dental note dated 07/26/23 revealed the resident had generalized caries and broken teeth, and the resident requested that all his teeth be pulled. Interview and observations on 04/23/24 at 11:10 A.M. and 05/01/24 at 10:40 A.M., with Resident #8 revealed his teeth were in poor condition, and he was supposed to see a specialist last year to have all his teeth extracted. The resident declined to let the surveyor observe his teeth, but pointed to one tooth, and the tooth was noted to be discolored and partially broken. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/01/24 at 2:55 P.M., with the MDS Nurse #335 confirmed the MDS dated [DATE] was inaccurately coded due to the residents' broken teeth and having caries per the dental notes and care plan at the time the MDS was completed. The MDS nurse reported she was not the MDS nurse at time.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985 Based on record reviews, interviews and facility policy review, the facility failed to ensure Pre-Admission Screening and Resident Reviews (PASRRs) reviews for Residents #6 and #17 were accurate. This affected two residents (#6 and #17) of two residents reviewed PASRRs. The facility census was 46. Findings included: 1. Record review revealed Resident #6 admitted to the facility on [DATE] with diagnoses including dementia, chronic obstructive pulmonary disease, hypertension, anxiety disorder, obsessive compulsive disorder (OCD), mild cognitive impairment, major depression. Diagnoses of anorexia nervosa and psychosis were added on 01/04/23. Review of a PASRR dated 03/28/24 revealed Resident #6 had a mood disorder and a panic disorder but did not list Resident #6's diagnoses of psychosis or anorexia nervosa. Interview on 04/25/24 at 3:39 P.M. with Social Services Designee (SSD) #347 confirmed Resident #6's most recent PASRR did not list diagnoses of anorexia nervosa or psychosis. 2. Record review revealed Resident #17 admitted to the facility on [DATE] with diagnoses including senile degeneration of the brain, dementia with behaviors, major depressive disorder, anxiety disorder, bipolar disorder. A diagnosis of psychosis was added on 07/20/22. Review of a PASRR dated 08/02/23 revealed Resident #17 had a mood disorder, anxiety disorder, and a personality disorder but did not list Resident #17's diagnosis of psychosis. Interview on 04/25/24 at 3:39 P.M. with SSD #347 confirmed Resident #17's PASRR did not list psychosis as a diagnosis. Review of a policy titled Pre-Admission, dated 03/24/20, revealed all level one and level two residents with newly diagnosed or possible serious mental disorder will be referral for a resident review to the Ohio Department of Aging or appropriate organization upon significant change in status assessment.

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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** 47985 Based on record review, observations, interviews, and facility policy review, the facility failed to provide nail care for Resident #1, who was dependent on staff for assistance with hygiene. This affected one resident (#1) of three residents reviewed for personal hygiene. The facility census was 46. Findings included: Record review revealed Resident #1 admitted to the facility on [DATE] with diagnoses including other specified intracranial injury with loss of consciousness greater than 24 hours with return to pre-existing conscious level, hemiplegia affecting right dominant rise, type II diabetes, aphasia, hypertension, contracture of muscle of right upper arm and hand, and Alzheimer's disease. Review of a care plan dated 01/28/10 revealed Resident #1 had a self-care deficit related to brain injury with hemiparesis and mobility impairment with a goal of Resident #1 having his activity of daily living (ADL) needs met daily. Interventions included providing needed assistance with self-care daily. Review of a care plan dated 08/30/19 revealed Resident #1 required extensive assistance for personal hygiene and grooming. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 required maximum assistance for personal hygiene. Observation and interview on 04/22/24 at 9:44 A.M. with Resident #1 revealed he had long fingernails, he did not like to have long fingernails, and he could not recall the last time his nails were trimmed. Observation on 04/24/24 at 11:31 A.M. revealed Resident #1 continued to have long fingernails. Interview on 04/24/24 at 2:34 P.M. with Licensed Practical Nurse (LPN) #327 revealed fingernails should be trimmed when they get long or per resident request. LPN #327 confirmed Resident #1's fingernails needed to be trimmed. Review of an undated policy titled, Personal Care/Bathing revealed nails should be checked daily during the bathing process for cleanliness and trimmed every week and/or as needed usually after the shower.

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F 0680 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure the activities program is directed by a qualified professional. 32801 Based on review of personnel files, review of the facility assessment, and interview the facility failed to ensure the activities director was qualified. This had the potential to affect all 46 residents residing in the building. Findings included: Review of the undated facility assessment revealed Activity Director (AD) #363 was listed as the facility Activity Director. Review of AD #363's personnel file revealed the AD was hired on 06/13/23 and signed the activity director job description on 06/15/23. The job description indicated the qualifications for the AD were to be a qualified therapeutic recreation specialist or and activities professional who was licensed by the state and is eligible for certification as recreation specialist or as an activities professional or must have two year experience in a social or recreation program within the last five years, one of which was a full-time in a patient activities program in a health care setting; or must have completed a training course approved by the state. Further review of AD #363 personnel file revealed no evidence the AD met the qualifications in the job description or per the federal regulations. Interview on 05/01/24 at 12:00 P.M., with the Administrator confirmed on 06/13/23 AD #363 was hired to be the Activities Director. The Administrator confirmed AD #363 did not meet federal qualifications to be the AD and stated this was her fault (she had read the regulatory requirements incorrectly). The Administrator indicated the facility following the identification of this concern planned to enroll the AD in a program (approved by the state) as soon as possible.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on record review, interview and facility policy review, the facility failed to ensure residents were provided timely care when a change of condition was noted, failed to ensure specialist appointments were made, and failed to ensure the bowel protocol was implemented timely. This affected one resident (#41) of two reviewed for hospitalization , one resident (#27) of six reviewed for pain management, and one resident (#32) of one reviewed for constipation. Findings included: 1. Record review revealed Resident #41 was admitted to the facility on [DATE] with diagnoses including dementia with behavioral disturbance, chronic obstructive pulmonary disease (COPD), acute respiratory failure with hypoxia, acute kidney failure, chronic kidney disease, hepatitis, and mental disorders. Review of Resident #41's admission assessment dated [DATE] revealed the resident was alert and oriented times three (person, place, and time), coherent, speech was clear, understood others, and able to make self-understand. a. Review of Resident #41's written orders dated [DATE] revealed the Nurse Practitioner (NP) wrote orders for a complete blood count (CBC) and Chem 8. There were no diagnoses or rational for order. Review of Resident #41's health status note dated [DATE] revealed the NP visited and new orders were received for labs (CBC and Chem 8) in the morning ([DATE]). The resident and resident representative were notified. Review of Resident #41's laboratory results revealed no evidence the CBC or Chem 8 was obtained on [DATE]. Review of Resident #41's Medication Administration Records (MAR) dated ,d+[DATE] revealed the resident was ordered an Albuterol inhaler two puffs as needed every six hours for shortness of breath on admission. Further review revealed on [DATE] the resident used the inhaler, and it was unknown if it was effective. The resident used the inhaler on [DATE], [DATE], [DATE], and [DATE]. There was no documented evidence that a respiratory assessment (lung sounds, respiration, pulse, oxygen saturation) was completed prior to administering the as needed albuterol for shortness of breath. The resident also had an order on admission for Vistaril 25 milligrams (mg) (antihistamine used to treat allergies/anxiety) two tablets every four hours as needed for allergies/anxiety. The resident was administered the Vistaril 27 times in [DATE], however there was no indication if it was administered for anxiety or allergies. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #41's health status note dated [DATE] at 11:30 P.M., revealed the resident has had cold symptoms for the past few days, but worsening today. The resident complained of sinus congestion and drainage with a runny nose and cough. At evening medication pass, the resident requested Vistaril for sinus drainage. It was noted that the resident didn't go out to smoke with the group but sat in chair. Resident #41 complained of feeling weak and short of breath, which was noticeable. Vital signs were checked and noted, pulse was 120 and oxygen saturation was 69%. The resident was placed on two liters of oxygen and oxygen saturation came up to 74%. The oxygen was increased to five liters, and the resident was placed on a simple mask. The resident's oxygen saturation increased to 84%. The physician was called and advised the resident be sent to the emergency room . The call was placed to 911. The squad arrived at 11:45 P.M. and transported the resident to the hospital. The resident was alert and oriented and pulse was in the 80's and oxygen saturation was 92%. Further review of the resident health status notes revealed no documented evidence the resident was having cold symptoms prior to the documented note on [DATE] at 11:30 P.M. or evidence the physician was notified the resident was having symptoms days prior. Review of health status note dated [DATE] at 2:55 A.M. revealed Resident #41 was admitted to the hospital with sepsis related to pneumonia. Review of Resident #41's emergency room summary dated [DATE] revealed the resident was seen and evaluated for 10 days of progressive cough and shortness of breath. The resident was reportedly found with an oxygen saturation of 68% on room air when the squad arrived at the facility. The resident doesn't wear oxygen at baseline. Upon arrival the resident was afebrile, with oxygen saturations in the low 90's on six liters via nasal cannula with mild accessory muscle used but speaking in full sentences. She was initially mildly tachycardic and she does have leukocytosis at 26.3 and does meet sepsis criteria. The chest x-ray shows evidence of multifocal pneumonia. Sepsis dose fluid bolus and antibiotics ordered. The resident will be admitted for multifocal pneumonia, sepsis, respiratory failure, and hypokalemia. Review of Resident #41's hospital notes dated [DATE] and [DATE] revealed for approximately 10 days the resident had a progressive cough and shortness of breath. The cough was initially dry, had become productive over the last 24 hours. The resident described the shortness of breath which was present during rest but worse with any sort of movement and cough. The squad reported they found her in her room with an oxygen saturation at 68% on room air. She did receive a breathing treatment while in route with considerable improvement of her breathing. Wheezing and rales were present. Review of Resident #41's plan of care revealed a respiratory plan of care was not initiated until [DATE]. Interview on [DATE] at 10:02 A.M., with Resident #41 revealed she was hospitalized for pneumonia and almost died because she kept telling the staff and doctor she wasn't feeling well, and they wouldn't listen to her. Interview on [DATE] at 9:28 A.M., with Assistant Director of Nursing (ADON) #361 confirmed the orders written on [DATE] were not obtained on [DATE] and the lab was there twice that week and verified the resident was sent to the hospital on [DATE] and was admitted on [DATE] with sepsis. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 2:09 P.M., with Corporate Nurse (CN) #334 confirmed the health status note dated [DATE] indicated Resident #41 had had symptoms for two days, however there was no documented evidence the resident had symptoms. The resident had started to use the as needed Albuterol inhaler on [DATE] for shortness of breath, however the resident had a diagnosis of COPD, so it was unclear if the shortness of breath was new. Resident #41 was not skilled, so a daily assessment was not completed on the resident including respiratory assessments, however staff should have completed a respiratory assessment (assess lungs, respiration, pulse, and oxygen saturation) prior to administering the as needed Albuterol, however there was no documented evidence a respiratory assessment was completed prior to the administration of the Albuterol. The CN also confirmed there was no documented evidence why the resident was administered Vistaril for most of the administered doses. b. Review of Resident #41's hospital discharge records dated [DATE] revealed the resident was to follow up with gastroenterology (GI) for liver cirrhosis and outpatient neurosurgery for L3 compression fracture. Review of Resident #41's medical record revealed no evidence follow up appointments were arranged for GI or neurosurgery. Review of Resident #41's plan of care revealed on [DATE] a plan of care was initiated revealed the resident had a history of compression fracture. There was no intervention to arrange appointment for neurosurgery. Further review revealed no evidence a plan of care was initiated on [DATE] for cirrhosis. Interview on [DATE] at 2:09 P.M., with CN #334 confirmed there was no evidence the GI or neurosurgery consults were made per the hospital discharge orders on [DATE]. 47985 2. Record review revealed Resident #27 admitted to the facility on [DATE] with diagnoses including paraplegia, emphysema, neuromuscular dysfunction of the bladder, and need for assistance with personal care. Review of a quarterly Minimum Data Set (MDS) assessment completed on [DATE] revealed Resident #27's cognition remained intact, she did not have any behaviors, she was dependent on staff for toileting and hygiene, she had an indwelling urinary catheter, and she had frequent pain. Review of orders revealed Resident #27's indwelling urinary catheter had been discontinued. Review of a nursing note completed on [DATE] at 8:45 A.M. by Licensed Practical Nurse (LPN) #368 revealed Resident #27 complained of abdominal pain and lower back pain, and LPN #368 asked the Director of Nursing (DON) to have the ADON, LPN #361 address Resident #27's pain and to send her to the hospital if needed. Review of a nursing note dated [DATE] at 2:26 P.M. revealed Resident #27 was assessed by the nurse practitioner who approved Resident #27 to be sent to the hospital for abdominal and lower back pain. Review of a nursing note dated [DATE] at 4:01 P.M. revealed Resident #27 was sent to the hospital via squad due to complaints of abdominal and lower back pain. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Riverside Landing Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 856 South Riverside Drive McConnelsville, OH 43756	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a nursing note dated [DATE] at 10:56 P.M. revealed Resident #27 readmitted to the facility with orders for Levaquin 750 mg (antibiotic) for five days for a urinary tract infection, an indwelling urinary catheter was inserted, and bedtime medications were provided. Review of a history and physical note from the hospital on [DATE] revealed Resident #27 presented to the hospital with abdominal pain, right flank pain, and urinary tract infection-like symptoms. Due to paraplegia, they were unable to determine if Resident #27 was voiding all the way. Resident #27 was diagnosed with a urinary tract infection and antibiotics were started as well as a new indwelling urinary catheter. Observation and interview on [DATE] at 12:01 P.M. revealed Resident #27 lying in bed sobbing and stated she was in severe pain. Resident #27 stated she received her pain medication, and she does receive a low-dose Fentanyl patch (narcotic pain medication), but she is having breakthrough pain. Resident #27 stated she requested to go to the hospital but was denied because ADON, LPN #361 stated Resident #27 needed to wait for the nurse practitioner to come evaluate her. Resident #27 stated she has recurring urinary tract infections and kidney stones; her aide told her that her urethra was red and irritated. State tested Nurse Aide (STNA) #313 was in the room at this time and confirmed. Resident #27 stated she used to have a catheter but due to the facility not performing peri-care properly and recurring infections, she no longer had the catheter. Resident #27 stated she was supposed to be straight cathed three times a day and the facility stopped doing that as well. Throughout the conversation, Resident #27 was crying, tears streaming down her face, and she was grimacing. Interview on [DATE] at 2:57 P.M. with LPN #368 revealed Resident #27 had complained of pain that morning and ADON, LPN #361 was supposed to address her concerns. LPN #368 stated she was unsure of what happened after LPN #368 talked to Resident #27, but she knew the nurse practitioner came in to assess Resident #27 and gave an order to send to the emergency department for evaluation. Interview on [DATE] at 4:08 P.M. with Resident #27 revealed she went to the hospital on [DATE] and the hospital gave her an indwelling urinary catheter because she was not voiding all the way on her own. Resident #27 stated when they inserted the catheter, she drained a chunky, yellow, milky substance and has felt much better since. Interview on [DATE] at 9:24 A.M. with Resident #34, Resident #27's roommate, revealed Resident #27 started to complain of pain over the previous weekend but did not let staff know she was in pain until Monday due to wanting to see her family. Resident #34 stated Resident #27 was told she would have to wait to talk to the nurse practitioner prior to receiving care. Resident #34 stated Resident #27 started crying around 8 A.M. on [DATE] and was not sent out until about 4:00 P.M. Resident #34 stated staff were in and out of their room all day so they were aware Resident #27 was crying in pain. Interview on [DATE] at 2:48 P.M. with STNA #313 revealed Resident #27 was upset and crying all day in pain. STNA #313 stated pain started around 7:00 A.M. to 7:30 A.M. on [DATE], and Resident #27 was grimacing and stating she would like to go to the hospital. STNA #313 stated Resident #27 was crying all day and asked staff to go to the hospital each time they came in her room. STNA #313 stated Resident #27 did not get to go to the hospital until later in the afternoon despite crying all day. STNA #313 stated Resident #27 was still crying while on the cot being taken out to the squad. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Landing Nursing and Rehabilitation	856 South Riverside Drive McConnelsville, OH 43756

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 9:16 A.M. with ADON, LPN #361 revealed Resident #27 was complaining of pain on [DATE]. She has constant pain because she has kidney stones, but she receives plenty of pain medications for her weight. She stated Resident #27 was sleeping when she went into the room to talk to her, Resident #27 stated she had some discomfort in her lower back and thought it was the kidney stones again. The nurse practitioner was coming in so she could address it once she was there. She did not believe Resident #27 was in any pain or discomfort when she was sent out, Resident #27 is a frequent flier and goes to the hospital several times a month. She stated it was not reported to her Resident #27 was in severe pain and crying. Interview on [DATE] at 1:05 P.M. with LPN #368 revealed she saw Resident #27 later in the morning on [DATE], but she wasn't showing signs of pain or discomfort. Interview on [DATE] at 9:42 A.M. with ADON, LPN #361 revealed Resident #27's pain was not real pain because it was due to kidney stones, she was up daily, and she had a Fentanyl patch. Resident #27 was just trying to get more pain medications and wanted an as needed medication in between her scheduled pain medications. She did not see signs of pain for Resident #27 including facial grimacing and if she was in pain she would not be outside laying out, she would be in bed crying. Interview on [DATE] at 1:47 P.M. with ADON, LPN #361 revealed another resident was having pain rated at a zero but was given an as needed narcotic to address pain because they were not allowed to judge a resident's pain level, they just have to take their word. She stated it was different for Resident #27 because there was no as needed pain medication in place, she has pain medications around the clock and no signs of facial grimacing. Interview on [DATE] at 8:25 A.M. with STNA #351 revealed when she arrived at the facility on [DATE] at 7:00 A.M., she went into Resident #27's room, and she was crying and wanted to be sent to the hospital. STNA #351 stated she reported this to LPN #368 who told ADON, LPN #361 to address it. STNA #351 stated a couple hours later, Resident #27 was still crying, and it was reported again but she was told Resident #27 had to wait to be seen by the in-house nurse practitioner before she could leave. STNA #351 stated if she was not sent to the hospital by 2:30 P.M., her family would call an ambulance themselves. STNA #351 stated Resident #27's pain was a solid eight or nine and you could tell between fake and real tears so she could tell it was real for sure. STNA #351 stated the nurses do not listen to Resident #27 because she is paralyzed so they don't think she knows what's going on with her body. STNA #351 stated Resident #27, who is alert and oriented, should have been sent out when she asked. Review of an undated policy titled Status Change in Resident Condition-Notification revealed the facility should promptly notify the resident and their physician of the change. 28923 3. Review of Resident #32's medical record revealed she was admitted to the facility on [DATE] with diagnoses including a history of a stroke, muscle weakness, difficulty walking, and unsteadiness on her feet. Review of the MDS assessment dated [DATE] revealed Resident #32 did not have any communication issues, and her cognition was moderately impaired. She did not receive any scheduled pain medication but did receive pain medication administered on an as needed basis. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #32's care plans revealed she had a care plan in place for being at risk for constipation related to a decrease in her mobility. Her goal was for her to have a bowel movement at least every three days. The interventions included implementing the bowel protocol if no bowel movement after three days per the facility's policy. They were also to administer medications as ordered and to monitor for constipation. Review of Resident #32's physician's orders revealed she had an order in place to receive Senna Plus 8.6 mg -50 mg (laxative) by mouth twice a day for constipation. She also had an order to receive a Bisacodyl Rectal Suppository 10 mg (laxative) rectally every 24 hours as needed (PRN) for constipation. Review of Resident #32's bowel record for the past 30 days ([DATE]- [DATE]) revealed the resident had no documented evidence of a bowel movement for eight days between [DATE] and [DATE]. She had a small bowel movement on [DATE] but did not have any further bowel movements until a small and a medium bowel movement was recorded on [DATE]. Review of Resident #32's MAR for [DATE] revealed the resident was not given the Bisacodyl 10 mg suppository rectally that was ordered on a PRN basis when she was noted to have gone without a bowel movement for eight days. Findings were verified by ADON, LPN #361 On [DATE] at 2:20 P.M., an interview with ADON, LPN #361 confirmed Resident #32 had no documented evidence of a bowel movement for eight days between [DATE] and [DATE]. She further confirmed the facility's nurses did not administer the resident her Bisacodyl suppository that should have been given if she did not have a bowel movement for three days. A review of the undated facility policy on Bowel Management and Treatment revealed the purpose of the policy was to achieve control of bowel evacuation on a routine basis, which may be indicated by an independent or assisted stool every two to three days to avoid constipation. Residents with a history of difficult and infrequent passing of hard, dry stools and fewer than three stools a week and those who voice a sensation of incomplete evacuation were placed on a promotional bowel regimen. Each shift, the nurse was to document on the MAR/TAR (treatment administration record) when a resident had a bowel movement. Residents who have not had a bowel movement for three consecutive days would have the facility's bowel protocol initiated, unless the resident had an individual order specific to bowel management, or where the orders below would be contraindicated for the resident.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on medical record review, review of therapy notes, and interview the facility failed to ensure range of motion (ROM) services were implemented per plan of care and failed to ensure therapy services were provided when a resident had a noted decline. This affected two residents (#8 and #41) of four residents reviewed for positioning/restorative. Findings included: 1. Record review revealed Resident #41 was admitted to the facility on [DATE] with diagnoses including respiratory failure, chronic kidney disease, hepatitis, mental disorder, and wedge compression fracture. Review of Resident #41's admission assessment dated [DATE] revealed the resident had no neurological or mobility impairments. The resident was alert and oriented times three and able to make needs known. Review of Resident #41's hospital discharge notes dated 10/04/23 revealed the resident was hospitalized from 09/17/23 to 10/04/23 for multifocal pneumonia, acute hypoxic respiratory failure, acute toxic metabolic encephalopathy, acute exacerbation of chronic obstructive pulmonary disease (COPD), acute kidney disease, hepatitis C cirrhosis, L3 compression fracture, and critical illness myopathy. Further review revealed the resident would need extensive rehab after discharging due to the critical myopathy. Review of Resident #41's re-admission assessment dated [DATE] revealed the resident had weakness and flaccidity, which the flaccidity was new. The resident had weakness in right hand, right leg, left leg, and right and left foot. Resident was unable to lift arms but could stand with assistance. The resident was alert and oriented time three. The resident was completely immobile. Review of Resident #41's physician note dated 10/09/23 revealed the resident was medically stabilized and transferred back to the skilled nursing facility for ongoing care and therapy. The resident was bed bound and had generalized weakness. She was alert and oriented times three. Review of Resident #41's nurse practitioner notes dated 10/11/23 and 10/16/23 revealed the resident was transferred back to skilled nursing for care and therapy. The resident was now bed bound. Physical therapy (PT) and occupational therapy (OT) for gain, strength, and endurance training. Review of Resident #41's therapy notes, paper medical record, and electronic medical record revealed no evidence the resident was screened by therapy upon re-admission on 10/04/23. Review of the PT notes dated 11/02/23 revealed Resident #41 was evaluated for services and was seen on 11/03/23, 11/05/23, and 11/06/23. The resident was discharged because she started to receive hospices services. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the OT notes dated 11/04/23 revealed Resident #41 received services on 11/04/23 and 11/06/23 and discharged on [DATE] because she started receiving hospice services. Review of Resident #41's census revealed the resident was hospice from 11/07/23 to 02/05/24. Review of Resident #41's therapy screen dated 02/18/24 revealed the resident did not trigger and occupational and physical evaluation due to the resident did not demonstrate a decline since last discontinued. Interview and observation on 04/22/24 at 10:05 A.M., revealed Resident #41 reported she had mobility when she was first admitted but she had gone to the hospital in October 2023 and when she got back, she could not walk and had been in bed ever since. She went to therapy twice, and she was not in any type of restorative program. Interview on 04/30/24 at 9:16 A.M. and 11:58 A.M., with OT #337 revealed the resident was ambulatory on admission, and then she went to the hospital. They picked her up for a few days in November 2023 but had to discharge her because she was admitted to hospice. The OT reported in October there was two staff off on maternity leave, and the communication was not very good and she was not sure why the resident was not seen by therapy until 11/02/23 and she was readmitted on [DATE]. The resident was re-screened in February 2024 by one of the staff that was previously off on maternity leave, and she had documented the resident had no changes, however there had been a change from admission due to the resident was ambulatory when she was admitted in August 2023. The staff member that screened the resident had only known the resident as being bed bound because she was off when the resident was admitted . The resident should have been picked up for therapy services in February 2023. The OT reported she evaluated the resident today and was going to pick up the resident up for therapy services. The resident's cognition had greatly improved since re-admission. The resident had only missed one question on her screening test today and she picked her up to work on activities of daily living (ADL), transfers, and would like to attempt to get her walking again. She does not recommend restorative programs due to there being no restorative program to refer to. Interview on 04/30/23 at 9:17 A.M. with Resident #41 revealed therapy never worked with her much when she was in therapy. They put her in a ski-looking machine to help her get out of bed a couple of times and that was it. The resident reported she doesn't recall every refusing therapy services and the reason the hospital sent her back there was for therapy. Interview on 04/30/24 at 3:21 P.M., with Corporate Nurse #334 revealed she had spoken to the occupational therapy assistant that was covering for the building in October 2023 when the facility had two staff members off and she recalled screening the resident in October, however she never documented the screening in the record, but had a handwritten paper she would like to provide. The therapy assistant had not scanned the handwritten paper in the electronic medical record, and it was done seven months ago. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the paper screening form dated 10/06/23 (which was not part of the medical record) revealed staff were to check all boxes to indicate changes in the resident condition which were blank for PT, OT, and speech therapy (ST). Under the PT comment the occupational therapy assistant (OTA) documented in collaboration with the physical therapy assistant (PTA), screen completed patient refused all services at this time. Education completed on importance of participation in therapy. Under OT the comment indicated the resident refused OT services after several attempts. NO therapy services warranted. Will continue to screen/evaluation quarterly/ and as needed depending on resident compliance. Under ST the comment indicated the no ST warranted at this time patient on regular diet. The screen was completed by OTA #700. Interview on 05/01/24 8:17 A.M , with OTA #700 revealed she was covering for the therapy director when she was on maternity leave in October 2023. She had the screening paper in her home office since October 2023 (seven months ago) and had not scanned them into the medical records. The OTA confirmed she had no documented evidence that the staff or physician was notified of the resident refusal of therapy, and it was probably relayed to staff during the daily/weekly meeting and was not directly reported to one specific person/staff. She confirmed she had no other documentation for the resident to provide that was not part of the medical record. 2. A review of Resident #8's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included paraplegia, unspecified psychosis not due to a substance or known physiological condition, anxiety disorder, depression, panic disorder, abnormal posture, muscle wasting and atrophy, muscle weakness, chronic pain, cerebral infarction, nondisplaced fracture of medial malleolus of right tibia, osteoporosis, and generalized anxiety disorder. Review of Resident #8's [NAME] Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact and two-person physical assistance required when moving or transferring. The resident was not receiving restorative therapy. Review of Resident #8's current plan of care revealed the resident had impaired functional range of motion related to decrease range of motion to bilateral ankles/feet. Intervention included active range of motion (AROM), active assisted range of motion (AAROM) and passive range of motion (PROM) per plan. Cue and prompt to complete program and assist as needed. Explain the procedure prior to beginning, provide slow and gentle range of motion. PROM to bilateral ankles/feet- 15 repetitions times two sets to each foot/ankle daily. Reassess quarterly and as needed. Refer to therapy as needed. Interview on 04/23/24 at 11:40 A.M., with Resident #8 revealed the resident reported he was not currently receiving restorative therapy; however, he would like to go to therapy to increase his core strength and range of motion. The resident reported the new aides were not trained to do the ROM exercise. Interview on 04/24/24 at 3:26 P.M., with State tested Nurse Aides (STNAs) #308 and #343 revealed there were only two residents on restorative on A Hall and Resident #8 was not one of the residents. The STNAs reported the difference between AROM and PROM was if the resident was standing or lying in bed. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/24/24 at 3:33 P.M., with the Administrator, revealed the facility did not have a restorative program. The Administrator confirmed Resident #8's plan of care indicated the resident was on a restorative program but there was no documented evidence the restorative program was being implemented. Interview on 04/30/24 at 10:11 A.M., with OT #337 confirmed the facility did not have a restorative program. The OT reported physical therapy evaluated Resident #8 and will pick up the resident for ROM. Interview on 04/30/24 at 12:04 P.M., with STNA #332 revealed the STNA could not define AROM or PROM.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review, observation, staff interview and facility policy review, the facility failed to ensure Resident #14, who had a history of falls, had fall prevention interventions in place according to the physician's orders and plan of care. This affected one resident (#14) of four residents reviewed for accidents. Findings included: Review of Resident #14's medical record revealed she was admitted to the facility on [DATE] with diagnoses including malignant neoplasm of the frontal lobe, unspecified psychosis, Type I (juvenile onset) diabetes mellitus, epilepsy (seizures), unsteadiness on her feet, abnormalities of gait and mobility, and a history of falling. Review of Resident #14's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident did not have any communication issues and was cognitively intact. She was not indicated to have displayed any behaviors or reject care during the seven-day assessment period. No mobility devices were indicated to have been used. Review of Resident #14's progress notes revealed a nurse's note dated 06/08/23 at 1:47 A.M. that indicated the resident was found sitting on the floor. She reported she went to stand up and fell on to her buttocks. No injuries were noted as a result of that fall. Review of the facility's fall investigation into Resident #14's fall that occurred on 06/08/23 at 1:47 A.M. revealed the immediate action taken at the time of the fall was for the use of gripper socks. That intervention was added to help prevent additional falls from occurring. Review of Resident #14's care plans revealed she was at risk for falls and potential injury related to weakness, needing assistance, incontinence, medications, and a history of falls. The goal was to minimize the potential risk factors related to falls. The interventions included the use of grippy socks when out of bed. That intervention had been put in place on 06/08/23. Review of a nurse's progress note dated 07/06/23 at 11:32 A.M. revealed Resident #14 had a fall while in another resident's room helping him put a beverage away. She was found sitting on the floor between the two beds in that room. A bruise was noted to the resident's left outer thigh, but no other injuries were noted. Review of the facility's fall investigation into Resident #14's fall that occurred on 07/06/23 at 11:32 A.M. revealed the resident was not noted to have gripper socks on at the time of the fall so gripper socks were applied. Review of Resident #14's physician's orders revealed they too included the need for the resident to wear gripper socks when out of bed when shoes were not being worn. That order had been written on 01/15/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/23/24 at 2:38 P.M., an observation of Resident #14 noted her to be sitting on the love seat in the common area with no shoes on her feet. She was wearing regular socks that did not have a non-skid sole on them. On 04/24/24 at 10:35 A.M., further observations of Resident #14 noted her to be sitting in a stationary chair in the common area participating in an activity. The resident was noted to be bare footed with no shoes or socks on her feet. On 04/24/24 at 10:37 A.M., an interview with Licensed Practical Nurse (LPN) #327 revealed she did not really consider Resident #14 to be at risk for falls. She denied the resident has had any falls in the two months that she had worked there. She was asked what fall prevention interventions were being used to prevent Resident #14 from falling. She reported the resident had an order to wear gripper socks when out of bed and not wearing shoes. She confirmed Resident #14 was out of bed and was not wearing shoes or gripper socks when attending the activity in the common area on 04/24/23 at 10:37 A.M. She further acknowledged an observation of Resident #14 was made on 04/23/24 at 2:38 P.M. where the resident was noted to be wearing socks that did not have a non-skid sole to it. Review of the facility's undated Fall Management policy revealed the facility would identify each resident who was at risk for falls and would develop a plan of care and implement interventions to manage falls. If a fall occurred, the licensed nurse would investigate the reason for the fall and implement an immediate intervention to attempt to prevent future falls from occurring.

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NAME OF PROVIDER OR SUPPLIER Riverside Landing Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 856 South Riverside Drive McConnelsville, OH 43756	

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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 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** 32801 Based on record review and interview, the facility failed to ensure tube feeding was administered as ordered by the physician and failed to ensure new orders were implemented timely. This affected one resident (#44) of one resident reviewed for tube feedings. Findings included: Record review revealed Resident #44 was admitted to the facility on [DATE] with diagnoses including aphasia, dysphagia, and gastrostomy. a. Review of Resident #44's dietary note dated 04/18/24 revealed to discontinue Jevity 240 milliliters (ml) with meals if oral intake was less than 50%. The resident reported she preferred house supplements eight ounces if she doesn't eat more than 50% of meals. New orders for houses supplement eight ounces if meal intakes are less than 50% per resident preference. Review of Resident #44's order dated 04/22/24 at 2:33 P.M., revealed the order for Jevity was still active, and there was no evidence the new order for house supplement was implemented. Interview on 04/25/24 at 9:39 A.M., with Assistant Director of Nursing (ADON) #361 confirmed the new order was not implemented until 04/22/24 due to the computer system was hacked Thursday and she doesn't work on Fridays, so she didn't receive the order until Monday. b. Review of Resident #44's order and medication administration records (MAR's) dated 04/2024 revealed from 04/01/24 to 04/22/24 the resident was ordered Jevity 240 ml bolus if the resident's intake were less than 50%. On 04/22/24 the Jevity was discontinued and new orders for house supplement 237 ml if intakes were less than 50% at meal. The resident was administered Jevity on 04/08/24 and 04/14/24 for dinner and the house supplement was administered on 04/23/24 and 04/24/24 for dinner and 04/24/24 for lunch. Review of the meal intakes revealed the resident ate less than 50% of the dinner meals on 04/03/24, 04/05/24, 04/09/24, 04/11/24, 04/18/24, and 04/22/24, and lunch meal on 04/09/24. There was no evidence the resident received Jevity when she ate less than 50% of meals. Review of Resident #44's weights revealed on 04/01/24 the resident weighed 237.7 pounds and on 04/12/24 234.3 pounds. Review of the resident's current plan of care revealed the resident required total feeding assistance in the dining room for all meals. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/24/24 at 3:00 P.M. with ADON #359 confirmed the State tested Nurses' Aides (STNA's) assist the residents in the dining room with her meals. The STNA then documents the meal intakes into the task. The ADON reported when she works on the floor, she will look at the meal tray after the resident was finished to determine the percent of intake before she administers the Jevity/house supplement, but she doesn't document the meal intake anywhere. The ADON reported she could not speak for the other nursing staff. The ADON confirmed according to the document meal intakes the resident ate less than 50% on the dinner meals on 04/03/24, 04/05/24, 04/09/24, 04/11/24, 04/18/24, and 04/22/24, and lunch meal on 04/09/24 and there was no evidence the resident received Jevity when she ate less than 50% of meals.

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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** 32801 Based on medical record review, review of transit receipt, and interview the facility failed to ensure a resident was referred to pain management clinic timely. This affected one (Resident #8) of six resident reviewed for pain. Findings included: A review of Resident #8's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included paraplegia; unspecified psychosis not due to a substance or known physiological condition; anxiety disorder; depression; panic disorder; abnormal posture; muscle wasting and atrophy; muscle weakness; chronic pain; cerebral infarction; nondisplaced fracture of medial malleolus of right tibia; osteoporosis; and generalized anxiety disorder. Review of Resident #8's current plan of care revealed the resident had alteration in comfort related to chronic pain, chronic wound to back with hardware visible, neuropathic pain, and gastric reflux disease. The resident intervention included an appointment with a pain specialist as needed. Review of Resident #8's order and progress note dated 08/31/23 revealed the physician referred the resident to a pain management clinic. Review of Resident #8's nursing note dated 10/11/23 revealed the facility called the pain management clinic to schedule an appointment. The pain management clinic was faxing over a referral for the physician to sign and requested that an magnetic resonance imaging (MRI) or computed tomography (CT) scan be done prior to appointment. Review of Resident #8's order dated 10/23/23 revealed CT of the lumbar spine due to increased pain. The CT was scheduled for 11/17/23 at 8:30 A.M. Review of Resident #8's medical record revealed no documentation on 11/17/23 regarding the resident appointment for the CT, no evidence the resident refused to go, nor was there evidence the resident had the CT of the lumbar done. Review of the transit receipt dated 11/17/23 revealed the resident was a no show. Interview on 04/23/24 at 11:10 A.M., with Resident #8 revealed he would like to go to the pain management clinic; however, the appointment has never been made. Interview on 04/24/24 at 1:40 P.M., with Social Service Designee #347 confirmed the pain management appointment has not been scheduled at this time due to the resident needing testing completed before they would schedule the appointment. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/02/24 at 7:42 A.M., via phone with Assistant Director of Nursing (ADON) #359 confirmed the physician had written an order on 08/31/23 referring the resident to go to the pain management clinic. The ADON confirmed the pain management clinic needed a CT scan of the lumbar completed before the appointment could be made. The physician orders a CT of lumbar on 10/23/23 and staff scheduled the appointment for 11/17/23. The ADON confirmed the CT of the lumbar was never done. The ADON confirmed the resident had a CT of the abdomen/pelvis on 03/29/24, however that was related to a separate issue. The resident was having abdominal pain related to his colostomy and it was not related to the pain management referral. The pain management clinic had requested a CT of the lumbar not the abdomen/pelvis and the physician order on 10/11/23 for the CT of the lumbar.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 32801 Based on review of the staffing daily posting, review of the schedule, review of timecards, review of the facility assessment, review of the quality assurance/performance improvement (QAPI), and interview the facility failed to ensure there was a Registered Nurse (RN) for eight consecutive hours and a full time Director of Nursing (DON). This had the potential to affect all 46 residents residing in the building. Findings included: 1. Review of the daily staffing posting dated 01/31/24 to 04/30/24 revealed there was no RN coverage for 01/06/24, 01/07/24, 01/13/24, 01/14/24, 01/20/24, 01/21/24, 01/27/24, and 01/28/24. Review of the facility assessment undated revealed the facility would have an RN at least eight hours daily. Review of the QAPI dated 02/01/24 to 03/01/14 revealed the problem was lack of RN coverage. The intervention was that the RDO would send out requests from other buildings to assist with coverage, offer sign on bonuses for RN coverage as of 02/22/24, and request requested others to participate from other buildings as of 03/2024. There was no evidence audits were completed or RN staff were hired to meet the facilities needs and to ensure RN coverage daily. Interview on 05/01/24 at 8:43 A.M., 12:00 P.M., 1:43 P.M and 4:01 P.M., with the Administrator confirmed the facility still doesn't have a full time RN except for the new DON that just started last month. The facility has an RN that works three days a week as MDS nurse and the facility was using sister facility staff to cover RN coverage for the weekends. The Administrator confirmed there were eight days in January when the facility did not have eight hours of RN coverage. The facility initiated QAPI, however there were no audits completed to ensure RN coverage. The facility can't not find RN's and they have advertised and offered bonuses. 2. Review of the facilities timeline for DON coverage undated revealed from February 21, 2024, to April 8, 2024, the DON was Corporate Nurse #334 and April 9, 2024, to current the DON is DON #605. Review of the daily postings dated 02/21/24 to 02/29/24 revealed there were only two days (02/27/24 and 02/08/24) the facility had a DON. The DON name listed for 02/27/24 and 02/28/24 was for the DON was Corporate Nurse #334. Review of the daily posting dated 03/01/24 to 03/31/24 revealed there was only one day (03/01/24) a DON was posted. The name listed for the DON on 03/01/24 was Corporate Nurse #334. Review of the daily posting dated 04/01/24 to 04/14/24 revealed no evidence a DON was listed. Review of March 2024 staffing schedule revealed the DON schedule was blank. Review of the facility assessment undated revealed the facility would have a DON on staff. (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of time sheets revealed the only time sheet provided for the DON from 01/23/24 to present was the Agency DON #603. Interview on 05/01/24 at 11:43 A.M., with Assistant Director of Nursing (ADON)/ Licensed Practical Nurse (LPN) #361 and RN #335 (MDS nurse) confirmed the facility didn't have a full time DON from February 21, 2024, to April 8, 2024. Interview on 05/01/24 at 3:42 P.M. with Corporate Nurse #334 confirmed she did not work full time as the DON from February 21, 2024, to April 8, 2024. The Corporate Nurse reported she was available to the staff 24/7 and visited the facility three or four times a week. The Corporate Nurse reported there was no documented evidence of the days she was at the facility during that timeframe, and she declined to put anything in writing stating which days she was present in the facility, however confirmed she was not there full time. Interview on 05/01/24 at 4:01 P.M., with the Administrator confirmed the Corporate Nurse #334 was listed as the DON from February 21, 2024, to April 8, 2024, however, was not full time. The Administrator reported the Corporate Nurse was the facility a few days a week and reported the MDS nurse works three days at the facility and two days at the sister facility as an MDS nurse, however she was not designated as the full time DON.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review and staff interview, the facility failed to ensure physician's orders for the use of over the counter and narcotic pain medication ordered on an as needed (prn) basis for pain included parameters on when to use those medications, failed to ensure another resident only received prn narcotic pain medications for pain levels specified in the parameters of the physician's orders, failed to ensure a physician was notified when a resident's systolic blood pressure was outside the parameters provided by the physician with use of a beta-blocker, and failed to ensure a resident's use of prn Vistaril was clearly identified in the medical record to show the reason it was being given when the Vistaril was being used for both allergies and anxiety. This affected four (Resident #3, #14, Resident #41, and #42) of six residents reviewed for unnecessary medications. Findings include: 1. A review of Resident #14's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included a malignant neoplasm of the frontal lobe, unspecified psychosis, wedge compression fracture T-11 and T-12 vertebra, and a history of falls. Review of Resident #14's physician's orders revealed she had the use of Oxycodone HCL (an opioid narcotic pain medication) 5 milligrams (mg) by mouth (po) every four hours and needed for pain of a 6-10 on a pain scale. She also had an order to receive Acetaminophen (Tylenol) 650 mg po every six hours as needed for pain between 1-5 on a 1-10 scale. Review of Resident #14's medication administration record (MAR) for April 2024 revealed the resident was given Oxycodone HCL 5 mg po nine times that month prn for pain. Three of the nine times the Oxycodone HCL was administered to the resident, her pain level was outside the parameters specified by the physician in which the prn pain medication was to be used. She received doses of the prn Oxycodone HCL on 04/07/24 at 7:10 P.M. for a reported pain level of 4 (below the 6-10 that was ordered by the physician), 04/08/24 at 10:31 P.M. for a pain level of 5, and on 04/15/24 at 1:15 P.M. for a pain level of 0. Her prn Acetaminophen that had been ordered on an as needed basis for pain levels between 1-5 had not been used that month. On 04/25/24 at 11:00 A.M., an interview with Licensed Practical Nurse (LPN) #359 confirmed Resident #14's orders for Acetaminophen and Oxycodone HCL to be given on a prn basis included parameters in which both prn medication should be used. She further confirmed the resident had been given the prn Oxycodone for pain levels below 6, which was below the specified pain level given by the physician in which the medication should be used. She stated the resident would ask for the prn Oxycodone when her pain levels were below 6 and the nurses would just give it to her. 2 Review of Resident #42's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included a history of a stroke (CVA), hypertension, adult onset diabetes mellitus, unspecified psychosis, and anxiety disorder. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Review of Resident #42's physician's orders revealed he had an order to receive Norco (Hydrocodone and Acetaminophen) 5-325 mg po every eight hours prn for pain. He also had an order to receive Acetaminophen 500 mg po every four hours prn for pain. Neither order included any parameters to direct the nurse as to when they should administer the prn Norco or the prn Acetaminophen. Review of Resident #42's MAR's for March 2024 revealed the resident was given the prn Acetaminophen (Tylenol) six times that month and was given the prn Norco five times since it had been ordered beginning on 03/28/24. The nurses did not record the resident's pain level at the time the prn pain medications were given. His pain was being assessed every shift and he was noted to not have pain every shift when asked. The times he did complain of pain, his pain level was recorded between a 3 and a 5 on a 1-10 scale. He was only indicated to have had a pain level of a 4 on the days he was given the prn Norco towards the end of the month. Four of the six times the prn Tylenol was given, the nurses indicated the Tylenol was effective in managing the resident's pain. He did not have use of the prn Norco, when the Tylenol was indicated to have been ineffective, the two times it was recorded as such. Review of Resident #42's MAR for April 2024 revealed the resident was given the prn Tylenol nine times and the prn Norco had been used 25 times. Again, the resident's pain level was not being recorded at the time the prn pain medications were administered. His pain continued to be assessed every shift and revealed he had pain less than daily, but did complain of pain most shifts. His pain was rated between a 2 and 5 most times. He only complained of pain at a 6 or higher on three of the 25 shifts when the prn Norco was used. b. Further review of Resident #42's physician's orders revealed the resident had an order to receive Metoprolol Succinate ER (a beta-blocker used to treat hypertension) 50 mg po every night at bedtime. The orders for Metoprolol Succinate ER had been in place since 04/10/24 and included parameters to call the physician if the resident's systolic blood pressure (SBP) was >150 or <100. There was no indication on the MAR of the resident's blood pressure being obtained at the time the Metoprolol Succinate was administered. Review of Resident #42's vital signs documented under the vital sign tab of the electronic medical record (EMR) revealed the resident's blood pressure was not being documented as having been checked daily and some of the times the blood pressure was being recorded did not coincide with the times the Metoprolol Succinate was being given. Some days the blood pressure was being checked once and other days it was being checked twice. The vital signs showed there were four times when the resident's SBP was outside of the parameters given with the Metoprolol Succinate in which the physician should have been called. On 04/11/24 at 12:56 A.M. the resident's blood pressure was 151/79. On 04/12/24 at 10:52 A.M. it was 166/94. On 04/17/24 at 7:26 P.M. it was 151/73. On 04/19/24 at 8:06 P.M. it was 89/50. All were above or below the parameters set by the physician in which notification of the physician should have occurred. Review of Resident #42's progress notes from 04/11/24 through 04/19/24 revealed there was no documented evidence of the physician being notified when the resident's SBP was >150 or <100 as included in the orders. Findings were verified by Regional Quality Assurance (QA) Nurse #334. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/29/24 at 4:52 P.M., an interview with Regional QA Nurse #334 confirmed there were no clear parameters on when to administer the resident's prn Tylenol versus the prn Norco. She also confirmed the resident's Metoprolol Succinate order included parameters in which the physician was to be called when the resident's SBP was >150 or <100 and there was no evidence of the physician notification taken place for the dates and times mentioned above. 47985 3. Record review revealed Resident #3 admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, hypertensive heart and chronic kidney disease with heart failure, osteoarthritic, atrial fibrillation, and neuromuscular dysfunction of the bladder. Review of physician orders revealed Resident #3 had an order in place for Norco oral tablet 5-325 milligrams give one tablet by mouth every eight hours as needed for pain dated 02/28/24 and Tylenol tablet 325 milligrams give two tablets by mouth every four hours as needed for increased pain rating 1-5/10 and do not exceed 3000 milligrams in 24 hours dated 01/31/24. Review of a medication administration record (MAR) for April 2024 revealed there were no parameters in place to determined which as needed pain medication to administer based on the numerical value Resident #3 stated his pain was. Interview on 04/30/24 at 1:47 P.M. with Director of Nursing (DON) and Licensed Practical Nurse (LPN) #361 confirmed there were no parameters in place to determine which as needed pain medication to administer to Resident #3 based on numerical pain level. DON confirmed Norco was administered when Resident #3 had a pain level of 5 on 04/02/24 at 6:07 A.M. and 3:05 P.M.; for a pain level of 4 on 04/05/24; for a pain level of 5 on 04/05/24, 04/06/24, 04/07/24, 04/08/24, 04/09/24, 04/11/24, 04/13/24, 04/14/24, 04/15/24, 04/16/24, and 04/18/24; a pain level of 4 on 04/19/24, a pain level of 5 on 04/20/24 and 04/25/24; a pain level of 0 and 4 on 04/27/24; a pain level of 3 on 04/28/24, and a pain level of 5 on 04/29/24 and 04/30/24. DON stated as needed Norco should not be administered for a pain level of 0. LPN #361 stated if the patient says they are in pain you cannot judge their level of pain. 32801 4. Record review revealed Resident #41 was admitted to the facility on [DATE] with diagnoses including dementia with behavioral disturbance, chronic obstructive pulmonary disease (COPD), acute respiratory failure with hypoxia, acute kidney failure, chronic kidney disease, hepatitis, and mental disorders. Review of Resident #41's September 2023 medication administration records revealed the resident had an order on since admission for Vistaril 25 milligrams (mg) two tablets every four hours as needed for allergies/anxiety. The resident was administered the Vistaril 27 times in September, however there was no indication if it was administered for anxiety or allergies. Interview on 04/30/24 at 2:09 P.M., with Corporate Nurse (CN) #334 confirmed the resident had received Vistaril 27 times in September 2023 and there was only two times staff had documented the indication for use.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 28923 Based on observation, staff interview, and policy review, the facility failed to ensure insulin flexpens were properly dated after they had been removed from the refrigerator and was used for the first time. This affected three residents (Resident #10, #13, and #16) whose insulin flexpens were found when reviewing two of two medication administration carts used by the facility for the storage of medications. Findings include: On 05/01/24 at 1:50 P.M., an observation of the medication administration cart for the A and B-hall revealed there were insulin flexpens found in the pull out drawer that had not been properly dated, after they had been removed from refrigeration during storage and used for the first time for the residents they were ordered for. Resident #16 was noted to have a Lantus flexpen (long acting insulin) 100 units/ milliliter (ml) that was in a plastic bag marked with a sticker to refrigerate. There was a label on the Lantus flexpen where the nurse was to date the flexpen, after it had been removed from the refrigerator and used for the first time. The label was left blank where the nurse was supposed to add a date to indicate when it was first used. Resident #13 was noted to have two insulin flexpens (Toujeo and Insulin Aspart) that had not been dated when they were removed from the refrigerator and used for the first time. On 05/01/24 at 1:55 P.M., an observation of the medication administration cart for the C-hall revealed additional concerns with insulin flexpens not being properly dated when put in use. A Lantus flexpen was found for Resident #10 in the third drawer of the medication administration cart that had not been dated when it was removed from the refrigerator and used for the first time. The Lantus flexpen was being stored in the same bag as a Insulin Aspart flexpen for that same resident. It had been dated but was being stored in the plastic bag for the Lantus flexpen instead of the plastic bag the Insulin Aspart flexpen was delivered in. Findings were verified by Licensed Practical Nurse (LPN) #366. On 05/01/24 at 1:57 P.M., an interview with LPN #366 confirmed insulin flexpens should be dated, after they had been removed from the refrigerator during storage and used for the first time. She was asked what the importance was of dating the flexpens and she replied they were only good for up to 28 days after they had been removed from the refrigerator and first used. She was not able to determine how long the flexpens for the three residents had been in use for, but confirmed they were all previously being used for the three residents. She removed them from the medication administration cart to dispose of them since they had not been dated and the discard date could not be determined. Review of the facility's policy for Storage of Medication from PharMerica Corp. copyrighted in 2007 revealed medications and biologicals were to be stored properly following manufacturer's or provider pharmacy recommendations, to maintain their integrity and to support safe, effective drug administration. Insulin products were to be stored in the refrigerator until opened. Note the date on the label for insulin vials and pens when first used.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Landing Nursing and Rehabilitation	856 South Riverside Drive McConnelsville, OH 43756

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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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on record review, interview, and policy review the facility failed to ensure laboratory testing was completed as ordered. This affected one (Resident #41) of two reviewed for hospitalization . Findings included: Record review revealed Resident #41 was admitted to the facility on [DATE] with diagnoses including dementia with behavioral disturbance, chronic obstructive pulmonary disease, acute respiratory failure with hypoxia, acute kidney failure, chronic kidney disease, hepatitis, and mental disorders. Review of Resident #41's written orders dated [DATE] revealed the Nurse Practitioner (NP) wrote orders for complete blood count (CBC) and Chem 8. There were no diagnoses or rational for order. Review of Resident #41's nurses note dated [DATE] written by the Assistant Director of Nursing (ADON) #361 revealed the NP visited and new orders were received for labs (CBC and Chem 8) in the morning. The resident and resident representative aware. Review of Resident #41's Medication and Treatment Records dated ,d+[DATE] revealed no evidence the CBC or Chem 8 was entered on the records per the facilities policy. Review of Resident #41's laboratory results revealed no evidence the CBC or Chem 8 was obtained on [DATE]. Review of Resident #41's health status note dated [DATE] and [DATE] revealed the resident was sent to the emergency room due to worsening cold symptoms. The resident was admitted on [DATE] for sepsis related to pneumonia. Interview on [DATE] at 10:02 A.M., with Resident #41 revealed she was hospitalized for pneumonia and almost died because she kept telling the staff and doctor she wasn't feeling well, and they wouldn't listen to her. Interview on [DATE] at 9:28 A.M., with the ADON #361 confirmed the orders written on [DATE] were not obtained on [DATE] and the lab comes twice weekly. The ADON confirmed the resident was sent to the hospital on [DATE] and was admitted on [DATE] with sepsis. Review of the facilities policy titled Lab Draws undated revealed the facility would implement lab orders as written and maintain written standards and practices guidelines regarding physician ordered lab draws. The nurse would review lab orders and clarify orders as needed. The nurse would sign orders and enter the lab into the computer to communicate the order to draw labs and transcribe onto the treatment records. The nurse transcribing the order would box off the date of ordered draw and another box would be entered for 48 hours later. The day shift nurse would verify the receipt of the lab results and sign in the second box verifying the lab results were received by the facility. If the lab results were not yet available, the nurse should contact the lab to request an update on the status of the lab.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on medical record review and interview, the facility failed to ensure dental services were arranged in a timely manner. This affected one (Resident #8) of two reviewed for dental services. Findings included: A review of Resident #8's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included paraplegia; unspecified psychosis not due to a substance or known physiological condition; anxiety disorder; depression; panic disorder; abnormal posture; muscle wasting and atrophy; muscle weakness; and generalized anxiety disorder. Review of Resident #8's dental plan of care dated 05/16/22 revealed the resident had dental caries and abscess teeth. Intervention included to coordinate arrangement for dental care, monitor for any dental problems needing attention, and to provide mouth care. Review of Resident #8 significant change minimum data set (MDS) dated [DATE] revealed the resident has no dental issues. Review of Resident #8 dental note dated 07/26/23 revealed the resident had generalized caries and broken teeth and the resident requested that all his teeth be pulled. The dentist made a referral to an oral surgeon and the Social Service Designee (SSD) #347 was notified of the referral. Review of Resident #8's progress note dated 10/10/23 revealed an appointment was made for an oral surgeon on 10/27/23 at 8:30 A.M. Review of Resident #8's progress note dated 10/27/23 revealed the resident refused to go to dental appointment. Left message with dental office that resident canceled. There was no documented evidence the appointment was rescheduled. Interview and observations on 04/23/24 at 11:10 A.M. and 05/01/24 at 10:40 A.M., with Resident #8 revealed his teeth were in poor condition and he was supposed to see a specialist last year to have all his teeth extracted. The resident declined to let the surveyor observe his teeth, but pointed to one tooth and the tooth was noted to be discolored and partially broken. The resident reported he was able to eat soft foods, however he was tired of mashed potatoes and would like dentures so he could eat again. Interview on 04/24/24 at 1:40 P.M. and 05/01/24 at 9:30 A.M and 11:00 A.M., with SSD #347 revealed it took her several months to find an oral surgeon who would take the residents insurance. She found a doctor about an hour away and made an appointment for 10/27/23, however the resident refused to go because he reported he was not notified of the appointment. The SSD provided evidence from a progress note that indicated the resident was notified of the appointment. The SSD confirmed the appointment was not rescheduled due to the resident refused, however there was no documented evidence to support the resident refused to have the appointment rescheduled. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/01/24 at 10:40 A.M., with Resident #8 confirmed he didn't refuse to have the oral surgeon appointment rescheduled.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review, observation, resident interview, staff interview, and review of the alternate meal menu, the facility failed to ensure a resident was provided a nutritious meal of choice when she declined the main meal being served for the lunch meal on 04/23/24. This affected one resident (Resident #37) of one residents reviewed for alternate meal choices. Findings include: Review of Resident #37's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included schizo-affective disorder of the bipolar type, morbid obesity due to excess calories, post traumatic stress disorder, Asperger's syndrome, anxiety disorder, psychotic disorder with delusions from known physiological condition, borderline personality disorder, and gastroesophageal reflux disease (GERD). Review of Resident #37's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident did not have any communication issues and was cognitively intact. She was able to make herself understood and was able to understand others. Review of Resident #37's care plans revealed she had a care plan in place for the potential for an alteration in her nutrition related to chronic diseases and being at risk for malnutrition. She was known to have a significant weight loss but was morbidly obese and was receiving Wegovy/ Mounjaro for desired weight loss. She was known to have a limited adherence to suggested diet restrictions related to a lack of value for behavior change regarding weight loss as evidenced by eating whatever she desired. Her goal was to maintain her weight without unplanned significant weight changes. The interventions included providing her diet as ordered (regular diet), honoring her food preferences as able, and to offer meal alternates if she refused a meal. On 04/23/24 at 11:51 A.M., an interview with Resident #37 revealed she was denied an alternate meal when she declined what was being served for the lunch meal on 04/23/24. She indicated they were having hotdogs and sauerkraut and she did not like that. She reported she had asked for two cheeseburgers in its place but was told she could not have that since she did not give them notice in time. They would not even make her a peanut butter and jelly sandwich and she was hungry. On 04/23/24 at 12:05 P.M., an observation of the lunch meal process revealed the nursing assistants were on Resident #37's hall delivering meal trays. State tested Nursing Assistant (STNA) #351 was approached and asked if Resident #37 was going to be getting a meal for lunch. She reported the resident had told her she did not want the hotdog and sauerkraut that was being served for that meal. She was asked if the resident was going to be receiving something else in its place since she did not want the main meal being served. STNA #351 replied the resident did not get her request into the kitchen before 10:00 A.M. therefore, she could not get anything else to eat. She was asked why that was the case, and replied that was just the rules from the kitchen. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/23/24 at 12:07 P.M., an interview with Licensed Practical Nurse (LPN) #368 confirmed the residents had to have their food requests into the kitchen by 10:00 A.M. She acknowledged Resident #37 did not want the meal being served and requested two cheeseburgers instead. The nurse advised the surveyor to speak with LPN #359 who was dealing with that request. On 04/23/24 at 12:08 P.M., an interview with LPN #359 revealed she was not aware of Resident #37 having any alternate requests for the lunch meal. She stated her name was given to the surveyor by mistake and she had no involvement in the resident's meal. She was informed by the surveyor that the resident reported she had requested two cheeseburgers in place of the hotdog and sauerkraut and was reportedly told that she could not have it. LPN #359 went to the kitchen to find out what was going on with the resident's meal request. Dietary Cook #364 was in the dining room by the entry door into the kitchen from the dining area. Dietary Manager #370 had been near the kitchen door and came out into the dining room with Dietary Cook #364 when she was being asked about Resident #37's request for an alternate meal. Dietary Cook #364 was heard telling LPN #359 that Resident #37 could not get an alternate meal as she had not put in her request by the cut off time, which was 10:00 A.M. Dietary Cook #364 and Dietary Manager #370 was asked what the relevance was with the 10:00 A.M. cut-off time for any alternate meal requests. They were informed a resident had the right to change their mind of what they wanted to eat and if the kitchen had the particular food item on hand that the resident was requesting then they should allow her to choose something else as opposed to not providing her a meal and making her go without. Dietary Manager #370 stated they did have hamburgers, as it was on their alternate meal choice menu, and would provide the resident with cheeseburgers as she requested. It would only take them 10 minutes to make. On 04/23/24 at 12:15 P.M., the facility's Administrator was informed Resident #37 was denied an alternate meal when she did not want what was served and had requested it from the kitchen. She stated the expectation was for alternate meal requests be made known to the kitchen by 10:30 A.M. The purpose of that was to allow the dietary staff adequate time to prepare it for the upcoming meal, but the residents could request an alternate meal at any time. She stated she would follow up with the dietary staff to ensure the resident was provided an alternate meal. On 04/23/24 at 2:15 P.M., a follow up with the facility's Administrator revealed she had talked with the dietary staff and the directive they were following was the instructions that was included at the bottom of their alternate meal menu. She stated the residents were given the option to select the items off their alternate meal choice menu that was available for lunch and dinner. The current alternate meal choice menu did specify that orders were to be turned in before 10:00 A.M. for lunch and 4:00 P.M. for dinner. She stated the dietary staff took that to heart and if the orders were not turned in at the specified times they were not making the residents an alternate meal. She stated she would remove that from the alternate meal choice menu so the staff all knew residents could make alternate meal requests when meals were refused.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 28923 Based on observation, review of the cycle menu for Week 1, and staff interview, the facility failed to ensure residents received all food items for each meal in accordance with the cycle menu. This had the potential to affect all but six residents (Resident #6, #17, #18, #20, #25, and #42) who the facility identified as being on a pureed diet. The facility's census was 46. Findings include: On 04/24/24 at 11:25 A.M., an observation of the tray line noted Dietary Cook #350 was preparing the trays for the residents for the lunch meal served. She started with the hall carts and then was to prepare trays for those residents eating in the dining room. The meal included sweet and sour meatballs, parsley noodles, carrots, ice cream and beverages of their choice. The residents receiving a pureed diet was noted to be receiving pureed bread, but none of the residents receiving a mechanical soft texture diet or a regular diet was receiving any type of bread product. Review of the cycle menu for week 1 for the lunch meal to be served on Wednesday 04/24/24 revealed the meal should include a choice of roll. Findings were verified by Dietary Manager #370 on 04/24/24 at 12:02 P. M. (after the hall carts had been loaded and prior to the residents in the dining room being served) that none of the residents that were provided regular textured diets or on mechanical soft diets were provided a dinner roll with their meal. On 04/24/24 at 12:03 P.M., an interview with Dietary Manager #370 revealed the rolls that had been delivered to the facility and were to be served with the lunch meal on 04/24/24 had been damaged and could not be used for the meal. She stated they were supposed to substitute that with bread and butter but that had been overlooked when the hall trays had been preapred and loaded on the food delivery carts. She stated she would have the dietary staff place bread and butter on the trays that had already been loaded on the food cart before they were delivered to the hall. She confirmed without surveyor intervention, the residents would not have received the meal in accordance with their cycle menu.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 28923 Based on observation, review of the pureed food recipes, and staff interview, the facility failed to prepare pureed food in a manner that conserved the nutritional value of the food being pureed in accordance with the recipes. This affected six residents (Resident #6, #17, #18, #20, #25, and #42) of six residents who the facility identified as being on a pureed diet. Findings include: On 04/24/24 at 10:45 A.M., an observation of the pureed food process noted Dietary Cook #350 to puree three different food items that were to be served with the lunch meal on 04/24/24. The first food item that was pureed was the parsley noodles. She was observed to puree the parsley noodles without referring to a recipe. She added the scoops of parsley noodles using the correct serving size (#8/ 4 ounce scoop) into the Robot Coupe food processor. She blended the noodles and then was noted to add an unmeasured amount of water to the noodles to try to obtain the desired consistency she needed. She did not add any type of broth of chicken/ beef base to the water before adding it to the noodles. The noodles did reach a proper consistency but was very bland and had no flavor. She then was observed to puree the sweet and sour meatballs. Two to three meatballs were added to the Robot Coupe food processor with each serving added. She blended the meatballs and first added some of the gravy that was in the meatballs to the pureed mixture to help obtain the desired consistency she needed for the pureed meatballs. When the proper consistency was not obtained, she was observed to add water to the meatball mixture to further liquefy it to the desired consistency. She again, did not reference a recipe when she pureed the meatballs. The carrots were able to be pureed by just adding the desired amount of carrots with the juice they were cooked in. On 04/24/24 at 12:03 P.M., an interview with Dietary Manager #370, who was there when Dietary Cook #350 pureed the food she needed with the lunch meal, confirmed Dietary Cook #350 did not use a recipe when she pureed the three food items she needed for lunch. She reported they had recipes available for use that was kept in a binder that also had the spreadsheets specifying proper serving sizes needed for each meal. The recipes were located behind the spreadsheet and did not get looked at when the pureed food was being prepared. A review of the recipe for the parsley noodles revealed the dietary cook should have added hot broth made by combining the hot water with the chicken base to the pasta noodles while processing. The recipe for the pureed sweet and sour meatballs revealed the cook should have added water plus the beef base and process until it was smooth in texture. Dietary Manager #370 confirmed Dietary Cook #350 did not follow the recipes and did not maintain the nutritive value of the food she was processing when she just added water without any chicken or beef base to the pureed mixture as was called for in the recipe. She acknowledged the pureed parsley noodles did not have any flavor as a result of just water being added to the noodles without the chicken base. Review of a list of resident diets provided by the facility revealed Resident #6, #17, #18, #20, #25, and #42 received a pureed diet.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 28923 Based on observation, taste testing of the pureed food, and staff interview, the facility failed to ensure pureed food was prepared in the form that met the needs of the residents. This affected six residents (Resident #6, #17, #18, #20, #25, and #42) of six residents who the facility identified as being on pureed diets. Findings include: On 04/24/24 at 10:45 A.M., an observation of the pureed food process for the lunch meal served on 04/24/24 revealed Dietary Cook #350 pureed three different food items that were to be served to the residents on a pureed diet for lunch. The first item pureed was the parsley noodles, followed by the sweet and sour meatballs, and then the carrots. The dietary cook did not taste any of the three food items that were pureed. She also did not follow any recipes when she pureed the three food items. The parsley noodles were of proper consistency despite her not tasting the noodles to verify that before putting them on the steam table until they were served for lunch. The sweet and sour meatballs were not at proper texture when she reported she achieved the consistency she was going for. Again she failed to test the pureed meatballs before she decided they were of proper consistency. The pureed meatballs were tasted by the surveyor and Dietary Manager #370, after Dietary Cook #350 reported they were ready to go. The pureed meatballs were gritty and had flecks of seasoning from the sauce they came in that were still noticeable and remained on your tongue after swallowing. Dietary Manager #370 confirmed they were not at the desired texture they needed to be at for a pureed diet. On 04/24/24 at 12:03 P.M., an interview with Dietary Manager #370 confirmed Dietary Cook #350 did not follow any recipes when she pureed the three food items. She also confirmed Dietary Cook #350 did not taste the pureed food to ensure it was at a proper consistency/ texture before she decided it was suitable for the residents who were on a pureed diet. Review of a list of resident diets provided by the facility revealed Resident #6, #17, #18, #20, #25, and #42 received a pureed diet.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 32801 Based on observation and interview the facility failed to ensure lunch meals were served in a sanitary manner. This potentially affected all 46 residents that reside in the building. Findings included: Observation on 04/22/24 at 11:43 A.M. of lunch meal service revealed the A and B Hall trays arrived at the unit in a cart. State tested Nurse's Assistant (STNA) #322 removed a container filled with condiments from the meal cart and placed it directly on the floor so she could get the coffee out. The STNA then picked up the condiment container and placed it back into the meal carts with the meal trays. Interview on 04/22/24 at 11:44 A.M., with STNA #322 confirmed she had placed the condiment container directly on the floor and placed it back into the meal cart with the resident meal trays. The STNA reported she didn't know what she was supposed to do because she was told she could not place anything on top of the meal cart and the kitchen staff always put the coffee behind the condiments container and she had to take the condiment container out to get to the coffee.

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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** 47985 Based on record review and interview, the facility failed to ensure enhanced barrier precautions were in place and failed to properly map infections in the facility. This had the potential to affect all 46 residents in the facility. Findings included: 1. Record review revealed Resident #3 admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, hypertensive heart and chronic kidney disease with heart failure, type II diabetes, and neuromuscular dysfunction of bladder. Review of physician orders revealed Resident #3 had an order in place dated 04/05/23 for may change 16 French 10 cc indwelling catheter related to neurogenic bladder as needed for blockage and dislodgement. Review of a care plan dated 05/01/24 revealed Resident #3 had an alteration in elimination and neurogenic bladder which resulted in needing an indwelling foley catheter 16 French 10 milliliter balloon. Observation on 04/23/24 at 8:45 A.M. revealed Resident #3 had an uncovered catheter bag which was visible from the hallway. There was no visible indication of enhanced barrier precautions. Interview on 04/24/24 at 10:55 A.M. with Licensed Practice Nurse (LPN) #361, who is also the Infection Preventionist, revealed the facility had not initiated enhanced barrier precautions in place yet for any resident who would require them due to not having a Director of Nursing (DON) in place to inform her of the new regulations. LPN #361 stated any resident who has a wound, tube feed, or IV should be in enhanced barrier precaution. LPN #361 stated she had not read the whole policy yet and was not up to date, but any indwelling device which could draw an infection should have enhanced barrier precautions. LPN #361 stated she had been the Infection Preventionist since 10/24/22. She stated she will typically get emails regarding infection control policy and changes but did not receive anything for enhanced barrier precautions until 04/23/24. LPN #361 stated all staff would be educated on 04/30/24, then enhanced barrier precautions would be rolled out. Review of a policy titled Enhanced Barrier Precautions dated 03/2024 revealed enhanced barrier precautions should be in place for any resident in the facility with an infection or colonization with a CDC-targeted MDRO when contact precautions do not otherwise apply or for wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with an MDRO. Indwelling medical devices may include central lines, urinary catheters, feeding tubes, and tracheostomies. Chronic wounds include pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous status ulcers. 2. Record review revealed Resident #27 admitted to the facility on [DATE] with diagnoses including paraplegia, emphysema, neuromuscular dysfunction of the bladder, and need for assistance with personal care. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Riverside Landing Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 856 South Riverside Drive McConnelsville, OH 43756	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of a quarterly Minimum Data Set (MDS) completed on 01/12/24 revealed Resident #27's cognition remained intact, she did not have any behaviors, she was dependent on staff for toileting hygiene, she had an indwelling catheter, and she had frequent pain. Interview on 04/23/24 at 4:08 P.M. with Resident #27 revealed she went to the hospital on 04/22/24 and the hospital gave her a catheter because she was not voiding all the way on her own. Resident #27 stated when they inserted the catheter, she drained a chunky, yellow, milky substance and has felt much better since. There was no indication Resident #27 was on enhanced barrier precautions. Interview on 04/24/24 at 10:55 A.M. with LPN #361, who is also the Infection Preventionist, revealed the facility had not initiated enhanced barrier precautions in place yet for any resident who would require them due to not having a DON in place to inform her of the new regulations. LPN #361 stated any resident who has a wound, tube feed, or IV should be in enhanced barrier precaution. LPN #361 stated she had not read the whole policy yet and was not up to date, but any indwelling device which could draw an infection should have enhanced barrier precautions. LPN #361 stated she had been the Infection Preventionist since 10/24/22. She stated she will typically get emails regarding infection control policy and changes but did not receive anything for enhanced barrier precautions until 04/23/24. LPN #361 stated all staff would be educated on 04/30/24, then enhanced barrier precautions would be rolled out. Review of a policy titled Enhanced Barrier Precautions dated 03/2024 revealed enhanced barrier precautions should be in place for any resident in the facility with an infection or colonization with a CDC-targeted MDRO when contact precautions do not otherwise apply or for wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with an MDRO. Indwelling medical devices may include central lines, urinary catheters, feeding tubes, and tracheostomies. Chronic wounds include pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous status ulcers. 3. Review of the infection control log revealed the facility mapping of infections for May 2023 was incomplete. Five infections were logged but the color code was the same for multiple different infections. In addition there were three UTI's, four wound infections, one skin infection, one fungal infection, and one yeast infection. Interview on 04/24/24 at 11 A.M. with LPN #361 confirmed the infection control mapping for May 2023 was inaccurate and hard to read. 32801 4. Record review revealed Resident #44 was admitted to the facility on [DATE] with diagnoses including cerebral infarction, enterocolitis due to clostridium difficile, dysphagia, and gastrostomy placed 12/07/23. Review of Resident #44's current order dated 04/2024 revealed no evidence the resident was ordered to be in enhance barrier precautions related to the gastrostomy tube. Review of Resident #44's plan of care revealed no evidence the resident was in enhance barrier precautions. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 04/22/24 at 2:29 P.M. revealed the resident had a gastrostomy tube with no evidence the resident was in enhance barrier precautions. Interview on 04/24/24 at 10:55 A.M. with the LPN #361 confirmed Resident #44 should have been placed in enhance barrier precautions because she had gastrostomy tube. LPN #361 reported she just found out yesterday about enhance barrier precautions and the facility plans to have a staff meeting next week to educate staff. The LPN reported she depends on corporate staff to provide her updates with infection control practices, and she was unaware of the new updates. 5. Record review revealed Resident #3 was admitted to the facility on [DATE] with diagnoses including stage four chronic kidney disease, congestive heart failure, Guillain-Barre syndrome, and neuromuscular dysfunction of bladder. Observation and interview on 04/29/24 at 9:56 A.M., of Resident #3's urinary catheter care with State tested Nurse Assistant (STNA) #321 revealed the STNA washed the meatus with a soapy washcloth and placed the washcloth back into the water basin after she used it, then she got a new washcloth and used the same water out of the water basin to wet the washcloth to rinse the meatus. After she rinsed the area, she placed the dirty rinse washcloth in the same water basin. She grabbed another washcloth and dried the meatus and placed that cloth in the same water basin. She then washed, rinsed, and dried the shaft of the penis in the same manner and placed all 3 dirty wash clothes in the same basin of water that the three previous washcloths were still in. She then cleansed and rinsed the tubing using the same manner; however, she had used a towel to dry. There was a total of eight wash clothes in the water basin. The STNA confirmed she should have placed the used wash clothes in the trash bag after each use instead of putting them and leaving them in the water basin. The STNA covered the resident back up with her gloved hands, took all the wash clothes out of the basin and placed in trash bag, and emptied the water in the toilet and flushed. The STNA reported she has not performed catheter care for some time. The trash can did not have a bag in it and she had placed the basin and her personal protective equipment (PPE) in the trash can anyways and reported she would go get a trash bag for those items and dispose of them properly later. The STNA washed her hands and checked on the resident and exited the room with the trash bag with the wash clothes in it. Review of the catheter care urinary competency assessment dated 2018 revealed to gather supplies and position male resident, into the supine position. Put on gloves and place bed protector under the resident. Wash the resident's genitalia and perineum thoroughly with soap and water. Rinse the area well and towel dry. Pour wash water down the commode and flush commode. For catheter care wash hands and put on clean gloves. Provide privacy and cover residents exposing perineal area. For a male use a washcloth with warm water and soap to cleanse around the meatus. Cleanse the glans using circular strokes form the meatus outwards. Change the position of the washcloth with each cleansing stroke. With a clean washcloth, rinse with warm water using the above technique. Return the foreskin to normal position. Use a clean washcloth with warm water and soap to cleanse and rinse the catheter from insertion site to approximately four inches outward. Secure catheter and check drainage tube. Reposition the bed covers. Interview on 05/29/24 at 10:54 A.M., with LPN #361 (ADON/IP) confirmed the STNA should have placed the dirty wash clothes in a trash bag and not put them back into the water basin and had a bag for the PPE and water basin. The ADON reported she had provided education to STNA #321 and staff. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	6. A review of Resident #8's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included history of MRSA, paraplegia; unspecified psychosis not due to a substance or known physiological condition; anxiety disorder; depression; panic disorder; abnormal posture; muscle wasting and atrophy; muscle weakness; and generalized anxiety disorder. Review of Resident #8's orders dated 04/2024 revealed the resident the resident to maintain colostomy to right upper quadrant every shift and to wash wound to interior back with quarter Dakin, pack with alginate silver and cover with dressing daily and as needed. Review of Resident #8's orders dated 04/2024 revealed no evidence the resident was ordered enhance barrier precautions. Review of Resident #8's current plan of care revealed no evidence the resident was ordered enhance barrier precautions. Observation on 04/23/24 at 11:10 A.M. of Resident #8 revealed no evidence the resident was placed in enhance barrier precautions. Interview on 04/24/24 at 10:55 A.M. with ADON/LPN #361 confirmed Resident #8 should have been placed in enhance barrier precautions because he had colostomy and wound.

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985 Based on record review and interviews, the facility failed to ensure residents met infection criteria for appropriate antibiotic use. This affected three (Residents #7, #17, and #24) of 10 residents reviewed for infection control. The facility census was 46. Findings included: 1. Record review revealed Resident #7 admitted to the facility on [DATE] with diagnoses including atrial fibrillation, dementia, and atherosclerotic heart disease without angina. Review of the infection control log for April 2024 revealed Resident #7 was treated for a urinary tract infection (UTI). Review of a urine culture dated 04/06/24 revealed Resident #7 tested positive for UTI with enterococcus Faecium VRE (Vancomycin resistant enterococcus). Review of McGeer Criteria for Infection Surveillance Checklist dated 04/08/24 revealed in order to be treated for a UTI criteria must be for section one (acute dysuria or pain, swelling, or tenderness of testes, epididymis, or prostate; fever of leukocytes and one of the following: acute costovertebral angle pain or tenderness, suprapubic pain, gross hematuria, new or marked increase in incontinence/urgency/frequency) and section two (10^5 cfu/mL of no more than 2 species of organisms in a voided urine sample or 10^2 cfu/mL of any organism in a specimen collected by an in-and-out catheter). Resident #7 met criteria two but criteria one was left blank. Interview on 04/24/24 at 11 A.M. with Licensed Practical Nurse (LPN) #361 confirmed the McGeer criteria was not completed in full to ensure appropriate antibiotic use for Resident #7. 2. Record review revealed Resident #17 admitted to the facility on [DATE] with diagnoses including senile degeneration of the brain and dementia. Review of the infection control log for April 2024 revealed Resident #17 was treated for a UTI. Review of McGeer Criteria for Infection Surveillance Checklist dated 04/15/24 revealed in order to be treated for a UTI criteria must be for section one (acute dysuria or pain, swelling, or tenderness of testes, epididymis, or prostate; fever of leukocytes and one of the following: acute costovertebral angle pain or tenderness, suprapubic pain, gross hematuria, new or marked increase in incontinence/urgency/frequency) and section two (10^5 cfu/mL of no more than 2 species of organisms in a voided urine sample or 10^2 cfu/mL of any organism in a specimen collected by an in-and-out catheter). Resident #17 met criteria two but criteria one was left blank. Interview on 04/24/24 at 11 A.M. with LPN #361 confirmed the McGeer criteria was not completed in full to ensure appropriate antibiotic use for Resident #17. 3. Record review revealed Resident #24 admitted to the facility on [DATE] with diagnoses including type II diabetes, asthma, and hypertension. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the infection control log for March 2024 revealed Resident #24 was treated for a UTI. Review of McGeer Criteria for Infection Surveillance Checklist dated 03/04/24 revealed order to be treated for a UTI criteria must be for section one (acute dysuria or pain, swelling, or tenderness of testes, epididymis, or prostate; fever of leukocytes and one of the following: acute costovertebral angle pain or tenderness, suprapubic pain, gross hematuria, new or marked increase in incontinence/urgency/frequency) and section two (10^5 cfu/mL of no more than 2 species of organisms in a voided urine sample or 10^2 cfu/mL of any organism in a specimen collected by an in-and-out catheter). Resident #24 met criteria two but criteria one was left blank. Interview on 04/24/24 at 11 A.M. with LPN #361 confirmed the McGeer criteria was not completed in full to ensure appropriate antibiotic use for Resident #24.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985 Based on record review and interview, the facility failed to administer the pneumococcal vaccine to a resident who consented to receiving it. This affected one (Resident #21) of five residents reviewed for vaccinations. The facility census was 46. Findings included: Record review revealed Resident #21 admitted to the facility on [DATE] with diagnoses including acute respiratory failure, metabolic encephalopathy, type II diabetes, and hypertension. Review of a consent form for a pneumococcal vaccination revealed Resident #21's responsible party consented to Resident #21 receiving the vaccine on 11/08/23. Review of the medical record provided no evidence the vaccination had been administered. Interview on 04/24/24 at 11 A.M. with Licensed Practical Nurse #361 confirmed Resident #21 had a consent to receive the pneumococcal vaccination on 11/08/23 but had not yet received it. Review of an undated policy titled Influenza, Pneumococcal, Shingles, and COVID-19 Immunization revealed each resident will be offered the medically appropriate vaccine upon admission, and as needed, according to the recommended schedule for pneumococcal immunization, unless the immunization is medically contraindicated or the resident had already been immunized, or completed the series as recommended.

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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985 Based on record review and interview, the facility failed to offer vaccinations for COVID-19. This affected three (Resident #3, #8, and #21) of five residents reviewed for vaccinations. The facility census was 46. Findings included: 1. Record review revealed Resident #3 admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, hypertensive heart and chronic kidney disease, type II diabetes, and respiratory failure. Review of vaccination consents revealed Resident #3 had not been offered a vaccination for COVID-19 since 11/14/22. Review of a handwritten statement dated 04/24/24 signed by Resident #3 revealed facility had offered the vaccine and he had declined. Interview on 04/24/24 at 11 A.M. with Licensed Practical Nurse (LPN) #361 confirmed the only consent available from Resident #3 was from 2022 2. Record review revealed Resident #8 admitted to the facility on [DATE] with diagnoses including paraplegia, chronic hepatitis, unspecified atherosclerosis, hypertension, and neuromuscular dysfunction of the bladder. Review of Resident #8's vaccination consents revealed COVID-19 vaccination had not been offered for administration. Interview on 04/24/24 at 11 A.M. with LPN #361 confirmed Resident #8 was not offered the COVID-19 vaccination. 3. Record review revealed Resident #21 admitted to the facility on [DATE] with diagnoses including respiratory failure, metabolic encephalopathy, type II diabetes, and hypertension. Review of Resident #21's vaccination consents revealed COVID-19 vaccination had not been offered for administration. Interview on 04/24/24 at 11 A.M. with LPN #361 confirmed Resident #21 was not offered the COVID-19 vaccination. Review of an undated policy titled Influenza, Pneumococcal, Shingles, and COVID-19 Immunizations revealed the nursing facility should offer the vaccine for COVID-19 per the manufacturer guidelines via the authorized provider unless the immunization is medically contraindicated, the resident refuses the immunization, or if the resident has already been immunized during the time period. The facility will record the receipt, refusal or contraindications within the patient's medical record.