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	06/10/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on review of a facility self reported incident (SRI), review of the facility's related investigation, staff interview, and policy review, the facility failed to ensure a resident was free from physical abuse when another resident with a history of aggressive behaviors struck the resident in the face. This affected one (Resident #1) of two residents reviewed for abuse. Findings include: Review of an SRI with the tracking number 249042 revealed an allegation of physical abuse was made on [DATE]. The initial source of the allegation was from a staff member and the alleged perpetrator was identified as being another resident. The involved residents identified included Resident #1 (alleged victim) and Resident #9 (alleged perpetrator). Both residents were indicated to have been able to provide meaningful information when interviewed. Resident #1 was indicated to have a scratch on his face by his nose and Resident #9 was indicated not to have any injury or harm to him. The narrative summary of the incident revealed both residents were in the dining room when Resident #9 got very angry when he was not able to get through. Resident #1's chair battery had died, so he was not able to move. Resident #9 was trying to maneuver around Resident #1, but was getting very irritated with him. When Resident #9 went to go around Resident #1, Resident #1 was shaking his finger/ fist at him (Resident #9) in his face. Resident #9 then struck Resident #1 in the face and knocked his glasses off. Resident #9 admitted that Resident #1 did not hit him, but was reaching over trying to hit him and shaking his fist. Resident #1 had a rough time communicating, but stated he did not hit the other resident. The two residents were separated immediately and the investigation was started. The residents were put on heightened monitoring. Skin assessments were completed. Resident #1 was the only one of the two with an injury (scratch on the side of his nose). As a result of the facility's investigation, they unsubstantiated the allegation as the evidence indicated that abuse did not occur. The facility's investigator was the prior Administrator, who no longer worked in the facility. Review of the facility's investigation revealed statements were obtained from the two involved residents from an interview by the facility's prior administrator. A typed statement of Resident #1's interview revealed he reported Resident #9 hit him. Resident #1 denied saying anything to Resident #9 and denied shaking his fist at him or trying to swing at him. His electric wheelchair was dead and would not move. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A statement obtained from Resident #9 on [DATE] revealed he reported Resident #1 had his wheelchair stopped in the middle of the isle. The wheelchair battery was dead, so he was not able to move. Resident #9 began yelling at Resident #1 and they had a verbal altercation. Resident #9 stated that Resident #1 started shaking his fist at him (like he was going to hit him) and he (Resident #9) hit his (Resident #1's) face and knocked his glasses off. A Personal witness statement from Dietary Employee #300 (undated) revealed she witnessed Resident #1 and Resident #9 fight. She watched Resident #9 hit Resident #1 in the dining room. She then got the nurse and informed her the residents were fighting. She observed the incident when she was putting the smoking materials up, after taking the residents out for a smoking break. She denied she saw Resident #1 hit Resident #9 during the altercation. She then observed Resident #9 drive off while saying what had happened. A clarification statement was added at the end of the witness statement by the prior administrator that indicated the staff member saw Resident #9 hit Resident #1, but did not see Resident #1 hit Resident #9. A personal witness statement from Licensed Practical Nurse (LPN) #191 revealed on [DATE] at 4:00 P.M. she was passing medications in the hallway when Dietary Employee #300 came to her and said Resident #9 and Resident #1 were in the dining room fighting. Upon the nurse entering the dining room, Resident #9 was leaving. The nurse asked Resident #1 what happened and he said Resident #9 slapped him. She assessed Resident #1 and left dietary with him while she went to the administrator to report it. The facility's investigation file included the face sheet and diagnoses of the involved residents. Resident #1's diagnoses included hemiplegia affecting his right dominant side, aphasia (speech difficulty), Alzheimer's disease, dementia without behavioral disturbances, bipolar disorder, contracture of the muscle of the right upper arm/ right leg and right hand, a brain injury as a result of a motor vehicle accident, and dependence on a wheelchair. A BIMS Evaluation completed on [DATE] at 4:10 P.M. revealed the resident was cognitively intact with a BIMS of 13. A skin assessment dated [DATE] at 5:14 P.M. revealed Resident #1 was noted to have a small scratch noted to his right nares. No bleeding was noted. First aid was provided to include cleansing and leaving the scratch open to air. They included his care plan for an alteration in mood and behavior related to being easily angered at times. It was updated on [DATE] to reflect he liked to shake his fist at other residents. Resident #9's face sheet revealed he was admitted to the facility on [DATE]. His diagnoses included paraplegia, unspecified psychosis, anxiety disorder, depression, and panic disorder. A BIMS evaluation completed on [DATE] at 4:11 P.M. revealed he was cognitively intact with a BIMS of 15. A skin assessment completed on [DATE] at 5:17 P.M. revealed the resident had no injuries. A copy of Resident #9's care plans the facility included in the investigation file noted the resident had a care plan in place for an alteration in mood with depression and anxiety related to being easily annoyed, angered at placement and care, persistent anger with others, and showing physical aggression with items in his room. His care plan was updated on [DATE] to reflect the resident to be hitting other residents. The interventions included calmly, but firmly remind the resident of unacceptable behaviors as warranted and to ensure his basic needs were met when noted having increased agitation and anxiety such as pain/ hunger/ thirst/ toileting needs etc. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's history of their SRI's revealed Resident #9 had a prior resident to resident altercation noted to have occurred on [DATE]. It involved him hitting another resident, but that incident of him hitting another resident was in response to him being hit first by the other resident. On [DATE] at 8:50 A.M., an interview with LPN #191 revealed she was the floor nurse working on [DATE] when the resident to resident altercation occurred between Resident #1 and #9. She denied she was present in the dining room when the altercation occurred, but recalled a dietary employee came and got her. When she went to the dining room, Resident #9 was leaving and Resident #1's glasses were noted to be crooked on his face. She reported Resident #1 was laughing about the incident. The dietary employee reported Resident #9 hit Resident #1. She assessed Resident #1 and noted he had a small scratch on the side of his nose. It looked like the scratch that was caused by his metal framed glasses. Resident #9 said Resident #1 was sitting in his electric wheelchair and would not move, after they came in from smoking. She told Resident #9 that was no reason to put his hands on someone. They separated the two and placed them on heightened monitoring. She was not aware of Resident #9 having had prior altercations with any residents, but she had only worked there for a couple of months at that time. He (Resident #9) had not been involved with any resident to resident altercations since she had been there. She could not recall if Resident #9 had anything in his care plans about any prior resident to resident altercations, or if he was known to have aggressive behaviors. She stated she notified the administrator of the incident and the administrator and the assistant directors of nursing (ADON's) at the time took over from there. She gave her statement for the facility's investigation. She was asked what she would consider to be physical abuse. She stated it would be anytime someone put their hands on another without consent. She was not sure how to answer if she felt this incident was physical abuse, as she said Resident #1 was laughing about it. She then stated she was not sure if Resident #9 physically put his hands on Resident #1 or if he only made contact with Resident #1's glasses. She then stated but anytime you put your hands on someone it would be considered physical abuse, if the other resident did not allow them to. She then reported she did not really recall if the dietary employee reported to her if the residents were just arguing or if the dietary employee actually saw Resident #9 hit his glasses. She reported the dietary employee mentioned no longer worked there and she could not even recall her name. She was not aware of what the dietary employee had said about the incident when giving her statement. On [DATE] at 9:06 A.M., an interview with the Director of Nursing (DON) revealed she had only been the facility's interim DON since [DATE]. She was not the DON when the incident occurred between Resident #1 and #9. She reviewed the SRI and the statements obtained by the facility's prior administrator as part of the facility's investigation. She indicated that she likely would not have substantiated the allegation of physical abuse either based on there not being a willful intent to harm the other resident. She was informed the definition of willful intent was changed from an intent to cause harm to a deliberate act. She acknowledged hitting someone in the face would be a deliberate act. She stated their corporate nurse would have more information, as she would have been part of that investigation, and was there at the time the resident to resident altercation occurred. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 9:15 A.M., an interview with Regional Director of Quality Assurance #210 revealed she was serving in her current role as the Regional Director of Quality Assurance when the incident occurred between Resident #1 and #9. She was provided the SRI report and statements obtained from Resident #1 and #9. She supported the facility's prior Administrator not substantiating the allegation of physical abuse due to no willful intent to harm Resident #1 by Resident #9. She acknowledged the definition of willful intent did not mean that Resident #9 intended to harm Resident #1, but the act was deliberate. Hitting another resident was a deliberate act. She felt the incident was provoked by Resident #1, who allegedly raised his fist to the other resident and attempted to hit him. She felt Resident #9's response was reactionary. She agreed residents in the facility had the right to be free from physical abuse and physical abuse included one resident hitting another, no matter if that resident was provoked or not. Review of the facility's abuse policy revealed the facility prohibited physical abuse. Residents would not be subjected to abuse by anyone. Abuse was defined as the willful infliction of injury with resulting physical harm, pain, or mental anguish. Physical abuse included but was not limited to hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment. Under prevention, residents identified to be potentially abusive should have an individualized care plan with interventions in an effort to prevent abuse, as well as possible psychological services. After all possible interventions were implemented, if the potentially abusive resident continued to be considered threatening to other residents, then the facility would issue a transfer in accordance with government regulations. Under protection, the facility recognizes it was obligated to keep it's residents safe and to protect them from any harm to whatever extent possible and within acceptable standards of practice.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and policy review, the facility failed to ensure residents did not have psychotropic medications ordered on an as needed basis (prn) limited to an initial 14 day order and only extended with a face to face evaluation of the resident with a clinical rationale as to why the prn psychotropic medication should be extended. They also failed to ensure non-pharmacological interventions (NPI's) were attempted prior to the use of an anti-psychotic medication intramuscularly (IM) ordered on a prn basis. This affected two (Resident #13 and #37) of five residents reviewed for unnecessary medications. Findings include: 1. Review of Resident #37's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included schizo-affective disorder (a mental health condition including schizophrenia and mood disorder symptoms), bipolar disorder, anxiety disorder, depression, and insomnia. Review of Resident #37's physician's orders revealed the resident had an order in place for the use of Zyprexa (an anti-psychotic medication used in the treatment of schizophrenia, bipolar disorder, and depression) 10 milligrams (mg) with directions to inject IM every 24 hours prn for agitation related to schizo-affective disorder x 180 days. The order was last updated on 04/17/25 and was not to end until 10/14/25. Review of Resident #37's pharmacy recommendations revealed the facility's consulting pharmacist recommended the physician review the resident's order for the use of Zyprexa to be given on a prn basis. The pharmacy recommendations were made as a result of a medication regimen review on 09/05/24 and 04/06/25. The pharmacist included a copy of the regulation under 483.45(e)(4) that indicated prn orders for psychotropic medications were limited to 14 days and requested that the physician note the new regulations which went into effect on 11/28/17. The pharmacist further indicated the new guidelines required a progress note from the prescriber for continued use that included how the medication was being used, a clinical rationale, and a time frame for when the prn medication would be reviewed again (suggesting a review again in 90 days). The pharmacy recommendation did not communicate to the physician that the use of anti-psychotics on an as needed basis was limited to a 14 day period and could not be renewed without an evaluation by the prescriber. The prescriber (psychiatrist) responded to the recommendation and only provided direction to order the prn IM Zyprexa x 180 days. The last recommendation was addressed by the prescriber on 04/16/25, which was why the current order was to be extended through 10/14/25. Review of Resident #37's medication administration records (MAR's) for December 2024 through April 2025 revealed the resident was given her Zyprexa IM on a prn basis 12 times during that five month period. 10 out of the 12 times the prn Zyprexa was administered IM, there was no evidence of any NPI's being attempted prior to the administration of the IM Zyprexa. Doses given without evidence of NPI's being attempted prior to it's administration included 12/12/24 at 8:07 A.M., 01/10/25 at 5:39 P.M., 01/18/25 at 9:04 A.M., 01/20/25 at 7:05 P.M., 01/27/25 at 9:21 A.M., 01/29/25 at 2:50 P.M., 02/03/25 at 11:00 A.M., 02/04/25 at 7:25 A.M., 03/03/25 at 9:39 A.M., and 04/05/25 at 10:18 P.M. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/05/25 at 2:30 P.M., an interview with the Director of Nursing (DON) confirmed Resident #37 had an order to receive Zyprexa 10 mg IM ordered every 24 hours prn for agitation related to schizo-affective disorder. She confirmed the resident has had the prn Zyprexa IM ordered on a couple of different occasions that exceeded 14 days. She further confirmed Resident #37's psychiatrist had been ordering the prn anti-psychotic for 180 days at a time. She stated she attempted to discuss the extended orders for prn psychotropic medications with the psychiatrist and had been told by the psychiatrist that he knew the regulations. It was told to her that the initial order was required to be for 14 days. If it was needed to be extended then the physician/ prescriber would have to see the resident and could order for an additional 14 days. At that time, if the prn psychotropic medication was to be extended again, the physician/ prescriber would have to re-evaluate the resident and then could order the medication for up to 180 days. She was informed the regulations addressed prn orders for anti-psychotics separate from prn psychotropics. The regulations for prn anti-psychotics specified a limitation of a 14 day order for use of anti-psychotics used on a prn basis with no exception. She acknowledged if the physician/ prescriber wanted to continue the use beyond 14 days, they would have to evaluate the resident at the end of the 14 days and re-order the medication for an additional 14 days. She was then informed of the 10 doses of the prn Zyprexa IM that had been given to Resident #37 between 12/12/24 and 04/05/25 that had no evidence of any NPI's being attempted prior to the use of the use of the prn IM Zyprexa. She stated she would reach out to see if she had any additional guidance from her physician/ psychiatrist or pharmacist regarding the use of the prn Zyprexa greater than 14 days. She would also look to see if they could find any evidence of NPI's being attempted prior to the use of the prn Zyprexa that was administered IM. However, no additional information was provided. Review of the facility's policy on Psychotropic Drug and Unnecessary Drug Use undated revealed the facility would use psychotropic drug therapy only when appropriate to enhance the resident's quality of life, while maximizing functional potential and well being of the resident. Qualified staff would assess the resident for the use of psychotropic medications quarterly and develop a comprehensive care plan that addressed behavioral and medication management with NPI's and pharmacological interventions. PRN orders for anti-psychotic medications were limited to 14 days and would not be renewed unless the attending physician or prescribing practitioner evaluated the resident in person, for the appropriateness of that medication. 2. Review of Resident #13's medical record revealed an admission date of 03/25/25, a re-entry date of 04/12/25 and diagnoses including an unspecified fracture of the sacrum, stomach cancer, neuropathy, anemia, hypertension, and anxiety. Resident #13 was a hospice client. Review of Resident #13's admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental status score of 13 indicating Resident #13 had intact cognition and had received antianxiety medication in the MDS assessment time frame. Review of Resident #13's physician orders revealed an order dated 05/19/25 for Xanax 0.5 milligrams by mouth every eight hours as needed for anxiety. The Xanax order had no end date to indicate the length of time the medication could be used for. Further review of Resident #13's physician orders revealed an order dated 06/03/25 for lorazepam 0.5 milligrams by mouth every eight hours as needed for anxiety. The lorazepam order had no end date to indicate the length of time the medication could be used for. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/05/25 at 11:14 A.M. the Director of Nursing (DON) verified the orders for the as needed medications Xanax and lorazepam did not have an end date to indicate the duration of use for the medications.

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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** 3. Review of Resident #1's medical record revealed the resident was admitted to the facility on [DATE]. His diagnoses included adult onset diabetes mellitus. Review of Resident #1's quarterly MDS assessment dated [DATE] revealed the resident was coded as having received an insulin injection during the seven day assessment period (05/19/25- 05/25/25). Section N.) of the MDS (Medications) coded the resident as having received one insulin injection during the last seven days. Review of Resident #1's medication administration record (MAR) for May 2025 revealed there was no evidence of the resident having been given any insulin between 05/19/25 and 05/25/25. The resident was only noted to have received Trulicity that was given as a subcutaneous (SQ) injection, but Trulicity was not considered to be an insulin. Review of a drug reference information from Medscape on Trulicity revealed it was classified as an antidiabetic, Glucagon-like Peptide-1 Agonist used in the treatment of adults with adult onset (type 2) diabetes mellitus. It acted as a GLP-1 receptor agonist to increase insulin secretion in the presence of elevated blood glucose. It was not classified as an insulin, as it only promoted the pancreas to secrete insulin naturally. 4. Review of Resident #3's medical record revealed the resident was admitted to the facility on [DATE]. His diagnoses included adult onset diabetes mellitus. Review of Resident #3's quarterly MDS dated [DATE] indicated the resident had received an insulin injection during the seven day assessment period of 04/15/25 through 04/21/25. Section N.) of the MDS indicated that he had received one insulin injection during that seven day period. Review of Resident #3's medication administration record (MAR) for April 2025 revealed there was no evidence of the resident having been given any insulin between 04/15/25 and 04/21/25. He was noted to have an order for Wegovy given as a SQ injection, but that was not an insulin injection. In addition, the resident had refused the dose of Wegovy that was scheduled to be received on 04/16/25. No injections had been given to the resident during that time. Review of a drug reference information from Medscape on Wegovy revealed it was classified as an antidiabetic, Glucagon-like Peptide-1 Agonist used in the treatment of adults with adult onset (type 2) diabetes mellitus. It acted as a GLP-1 receptor agonist to increase insulin secretion in the presence of elevated blood glucose. It was not classified as an insulin, as it only promoted the pancreas to secrete insulin naturally. On 06/10/25 at 11:04 A.M., an interview with the Director of Nursing (DON) confirmed Resident #1 and Resident #3's quarterly MDS assessments were not coded accurately under the medication section of the MDS. She acknowledged both Wegovy and Trulicity, although given for diabetes mellitus, was not classified as insulin and should not have been coded on the MDS as such. She suspected the two MDS nurses, who had completed those MDS assessments, just did not realize Trulicity and Wegovy were not classified as insulin. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and interview the facility failed to ensure Minimum Data Set (MDS) assessments were accurate. This affected four residents (Resident #1, #2, #3 and #9) of 14 residents reviewed for accurate assessments. The facility census was 42. Findings include: 1. Review of Resident #2's medical record revealed an admission date of 04/28/25 and diagnoses including chronic obstructive pulmonary disease, dementia, dysphagia, hypothyroidism, hypertension, anxiety, schizoaffective disorder, and depression. Review of a care conference dated 04/29/25 and held with Resident #2 and her daughter revealed the resident had concerns about her broken lower denture. Review of Resident #2's admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15. Further review of the MDS revealed section L (Oral/Dental Status) question A regarding broken or loosely fitting full or partial denture was marked as no. In an interview on 06/02/25 at 4:21 P.M. Resident #2 stated that her dentures were broken at her previous facility. A follow-up interview on 06/04/25 at 3:54 P.M. revealed her bottom dentures were broken and her upper dentures were loose. She stated that she does not have any of her natural teeth. An observation made at the time of the interview revealed Resident #2 was wearing an upper denture but was edentulous on the bottom. In an interview on 06/05/25 at 11:11 A.M. the Director of Nursing (DON) verified the MDS section L question A was marked inaccurately. 2. Review of Resident #9's medical record revealed an admission date of 12/12/19, a re-entry/readmission date of 01/18/25 and diagnoses including acute respiratory failure, paraplegia, unspecified psychosis, asthma, and chronic hepatitis. Review of Resident #9's therapy records revealed an occupational therapy evaluation completed on 07/04/24 that indicated the resident did not require occupational therapy and referred/recommended the resident to the restorative nursing program. Review of Resident #9's annual Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 and indicated that restorative nursing programs were performed for at least 15 minutes a day on five days for passive range of motion, active range of motion and bed mobility in the past seven days. Review of Resident #9's physicians orders for the past year revealed no orders for a restorative program. Review of Resident #9's medical record failed to reveal any documentation of restorative nursing program minutes being provided for passive range of motion, active range of motion or bed mobility in the past year. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/10/25 9:31 A.M. the Director of Nursing (DON) verified there was no documentation of restorative nursing program minutes being provided for passive range of motion, active range of motion or bed mobility in the past year could be found in Resident #9's medical record. The DON verified the restorative nursing programs, marked as being performed for at least 15 minutes a day on five days for passive range of motion, active range of motion and bed mobility in the past seven days on the 04/20/25 MDS assessment, were marked inaccurately.

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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 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** Based on record review, staff interview and policy review, the facility failed to ensure a Preadmission Screening and Resident Review (PASRR) Identification Screen submitted to the state Department of Medicaid was completed accurately to reflect all the resident's mental illness diagnoses. This affected one (Resident #17) of one residents reviewed for PASRR. Findings include: Review of Resident #17's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included paranoid schizophrenia, bipolar disorder, anxiety disorder, and other specified depressive disorder. All listed diagnoses were in place at the time of her admission on [DATE]. Review of a PASRR Identification Screen completed for Resident #17 on 04/26/24 revealed the resident review was completed for a significant change in condition that was deemed to be a decline. Section E.) of the identification screen included indications of serious mental illness. The assessor was to check all the listed diagnoses that applied. The assessor failed to check the box for a mood disorder despite the resident having the diagnoses of Bipolar disease, which was a mood disorder. The identification screen was completed by Social Service Designee #141. Review of the PASRR result notice for the PASRR Identification Screen completed for Resident #17 on 04/26/24 revealed the results of that screen was received on 04/26/24. A referral had been made for a Level II evaluation (an evaluation completed to determine the need for any specialized services while residing in the facility. Review of the results of the Level II evaluation for Resident #17 dated 05/17/24 from the state Department of Developmental Disabilities Division of Medicaid Development and Administration revealed based on the information reviewed describing the resident's current physical and medical needs, as well as her functional abilities, they made two determinations. The first determination was that the resident required the level of services provided by a nursing facility and the resident may continue to reside in the nursing facility. The second determination was that the resident did not need specialized services provided or arranged by the county board at that time. Further review of Resident #17's medical record revealed another PASRR Identification Screen had been completed on 06/02/25. Again, that PASRR Identification Screen indicated the identification screen was completed for a significant change in condition for a decline. Section E.) of the identification screen, where the assessor (SSD #141) documented the resident's mental disorders, included a mood disorder that had not been identified during the prior PASRR screen completed on 04/26/24. Again, a referral had been made for a Level II evaluation. As of the time of the PASRR review, the results of that Level II evaluation was still pending. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/03/25 at 1:05 P.M., an interview with SSD #141 revealed she completed the second PASRR Identification Screen on 06/02/25 for Resident #17, after she completed a self audit on PASRR's the prior week, and noted the the resident's PASRR Identification Screen completed on 04/26/24 was not completed accurately. She claimed she did the self audits on PASRR's every three or four months to ensure they were all completed accurately. She reported the prior PASRR Identification Screen did not accurately reflect Resident #17 had a mood disorder despite her having Bipolar disorder. She denied she had any documented evidence to support she recognized the inaccuracy of the resident's prior PASRR, as part of a self audit last week. She was asked, if she had noted the PASRR was not accurate the previous week, then why was an updated PASRR Identification Screen not completed prior to 06/02/25. She stated she had several that were not accurate and needed new PASRR's completed. She further acknowledged, if she was completing PASRR audits every three to four months as indicated, the resident's inaccurate PASRR completed on 04/26/24 should have been identified as being inaccurate prior to 06/02/25. She confirmed the resident's results notice for her Level II evaluation was still pending. Review of the facility's policy on PASRR updated 01/01/19 revealed the purpose of the policy was to assure that all admissions to the nursing facility were screened for indications of serious mental illness or developmental disabilities in an effort to prevent inappropriate admissions to the nursing facility. The Admissions Director or designee would complete the resident review (RR) if the resident had experienced a significant change in condition. All level I and level II residents with newly diagnosed or possible serious mental disorder, intellectual disability, or a related condition for level II would be referred for resident review to the Ohio Department of Aging or appropriate required organization upon a significant change in status assessment.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to develop a comprehensive care plan for catheter care. This affected one resident (#6) of one sampled for catheter use. The facility census was 42. Findings include: Review of Resident #6's medical record revealed an admission date of 10/12/24 and diagnoses including malignant neoplasm of endometrium, diabetes, chronic obstructive pulmonary disease, lumbosacral disorder, fibromyalgia, hypertension, anemia, protein-calorie malnutrition, neurogenic bladder, and lumbosacral plexus disorder. Review of Resident #6's annual Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition and reflected the use of an indwelling (urinary) catheter. Review of Resident #6's physician orders revealed the following orders dated 02/10/25: monitor urine for color, consistency and odor every shift, may irrigate catheter with 30 cubic centimeters (cc) of normal saline every 24 hours as needed for blockage; the resident has #16 french (size of catheter) with 10 cc indwelling catheter for the diagnosis of urinary retention, catheter care every shift, ensure privacy bag is in place, and may change catheter and catheter bag every 30 days or as needed for blockage. Review of Resident #6's care plan revealed no care plan in place for catheter care. In an interview on 06/09/25 at 2:14 P.M. the Director of Nursing (DON) verified there was not a care plan in place for catheter care.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3. Review of Resident #37's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included hypertension and urinary retention. Review of Resident #37's active care plans revealed the resident had a care plan in place for receiving diuretic therapy related to acute renal failure. The care plan was initiated on 04/28/24. The goal was for the resident to be free from any discomfort or adverse reactions while receiving diuretic therapy through the review date. The target date was 08/13/25. Interventions included the need to administer medications as ordered. Review of Resident #37's active physician's orders revealed the resident did not have an order in place for the use of any diuretics. Review of her discontinued orders revealed the resident had not been on a diuretic medication since 06/26/24, when a diuretic had been discontinued. On 06/04/25 at 10:10 A.M., an interview with the facility's Director of Nursing (DON) confirmed Resident #37's active care plans reflected she had the use of a diuretic related to acute renal failure. She acknowledged the resident had not been on a diuretic for almost a year now. She further acknowledged the resident's active care plans should have been revised to reflect she was no longer receiving diuretic therapy. Based on record review, observation and interview the facility failed to revise comprehensive resident care plans to reflect current care and treatment. This affected one resident (#13) of one sampled for falls and two residents (#37 and #39) of five sampled for unnecessary medications. The facility census was 42. Findings include: 1. Review of Resident #13's medical record revealed an admission date of 03/25/25, a re-entry date of 04/12/25 and diagnoses including an unspecified fracture of the sacrum, stomach cancer, neuropathy, anemia, hypertension, and anxiety. Further review revealed Resident #13 was a hospice client. Review of Resident #13's admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13 indicating Resident #13 had intact cognition and had not experienced falls. Review of Resident #13's medical record revealed she had fallen on 04/07/25 at 11:15 P.M. while in the bathroom. Resident #13 stated she was turning to dry her hands and lost her balance. Review of Resident #13's fall care plan revealed the following interventions were in place to minimize the potential risk factors related to falls and fall related injuries: facility staff was to offer to help the resident with toileting before bed (implemented on 04/07/25), commonly used items such as the resident's water cup, remote control, and call light were to be kept within easy reach of the resident (implemented on 04/15/25), and a visual cue (sign) was to be placed in the room to remind the resident to use her call light for assistance with transfers and ambulation (implemented on 04/15/25). (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 06/03/25 at 5:00 P.M. revealed there was no visual cue (sign) in Resident #13's room to remind the resident to use her call light for assistance with transfers and ambulation. In an interview on 06/03/25 at 5:00 P.M. Certified Nursing Assistant (CNA) #134 stated Resident #13 always rang her call light for assistance and waited for facility staff to help her. CNA #134 further stated that was probably why she did not have a visual cue (sign) in her room. In an interview on 06/03/25 at 5:13 P.M. Social Services Designee (SSD) #181 stated the visual cue (sign) was not in the room because Resident #13 was upset by it and found it demeaning when it was placed in her room. SSD #181 further stated the intervention for the visual cue (sign) was supposed to have been removed from the care plan on 04/15/25. In an interview on 06/03/25 at 5:13 P.M. the Director of Nursing (DON) confirmed the intervention of a visual cue (sign) was to be placed in the room to remind the resident to use her call light for assistance with transfers and ambulation remained on Resident #13's care plan. 2. Review of Resident #39's medical record revealed an initial admission date of 08/03/24, a discharge date of 01/05/25, a re-entry/readmission date of 03/16/25 and diagnoses including chronic respiratory failure, acute respiratory failure, diabetes, depression, heart failure, atrial fibrillation, bradycardia, unspecified protein-calorie malnutrition, end stage renal disease, and an unspecified fracture of the shaft of the left humerus. Further review revealed Resident #39 was a hospice client. Review of Resident #39's admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating the resident's cognition is intact. Further review of the MDS revealed Resident #39 was receiving hospice services. Review of a hospice visit note dated 05/21/25 revealed the resident requested a sling for her left arm related to swelling. Review of Resident #39's physician orders revealed an order dated 05/23/25 for a sling to the left arm as needed and as the resident will tolerate for pain or swelling. Review of Resident #39's care plan revealed no mention of the sling to the left arm as needed for pain and swelling. In an interview on 06/05/25 at 4:20 P.M. Director of Nursing (DON) confirmed the sling to the left arm for pain and swelling was not reflected on Resident #39's care plan.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and policy review, the facility failed to ensure a resident's pressure ulcer was assessed weekly for measurements and evidence of healing. This affected one (Resident #28) of three residents reviewed for pressure ulcers. Findings include: Review of Resident #28's medical record revealed the resident was admitted to the facility on [DATE]. His diagnoses included a motor vehicle accident with a fracture of the pelvis, adult onset diabetes mellitus with diabetic neuropathy and a foot ulcer, protein-calorie malnutrition, anemia, and peripheral vascular disease. Review of Resident #28's progress notes revealed a note dated 04/25/25 at 10:41 A.M. by the wound nurse practitioner that indicated the resident had a deep tissue pressure injury (DTPI) to the left heel that was present upon his admission. A DTPI was a localized area of discolored, intact skin, or a blood filled blister due to underlying soft tissue damage from pressure and/ or shear. The discolored area was typically purple or maroon in color. Review of Resident #28's active care plans revealed the resident had a care plan in place for having an actual impaired skin integrity/ pressure ulcer related to a DTPI on his left heel. The care plan was initiated on 04/18/25. The interventions included the need to complete a skin assessment and documentation per the facility's policy. Review of Resident #28's weekly wound assessments of the DTPI to the left heel revealed the pressure ulcer was assessed on 04/25/25, 05/08/25, 05/22/25, 05/29/25, and 06/05/25. The subsequent assessments continued to classify the pressure ulcer as a DTPI and showed evidence of healing. There was no evidence of any weekly assessment of the DTPI being completed on 05/02/25 or on 05/15/25. Review of Resident #28's progress notes revealed no explanation as to why weekly wound assessments of the DTPI on the left heel was not assessed on 05/02/25 or on 05/15/25. The resident was not noted to be out of the facility on those days or known to have refused any assessment of the left heel pressure ulcer. On 06/09/25 at 1:30 P.M., an interview with Licensed Practical Nurse (LPN) #191 revealed she was the employee that rounded with the wound nurse practitioner weekly. The weekly wound assessments were completed on Thursdays. She obtained measurements on that day when the wound nurse practitioner assessed the wound. Wounds were to be assessed every seven days for measurement purposes and to monitor for healing. She denied she was working when Resident #28 did not have his DTPI to the left heel assessed on 05/02/25 or on 05/15/25. She was off work during those times due to an excused work absence. She reported the facility's prior Minimum Data Set (MDS) nurse and acting interim Director of Nursing (DON) at the time should have assessed the resident's wound. Neither employee she mentioned was still working in the facility. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/09/25 at 3:10 P.M., an interview with the facility's current interim DON confirmed Resident #28 was admitted with the DTPI to the left heel. She acknowledged there was no documented evidence of the facility's nursing staff assessing the resident's pressure ulcer on 05/02/25 or on 05/15/25. She was not able to provide any additional documentation for evidence of the facility assessing the resident's wound to the left heel on those days. She stated that was during the time LPN #191 was off of work and no one else documented the wound as having been assessed. Review of the facility's policy on Pressure Ulcers revised April 2016 revealed the purpose of the policy was for the facility to assess each resident with skin conditions and measure the skin areas as was indicated in the regulatory guidelines and NPUAP (National Pressure Ulcer Advisory Panel) guidelines. The information was taken from the revised version of the Quick Reference Guide by NPUAP. Review of the facility's policy on Pressure Ulcer Prevention and Risk Identification undated revealed, if a new skin area was identified on an assessment or during any other type of care or service, the licensed nurse would initiate a skin grid/ measurement flow record. The skin grid would then be updated every seven days until the area was resolved.

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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** Based on record review and interview, the facility failed to provide recommended restorative programs for a resident. This affected one resident (#9) of two residents reviewed for rehabilitative services. The facility census was 42. Findings include: Review of Resident #9's medical record revealed an admission date of 12/12/19, a re-entry/readmission date of 01/18/25 and diagnoses including acute respiratory failure, paraplegia, unspecified psychosis, asthma, and chronic hepatitis. Review of Resident #9's therapy records revealed an occupational therapy evaluation completed on 07/04/24 that indicated the resident did not require occupational therapy and referred/recommended the resident to the restorative nursing program. Review of Resident #9's medical record revealed a quarterly restorative assessment dated [DATE] that indicated the resident had been referred to the restorative nursing program by therapy, and that restorative nursing program was indicated for passive range of motion, active range of motion and bed mobility and would be continued. Further review of Resident #9's medical record failed to reveal any documentation of restorative nursing program minutes being provided for passive range of motion, active range of motion or bed mobility. Review of Resident #9's physicians orders for the past year revealed no orders for a restorative program. Review of Resident #9's annual Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition and restorative nursing programs were performed for at least 15 minutes a day for five days related to passive range of motion, active range of motion and bed mobility in the past seven days. In an interview on 06/10/25 9:31 A.M. the Director of Nursing (DON) verified there was no documentation of restorative nursing program minutes being provided for passive range of motion, active range of motion or bed mobility found in Resident #9's medical record. The DON further verified the restorative nursing programs for passive range of motion, active range of motion and bed mobility were not being provided.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record review, staff interview, and policy review, the facility failed to ensure pharmacy recommendations were appropriately implemented when agreed upon by the physician. This affected one (Resident #37) of five residents reviewed for unnecessary medications/ monthly medication regimen reviews. Findings include: Review of Resident #37's medical record revealed the resident was admitted to the facility 04/27/24. Her diagnoses included hypothyroidism. Review of Resident #37's physician's orders revealed the resident had an order in place to receive Levothyroxine Sodium 75 micrograms (mcg) by mouth (po) every morning for hypothyroidism. The resident also had an order to receive Ferrous Sulfate 325 milligrams (mg) po every morning and Magnesium Oxide 400 mg po every morning as supplements. Review of Resident #37's pharmacy recommendations revealed the facility's contracted pharmacist made recommendations following monthly reviews of the resident's medication regimen. There were two recommendations made by the pharmacist that addressed the administration time for the Levothyroxine Sodium in relation to the administration times of the Ferrous Sulfate and the Magnesium Oxide. A pharmacy recommendation for Resident #37 dated 06/11/24 revealed the pharmacist requested the physician to evaluate and consider modification of the current administration times for Levothyroxine Sodium (Synthroid) one tablet po every day between the hours of 4:00 A.M. and 6:00 A.M., Ferrous Sulfate one tablet po every day between the hours of 7:00 A.M. and 10:30 A.M., and Magnesium Oxide 400 mg po twice a day between the hours of 7:00 A.M. to 10:30 A.M. and again between 8:00 P.M. and 11:30 P.M. The pharmacist explained due to the potential for binding, administration of Synthroid was recommended to be administered first thing in the morning, at least 30 minutes prior to all other medications, and separated by at least four hours from Iron and Magnesium containing products. The nurse practitioner responded to the recommendation on 06/13/24 and agreed with the recommendation. A second pharmacy recommendation for Resident #37 dated 10/03/24 revealed the facility's contracted pharmacist again requested the physician evaluate the resident and consider modification of the current administration times for Synthroid and Ferrous Sulfate. The same explanation, as to the potential for binding with the administration of Synthroid concurrently or within four hours of Iron and Magnesium containing products, was included for the physician's consideration. The physician reviewed the recommendation and agreed to it on 10/09/24. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #37's electronic medication administration records (eMAR's) for October and November 2024 revealed the facility continued to administer the resident's Levothyroxine Sodium within four hours of her Ferrous Sulfate and Magnesium Oxide. The resident's Levothyroxine Sodium had an administration time of every 24 hours as did the Ferrous Sulfate. The nurses initialed the eMAR under the day the medications were administered and recorded the time of the administration inside the box where they entered their initials. Out of the 30 days in which the resident received the medications, four times the Levothyroxine and the Ferrous Sulfate were administered at the same time. 24 times the two medications were documented as having been administered within four hours from one another. Only two of the 30 times the resident was given those medications were the administration times separated by four hours as recommended by the pharmacist and agreed upon by the physician and/ or nurse practitioner. The Magnesium Oxide 400 mg was set up for administration in the am. It was not clear what time the Magnesium Oxide was given and if it was separated by at least four hours from the Levothyroxine administration time. One of the 30 times the resident was given Levothyroxine, had the administration time of 8:59 P.M. and was not administered first thing in the morning as recommended by the pharmacist and ordered by the physician. Review of Resident #37's eMAR for June 2025 revealed the resident continued to receive Levothyroxine, Ferrous Sulfate, and Magnesium Oxide. The administration times for all three were set for early and they were being administered at the same time. The facility was not following the pharmacist's previous two recommendations or the physician's orders regarding the separation of administration times of the Levothyroxine from Ferrous Sulfate and Magnesium. Findings were verified by Regional Director of Quality Assurance #210. On 06/03/25 at 3:24 P.M., an interview with Regional Director of Quality Assurance #210 revealed she suspected Resident #37's administration times for the Levothyroxine, Ferrous Sulfate, and the Magnesium got changed during one of the resident's hospitalizations. She acknowledged two separate recommendations had been made by their contracted pharmacist pertaining to the administration times of those medications with the latest being on 10/03/24. She was informed the eMAR for November 2024 showed the medications were being given within four hours of each other prior to the resident going out to the hospital in the middle of the month. She was not able to explain why the times of administration for all three medications were set for early on the June 2025 eMAR. She acknowledged administering the Levothyroxine within four hours of the other two medications could affect the Levothyroxine's absorption. Review of the facility's policy on Consultant Pharmacist Services Provider Requirements dated October 2007 revealed regular and reliable consultant pharmacist services were to be provided to the residents. Medication regimen reviews were to be completed monthly for each resident in the skilled nursing facility. They were to communicate to the responsible prescriber and the director of nursing or actual problems detected and other findings related to medication therapy orders at least monthly. They were also to assist nursing care center staff in outlining medication administration schedules to maximize the effectiveness and to avoid potential interactions. The policy did not address the need for the facility staff to implement the recommendations as made and agreed to by the physician.

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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. Based on review of the facility's cycle menu/ spreadsheet, observation, and staff interview, the facility failed to ensure residents were served meals in a form that met their needs. This had the potential to affect seven residents (Resident #1, #10, #16, #19, #23, #41, and #95) of seven residents who the facility identified as being on a mechanical soft diet. Findings include: Review of the cycle menu for the Summer of 2025 revealed the residents were to receive chicken parmesan, spaghetti noodles, Italian blend mixed vegetables, choice of a roll, and cake. The spread sheet that went along with the cycle menu revealed the residents on a mechanical soft diet were to receive four ounces of chopped Italian blend mixed vegetables as part of their meal. On 06/04/25 at 12:10 P.M., an observation of the tray line for the lunch meal served revealed the facility had three different diets that were being provided to the residents. Of the three different diets, seven residents were ordered to receive mechanical soft diets. Each type of diet was observed to be served. The first mechanical soft diet was dipped from the steam table to be served to Resident #41, who was eating her meal in the dining room. Dietary [NAME] #204 was noted to dip the tray from the steam table and placed the Italian blend mixed vegetables on a plate for Resident #41. She did not chop the Italian blend mixed vegetables, as was indicated to be required on the cycle menu's spreadsheet. The tray was placed on an open cart and another dietary aide was in the process of taking it out to the dining room to be served. Dietary Manager #188 was asked to verify if the Italian blend mixed vegetables that were being served to Resident #41 were supposed to be chopped. She verified the spreadsheet for the cycle menu did indicate the vegetables were to be chopped. She contacted the facility's dietitian and confirmed the vegetables needed to be chopped for those residents requiring a mechanical soft diet.

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	06/10/2025

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to follow protocols for the use of an antibiotic to treat a urinary tract infection. This affected one resident (#6) of one residents reviewed for catheter use. The facility census was 42. Findings include: Review of Resident #6's medical record revealed an admission date of 10/12/24 and diagnoses including malignant neoplasm of endometrium, diabetes, chronic obstructive pulmonary disease, lumbosacral disorder, fibromyalgia, hypertension, anemia, protein-calorie malnutrition, neurogenic bladder, and lumbosacral plexus disorder. Review of Resident #6's annual Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The resident also had an indwelling catheter. Review of Resident #6's progress notes revealed on 05/19/25 at 11:06 P.M. an order was obtained to obtain a urine specimen for urinalysis and culture and sensitivity related to the resident having cloudy urine with an abnormal smell. On 05/20/25 at 3:04 A.M. the urine specimen was obtained. Further review of Resident #6's progress notes revealed on 05/22/25 at 3:00 P.M. the urine specimen results were reported to the resident's primary care provider. Review of Resident #6's urine culture revealed two organisms were grown. Klebsiella pneumoniae 70-99,000 CFU/ml (colony-forming units per milliliter) and proteus mirabilis 70-99,000 CFU/ml (colony-forming units per milliliter). Review of Resident #6's physicians orders revealed an order on 05/22/25 for ciprofloxacin 500 milligrams by mouth two times a day for five days for urinary tract infection. Review of the facility's criteria for urinary tract infection (UTI) surveillance revealed Resident #6 did not meet the criteria for a UTI as her culture did not have greater than 100,000 CFU/ml (colony-forming units per milliliter) of any organism. In an interview on 06/09/25 at 2:14 P.M. the Director of Nursing (DON) verified Resident #6 was treated for a urinary tract infection that did not meet the facility's criteria for a UTI as her culture did not have greater than 100,000 CFU/ml (colony-forming units per milliliter) of any organism.