

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366180	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER Riverview Pointe Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 9027 Columbia Road Olmsted Falls, OH 44138	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on kitchen observation, staff interview, review of cleaning schedules and policy review, the facility failed to maintain a clean and sanitary kitchen area and failed to ensure appropriate storage of food. This had the potential to affect all residents residing in the facility. The facility did not identify any residents with a nothing by mouth (NPO) diet order. The facility census was 115. Findings include: Observation of the facility kitchen on 09/15/25 at 8:15 A.M. revealed inside the walk-in freezer there was a box of brown rice and a stack of boxes on top of a box of potato pancakes on the floor. There was also a box of chicken tenders left open to air. Observation inside the walk-in refrigerator revealed half of a pork loin wrapped in plastic wrap resting on top of a container of watermelon chunks also covered in plastic wrap. The pork loin was observed to have released blood and juices onto the container of watermelon. The pork loin was not labeled or dated. There was a spill on the floor of the walk-in refrigerator that appeared to be a clear liquid. There were also several plastic lids and various debris on the floor of the walk-in refrigerator. Observation of a preparation table next to the ice machine revealed a can opener with dried spills on the table. Throughout the kitchen there were various food debris and splatters on food prep tables and equipment. Observation of the preparation sinks across from the ice machine revealed various food debris left in the sink. Observation of dish machine area revealed various food debris and splatter on walls and equipment. The flooring throughout the kitchen was sticky with various food debris and crumbs. The flooring was a light gray color with significant dark/black buildup. Observation of deep fryer revealed the oil was dark and unable to be seen through. There was food debris floating in the oil. There were splatters of oil down front and sides of the equipment. The floors surrounding the deep fryer were slippery. Observation of equipment including range, convection oven, fryer, and tilt skillet revealed dried food splatter and debris. The grates of the range were dark with grease buildup and had various food debris on top. Observation of a reach in cooler revealed a plastic container with two open packages of Canadian bacon with no label or date and a half bag of shredded lettuce with no label and date. The lettuce appeared to be rotten and had an odor. Observation of reach in coolers and freezers throughout the kitchen revealed dried food splatters on the outside and various food debris inside. The handles were sticky to touch. Observation of the dry storage room revealed various debris including cardboard pieces and tape on the floor. Findings were verified with the Licensed Nursing Home Administrator (LNHA) and Diet Tech #879 at the time of the observation. All findings were verified 09/15/25 by 8:30 A.M. Diet Tech #879 indicated she does monthly sanitation audits and had identified some kitchen cleanliness concerns in recent months. Review of the facility policy Dietary/Food Handling dated October 2022 revealed employees shall maintain a clean and sanitary work environment following manufacturing guidelines and Ohio Food Code. Review of the undated Daily Cleaning List: Kitchen Cook revealed insides of coolers would be cleaned on Mondays, the tilt skillet and stove top would be cleaned on Wednesdays, the oven would be cleaned and cooler/freezer would be organized on Thursdays, the fryer and sinks would be cleaned on Fridays, the flat top grill would be cleaned on Saturdays, and labeling and dating in coolers and sweeping/mopping floors on Sundays.		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview and review of the facility policy, the facility failed to maintain infection control practices during meal service. This affected five (Residents #28, #32, #67, #03 and #15) had the potential to affect 13 additional (Residents #08, #14, #37, #48, #51, #66, #68, #78, #84, #98, #102, #119 and #130) who received meals from the [NAME] Gardens Hall (KGH) kitchenette. The facility census was 115. Findings include: Observation on 09/15/25 at 12:12 P.M. revealed Certified Nursing Assistant (CNA) #825 entered Resident #28's room with a lunch meal tray. CNA #825 moved things on the bedside table to make room for the meal tray. She used Resident #28's facility phone to make an outside call for Resident #28. CNA #825 then used the bed remote to elevate the head of the bed. CNA #825 then cut Resident #28's food and left the room. At 12:15 P.M., CNA #825 went to the kitchenette on KGH and got another tray without cleansing her hands. She got a meal tray for Resident #32 and took it to her room. Before setting the tray on the bedside table, CNA #825 moved a cup of water. CNA #825 then set the tray down, opened all the containers then cut Resident #32's food. CNA #825 left the room and went to the KGH kitchenette where she washed her hands before getting a new meal tray. CNA #825 took the new meal tray to Resident #67's room. After setting the meal tray on the bedside table, CNA #825 cut her food and opened a can of soda, left the room and returned to the KGH kitchenette. CNA #825 did not wash her hands. In the kitchenette on KGH, she got a cup and filled it with coffee and cream then got the next meal tray and took it to Resident #03. CNA #825 put a clothing protector on him and opened all the lids on his food, cut his food and buttered the roll. She shut his door per his request. CNA #825 washed her hands in the KGH kitchenette. She obtained a cup of hot tea and honey then got a new meal tray. She took the meal tray to Resident #15. Before setting the meal tray down, CNA #825 moved eyeglasses and a drink then pulled Resident #15 up in bed by pulling on the pad under her standing at the head of the bed. CNA #825 used the remote to raise the head of the bed and applied a clothing protector. CNA #825 opened all the lids on her food containers then cut up her food. In the KGH kitchenette CNA #825 washed her hands. Interview on 09/15/25 at 12:32 P.M. CNA #825 was asked when she cleanses her hands when passing meal trays, she replied, after every third resident. She verified she did not cleanse her hands after every resident. Review of the facility policy, Infection Prevention and Control Program (IPCP), dated 11/28/17, revealed the hand hygiene protocol required staff to perform hand hygiene between resident contacts and per facility's established hand hygiene procedure.		

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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 medical record review, observation and interview, the facility failed to ensure orders for splints were obtained for Resident #107, who was known to have impairments of range of motion (ROM) to bilateral upper extremities. This affected one (Resident #107) of two residents reviewed for positioning and mobility. The facility census was 115. Findings include: Review of the medical record for Resident #107 revealed an admission date of 04/28/24 with diagnoses including Multiple Sclerosis (MS), contracture of unspecified joint, and restless legs syndrome. Review of the care plan dated 01/02/25 revealed Resident #107 may require assistance with activities of daily living (ADL) related to disease process and condition including MS. Interventions included to provide necessary adaptive equipment to meet daily needs, half side rail for bed mobility, total assistance for ADL, mechanical lift for transfers, and notify therapy of any declines in condition. There was no plan of care to directly address limitations of ROM or hand splints. Review of the Occupational Therapy (OT) Evaluation and Plan of Treatment dated 06/05/25 revealed Resident #107 had bilateral upper extremity contractures, was dependent on staff or all ADL, and had diagnosis of progressive MS. Resident #107 had ROM impairments of bilateral elbows, wrist, and fingers. Resident #107 was noted to have impairments of dexterity, fine motor coordination, mobility and strength limitations which resulted in limitations in areas of self-care and general tasks. OT services to develop and instruct on adaptation techniques, compensatory strategies, facilitate independence with ADL, and assess safety with adaptive equipment. It was recommended Resident #107 wear a palmar guard and to further assess, order, and fabricate other splints. Review of the OT Treatment Encounter Notes from 06/05/25 to 06/18/25 revealed Resident #107 was educated on adaptive equipment to increase independence. Resident #107 practiced ROM techniques with therapy. Review of the OT Discharge summary dated [DATE] revealed Resident #107 was dependent for grasping and holding items. Resident #107 was agreeable to ROM and acquiring adaptive equipment. The adaptive equipment was not specified. It was noted Resident #107's prognosis was good with consistent staff follow-through. Review of the progress notes from June 2025 to September 2025 revealed no evidence of application of hand splints, refusals of such splints, or contraindications to hand splints. Review of the Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #107 had intact cognition with no noted behaviors. Resident #107 had ROM impairments to bilateral upper and lower extremities. Resident #107 was dependent on staff for ADL. Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) for August 2025 and September 2025 revealed no evidence of staff applying hand braces to Resident #107 or refusals of such splints. Observation and interview on 09/16/25 at 9:08 A.M. with Resident #107 revealed she reported she felt her arms and hands were more contracted from the last time she received therapy services. Resident #107 reported her hands hurt, and she tried to stretch them herself. Resident #107 stated she had two hand braces that she would have to ask staff to put on her. At the time of interview, Resident #107's left arm was bent at the elbow and brought up to her chest under her neck. Resident #107's hands were visibly contracted. Resident #107's hand splints were hanging on the bed rail. Review of the physician's orders on 09/17/25 revealed there was no evidence of physician's order for hand splints. Interview on 09/18/25 at 7:53 A.M. with Licensed Practical Nurse (LPN) #800 revealed Resident #107 did have ROM issues with her hands. LPN #800 indicated Resident #107 was able to use her right hand more than the left. LPN #800 confirmed Resident #107 had hand splints. LPN #800 indicated staff always offered the hand splints; however, at times, Resident #107 would refuse them. LPN #800 reviewed the physician's orders and verified there was no order for hand splints for Resident #107. Interview on 09/18/25 at 10:51 A.M. with Rehab Director #957 confirmed Resident #107 had been working with therapy on use of hand splints. Rehab Director #957 indicated there was not a discharge order written (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for hand splints. Rehab Director #957 indicated the hand splints already had Resident #107's name on them, so they left them in her room. Rehab Director #957 indicated there would be no harm caused to Resident #107 by wearing the splints. A physician's order was obtained on 09/18/25 for the splints. Interview on 09/18/25 at 12:58 P.M. with the Director of Nursing (DON) indicated nursing staff should not be applying hand splints without a physician's order. The DON indicated there were no contraindications to the hand splints for Resident #107. Interview on 09/18/25 at 1:55 P.M. with the Licensed Nursing Home Administrator (LNHA) revealed the facility did not have a policy for splints or contracture management.		