

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: 366486	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/17/2025
NAME OF PROVIDER OR SUPPLIER Rockland Ridge Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2511 Washington Blvd Belpre, OH 45714	
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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview, the facility failed to ensure call lights were maintained in a resident's reach. This affected one resident (#78) of 24 residents reviewed for observations during the initial pool. The facility's census was 66. Findings Include: Review of the medical record revealed Resident #78 was admitted to the facility on [DATE]. Diagnoses included left knee replacement, osteoarthritis of the left knee, diabetes, left foot drop, lumbar sacral plexus disorder, hypertension, anxiety disorder, varicose veins of the lower extremities, radiculopathy, sacrococcygeal disorders, hip trochanteric bursitis, low back pain, thoracic spine pain, sciatica, Raynaud's syndrome, spinal stenosis, pacemaker, and anemia. Review of the admission note dated 09/21/25 at 12:10 P.M. revealed Resident #78 had a surgical incision to the left knee with 43 staples. She was transferred to bed with three staff assistance. Observation and interview on 09/22/25 at 10:15 A.M. revealed Resident #78 was sitting up in her recliner with her feet elevated. She stated her call light was over on the bed. The call light cord was lying across her bed, out of reach. On 09/22/5 at 10:19 A.M. an interview with Registered Nurse #111 confirmed the call light for Resident #78 was lying across her bed, out of her reach.		

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: 366486	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/17/2025
NAME OF PROVIDER OR SUPPLIER Rockland Ridge Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2511 Washington Blvd Belpre, OH 45714	
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 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 medical record review, observation, interview, and policy review the facility failed to ensure a pressure ulcer was accurately assessed and treatment implemented timely. This affected one (Resident #5) of two reviewed for pressure ulcers. Medical record revealed Resident #5 was admitted to the facility on [DATE] with diagnoses including stage III pressure ulcer (full-thickness loss of skin), diabetes, venous insufficiency, and heart failure. Review of Resident #5's Minimum Data Set (MDS) dated [DATE] revealed the resident was at risk for pressure ulcer and had one stage III pressure ulcer. Review of Resident #5's current plan of care for alteration in skin integrity as evidence by pressure ulcers to coccyx and left buttocks revealed assess areas for size, color, drainage, pain weekly and as needed and to administer treatments as ordered. Review of Resident #5's progress notes and assessment dated [DATE] to 09/24/25 revealed no evidence of a comprehensive assessment of the pressure ulcer on left buttocks or coccyx. Review of Resident #5's miscellaneous documentation tab dated 07/02/25 to 09/24/25 revealed Resident #5 had been seen weekly by a visiting wound company nurse practitioner (NP). On 09/10/25 the visiting wound team had seen Resident #5 for a follow-up for a stage III pressure injury to the coccyx and left buttocks and skin tear to the left shin. The left shin skin tear measured 5.5 centimeters (cm) by 2.3 cm by unable to determine due to scabbed/crusted. The in-house acquired stage III pressure ulcer on the coccyx measured 0.3 cm by 0.3 cm by 0.1 cm. No new orders. Continue with Xeroform gauze (petrolatum-impregnated gauze) daily with large, bordered foam dressing. The in-house acquired stage III pressure ulcer on the left buttocks measured 0.5 cm by 0.4 cm by 0.1 cm. No new orders. Continue with Xeroform gauze daily with a silicone bordered foam dressing. The care plan was discussed with nursing staff and residents. Please have the resident follow up with the visiting wound team in one week. On 09/17/25 at 7:41 A.M., the visiting wound team saw Resident 5 for a follow-up on the stage III pressure ulcer on the coccyx and left buttocks and skin tear to left shin. The coccyx wound was larger and declined, and treatment plan was changed. The left buttocks and left shin area was healed but will continue to follow for another week. The coccyx wound measured 2.1 cm by 1.9 cm by 0.1 cm. New orders collagen gauze daily with a large foam dressing. The left buttocks had healed however orders to continue the Xeroform gauze with a silicone bordered foam dressing. The plan of care was discussed with nursing staff and resident. Please have the resident follow up with the visiting wound team in one week. Review of Resident #5's progress note dated 09/17/25 at 4:37 P.M., revealed the resident was seen by wound care. A skin tear to left shin measured 5.5 cm by 2.3 cm by unable to determine, clustered wound. Order to continue to cleanse skin tear to left shin with soap and water and pat dry. Apply silicone contact dressing every Wednesday and as needed. The coccyx measured (0.3 cm by 0.3 cm by 0.1 cm) stage II. Continue to cleanse coccyx with soap and water or normal saline and apply Xeroform then cover with foam dressing. The left buttocks measured (0.5 cm x 0.4 cm x 0.1 cm) continue to cleanse left buttocks with soap and water or normal saline then apply xeroform cover with daily dressing daily. The physician and family are aware. Review of Resident #5's orders and treatment administration records dated 09/17/25 to 09/22/25 revealed no evidence of resident was ordered or received collagen gauze daily to the coccyx. Review of the visiting wound nurse amendment note dated 09/22/25 at 6:37 P.M. for 09/17/25 revealed the NP changed the order to the coccyx from Collagen to Collagen with silver and added a note that she was notified by the wound nurse that supply of collagen with silver was not available and will have to be ordered. Will continue previous order for dressing of Xeroform daily to wound until collagen with silver was made available. At that time, dressing would be changed to collagen with silver daily. Review of invoice dated 09/23/25 revealed the facility had ordered Collagen and Collagen with silver dressing on 09/23/25. Observation on 09/24/25 at 9:35 A.M., of Resident #5 with visiting wound nurse practitioner (NP) #300 and Registered Nurse (RN) (facility (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366486	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/17/2025
NAME OF PROVIDER OR SUPPLIER Rockland Ridge Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2511 Washington Blvd Belpre, OH 45714	
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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wound nurse) #101 revealed the coccyx pressure ulcer measured 0.9 cm by 0.3 cm by 0.1 cm. The left buttocks had three open areas measuring 4.1 cm by 1.5 cm by 0.1 cm. The visiting wound NP #300 reported she was just covering today due to the wound NP that usually comes weekly was on vacation. The NP reported the areas on the left buttocks appeared to be moisture associated dermatitis. The facility's wound nurse RN #101 reported she had been on vacation last week and the areas on the left buttocks were new. RN #101 reported she usually measures wounds with the NP oversight, however several months ago (not sure the exact date, however after the last annual) the facility stopped documenting comprehensive assessment and just use the visiting wound nurse assessment, unless the wound NP doesn't arrive she would complete a paper assessment and scan it into the electronic medical record under the miscellaneous tab. The wound NP #300 confirmed the facility receives her progress note the same day as the assessment for the facility's records. The NP reported she usually types her reports prior to leaving the facility. Interview on 09/24/25 at 1:21 P.M., 2:26 P.M. and 3:21 P.M. with the Director of Nursing (DON) revealed Licensed Practical Nurse (LPN) #103 was covering for RN #101 last week and entered inaccurate measurement and treatment plan in the progress note on 09/17/25 for Resident #5. The DON reported LPN #103 was on vacation this week, however it was her understanding the Collagen was not available last week and the visiting wound NP, which was on vacation this week as well, have orders to continue the Xeroform until the Collagen was available, however neither the LPN or visiting wound NP had documented or wrote orders. The DON confirmed she had contacted the visiting wound NP on 09/22/25 (after the survey was entered and concerns identified) and had the visiting wound NP add an addendum to her progress note on 09/17/25. The DON also confirmed on 09/22/25 she clarified the Collagan with the visiting wound NP and new orders were received for Collagen with silver daily to the coccyx, discontinued the order to the left shin, and continue the Xeroform to the left buttocks. The DON reported the Corporate Nurse had stopped and picked up Collagan with silver from a sister facility on 09/22/25 due to the facility places orders on Thursday and they usually don't arrive until Monday, and the Collagen never arrived due to it being not ordered. The DON confirmed the physician and family were updated on new orders on 09/22/25. Interview on 09/24/25 at 1:34 P.M., with RN #101 confirmed the measurement and treatments LPN #103 had documented on 09/17/25 were the same measurement and treatments that were done on 09/10/25. The RN confirmed LPN #103's documentation on 09/17/25 did not match the comprehensive assessment or orders the visiting wound NP had documented on 09/17/25. Interview on 09/24/25 at 1:36 P.M., with the Administrator revealed the Collagen was never ordered until 09/23/25. The Administrator reported that the facility realized the Collagen was never ordered the Corporate Nurse had stopped at the facility's sister facility and picked up Collagen with silver on Monday so the nurse could start the treatment and the Collagen with silver was also ordered on 09/23/25. Review of the facility policy titled Skin assessment dated [DATE] and revised 03/15/24 revealed skin assessments include a collection of objective and subjective data by the licensed nurses that contributes to the nursing process, including observation, measurements, and comparative analysis of a wound. Data collected for the completion of skin assessments would be documented by the licensed nurses in the resident's medical record. The licensed nurse collaborates with other members of the healthcare team to ensure necessary treatments and services are provided related to data collected for completion of skin assessments and documented per facility policy.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366486	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/17/2025
NAME OF PROVIDER OR SUPPLIER Rockland Ridge Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2511 Washington Blvd Belpre, OH 45714	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview, and policy review, the facility failed to ensure appropriate infection control practices were followed during urinary incontinence care and wound care. The facility also failed to ensure a resident's indwelling urinary catheter's collection bag was maintained off the floor to prevent possible contamination/ infection. This affected one (Resident #23) of three residents reviewed for pressure ulcers and two (Resident #3 and #5) of four residents reviewed for catheters and/ or urinary tract infections. Findings include: 1. Review of Resident #23's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included an encounter for other orthopedic aftercare, staphylococcal arthritis of the right hip, infection and inflammatory reaction due to internal right hip prosthesis, presence of right artificial hip joint, osteoarthritis, need for assistance with personal care, muscle weakness, and abnormalities of gait and mobility. Review of Resident #23's admission skin record dated 08/16/25 revealed the resident had an unstageable pressure ulcer (full thickness skin and tissue losses in which the extent of the tissue damage could not be determined because it was obscured by slough and/ or eschar) to her sacrum, left proximal buttock, and left distal buttock upon admission. The sacral wound measured 2.3 centimeters (cm) by 1.7 cm, the left proximal buttock wound measured 0.8 cm by 0.7 cm, and the left distal buttock wound measured 2 cm by 2.6 cm. Review of Resident #23's admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was known to be frequently incontinent of her bowel and bladder and was considered to be at risk for pressure ulcers. She was known to have three unstageable pressure ulcers that were present upon admission. Review of Resident #23's weekly wound assessments completed through 09/24/25 revealed the unstageable pressure ulcer to the sacrum had resolved on 09/10/25 and the unstageable pressure ulcer to the left proximal buttock resolved on 09/17/25. The unstageable pressure ulcer to the left distal buttock was the only pressure ulcer that remained as of 09/24/25 and was classified as a stage III pressure ulcer (full thickness skin loss that extended into the subcutaneous tissue but did not expose muscle, tendon, or bone). Review of Resident #23's active physician's orders revealed the resident had orders in place to treat the left proximal buttock and the left distal buttock. The treatment was the same for both and included the need to cleanse the areas with normal saline or soap and water and apply Triad paste every shift and as needed (prn). They were to leave both areas open to air (OTA). On 09/25/25 at 9:00 A.M., an observation of Resident #23's treatment of the stage III pressure ulcer to her left distal buttock revealed the treatment was performed by Registered Nurse (RN) #112. She was assisted by RN #101. The nurses donned personal protective equipment (PPE) to include a gown and gloves upon entering the room, due to the resident being on enhanced barrier precautions due to her wounds. Hand hygiene was performed prior to starting the treatment and supplies were set up on the bedside table. RN #101 assisted the resident with turning over on her left side. Resident #23 was noted to have had a small bowel movement that was found in her incontinence brief when RN #112 was getting ready to do the treatment. She proceeded to provide incontinence care to the resident with the disposable gloves that she already had on. Several disposable wipes were used to clean the stool from around her rectal area. The resident had dried Triad paste coating her buttocks that had been applied during a previous treatment. Once the nurse finished wiping the stool from around the (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366486	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/17/2025
NAME OF PROVIDER OR SUPPLIER Rockland Ridge Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2511 Washington Blvd Belpre, OH 45714	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's rectal area, she proceeded to use another disposable wipe to clean off the dried Triad paste that was already on her buttocks. She wiped the Triad paste from over top of the area (where the resident had her stage III pressure ulcer on the left distal buttocks) exposing the area of the resident's wound. She did not remove her contaminated gloves and perform hand hygiene, after cleaning the resident's rectal area to remove the stool, before she proceeded with wiping the area on the left distal buttock where the wound was. It was not until she had wiped the wound area to where it was clear of any Triad paste that she removed her gloves and performed hand hygiene. She donned new gloves, after washing her hands, and then proceeded to wash the pressure ulcer with soap and water. She completed the treatment as ordered and then finished changing the resident before gathering her used supplies and left the room. On 09/25/25 at 9:20 A.M., an interview with RN #112 confirmed she did not change her gloves or perform hand hygiene between wiping Resident #23's rectal area following an unexpected bowel movement and wiping the dried Triad paste off her left buttock where her stage III pressure ulcer was. She acknowledged she should have removed her gloves, performed hand hygiene, and then donned new gloves before wiping the Triad paste off her left buttock directly over the area where her pressure ulcer was. She acknowledged by doing so, she risked the contamination of the resident's pressure ulcer cite with Escherichia coli (E.Coli) commonly found in the intestines and stool. Review of the facility's policy on Dressing Changes dated 09/29/17 revealed dressing changes were to be changed following the manufacturer's recommendations and as needed. The procedure included the need to use proper hand hygiene techniques and glove changes when performing dressing changes. 2. Review of the medical record revealed Resident #3 was admitted to the facility on [DATE]. Diagnoses included right side hemiplegia, aphasia, apraxia, diabetes, dysarthria, cerebral infarction, hypothyroidism, major depressive disorder, interstitial cystitis, paroxysmal vertigo, carpal tunnel osteoporosis, osteoarthritis, cataracts, atherosclerotic heart disease, dysfunction of the bladder, anxiety disorder and hypertension. Observation of incontinence care on 09/23/25 at 1:05 P.M. revealed Certified Nursing Assistant (CNA) #301 and CNA #168 provided care to Resident #3. CNA #301 provided perineal care to the labial area of Resident #3 with no concerns with infection control. However, when she rolled Resident #3 over to provide perineal care to her rectum and buttocks area she washed and rinsed Resident #3 from the rectum to the vaginal area, potentially contaminating the vagina with feces. On 09/23/25 at 1:18 P.M. an interview with CNA #301 confirmed she washed and rinsed Resident #3 from the rectum to the vagina. Review of the facility policy titled, Perineal Care, revealed the purpose was to provide care to the genitalia and rectal areas, to prevent broken skin and infection to provide comfort and cleanliness and to prevent body odors. The policy indicated for females to always wipe front to back, using a different part of the washcloth for each wipe. 3. Review of Resident #5's medical record revealed Resident #5 was admitted to the facility on [DATE] with diagnoses including benign prostatic hyperplasia with lower urinary tract symptoms, obstructive and reflux uropathy, urinary retention, and obstructive reflux uropathy. Review of Resident #5 Minimum Data Set (MDS) dated [DATE] revealed the resident had an (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366486	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/17/2025
NAME OF PROVIDER OR SUPPLIER Rockland Ridge Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2511 Washington Blvd Belpre, OH 45714	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indwelling catheter. Review of Resident #5's orders dated 09/2025 revealed catheter care every shift and to change suprapubic catheter monthly and as needed per urologist recommendations. Review of Resident #5's alteration in elimination plan of care dated 07/08/25 and revised 02/11/25 revealed the resident had a suprapubic catheter for obstructive uropathy. Review of Resident #5's urine culture dated 08/18/25 revealed the resident had Enterobacter Cloacae Complex (ECC), Methicillin Resistant Staphylococcus Aureus (MRSA) and Enterococcus Faecalis (VRE). Observation on 09/22/25 at 1:13 P.M., of Resident #5 revealed the resident was sitting in a wheelchair with his urinary catheter bag under the seat of the wheelchair directly touching the floor without a barrier or covering over the urinary catheter bag. The surveyor activated the call light for the resident due to his oxygen tubing being disconnected from the portable tank. Licensed Practical Nurse (LPN) #122 assisted the resident with oxygen tubing, however, did not move the urinary catheter bag to ensure it was not touching the floor directly. Observation on 09/22/25 at 1:44 P.M. revealed Resident #5 was still up in the wheelchair, and the urinary catheter bag was directly touching the floor. Observation on 09/24/25 at 11:16 A.M. revealed Resident #5 was being pushed down the hall in a wheelchair by Certified Nursing Assistant (CNA) #302. The Resident's urinary catheter bag was dragging on the floor as the CNA was pushing the resident down the hall. The urinary catheter bag was in direct contact with the floor without a barrier/covering. Interview on 09/24/25 at 11:16 A.M. with CNA #302 confirmed Resident #5's urinary catheter bag was directly dragging onto the floor. The CNA confirmed the urinary catheter bag should not be touching the floor. The CNA then removed the urinary catheter bag from the bottom of the wheelchair and moved it to the side of the wheelchair and took the resident to the dining room. Interview on 09/24/25 at 12:03 P.M., with the Director of Nursing (DON) confirmed urinary catheter bags should not be directly touching the floor. The DON reported she had recently educated staff on the catheter care policy; However, the facility's policy didn't include placement of the catheter bag. The DON confirmed last month the resident was treated for a urinary tract infection that contained VRE, MRSA, and Enterobacter Cloacae.		