STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: 00 B. WING:	01/13/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIVERSIDE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **185402**	**100 8TH STREET** **MCKEESPORT, PA 15132**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification survey, State Licensure survey, Civil Rights Compliance, and an Abbreviated survey in response to a complaint completed on 1/13/25, it was determined that Riverside Health and Rehabilitation Center with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care and the 28 Pa. Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0636 SS=E		F 0636		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0636 SS=E	Continued from page 1 483.20(b)(1)(2)(i)(iii) Comprehensive Assessments & Timing §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning.	F 0636	Preparation and submission of this Plan of Correction does not constitute an admission of agreement by the provider of the facts alleged or the correctness of the conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and submitted solely because of requirements under state and federal laws. A comprehensive Minimum Data Set (MDS) assessment was completed for all residents who were identified. The completion dates for the assessments cannot be modified. The facility's Registered Nurse Assessment Coordinator, or a designee, will audit the assessment reference dates of the required next annual MDS assessment or admission MDS assessment for the in-house residents. She will ensure that the Interdisciplinary Team staff involved in the assessment process are provided with the audit information to assure compliance	Completion Date: **02/12/2025** Status: **APPROVED** Date: **01/28/2025**

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F 0636 SS=E	Continued from page 2 (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by:	F 0636	with subsequent completion dates. The members of the Interdisciplinary Team involved in the assessment process will be re-trained on the requirements and procedures for conducting comprehensive assessments by the Regional Clinical Reimbursement Specialist or a designee. The Regional Clinical Reimbursement Specialist, or a designee, will conduct audits of residents' annual and admission MDS assessments to ensure compliance with F636 requirements related to completion timing twice weekly times two, weekly times two and monthly times two. The audit results will be reviewed in the monthly quality assurance meetings to address any identified issues promptly.	

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F 0636 SS=E	Continued from page 3 Based on review of the Resident Assessment Instrument User's Manual, clinical records, and staff interview, it was determined that the facility failed to make certain that comprehensive Minimum Data Set assessments were completed in the required time frame for six of 24 residents (Resident R67, R147, R148, R153, R248, and R249). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing required Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2023, indicated that an admission MDS assessment was to be completed no later than 14 days following admission. Resident R67 had an admission date of 12/4/24, with an MDS completion date of 1/8/25. Resident R147 had an admission date of 12/2/24, with an MDS completion date of 1/11/25.	F 0636		

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F 0636 SS=E	Continued from page 4 Resident R148 had an admission date of 12/20/24, with an MDS not completed as of 1/13/25. Resident R153 had an admission date of 11/29/24, with an MDS completion date of 1/5/25. Resident R248 had an admission date of 12/21/24, with an MDS completion date of 1/13/25. Resident R249 had an admission date of 12/21/24, with an MDS not completed as of 1/13/25. During an interview on 1/8/24, at 1:35 p.m. the Registered Nurse Assessment Coordinator (RNAC) Employee E9 confirmed that the facility failed to make certain that MDS assessments were completed in the required time frame for six of 24 residents. 28 Pa. Code: 211.5(f) Clinical records.	F 0636		
F 0638 SS=E		F 0638		

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F 0638 SS=E	Continued from page 5 483.20(c) Qrtly Assessment at Least Every 3 Months §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by:	F 0638	A quarterly Minimum Data Set (MDS) assessment was completed for all residents who were identified. The completion dates for the assessments cannot be modified. The facility's Registered Nurse Assessment Coordinator, or a designee, will audit the assessment reference dates of the required next quarterly MDS assessment for the in-house residents. She will ensure that the Interdisciplinary Team staff involved in the assessment process are provided with the audit information to assure compliance with subsequent completion dates. The members of the Interdisciplinary Team involved in the assessment process will be re-trained on the requirements and procedures for conducting quarterly assessments by the Regional Clinical Reimbursement Specialist or a designee. The Regional Clinical Reimbursement Specialist, or a	Completion Date: **02/12/2025** Status: **APPROVED** Date: **01/28/2025**

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F 0638 SS=E	Continued from page 6	F 0638	designee, will conduct audits of residents' quarterly MDS assessments to ensure compliance with F638 requirements related to completion timing twice weekly times two, weekly times two and monthly times two. The audit results will be reviewed in the monthly quality assurance meetings to address any identified issues promptly	

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F 0638 SS=E	Continued from page 7 Based on review of the Resident Assessment Instrument User's Manual, clinical records, and staff interview, it was determined that the facility failed to make certain that that quarterly Minimum Data Set (MDS- periodic review of resident care needs) assessments were completed within the required time frame for three of eight residents reviewed (Resident R44, R52, and R76). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing required MDS assessments, dated October 2023, indicated that quarterly MDS assessments were to be completed no later than 14 days after the Assessment Reference Date (ARD). Resident R44 had an ARD of 12/5/24, with an MDS completion date of 1/7/25. Resident R52 had an ARD of 12/18/24, with the MDS not completed as of 1/13/25.	F 0638		

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F 0638 SS=E	Continued from page 8 Resident R76 had an ARD of 12/5/24, with an MDS completion date of 1/7/25. During an interview on 1/8/24, at 1:35 p.m. the Registered Nurse Assessment Coordinator (RNAC) Employee E9 confirmed that the facility failed to make certain that MDS assessments were completed in the required time frame for three of eight residents residents. 28 Pa. Code: 211.5(f) Clinical records.	F 0638		
F 0640 SS=A		F 0640		

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F 0640 SS=A	Continued from page 9 483.20(f)(1)-(4) Encoding/Transmitting Resident Assessments §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment.	F 0640	The completion dates for the discharge assessments cannot be modified. The facility's Registered Nurse Assessment Coordinator, or a designee, will audit the assessment reference dates of the required discharge MDS assessment for residents who have discharged in the last 30 days. She will ensure that the Interdisciplinary Team staff involved in the assessment process are provided with the audit information to assure compliance with subsequent completion dates. The members of the Interdisciplinary Team involved in the assessment process will be re-trained on the requirements and procedures for conducting discharge assessments by the Regional Clinical Reimbursement Specialist or a designee. The Regional Clinical Reimbursement Specialist, or a designee, will conduct audits of	Completion Date: **02/12/2025** Status: **APPROVED** Date: **01/28/2025**

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F 0640 SS=A	Continued from page 10 (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by:	F 0640	residents who have discharged to ensure compliance with F640 requirements related to completion timing twice weekly times two, weekly times two and monthly times two. The audit results will be reviewed in the monthly quality assurance meetings to address any identified issues promptly.	

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F 0640 SS=A	Continued from page 11 Based on review of the Resident Assessment Instrument, clinical records, and staff interviews, it was determined that the facility failed to transmit Minimum Data Set (MDS - periodic assessment of resident care needs) assessments to the required electronic system, the Centers for Medicare and Medicaid Services (CMS) Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) System, within 14 days of completion for one of four residents (R83). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing MDS assessments, dated October 2023, indicated discharge tracking records must be completed and transmitted within 14 days of the Event Date (Section A2000 plus 14 days). Review of Resident R83's "Discharge Summary"	F 0640		

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F 0640 SS=A	Continued from page 12 indicated a discharge date of 11/25/24. Review of Resident R83's MDS assessments failed to reveal a Discharge MDS completed. During an interview on 1/8/24, at 1:35 p.m. the Registered Nurse Assessment Coordinator (RNAC) Employee E9 confirmed that the facility failed to make certain that MDS assessments were transmitted in the required time frame for one of four residents. 28 Pa. Code 211.5(f) Clinical Records.	F 0640		
F 0655 SS=D		F 0655		

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F 0655 SS=D	Continued from page 13 483.21(a)(1)-(3) Baseline Care Plan §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:	F 0655	Residents 22, 32, 44, 150, and 195 have been in the center greater than 48 hours. Their care plans were reviewed and care plans updated to reflect diabetes by the RNAC/ designee. New admissions and readmissions have the potential to be affected. A review of residents admitted from 1/13/2025 – 1/17/2025 was conducted by the DON/ designee to ensure baseline care plans included diabetes diagnosis. Corrections will be made as needed. To prevent recurrence, licensed nursing staff will be educated on the Interim Baseline Care Plan policy by the DON/ designee. To monitor and maintain compliance, new admission and readmissions with diabetes will be audited by the DON/ designee weekly x 4 weeks and monthly x 2 months to ensure baseline care plans include diabetes as appropriate.	Completion Date: **02/12/2025** Status: **APPROVED** Date: **01/28/2025**

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F 0655 SS=D	Continued from page 14 (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by:	F 0655	Results of the audits will be forwarded to the center QAPI committee for review and recommendations	

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F 0655 SS=D	Continued from page 15 Based on review of clinical record, facility policy, and staff interview, it was determined that the facility failed to develop a baseline care plan that included diabetes care and interventions needed to provide effective and person-centered care for four of fourteen residents (Resident R22, R32, R44, R150, and R195) . Finding include: The facility policy "Baseline-Care Plans" reviewed 1/2/24, indicated a baseline care plan to meet the resident's immediate needs shall be developed within forty-eight hours of the resident's admission. Review of the admission record indicated Resident R22 was admitted to the facility on 1/9/25, with the diagnosis of diabetes mellitus (too much sugar in the blood). Review of Resident R22's baseline care plan completed on 1/11/25, indicated the resident has not been care planned for diabetes.	F 0655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: __00_____ B. WING: _____	01/13/2025

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F 0655 SS=D	Continued from page 16 Review of the admission record indicated Resident R32 was admitted to the facility on 11/9/24, with the diagnosis of diabetes mellitus. Review of Resident R32's baseline care plan completed on 11/9/24, indicated the resident has not been care planned for diabetes. Review of the admission record indicated Resident 150 was admitted to the facility on 12/4/24, and readmitted on 1/6/25, with the diagnosis of diabetes mellitus. Review of Resident R150's baseline care plan completed 11/30/24, indicated the resident has not been care planned for diabetes. Review of the admission record indicated Resident R195 was admitted to the facility on 8/21/24, and readmitted 12/21/24, with the diagnosis of diabetes mellitus.	F 0655		

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F 0655 SS=D	Continued from page 17 Review of Resident R195's baseline care plan completed 9/2/24, indicated the resident was not care planned within 48 hours and has not been care planned for diabetes. During an interview on 1/8/25, at approximately 11:30 a.m. the Director of Nursing and Assistant Director of Nursing confirmed that the baseline care plan for Residents R22, R32, R44, R150, and R195 did not accurately include their immediate care needs. 28 Pa. Code: 211.11 (a)(c)(d) Resident care plan. 28 Pa. Code 211.12 (d)(1)(5) Nursing services.	F 0655		
F 0656 SS=D		F 0656		

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F 0656 SS=D	Continued from page 18 483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future	F 0656	Residents 22, 32, 44, 150, and 195's care plans were reviewed and care plans were updated to reflect diabetes by the RNAC/ designee. Current residents with diabetes have the potential to be affected. A comprehensive audit of current residents with diabetes was completed by the RNAC/ designee to ensure diabetes is reflected in the care plan. Corrections were made as needed. To prevent recurrence, the IDT will be educated on the Comprehensive Care Plan policy by the NHA/ designee. To maintain and monitor compliance, the DON/ designee will audit 5 residents with a diabetes diagnosis weekly x 4 weeks and monthly x 2 months to ensure diabetes is reflected in the care plan. Results of the audits will be forwarded to the center QAPI committee for review and recommendations.	Completion Date: **02/12/2025** Status: **APPROVED** Date: **01/28/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0656 SS=D	Continued from page 19 discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:	F 0656		

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F 0656 SS=D	Continued from page 20 Based on review of Resident Assessment Instrument (RAI) User's Manual, facility policies, clinical records, and staff interviews, it was determined that the facility failed to develop comprehensive care plans to meet resident care needs for five of fourteen residents (R22, R32, R44, R150, R195). Finding include: The Resident Assessment Instrument (RAI) User's Manual, which gives instructions or completing Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2023, indicated the following instructions for Section V Care Area Assessment (CAA) Summary, Questions V0200: "For each triggered Care Area, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment of the care area. The Care Planning Decision column must be completed within 7 days of completing the RAI (MDS and CAA(s)). Check column B if the triggered care area	F 0656		

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F 0656 SS=D	Continued from page 21 is addressed in the care plan." Review of the facility "Comprehensive Care Planning Policy" dated 1/13/25, previously reviewed 1/2/24, indicated the "facility must develop a comprehensive, person-centered care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessments". Review of Resident R22's admission record indicated she was admitted to the facility on 1/9/25. Review of the MDS dated 1/15/24, included diagnoses of diabetes mellitus (too much sugar in the blood)and chronic kidney disease (kidneys have trouble filtering waste out of the blood). Review of the MDS dated 1/15/24, Section V Care Area Assessment (CAA) Summary, Question V0200 was not completed.	F 0656		

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F 0656 SS=D	Continued from page 22 Review of Resident R22's care plan dated 1/9/25, failed to include goals and interventions related to diabetes mellitus. Review of Resident R32's admission record indicated he was admitted to the facility on 11/9/24. Review of the MDS dated 12/12/24, included diagnoses of diabetes mellitus (too much sugar in the blood)and end-stage renal disease (severe loss of kidney function). Review of the MDS dated 12/12/24, Section V Care Area Assessment (CAA) Summary, Question V0200 was not completed. Review of Resident R32's care plan dated 1/9/25, failed to include goals and interventions related to diabetes mellitus. Review of Resident R44's admission record indicated he was admitted to the facility on 7/27/23.	F 0656		

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F 0656 SS=D	Continued from page 23 Review of the MDS dated 12/5/24, included diagnoses of diabetes mellitus,and heart failure (heart doesn't pump blood as well as it should). Review of the MDS dated 12/5/24, Section V Care Area Assessment (CAA) Summary, Question V0200 was not completed. Review of Resident R44's care plan dated 1/9/25, failed to include goals and interventions related to diabetes mellitus. Review of Resident R150's admission record indicated she was admitted to the facility on 12/4/24 and readmitted 1/6/25. Review of the MDS dated 12/4/24, included diagnoses of diabetes mellitus and dementia (thinking and social symptoms that interferes with daily functioning). Review of the MDS dated 12/4/24, Section V Care Area Assessment (CAA) Summary, Question	F 0656		

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F 0656 SS=D	Continued from page 24 V0200 was not completed. Review of Resident R150's care plan dated 1/9/25, failed to include goals and interventions related to diabetes mellitus. Review of Resident R195's admission record indicated he was admitted to the facility on 8/21/24 and readmitted 12/21/24. Review of the MDS dated 11/4/24, included diagnoses of diabetes mellitus and lung cancer. Review of the MDS dated 11/4/24, Section V Care Area Assessment (CAA) Summary, Question V0200 was not completed. Review of Resident R195's care plan dated 1/9/25, failed to include goals and interventions related to diabetes mellitus. During an interview on 1/8/25, at approximately 11:30 a.m. the Nursing Home Administrator and	F 0656		

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F 0656 SS=D	Continued from page 25 Director of Nursing confirmed the facility failed to develop and implement comprehensive care plans to meet residents care needs for five of fourteen residents. 28 Pa. Code 211.11(d) Resident care plan.	F 0656		
F 0657 SS=E		F 0657		

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F 0657 SS=E	Continued from page 26 483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 0657	Resident 5's care plan will be reviewed by the DON/ designee and updated to reflect goals and interventions related to hospice services. Resident 195's care plan will be reviewed by the DON/ designee and updated to reflect goals and interventions related to oxygen therapy. Current residents who receive hospice services and/ or require oxygen therapy have the potential to be affected. A comprehensive audit will be conducted by the DON/ designee to ensure hospice services and/ or oxygen therapy is reflected in the care plan. Corrections will be made as needed. To prevent recurrence, the IDT will be educated on the Comprehensive Care Plan policy by the NHA/ designee. To maintain and monitor compliance, residents with new orders for hospice services or oxygen therapy will be audited by the DON/	Completion Date: **02/12/2025** Status: **APPROVED** Date: **01/28/2025**

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F 0657 SS=E	Continued from page 27	F 0657	designee to ensure care plans have been revised weekly x 4 weeks and monthly x 2 months. Results of the audits will be forwarded to the center QAPI committee for review and recommendations.	

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F 0657 SS=E	Continued from page 28 Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to revise/update care plans for two of eight residents to accurately reflect the current status of the resident (Residents R5 and R195). Findings include: Review of facility "Comprehensive Care Planning Policy" dated 1/13/25, previously reviewed 1/2/24, indicated that in cases of significant changes in the resident's condition, the care plan must be updated within seven days of the new MDS. Review of the admission record indicated Resident R5 was admitted to the facility on 1/13/15. Review of Resident R5's Minimum Data Set (MDS- a periodic assessment of care needs) dated 11/4/24, indicated the diagnoses of Alzheimer ' s disease (a type of brain disorder that causes problems with memory, thinking and behavior), anemia (too little iron in the body causing fatigue), and chronic kidney	F 0657		

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F 0657 SS=E	Continued from page 29 disease (gradual loss of kidney function). Review of Resident R5's physician order dated 6/11/24, indicated to that Resident R5 began receiving hospice services. Review of Resident R5 ' s Significant Change MDS dated 6/25/24, indicated Resident R5 began receiving hospice care while a resident. Review of Resident R5's current care plan on 1/9/25, failed to include goals and interventions related to Resident R5 receiving hospice services. Review of the admission record indicated Resident R195 was admitted to the facility on 8/21/24. Review of Resident R195's MDS dated 11/4/24, indicated the diagnoses of chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness), respiratory failure with hypoxia (condition where the body doesn't have enough	F 0657		

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F 0657 SS=E	Continued from page 30 oxygen in the tissues), and lung cancer. Review of Resident R195's physician order dated 12/22/24, indicated to that Resident R195 was to receive continuous oxygen therapy. During an observation on 1/8/25, at approximately 1:30 p.m. Resident R195 was noted to be wearing a nasal canula (flexible tube that gives additional oxygen through the nose). Review of Resident R195's current care plan on 1/8/25, failed to include goals and interventions related to Resident R195 receiving oxygen therapy. During an interview on 1/13/25, at approximately 3:00 p.m. the Director of Nursing confirmed the facility failed to revise/update care plans for two of eight residents to accurately reflect the current status of the resident. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0657		

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F 0657 SS=E	Continued from page 31 28 Pa. Code 211.11(e) Resident care plan.	F 0657		
F 0684 SS=K		F 0684		

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F 0684 SS=K	Continued from page 32 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	Resident R 150 was assessed for s/s hyperglycemia by the Assistant Director of Nursing (ADON) and none were noted. The blood sugar of 509 was reported to the physician by the RN supervisor and there were no new orders. Residents R 150, R195, R8, R6, R 57, R56, R79, R32, R44, R65, R22, R38, R39, and R59's blood sugars from the previous 24 hours (1/8/2025- 1/9/2025) was completed to ensure no blood sugars out of range did not have physician notification. Residents R 150, R195, R8, R6, R 57, R56, R79, R32, R44, R65, R22, R38, R39, and R59's care plans were reviewed to ensure care plans reflected diabetes and had approaches for hypo and hyperglycemia management on 1/8/2025 by the Registered Nurse Assessment Coordinator (RNAC)/ designee. Current residents and new admissions and readmissions with diabetes have the potential to be affected. Blood sugars of current residents with diabetes were	Completion Date: **02/12/2025** Status: **APPROVED** Date: **01/29/2025**

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F 0684 SS=K	Continued from page 33	F 0684	reviewed on 1/8/2025 by the ADON to determine if any blood sugars were out of range and none were noted. Current residents with diabetes had their care plans reviewed by the RNAC/ designee to ensure care plans reflected diabetes and had approaches for hypo and hyperglycemia management. A review of current residents with diabetes who require sliding scales will be conducted by the DON/designee to ensure sliding scales have physician ordered parameters appropriate to the resident. To prevent recurrence, licensed nursing staff was educated by the Director of Nursing/ designee on the Diabetic Protocol, the Hypoglycemia policy, and the Change of Condition policy to include notification of physician of blood sugars out of range. Newly hired licensed nursing staff will receive the education in orientation by the Director of Nursing/ designee.	

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F 0684 SS=K	Continued from page 34	F 0684	Licensed nursing staff will receive directed in servicing on F 684 by Affinity Health Services on 1/27/2025. To monitor and maintain compliance, The DON/ designee has reviewed blood sugars daily x 1 week and will continue to review blood sugars daily x 1 more week, then 3x a week for 2 weeks, then weekly x 2 weeks to ensure physician notification is made for out of range blood sugars. To monitor and maintain compliance, new admissions/ readmissions have been reviewed by the DON/ designee 5x a week for 1 week and will continue 5x a week for 1 more week, then 3x a week for 2 weeks then weekly x 2 weeks to ensure care plans implemented for diabetes management. Results of the audits will be forwarded to the center QAPI committee for review and recommendations.	

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F 0684 SS=K	Continued from page 35 Based on facility review of policy, manufacturer's instructions, clinical records and staff interviews, the facility failed to notify physicians of elevated or decreased Capillary Blood Glucose (CBG) levels, failed to assess residents for hyperglycemia (high blood glucose) and hypoglycemia (low blood sugar) resulting in immediate jeopardy for 14 of 22 residents (R6, R8, R22, R32, R38, R39, R44, R56, R57, R59, R65, R79, R150, R195). Findings Include: Review of facility policy "Diabetic Protocol" dated 1/2/24, indicated provider and staff will work together to give appropriate treatment to manage diabetes. The provider will follow up on any acute episodes associated with significant blood glucose level changes and deterioration of previous glucose control and document resident status at subsequent visits until the acute situation is resolved. The staff will identify and report complications such as hypoglycemia.	F 0684		

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F 0684 SS=K	Continued from page 36 Review of the facility "Hypoglycemia Policy" dated 1/2/24, indicated nursing personnel are responsible for recognizing signs and symptoms of hypoglycemia and responding accordingly. "When acute hypoglycemia is suspected, assess mental status (alert, drowsy, uncooperative, or unconscious) and use glucometer to determine the resident's blood sugar level. A blood glucose of 70 mg/dL or less may indicate the need for intervention. If there are no provider orders for specific treatment do the following: -If the resident is conscious and treatment is indicated, give 1 tube of dextrose gel (15 grams). -After 15 minutes, repeat blood sugar and if still under 70 mg/dL, repeat glucose gel. -After 15 minutes repeat blood sugar. If above 70 mg/dL, give a snack of protein and a carbohydrate (ex. ½ sandwich with bread and a protein or crackers and a protein.) Monitor until stable. -If the resident is drowsy or unconscious or is unable or unwilling to consume anything orally, administer glucagon 1 mg subcutaneously. Monitor	F 0684		

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F 0684 SS=K	Continued from page 37 the resident for 15 minutes after treatment. -If, after 15 minutes, the resident is conscious and able to consume orally, give a snack of a protein and a carbohydrate (ex. ½ a sandwich with bread and a protein or crackers and a protein). Monitor until stable; -If, after 15 minutes the resident still cannot consume anything orally, repeat glucagon 1 mg subcutaneously and call 911." Further review of the policy failed to reveal procedures in the event of a resident experiencing hyperglycemia. Review of the Facility Assessment dated 11/21/24, indicated the facility will provide care for residents diagnosed with diabetes. Review of the glucometer manufacturer's instructions indicated "Low" refers to less than 20 mg/dl, and "High" refers to greater than 600 mg/dl. Review of the clinical record indicated that Resident	F 0684		

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F 0684 SS=K	Continued from page 38 R150 was admitted to the facility on 11/30/24. Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 12/4/24, included diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time) with hyperglycemia and severe chronic kidney disease (gradual loss of kidney function). Review of physician orders dated 11/30/24, 12/5/24, and 1/6/25, indicated to check blood sugar before meals, and call MD (Doctor of Medicine) for BS (blood sugar) <70 and >340. Review of Resident R150's plan of care failed to reveal goals and interventions related to diabetes and blood sugar level maintenance. Review of Resident R150's blood sugar record indicated that on 1/8/24, at 12:25 p.m. Resident R150's blood sugar was 509, documented by Licensed Practical Nurse (LPN) Employee E1.	F 0684		

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F 0684 SS=K	Continued from page 39 During an interview on 1/8/25, at approximately 2:30 p.m. LPN Employee E1 stated she had advised the Registered Nurse Supervisor (RNS) Employee E2 but had not had a response from her or the provider, and that no additional interventions or blood sugar rechecks had been completed on Resident R150. LPN Employee E1 further confirmed that the facility process is to notify the RNS, who then notifies the provider. During an interview on 1/8/25, at approximately 2:40 p.m. RNS Employee E2 stated she was not informed until 1:21 p.m. but she had not notified the provider stating, "It is on my list." RNS Employee E2 confirmed no additional interventions or blood sugar rechecks had been completed on Resident R150. During an interview on 1/8/25, at approximately 2:45 p.m. the Director of Nursing (DON) confirmed that out of range blood sugar levels need to be addressed at the time of occurrence, and that a	F 0684		

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F 0684 SS=K	Continued from page 40 delay of greater than two hours was not appropriate. Further review of Resident R150's blood sugar record failed to reveal documentation of notification or follow-up for the following: 12/6: Result "high" 12/4: 448 Review of the clinical record indicated that Resident R195 was admitted to the facility on 8/21/24 and then readmitted 12/21/24. Review of the MDS dated 11/4/24, included diagnoses of diabetes with hyperosmolarity (life threatening metabolic complication with severe high blood sugar) and lung cancer. Review of physician orders dated 12/21/24, indicated to check blood sugar twice a day (before breakfast and dinner), and call MD for BS <60 and >350.	F 0684		

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F 0684 SS=K	Continued from page 41 Review of Resident R195's plan of care failed to reveal goals and interventions related to diabetes and blood sugar level maintenance. During an interview on 1/8/25, at approximately 2:48 p.m. the Director of Nursing (DON) confirmed that out of range blood sugar levels need to be addressed at the time of occurrence, and that a delay of greater than two hours was not appropriate or documenting 24-48 hours later is not acceptable. Further review of Resident R195's blood sugar record failed to reveal documentation of notification or follow-up for the following: 12/1: Went out to the hospital for change in condition and no BS done per protocol 11/9: Result 59-Note placed 48 hrs later 11/7: Result "High"-No note showing notification or follow-up 9/25: Result 473-No note documented until 24 hrs later Review of the clinical record indicated that Resident	F 0684		

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F 0684 SS=K	Continued from page 42 R32 was admitted to the facility on 11/9/24. Review of the MDS dated 11/15/24, included diagnoses of diabetes and end stage renal disease (ESRD - an inability of the kidneys to filter the blood). Review of a physician order dated 11/9/24, indicated for Resident 32 to receive Glipizide extended release (oral medication to treat diabetes) once daily. Review of physician's orders for November 2024, failed to reveal an order to check Resident R32's blood sugar level. Review of Resident R32's plan of care failed to reveal goals and interventions related to diabetes. Review of a progress note dated, at 11/17/24, at 9:00 a.m. indicated, "Notified by RN assigned to resident that resident was observed on floor. Resident assessed no injuries at time of incident.	F 0684		

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F 0684 SS=K	Continued from page 43 Resident states he hit head neuro-checks initiated at time of incident and noted with some confusion but resident baseline. Resident able to state place and time and current needs at time of incident." Review of a progress note written by RNS Employee E8 dated 11/17/24, at 6:47 p.m. indicated, "Notified by nurse assigned to resident that resident has become more confused throughout the day. Assessed resident and resident noted with increased confusion and speaking in incoherent sentences. Resident speech noted slurred, noted unable to hold self-up in wheelchair. Resident skin noted pale in color, pupils unequal but reactive to light. Resident able to state name but unable to state where he was. Obtained order from doctor and resident sent out to [hospital] via ambulance. Review of Resident R32's dietary intake indicated he did not eat breakfast or lunch, and there was no documentation of dinner. Review of Resident R32's blood sugar record failed	F 0684		

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F 0684 SS=K	Continued from page 44 to reveal that his blood glucose level was checked at the time of the fall as a possible reason for the fall, and failed to reveal that his blood sugar was checked at his change in mental status as a possible reason. Review of a progress note dated 11/18/24, at 3:02 a.m. indicated Resident R32 was admitted to the hospital with a diagnosis of hypoglycemia. Review of a hospital note dated 11/18/24, at 3:31 p.m. indicated, "Blood glucose monitoring found severe hypoglycemia" and further stated, "EMS (emergency medical services) checked BG (blood glucose) at nursing home and was noted to be 27. During an interview on 1/11/25, at 3:21 p.m. RNS Employee E8 confirmed she wrote the above note about Resident R32's change in condition, and stated the LPN who was assigned to Resident R32 stated she had checked Resident R32's blood sugar. Review of the clinical record indicated that Resident	F 0684		

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F 0684 SS=K	Continued from page 45 R44 was admitted to the facility on 7/27/23. Review of the MDS dated 12/5/24, included diagnoses of diabetes with hyperglycemia, right leg-below knee amputation, high blood pressure and heart failure (heart doesn ' t pump blood as well as it should). Review of a physician orders dated 8/3/24, and remained current, indicated to check blood sugar before meals and to call MD for BS <70 and >340. Review of Resident R44's plan of care for diabetes diagnosis; Interventions do not include instructions for staff on actions to take for hyper/hypoglycemia. Further review of Resident R44's blood sugar record failed to reveal documentation of notification or follow-up for the following: 9/2: Result "High"-No note showing notification, Result 4:46 p.m. 368-no documentation of notification. 9/1: Result 445-No note showing notification or	F 0684		

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F 0684 SS=K	Continued from page 46 follow-up. 8/31: Results 5:39 a.m.: 405, 11:23 a.m.: 415 (insulin given, recheck-470 with no further notes for further instruction), 4:29 p.m.: 404-No documentation of notification or follow-up. 8/29: Result 4:59 p.m.: 526, 6:00 p.m.:557-instructed to give insulin but no order to repeat or if more insulin should be given after repeated. Result 8:27 p.m.: 478-no documentation. Review of the clinical record indicated that Resident R65 was admitted to the facility on 8/11/20. Review of the MDS dated 10/2/24, included diagnoses of diabetes with hyperglycemia and dementia (group of thinking and social symptoms that interferes with daily functioning). Review of a physician orders dated 11/9/23, and remained current, indicated to check blood sugar before meals and at bedtime, to call MD for BS >420.	F 0684		

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F 0684 SS=K	Continued from page 47 Review of Resident R65's plan of care included a diabetes diagnosis. No further documentation or interventions regarding this was noted. Further review of Resident R65's blood sugar record failed to reveal documentation of notification or follow-up for the following: 12/22: Result 487-Note documented 12/23 (the next day) 12/5: Result 422-Note documented 12/6 (the next day) 7/13: Result High-Note documented 7/15 (Notes from 7/13 discuss resident receiving long-acting insulin at 7:29 p.m. and then the nurse attempting to give 6 Units of coverage but resident was screaming and punching people, so insulin not administered). 7/7: Result High-Note documented 7/8 (the next day) During an interview on 1/11/25, at 3:02 p.m. LPN Employee E3 reviewed with the surveyor the blood sugar level of 487 for Resident R65 on 12/22/24. LPN Employee E3 stated she usually puts in a note	F 0684		

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F 0684 SS=K	Continued from page 48 and is unsure why she did not that day. Review of the clinical record indicated that Resident R22 was admitted to the facility on 5/29/24. Review of the MDS dated 10/2/24, included diagnoses of diabetes and dementia. Review of a physician orders dated 5/29/24, and remained current, indicated to check blood sugar twice daily at breakfast and dinner and to call MD for BS <70 and >400. Review of Resident R22's plan of care failed to reveal goals and interventions related to diabetes. Review of Resident R22's blood sugar record failed to reveal documentation of notification or follow-up for the following: 1/3: 412 12/11: 478 12/5: 411	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: __00_____ B. WING: _____	01/13/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIVERSIDE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **185402**	**100 8TH STREET MCKEESPORT, PA 15132**

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F 0684 SS=K	Continued from page 49 11/14: 443 11/08: 400 10/27: 439 During an interview on 1/11/25, at 3:32 p.m. RN Employee E7 reviewed with the surveyor the blood sugar level of 478 on 12/11/24. RN Employee E3 stated she would have informed the RNS but was not able to provide a reason why it was not documented. Review of the clinical record indicated that Resident R38 was admitted to the facility on 11/3/23. Review of the MDS dated 11/5/24, included diagnoses of diabetes with hyperglycemia and chronic kidney disease. Review of a physician orders dated 11/9/23, and remained current, indicated to check blood twice a day and to call MD for BS <70 and >420. Resident R38 is care planned for diabetes diagnosis.	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0684 SS=K	Continued from page 50 Further review of Resident R38's blood sugar record failed to reveal documentation of notification or follow-up for the following: 12/31: Result 441-No note showing notification or follow-up. 12/29: Result 401-No note showing notification or follow-up. 12/28: Result 470-No note showing notification or follow-up. 12/25: Result 415-No note showing notification or follow-up. 12/21: Result 499-No note showing notification or follow-up. 12/20: Result 470-No note showing notification or follow-up. 12/19: Result 484-No note showing notification or follow-up. 12/17: Result 524-No note showing notification or follow- up Review of the clinical record indicated that Resident R39 was admitted to the facility on 12/19/23.	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0684 SS=K	Continued from page 51 Review of the MDS dated 11/13/24, included diagnoses of diabetes with hyperglycemia. Review of a physician orders dated 8/14/24, and remained current, indicated to check blood sugar before meals and at bedtime and to call MD for BS <70 and >450. Resident R39 is care planned for diabetes diagnosis. Further review of Resident R39's blood sugar record failed to reveal documentation of notification or follow-up for the following: 11/14: Result 574-Note documented 11/15 (the next day). 10/2: Result HIGH-No note showing notification or follow-up. Review of the clinical record indicated that Resident R8 was admitted to the facility on 3/19/19. Review of the MDS dated 10/1/24, included	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0684 SS=K	Continued from page 52 diagnoses of diabetes. Review of a physician orders dated 12/28/23, and remained current, indicated to check blood sugar twice a day and to call MD for BS <60 and >500. Resident R8 is care planned for diabetes diagnosis. Further review of Resident R8's blood sugar record failed to reveal documentation of notification or follow-up for the following: 12/27: Result HIGH-No note showing notification or follow-up. 12/13: Result HIGH-No note showing notification or follow-up. 12/1: Result HIGH-No note showing notification or follow-up. 11/19: Result HIGH-Note documented 11/20 (the next day). During an interview on 1/11/25, at 3:11 p.m. LPN Employee E5 reviewed with the surveyor the blood sugar levels of HIGH on 12/13/24, and 12/27/24.	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0684 SS=K	Continued from page 53 LPN Employee E5 stated always does a recheck but is unsure why it is not showing up in the electronic charting system. Review of the clinical record indicated that Resident R6 was admitted to the facility on 8/21/23. Review of the MDS dated 8/27/24, included diagnoses of diabetes. Review of a physician orders dated 12/28/23, and remained current, indicated to check blood sugar before meals and bedtime and to call MD for BS <60 and >500. Resident R6 is care planned for diabetes diagnosis. Further review of Resident R6's blood sugar record failed to reveal documentation of notification or follow-up for the following: 12/13: Result HIGH-No note showing notification or follow-up. 8/14: Result HIGH-No note showing notification or	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0684 SS=K	Continued from page 54 follow-up. During an interview on 1/11/25, at 3:11 p.m. LPN Employee E5 reviewed with the surveyor the blood sugar levels of HIGH on 12/13/24. LPN Employee E5 stated always does a recheck but is unsure why it is not showing up in the electronic charting system. Review of the clinical record indicated that Resident R57 was admitted to the facility on 5/4/24. Review of the MDS dated 12/13/24, included diagnoses of diabetes and chronic kidney disease. Review of a physician orders dated 6/12/24, and remained current, indicated to check blood sugar twice a day and to call MD for BS <70 and >340. Resident R57 is care planned for diabetes diagnosis. Further review of Resident R57's blood sugar record failed to reveal documentation of notification or follow-up for the following:	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0684 SS=K	Continued from page 55 11/28: Result 390-No note showing notification or follow-up. 11/14: Result 407-Note documented 11/15 (the next day). 9/6: Result 529-No note showing notification or follow-up. Review of the clinical record indicated that Resident R56 was admitted to the facility on 10/24/24. Review of the MDS dated 11/11/24, included diagnoses of diabetes. Review of a physician orders dated 10/24/24, and remained current, indicated to check blood sugar before meals and at bedtime and to call MD for BS <70 and >400. Resident R56 is care planned for diabetes diagnosis. Further review of Resident R56's blood sugar record failed to reveal documentation of notification or follow-up for the following:	F 0684		

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F 0684 SS=K	Continued from page 56 11/8: Result HIGH-No note showing notification or follow-up. Review of the clinical record indicated that Resident R79 was admitted to the facility on 1/7/24. Review of the MDS dated 9/17/24, included diagnoses of diabetes mellitus and dementia. Review of a physician order dated 3/8/24,and remained current, indicated to check blood sugar twice a day on Sunday, Monday, Wednesday, and Friday before breakfast and before dinner, check blood sugar twice a day on Tuesday, Thursday and Saturday between 11:00 a.m. and 2:00 p.m., 8:00 p.m. and 11:00 p.m., all without a sliding scale. Resident R79 is care planned for diabetes diagnosis only related to skin integrity. No information provided on hyper/hypoglycemia. Further review of Resident R79's blood sugar record failed to reveal documentation of notification	F 0684		

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F 0684 SS=K	Continued from page 57 or follow-up for the following: 11/18: Result Low-No documentation of notification or follow-up. Review of the clinical record indicated that Resident R59 was admitted to the facility on 7/25/24. Review of the MDS dated 11/6/24, included diagnoses of diabetes mellitus and ESRD. Review of Resident R59's plan of care on 1/8/24, revealed that the care plan for diabetes did not include instructions for staff on actions to take for hyper/hypoglycemia. Review of a physician order dated 7/25/24, and remained current, indicated to check blood sugar before meals and to call MD for BS <70 and >340. Review of Resident R59's blood sugar record failed to reveal documentation of notification or follow-up for the following: 11/5/24: 49	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0684 SS=K	Continued from page 58 During an interview on 1/8/25, at approximately 2:50 p.m. LPN Employee E3 was able to describe where to find parameters for notification on physician's order. Stated that she would notify RNS if blood sugar was out of range and document a nursing note in the medical record. During an interview on 1/8/25, at approximately 2:55 p.m. LPN Employee E4 stated low is below 70, and the high can be dependent on parameters in the physician's orders. Stated that if blood sugar was out of range she would notify the RNS, and if no response from RNS, she would text the provider directly. During an interview on 1/8/25, at approximately 3:00 p.m. LPN Employee E5 stated parameters are on the MD order, and she stated she would call the MD if outside the parameters. After prompting from the surveyor, stated she would document symptoms and follow-up in the medical record.	F 0684		

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F 0684 SS=K	Continued from page 59 During an interview on 1/8/25, at approximately 3:00 p.m. RN Employee E6 stated the parameters for blood sugar are on the sliding scale order. Stated for out of range blood sugars, she would recheck the blood sugar. Stated for high, she would call the doctor, and for low she would initially provide a snack and recheck. Stated she is often RNS, and staff report high and low blood sugars to her, and she notifies the provider. The Nursing Home Administrator (NHA) and the DON were made aware that an Immediate Jeopardy situation existed for residents on 1/9/24, at 1:34 p.m. and a corrective action plan was requested. The Immediate Jeopardy template was provided to the facility administration at this time. On 1/9/24, at 6:29 p.m. an acceptable Corrective Action Plan was received which included the following interventions: After record review, it was determined that [the facility] failed to notify the physician of blood sugars	F 0684		

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F 0684 SS=K	Continued from page 60 out of range timely for 14 residents and care plans were absent or did not include approaches for diabetic emergency management. Immediate Actions: -Resident R150 was assessed by the Assistant Director of Nursing on 1/8/25 at 3:30 p.m. Resident had no s/s (signs or symptoms) of hyperglycemia at that time. -RNS Employee E2 spoke with the physician at 3:46 p.m. and reported the blood sugar of 509. The physician did not give any further orders. -Education was initiated on 1/8/25, with facility RNs and LPNs on the Diabetic Protocol, the Hypoglycemia policy, and the Resident Change in Condition policy to include hyperglycemia is a change in condition, and notifications to the physician of blood sugars out of range. -On 1/9/25, Residents R150, R195, R8, R6, R57, R56, R79, R32, R44, R65, R22, R38, R39, and R59's blood sugars were reviewed from the past 24 hours to ensure none were out of range without physician notification.	F 0684		

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F 0684 SS=K	Continued from page 61 -On 1/9/25, an ad hoc QAPI (Quality Assurance and Performance Improvement) committee meeting was held, and the medical director was made aware of the findings. -On 1/9/25, the RN assessment coordinator is reviewing the care plans for residents R150, R195, R8, R6, R57, R56, R79, R32, R44, R65, R22, R38, R39, and R59 to ensure the care plan reflects diabetes and there are approaches for diabetic emergency management. This will be completed by 1/9/25, at 10:00 p.m. Like Residents: -Current residents with diabetes have the potential to be affected. Current residents with diabetes were reviewed on 1/8/25 by the ADON (Assistant Director of Nursing) to determine if blood sugars were out of range and none were noted out of range. -Current residents with diabetes are being reviewed by the RN assessment coordinator on 1/9/25, to ensure the care plan reflects diabetes and there are approaches for diabetic emergency management	F 0684		

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F 0684 SS=K	Continued from page 62 and will be completed by 1/9/25 at 10:00 p.m. Correction of System: -Root cause analysis completed by the center QAPI committee on 1/9/25, and determined failure to follow the Resident Change in Condition policy led to the allegation. -To prevent recurrence, the Director of Nursing initiated education with facility RNs and LPNs including agency staff on 1/8/25, on the Diabetic Protocol, the Hypoglycemia policy, and the Resident Change in Condition policy to include hyperglycemia is a change in condition and notification of the physician of blood sugars out of range. RNs and LPNs that were not on duty received education via phone and will receive in person education on their next scheduled shift. -Newly hired RNs and LPNs will be educated on the Resident Change of Condition policy, the Diabetic Protocol, and the Hypoglycemia policy in orientation by the Director of Nursing/ designee. Monitoring:	F 0684		

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F 0684 SS=K	Continued from page 63 -To monitor and maintain compliance, the Director of Nursing/ designee will review blood sugars daily x 2 weeks, 3x a week x 2 week and then weekly x 2 weeks to determine if any blood sugars were out of range and notifications made. If notification not documented, the physician will be contacted at the time of discovery and notified, and new orders implemented as needed. -To monitor and maintain compliance, new admissions/ readmissions with diabetes will be reviewed by the DON/ designee to ensure a care plan is implemented for diabetes including approaches for diabetic emergency management 5 x a week for 2 weeks, then weekly x 3 weeks. -Results of the audits will be forwarded to the center QAPI committee for review and recommendations. On 1/10/24, care plans for affected residents were reviewed, and confirmed they were corrected to show goals and interventions related to diabetes and blood glucose monitoring. On 1/10/24, the whole house audit was reviewed by	F 0684		

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F 0684 SS=K	Continued from page 64 surveyors, revealing its completion and accuracy. During interviews beginning at approximately 9:00 a.m. on 1/10/24, five LPNs and RNs were able to describe the correct procedure for documenting, monitoring, and needs of notification for blood sugars outside of the ordered parameters. During interviews beginning at approximately 1:30 p.m. on 1/10/24, three additional LPNs and RNs were able to describe the correct procedure for documenting, monitoring, and needs of notification for blood sugars outside of the ordered parameters. The Immediate Jeopardy was removed on 1/10/24, at 2:13 p.m. when the action plan implementation was verified. During an interview on 1/13/24, at approximately 3:00 p.m. the Nursing Home Administrator and the Director of Nursing confirmed the facility failed to notify physicians of elevated or decreased Capillary Blood Glucose (CBG) levels, failed to assess	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0684 SS=K	Continued from page 65 residents for hyperglycemia (high blood glucose) and hypoglycemia (low blood sugar) resulting in immediate jeopardy for 14 of 22 residents. 28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services.	F 0684		
F 0865 SS=E		F 0865		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0865 SS=E	Continued from page 66 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) QAPI Prgm/Plan, Disclosure/Good Faith Attmpt §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and	F 0865	The NHA/DON will conduct a root cause analysis for F 684 from the 1.13.25 survey. Those results will present to the facility QAPI for review and will provide guidance to the plan of correction. To prevent recurrence, the NHA/ designee will implement a plan of correction including correction of the practice for residents identified in the citation F 684, identification and correction as needed of other residents who have the potential to be affected, system correction including education on the diabetic protocol, the hypoglycemia policy, and the change in condition policy including hyperglycemia is a change of condition to the licensed nurses. Ongoing monitoring of blood sugar results and care plans for diabetic residents to maintain compliance will be conducted by the DON/ designee. The facility's QAPI members will be	Completion Date: **02/12/2025** Status: **APPROVED** Date: **01/29/2025**

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F 0865 SS=E	Continued from page 67 §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that:	F 0865	educated on the QAPI policy by the NHA/ designee. Weekly reviews with the QAPI team of the plan of correction audits for the citations from the 1.13.25 survey x 5 weeks and monthly for 2 months and recommendations will be made as needed if noncompliance identified.	

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F 0865 SS=E	Continued from page 68 §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions.	F 0865		

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F 0865 SS=E	Continued from page 69 Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by:	F 0865		

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F 0865 SS=E	Continued from page 70 Based on a review of facility documentation, cited deficiencies from previous surveys, review of plan of correction documentation, and staff interview, it was determined that the facility's Quality Assurance and Performance Improvement (QAPI) program failed to correct previously cited deficiencies. This has the potential to affect 26 of 84 residents. Finding include: Review of the facility policy Quality Assurance and Performance Improvement (QAPI) Program Policy dated 1/13/2025, indicated objectives of the QAPI program include providing a means to establish and implement performance improvement projects to correct identified negative or problematic indicators and to establish systems through which to monitor and evaluate corrective actions involving all levels of the organization. The facility's deficiencies and plan of correction for the State Survey and Certification (Department of Health) survey ending 1/5/24, revealed the facility	F 0865		

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F 0865 SS=E	Continued from page 71 developed a plan of correction that included quality assurance systems to ensure the facility maintained compliance with cited nursing home regulations. Review of the plan of correction for the survey ending 1/5/24, revealed the following: - To identify other residents that have the potential to be affected, the Director of Nursing/designee will conduct a 14 day look back by 1/29/24, of current residents who receive glucometers to ensure blood glucose results outside of ordered parameters have been called to the physician. -To prevent recurrence, licensed nursing staff will be reeducated by the Director of Nursing/designee by 1/26/24 on calling the physician for blood glucose results outside of ordered parameters. -To monitor and maintain ongoing compliance, the Director of Nursing/designee will conduct audits weekly x 4 and monthly x2 of 7 residents who receive glucometers to ensure blood glucose results outside of ordered parameters have been called to the physician. -Results of the audits will be forwarded to the center	F 0865		

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F 0865 SS=E	Continued from page 72 QAPI committee for review and recommendations. The results of the current survey, ending 1/13/24, identified a repeated deficiency related to documentation of hypo/hyperglycemia, plan of care, and notification to the medical director in a timely manner. During the survey process the following was revealed: Resident R195- Order: if blood sugar (BS) <60 or >350 notify Medical Director (MD) -12/1: went out to the hospital for a change in condition and no blood sugar obtained as per protocol -11/9: Result 59 -note placed 48 hrs later -9/25: Result 473-note documented 24 hrs later Resident R150- Order: if BS <70 or >340 notify MD -12/6: Result "High"- No documentation or notification	F 0865		

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F 0865 SS=E	Continued from page 73 -12/4: Result 448- No documentation or notification Resident R32-Order: if BS <70 or >350 notify MD -11/18: Admitted to the hospital with severe hypoglycemia, result obtained by EMS was 27, staff did not follow the protocol for change in condition. Resident R44: Order-If BS <70 or >340 notify MD -9/2: Result "High"-No documentation -9/2: Result 368-No documentation of notification -9/1: Result 445-No documentation of notification -8/31: Results- 539 am-405 (no documentation), 1123 am-415 (insulin given recheck 470 with no documentation of what to do next), 429 pm-404 (no documentation or follow-up) -8/29: Results- 459 pm-526 (no documentation), 600 pm-557 (instructed to give insulin but no order to repeat or if more insulin should be given after repeated), 827 pm-478 (no documentation) Resident R65: Order-If BS >420 notify MD -12/5: Result 422-Note placed on 12/6 -7/13: Result "High"-Note documented 7/15 (Note	F 0865		

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F 0865 SS=E	Continued from page 74 on 7/13 received long acting insulin at 729 pm and nurse attempting to give 6 Units of coverage but resident screaming and punching people, so no insulin administered). -7/7: Result "High"- documented on 7/8 Resident R22: Order-If BS <70 or >400 notify MD -1/3: Result 412-No documentation or notification -12/11: Result 478-No documentation or notification -12/5: Result 411- No documentation or notification -11/14: Result 443-No documentation or notification -11/8: Result 400- No documentation or notification -10/27: Result 439-No documentation or notification Resident R38: Order-If BS <70 or >400 notify MD -12/31: Result 441- Note does not match BS result -12/29: Result 401-No documentation or notification -12/28: Result 470-No documentation or notification	F 0865		

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F 0865 SS=E	Continued from page 75 -12/25: Result 415-No documentation or notification -12/21: Result 499-No documentation or notification -12/20: Result 470-No documentation or notification -12/19: Result 484-No documentation or notification -12/17: Result 524-No documentation or notification Resident R39: Order- If BS <70 or >340 notify MD -12/14: Result 445-No documentation or notification -12/13: Result 357-No documentation or notification -11/14: Result 574-Documentation 24 hrs later by ADON -11/3: Result 441-No documentation or notification -10/17: Result 371-No documentation or notification -10/2: Result "High"-No documentation or	F 0865		

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F 0865 SS=E	Continued from page 76 notification -8/4: Result 375-No documentation or notification -8/3: Result 560- Note placed 48 hrs later by ADON Resident R8: Order- If BS <60 or >500 notify MD -12/27: Result "High"- No documentation or notification -12/13: Result "High"- No documentation or notification -12/1: Result High"- No documentation or notification -11/19: Result "High"-No documentation or notification Resident R6: Order- If BS <60 or >500 notify MD -12/13: Result "High"-No documentation or notification -8/14: Result "High"-No documentation or notification Resident R57: Order-If BS <70 or >340 notify MD -11/28: Result 390-No documentation or	F 0865		

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F 0865 SS=E	Continued from page 77 notification -11/14: Result 407- Note placed 24 hrs later by ADON -9/6: Result 529-No documentation or notification Resident R56: Order-If BS <70 or >400 notify MD -11/8: Result "High"-No documentation or notification Resident R79: Order-No order for low or high levels, policy states if <70 notify MD -11/18: Result "Low"-No documentation or notification Resident R59: Order- If BS < 70 or >340 notify MD -11/5: Result 49- No documentation or notification During an interview on 1/8/25, at approximately 2:38 p.m. the Nursing Home Administrator and Director of Nursing confirmed that the facility failed to maintain an effective Quality Assurance Committee to ensure that the concerns related to	F 0865		

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F 0865 SS=E	Continued from page 78 documentation and notification of hypo/hyperglycemic events, with the potential to affect 26 of 84 residents. 42CFR 483.75(a)(2)(h)(i) QAPI Program/Plan, Disclosure/Good Faith Attempt. 28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 201.18 (e)(2)(3)(4) Management.	F 0865		
F 0880 SS=D		F 0880		

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F 0880 SS=D	Continued from page 79 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 0880	Annual Legionella testing was completed in the facility on March 25, 2024, and no legionella species were detected. To prevent recurrence, the NHA will be educated on the Legionella Assessment and Prevention Program by the RVPO/ designee. To prevent recurrence, the NHA will assign persons responsible to complete the required Legionella assessment. A text and flow diagram will be formulated to describe the facility's water system. A risk assessment with control methods including physical controls, temperature management, and disinfection level control if a cooling tower or evaporative condenser is present, visual inspection/ environmental testing for pathogens, and corrective actions will be completed by the assigned persons. After the assessment is completed, the assessment team will develop a plan for any areas identified that	Completion Date: **02/12/2025** Status: **APPROVED** Date: **01/29/2025**

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F 0880 SS=D	Continued from page 80 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 0880	require a plan. To maintain and monitor compliance, annual legionella testing will be conducted in March 2025. Additional risk assessment will be completed if new equipment meeting assessment criteria has been placed or replaced, local authorities and/ or utility providers announce a boil water order, there is loss of service, or there is a service main break immediately adjacent to the center.	

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STATE LICENSE NUMBER: **185402**	

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F 0880 SS=D	Continued from page 81	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: __00_____ B. WING: _____	01/13/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIVERSIDE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **185402**	**100 8TH STREET MCKEESPORT, PA 15132**

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F 0880 SS=D	Continued from page 82 Based on policy review, documentation and review of Centers for Disease Control (CDC) guidelines for Legionella (bacteria that causes disease found in contaminated water) control, and staff interviews it was determined that the facility failed to maintain a comprehensive program for water management to monitor the potential development and spread of Legionella and failed to implement control measures for Legionella within the facility for ten of twelve months (April 2024 through January 2025). Finding include: Review of the facility policy "Legionella Assessment and Prevention Program" dated 1/13/25, previously dated 1/2/24, indicated the facility will utilize water management practices to reduce the risk of growth and spread of Legionella and other opportunistic pathogens in building water systems. Core Elements of the Water Management Plan are: 1. Establish Water Management Plan team. 2. Describe Center's water system using text and	F 0880		

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F 0880 SS=D	Continued from page 83 flow diagram. 3. Risk assessment with control methods and corrective actions. 4. Monitoring control measures. 5. Corrective actions. 6. Verification and validation. 7. Documentation and communication. Review of Department of Health and Human services, Centers for Medicare and Medicaid services (CMS) memo, "Requirement to Reduce Legionella Risk in Healthcare Facility Water Systems to Prevent Cases and Outbreaks of Legionnaires' Disease (LD)" dated 7/6/18, revealed, "Facilities must develop and adhere to policies and procedures that inhibit microbial growth in building water systems that reduce the risk of growth and spread Legionella and other opportunistic pathogens in water. This policy memorandum applies to Hospitals, Critical Access Hospitals (CAHs) and Long-Term Care (LTC). However, this policy memorandum is also intended to provide general awareness for all healthcare organizations. Facilities	F 0880		

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F 0880 SS=D	Continued from page 84 must have water management plans and documentation that, at minimum, ensure each facility: -Conducts a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens (e.g. Pseudomonas, Acinetobacter, Nontuberculous Mycobacteria, Burkholderia, Stenotrophomonas, and fungi) could grow and spread in the facility water system. -Develops and implements a water management program that considers the ASHRAE (American Society of Heating, Refrigerating, and Air Conditioning Engineers) industry standard and the CDC toolkit. -Specifies testing protocols and acceptable ranges for control measures and document the results of testing and corrective actions taken when control limits are not maintained. -Maintains compliance with other applicable Federal, State and local requirements. Review of the ASHRAE guidance "Managing the Risk of Legionellosis Associated with Building Water Systems" dated December 2020, indicated	F 0880		

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F 0880 SS=D	Continued from page 85 the most commonly used supplemental disinfection methods are treatment with chlorine, chlorine-dioxide, copper-silver ions, and monochloramine." The guidance further indicated the recommended levels of residual chlorine are 0.50-3.00 ppm (part per million). Review of the facility provided water management information failed to include specific testing protocols and acceptable ranges for control measures along with a description of the facility's water system using a flow diagram. Review of the Water Management Program Control Measures did not contain a log for Point of Use Disinfectant (the level of chlorine concentration in the water) indicated to measure and record hot water and cold water chlorine concentration as point of use, and to note that chlorine concentration below 0.5 ppm and above 4.0 ppm as outside the control limits. During an interview on 1/8/25, at approximately	F 0880		

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F 0880 SS=D	Continued from page 86 11:30 a.m. the Nursing Home Administrator confirmed that they do not have a Maintenance Director and that the facility failed to maintain a comprehensive program for water management to monitor the potential development and spread of Legionella and failed to implement control measures for Legionella within the facility. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(b)(1)(e)(1) Management.	F 0880		

Certified End Page

RIVERSIDE HEALTH & REHAB CENTER

STATE LICENSE NUMBER: 185402

SURVEY EXIT DATE: 01/13/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY