STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115375	A. Building B. Wing	10/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Health Care Center	5100 West St NW Covington, GA 30014

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 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, family, resident and staff interviews, record review, and review of the facility's policy titled, Accident and Incident Prevention, Reporting, and Response, the facility failed to provide adequate supervision to prevent accidents for one of three residents (R) (R1) reviewed for falls with major injury. Actual harm occurred on 8/17/2025 when Certified Nursing Assistant (CNA) AA transferred R1 unassisted from his bed to the wheelchair resulting in R1 sustaining a fall during transfer that resulted in a closed displaced spiral fracture of the right femur. Findings include:A review of the facility's policy titled, Care Plan-Comprehensive, dated September 2025 under Policy revealed: A comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs shall be developed for each resident. Under the section Policy Interpretation and Implementation number 2 (e) identify the professional services that are responsible for each element of care and (h) ensure care plan is individualized and person-centered and reflects the resident's goals for admission and desired outcomes.A review of the electronic medical record (EMR) revealed R1 was admitted to the facility with a diagnosis that included but was not limited to, displaced spiral fracture of shaft of right femur (thigh bone) subsequent encounter for closed fracture with routine healing, flaccid hemiplegia affecting right dominant side (weakness on right side of the body), encountering for other specified surgical aftercare, unspecified fall, pain in right knee, and difficulty in walking not specified elsewhere classified.A review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] for R1 revealed Section GG (Functional Abilities and Goals) revealed, R1 was dependent on staff for chair/bed-to chair or wheelchair transfer indicating the assistance of two or more helpers required for the resident to complete the activity.A review of the care plan dated 11/1/2021 revealed R1 had potential for injury from falls related to right hemiparesis, episodes of weakness with interventions to use two persons for transfers.A review of the EMR under the Kardex Report the section Safety revealed R1 required two persons for transfers.In an interview on 10/27/2025 at 1:36 pm with CNA AA confirmed she transferred R1 alone and stated she never looks at his point of care in the EMR and is familiar with R1 mobility transfers based on observations from other staff on the unit transferring R1.In an interview on 10/27/2025 at 1:47 pm with CNA EE stated R1 has always been a two-person transfer.In an interview on 10/27/2025 at 2:24 pm with the Care Plan Coordinator (CPC) stated if there is an intervention on the most updated care plan the staff are expected to follow them. The CPC continued to state the Kardex reflects the resident care plan, and this is the information that shows up on the Plan of Care (POC) for their task. While looking at R1 care plan she stated the staff should be following the two-person assistance for R1 transfers.In an interview on 10/27/2025 at 2:39 pm with the Director of Nursing (DON) stated the CNAs should follow the Kardex while working on the floor. She stated under the section titled Safety is defined as keeping the resident safe so there is no harm and confirmed R1 is a (continued on next page)

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

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

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F 0656 Level of Harm - Actual harm Residents Affected - Few	two person assist. The DON further stated her expectations are that the Kardex should match the care plan and when a fall occurs the care plan should be updated immediately.In an interview on 10/28/2025 at 12:38 pm with the Administrator stated she expects the staff to follow the care plans and the Kardex.[Cross Reference - F689]

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, family, resident and staff interviews, record review, and review of the facility's policy titled, Accident and Incident Prevention, Reporting, and Response, the facility failed to provide adequate supervision to prevent accidents for one of three residents (R) (R1) reviewed for falls with major injury. Actual harm occurred on 8/17/2025 when Certified Nursing Assistant (CNA) AA transferred R1 unassisted from his bed to the wheelchair resulting in R1 sustaining a fall during transfer that resulted in a closed displaced spiral fracture of the right femur. Findings include:A review of the facility's policy titled, Accident and Incident Prevention, Reporting, and Response, dated July 2025 under Purpose: To ensure a safe environment for all residents by minimizing accidents hazards, providing adequate supervision and assistive devices, and implementing a proactive and systematic approach to preventing, investigating, and mitigating accidents and incidents in accordance with federal regulations (F689), facility policies, and resident- centered care principles. Under Policy Statement: The facility is committed to ensuring adequate supervision and appropriate use of assistive devices to reduce the risk of accidents and incidents. A review of the Electronic Medical Record (EMR) revealed R1 was admitted to the facility with a diagnosis that included but was not limited to, displaced spiral fracture of shaft of right femur (thigh bone) subsequent encounter for closed fracture with routine healing, flaccid hemiplegia affecting right dominant side (weakness on right side of the body), encountering for other specified surgical aftercare, unspecified fall, pain in right knee, and difficulty in walking not specified elsewhere classified.A review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] for R1 revealed, Section C (Cognitive Patterns), a Brief Interview for Mental Status (BIMS) score of 9 which indicated moderate cognitive impairment and Section GG (Functional Abilities and Goals) revealed, R1 was dependent on staff for chair/bed-to chair or wheelchair transfer indicating the assistance of two or more helpers required for the resident to complete the activity.A review of the care plan dated 11/1/2021 revealed R1 had potential for injury from falls related to right hemiparesis, episodes of weakness with interventions to use two persons for transfers. A review of the Nurse's Note dated 8/17/2025 documented tech called me into patient (pt) room to notify me of fall that occur previously during care. Pt was seen sitting on commode asking to be put back in bed, pt was assisted back to bed, vital signs (vs) taken and documented, family called and notified, clinician orders to transport pt to emergency department (ED) for follow up treatment (tx). (Sic)A review of the EMR under the Kardex Report the section Safety revealed R1 requires two persons for transfers.In a telephone interview on 10/23/2025 at 3:57 pm with CNA AA confirmed she transferred R1 without assistance while preparing him for a shower from his bed to his wheelchair. CNA AA stated while transferring R1 he grabbed the bedrails which caused both of them to become unsteady and caused her fall back on R1 and into the wheelchair. She continued to state she called for assistance from another CNA and the nurse to assess R1 post fall because he was complaining of leg pain. Continued interview also revealed that CNA AA stated she never looks at his point of care in the EMR and is familiar with R1 mobility transfers based on observations from other staff on the unit transferring R1.In an interview on 10/27/2025 at 1:15 pm with the family member of R1 revealed she was informed by the CNA that she was caring for R1 alone and while transferring him to his wheelchair she fell on top of him resulting in R1 having a broken leg.In an interview on 10/27/2025 at 1:18 pm with R1 revealed he does not remember much from the fall other than falling. However, he stated there is usually one staff assisting him with transfers.In an interview on 10/27/2025 at 1:47 pm with CNA EE revealed that R1 had always been a two-person transfer.In an interview on 10/27/2025 at (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	1:50 pm with Licensed Practical Nurse (LPN) FF stated the CNA on the floor should be looking at the policy, asking questions to the nurses on the floor, and looking at the residents EMR to determine the type of care that should be provided for the residents.In an interview on 10/27/2025 at 2:39 pm with the Director of Nursing (DON) stated she was informed about R1 fall occurring during a transfer from the bed to the wheelchair by CNA AA. During the interview it was disclosed that the DON expects for the nursing staff to follow the residents plan of care when care is provided. [Cross Reference - F656]