STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265358	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverbend Heights Health & Rehabilitation	1221 Highway 13 South Lexington, MO 64067

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19916 Based on observation and interview, the facility failed to maintain the commode riser in resident room [ROOM NUMBER] in an easily cleanable condition; failed to maintain the restroom ceiling vents free of a heavy buildup of dust inside the ceiling vents in resident rooms 17, 60, 61, 71, 83, 81, 80; failed to maintain the ceiling vent in Greystone shower room free from a heavy buildup of dust; failed to maintain the commode seat in the Greystone shower room fee of numerous indentations; failed to maintain a personal fan free of dust in resident room [ROOM NUMBER]; failed to maintain the ceiling fans in the resident smoke room free of a buildup of dust. The facility census was 92 residents. 1. Observation on 6/10/24 at 1:47 P.M., with the Maintenance Director, showed the presence of rust spots on the commode riser (assistive devices to improve the accessibility of toilets to older people or those with disabilities. They can aid in transfer from wheelchairs and may help prevent falls) in resident room [ROOM NUMBER] which caused the commode riser to be not easily cleanable. During an interview on 6/10/24 at 1:48 P.M., the Maintenance Director said he/she did not know the commode riser had rust spots but would have to get that one changed. During a phone interview on 6/21/24 at 12:19 P.M., the Maintenance Director said facility staff was supposed to tell him/her about the commode risers, because he/she was not asked to check those. 2. Observation on 6/10/24 at 2:30 P.M., with the Maintenance Director, showed a heavy buildup of dust in the restroom ceiling vent of resident room [ROOM NUMBER]. 3. Observation on 6/10/24 at 3:08 P.M., showed a personal fan with a heavy buildup of dust in resident room [ROOM NUMBER]. During a phone interview on 6/21/24 at 12:33 P.M., the Housekeeping Director said: -He/she usually had the maintenance department clean the fans because they had the tools to take the fans apart. -The housekeeping department had an extendable duster that they can use to clean the ceiling vents. 4. Observation on 6/11/24 at 9:41 A.M., showed the following; (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A heavy buildup of dust in the ceiling vent of the Greystone Shower room. -Numerous indentations on the commode seat which caused the commode seat in the Greystone shower room to not be easily cleanable. During an interview on 6/11/24 at 9:42 A.M., the Maintenance Director said staff should have notified him/her about that commode seat. During a phone interview on 6/21/24 at 12:37 P.M., the Housekeeping Supervisor said the housekeeping employees do check the commode seats for damage. 5. Observations on 6/11/24 with the Maintenance Director showed: -At 12:36 P.M., a heavy buildup of dust inside the restroom ceiling vent in resident room [ROOM NUMBER]. -At 12:37 P.M., a heavy buildup of dust inside the restroom ceiling vent in resident room [ROOM NUMBER]. -At 12:59 P.M., a heavy buildup of dust inside the restroom ceiling vent in resident room [ROOM NUMBER]. -At 1:50 P.M., a heavy buildup of dust inside the restroom ceiling vent in resident room [ROOM NUMBER]. -At 1:51 P.M., a heavy buildup of dust inside the restroom ceiling vent in resident room [ROOM NUMBER]. -At 1:53 P.M., a heavy buildup of dust inside the restroom ceiling vent in resident room [ROOM NUMBER]. -At 2:03 P.M., a heavy buildup of dust inside the restroom ceiling vent in resident room [ROOM NUMBER]. -At 2:06 P.M., a heavy buildup of dust in the ceiling fans in the resident smoke room. During a phone interview on 6/21/24 at 12:17 P.M., the Maintenance Director said the following: -The housekeeping department was supposed to clean the ceiling vents. -All the attachments on ceilings were the responsibility of the housekeeping department. -The housekeepers have handles on their cleaning tools that can extend to reach attachments such as ceiling vents and fans. During a phone interview on 6/21/24 at 12:33 P.M., Housekeeping Director said the housekeeping department had an extendable duster that they could use to clean the ceiling vents.

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19016 Based on observation, interview, and record review, the facility failed to ensure activities identified as being of interest were offered daily on a 1:1 basis or adapted to meet the resident's cognitive and physical limitations and offered at bedside or at a time when the resident was likely to be out of bed for one sampled resident (Resident #72) out of 19 sampled residents. The facility census was 92 residents. Review of the facility's Resident Self-Determination and Participation policy, revised February, 2021 showed: -Each resident is allowed to choose activities consistent with his/her interests. -Staff will: --Gather information about the residents' personal preferences on initial assessment and periodically thereafter and document preferences in the medical record. --Include information about the resident's preferences in the care planning process. --Document medical limitations affecting participation. -Residents are provided assistance as needed to engage in preferred activities on a routine basis. 1. Review of Resident 72's Admission Record showed the resident was admitted to the facility on [DATE] with diagnoses that included: -Huntington's disease (an inherited disease in which nerve cells in the brain break down over time resulting in progressive movement, cognitive, and psychiatric symptoms). -Major depression (a state of intense sadness or despair that has advanced to the point of being disruptive to an individual's social functioning and/or activities of daily living). -Anxiety disorder (a psychiatric disorder causing feelings of persistent anxiety). -Restlessness and agitation. Review of the resident's Isolation From Friends/Family Care Plan, initiated 6/12/23 showed: -Encourage phone call, Face Time, Skype, and Video phone. -Encourage participation in Activity program. -Offer supportive visits and in-room activities aided by technology as appropriate. Review of the resident's Activities Evaluation, dated 6/15/23, showed the resident liked: (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Going to church. -BINGO. -Gardening and being outdoors. -Music and talk radio. -Looking at nature magazines. -Listening to country music, especially [NAME]. -Note: Information for the evaluation was provided by family and/or friend. Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning), dated 6/18/23, showed the resident: -Was able to be understood and could understand others. -Had adequate hearing without hearing aids. -Could read large print without eyeglasses. -Had problems with memory and recall and was significantly cognitively impaired. -Had no behaviors. -Required supervision, moderate assistance, or maximal assistance with Activities of Daily Living (ADL - dressing, grooming, bathing, eating, and toileting). -Required supervision with transfers and walking. -Enjoyed the following activities: --Listening to music. --Being around animals. --Doing things with groups of people. --Spending time outdoors. Review of the resident's Meeting Emotional, Intellectual, Physical and Social Needs Care Plan, initiated 6/18/23, showed: -The resident was dependent upon staff to meet his/her needs related to his/her neurocognitive disorder and need for ADL assistance. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Activities should be compatible with the resident's physical and mental capabilities and interests and be adapted as needed such as large print, holders if resident lacks hand strength, and task segmentation. -Provide a program of activities that is of interest, allowing choice and self-expression. -Provide escort to activity functions and assistance with games and crafts. -Engage in simple, structured activities such as going outdoors, simple gardening, and being out on the patio. -The resident prefers: --Country music stations and loves [NAME]. --Church or religious TV channels and activities. --Talk shows. --Being in groups of people. --Being outdoors, gardening, and sitting outdoors. Review of the resident's Activity Calendar, dated January 2024, showed: -Church Services on Wednesdays at 10:00 A.M. (unit location was not indicated). -Karaoke on Fridays at 10:00 A.M. -No 1:1, individualized, or bedside activity time was designated for the resident's unit. Review of Activity Participation sheets, dated January 2024, showed the resident attended: -A snowman craft on 1/3/24. -Painting/crafts on 1/8/24. -Coffee/hot chocolate on 1/8/24. -BINGO on 1/9/24. -Crafts on 1/25/24. -Note: The resident did not participate in any music, pet/animal, 1:1, or religious activities. There was no documentation why he/she didn't engage in any of these activities of interest. Review of the resident's Activity Calendar, dated February 2024, showed: (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Church services on Wednesdays at 10:00 A.M. (unit location was not specified). -Karaoke on Fridays at 1:00 P.M. -Only two activities besides Karaoke were on the monthly activity calendar for the resident's unit. -No 1:1, individualized, or bedside activity time was designated on the calendar for the resident's unit. Review of the resident's participation sheets, dated February 2024, showed the resident attended: -A Valentines activity on 2/2/24. -Valentine's cupcakes/punch and cards on 2/14/24. -BINGO and ice cream on 2/20/24. -BINGO on 2/27/24. -[NAME] Day party on 2/29/24. -Note: The resident did not participate in any music, pet/animal, 1:1, or religious activities. There was no documentation why he/she didn't engage in these activities. Review of the resident's Activity Calendar, dated March 2024, showed: -Church services on Wednesdays at 10:00 A.M. (unit location was not specified). -Karaoke on 3/22/24 and 3/29/22. The time and specific unit location were not indicated. -No activity except shopping lists was mentioned for the resident's unit for the entire month. Review of the resident's participation sheets, dated March 2024, showed the resident attended: -BINGO on 3/5/24. -Oreo Cookie Day on 3/6/24. -BINGO on 3/12/24. -Salt art on 3/14/24. -BINGO on 3/14/24. -Trivia on 3/27/24. -Easter Bunny activity on 3/29/24. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Note: The resident did not participate in any music, pet/animal, 1:1, or religious activities. There was no documentation why he/she didn't engage in these activities. Review of the resident's significant change MDS, dated [DATE], showed the resident: -Was receiving hospice services (comfort care for a person with a serious illness who is approaching the end of life). -Had inattention and disorganized thinking. -Wandered four to six days a week, but wandering did not significantly intrude on others. -Required moderate assistance with most ADLs. -Was independent with repositioning and walking. -The following activities were very important: --Using the phone. --Listening to music. --Being around animals. --Doing things with groups of people. --Going outside for fresh air. --Participating in religious services. Review of the resident's Activity calendar, dated April 2024, showed: -Church services were scheduled on Wednesdays at 10:00 A.M. (unit location was not specified). -Karaoke was scheduled on the first three Fridays of the month. A time and unit were not indicated on any of the dates. -There were no 1:1 or bedside activity times designated for the resident's unit. Review of the resident's Activity Participation logs, dated April 2024, showed: -BINGO on 4/2/24. -Truths and Lies game on 4/4/24. -BINGO on 4/11/24. -BINGO on 4/16/24. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-BINGO on 4/23/24. -Note: The resident did not participate in any outdoor, patio, gardening, music, pet/animal, 1:1, or religious activities. There was no documentation why he/she didn't engage in any of these activities of interest. Review of the resident's Activity Calendar, dated May 2024, showed: -Outdoor games for Units 2 and 3 were scheduled on 5/6/24. -Bird Feeders was scheduled for Units 2 and 3 on 5/21/24. -Karaoke was scheduled on three of the five Fridays in May. No unit or times were specified on any of the dates. -No church services, religious music or other music activities were on the schedule. -No 1:1 or bedside activity times were designated on the calendar. Review of the resident's Activity Participation sheets, dated May 2024, showed the resident participated in the following: -BINGO on 5/10/24. -Hot chocolate on 5/14/24. -Chocolate Chip Day on 5/15/24. -Donuts and Fruit Kabobs on 5/22/24. -Note: The resident did not participate in any outdoor, patio, gardening, music, pet/animal, 1:1, or religious activities. There was no documentation why he/she didn't engage in these activities. Review of the residents' Activity Calendar, dated June 2024, showed: -There was no mention of any activity on the resident's unit. -Social Hour outside was scheduled on 6/3/24 for Units 2 and 3 only. -No church services or religious music activity was on the schedule. -Karaoke was on the schedule for 6/14/24 and 6/28/24 for Units 2 and 3 only. -There were no 1:1 or bedside activity times shown for the resident's unit. Review of the resident's Activity Participation sheets, dated 6/1/24 to 6/13/24, showed the resident participated in: (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-[NAME] video on 6/5/24. -BINGO on 6/7/24. -Hydration station on 6/12/24. -Note: The resident did not participate in any outdoor, gardening, music, pet/animal, 1:1, or religious activities. There was no documentation why he/she didn't engage in these activities of interest. Observation on 6/10/24 between 10:30 A.M. and 11:35 A.M., showed: -The Activity Director and Activity Assistants A and B were in the dining room and were observed interacting with some of the residents in the area. -At 11:04 A.M., the resident was observed lying quietly in bed covered in a blanket. The resident was not engaged in a group, 1:1 activity, or interaction with staff and no music was being played for the resident. -Residents who smoked had gone outside during the cooler morning hours. -No other residents were given the opportunity to go outside in the morning. Observation on 6/10/24 between 1:00 P.M. and 2:00 P.M., showed: -The resident was not engaged in a group or 1:1 activity or interaction with staff or other residents. -No activity was on the calendar for any of the units for the 1:00 P.M. to 2:00 P.M. time period. Observation on 6/11/24 between 9:30 A.M. and 11:10 A.M., showed: -The resident was not engaged in a group, music, or 1:1 activity or interaction with staff. -At 9:41 A.M. the resident was observed lying in bed with a blanket covering his/her head. -At 9:50 A.M. Activity Aides A and B were observed going throughout the unit and offering beverages to residents while the Dietary Manager offered residents cookies. -Residents who smoked had gone outside during the cooler morning hours. -No other residents were given the opportunity to go outside in the morning. Observation on 6/11/24 between 1:05 P.M. and 2:00 P.M., showed: -The resident was not engaged in a group or 1:1 activity or interaction with staff or other residents. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-No activity was shown as scheduled for any of the units for the 1:00 P.M. to 2:00 P.M. time period. -The calendar showed BINGO on 6/11/24 with no time or unit specified and Unit 2 Shopping lists, with no time specified. Observation on 6/12/24 from 9:23 A.M. to 10:35 A.M., showed: -The resident was not engaged in a group or 1:1 activity or in interactions with staff. -At 9:26 A.M., the resident was in bed with eyes closed. -At 10:08 A.M., the resident walked into the common area and sat at a table with another resident. The two residents did not interact, and staff in the common area did not interact with the resident during this time. -No music was being played for residents. -Residents who smoked had gone outside during the cooler morning hours. -No other residents were given the opportunity to go outside in the morning. Observation on 6/13/24 between 8:40 A.M. and 9:30 A.M., showed: -The resident was not engaged in a group or 1:1 activity or in interaction with staff. -At 9:20 A.M., the resident entered the common area. He/She stood near the Nurses' station. Certified Nurse Aide (CNA) A told the resident to sit at a table, but did not otherwise greet or interact with him/her. A few minutes later CNA A gave the resident his/her breakfast without interacting with the resident. Observation on 6/14/24 between 8:50 A.M. and 9:25 A.M. and at 1:30 P.M., showed: -The resident was not engaged in a group or 1:1 activity or in any interaction with others. -No activities were taking place on the unit during the observation times. -Donuts with Dad was scheduled on 6/14/24 for Unit 2 at 10:00 A.M. and for Unit 3 at 10:45 A.M. Karaoke was scheduled on 6/14/24 and 6/28/24 for Unit 2 at 2:00 P.M. and for Unit 3 at 3:00 P.M., but was not shown as scheduled for the the resident's unit. During an interview on 6/14/24 at 8:10 A.M., Activity Assistant B said: -The resident would sit at the table briefly during BINGO, but couldn't stay focused on the activity even with prompting. -The resident mainly liked consuming food during social activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/14/24 at 10:11 A.M., Activity Assistant A said: -Whatever activities were planned for Units 2 and 3 were usually done on the Serenity Unit (the resident's unit) as well, although they usually didn't put Serenity on the monthly calendar. Serenity didn't have a separate monthly calendar. -One of the hospice chaplains did the church services. They either did them on the Serenity Unit or on Unit II depending on how many residents were up on the Serenity Unit. If the services were done on Unit II, the residents on the Serenity Unit didn't attend because that would confuse them, and no alternate activity was scheduled on Serenity. -Church services used to be every Wednesday, but for the past couple of months they were every other Wednesday. When church took place on the Serenity Unit the chaplain usually played religious music on his/her phone. Activity staff brought the Serenity Unit residents to the church services when they were held on the unit, so they knew which Serenity residents attended. -Residents who had difficulty focusing on typical activities could sit during Karaoke or eat during a food activity. If they seemed to be focusing at any point, activity staff documented the resident participated. -Residents who had difficulty focusing could participate in 1:1 activities, go outside, or listen to music. -The resident was mainly active in drinking coffee and eating donuts during social activities. -He/She didn't know what kind of music the resident liked but the resident was capable of watching others during karaoke. -The resident didn't have good hand motor skills, but was capable of watching while a staff person did a craft or activity and could understand if staff talked about the activity they were doing. -The resident was capable of patting down soil with assistance if someone planted a plant or flower and could listen to music. -The resident usually wasn't awake at 10:00 A.M. when morning activities took place. -Activity staff had done some 1:1 activities with four residents on the Serenity Unit, but they hadn't done 1:1 activities with the resident. During an interview on 6/14/24 at 12:21 P.M., the Director of Nursing (DON) said: -Activities should be offered daily for all residents who would like them. -Simple group activities and individual activities should be offered to residents who had difficulty focusing. Ideas of simple activities were looking at magazine pictures, making a collage of cut out pictures, and church activities focusing on music. There were pianos on all the units, and someone could play the piano for residents. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident liked to watch others in group activities and might like sensory items and activities. -A resident's activity program should reflect the resident's interests.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43345 Based on interview and record review, the facility failed to have parameters listed in the medication orders for medications that contained Acetaminophen (medication used to treat pain and reduce fever) for three sampled residents (Residents #38, #52, and #54) of out of 19 sampled residents. The facility census was 92 residents. A policy was requested on medication parameters and the facility did not provide one. 1. Review of Resident #54's Admission Record showed the resident was admitted to the facility on [DATE]. Review of the resident's Medication Review Report, dated June 2024, showed the following orders: -Acetaminophen 325 milligram (mg) give two tablets by mouth every six hours as needed for pain, order was dated 2/6/22 -The order failed to have the parameters of not to exceed three grams of Acetaminophen in 24 hours from all sources. 2. Review of Resident #38's Admission Record showed the resident was admitted to the facility on [DATE]. Review of the resident's Medication Review Report, dated June 2024, showed the following orders: -Acetaminophen 325 mg tablet give 650 mg by mouth at bedtime for pain order dated 2/28/22. -Acetaminophen 325 mg give two tablets by mouth every four hours as needed for pain order dated 6/14/21. -Both orders failed to have the parameters of not to exceed three grams of Acetaminophen in 24 hours from all sources. 3. Review of Resident #52's Admission Record showed the resident was admitted to the facility on [DATE]. Review of the resident's Medication Review Report, dated June 2024, showed the following orders: -Acetaminophen Extended Release 650 mg give 650 mg by mouth every six hours as needed for pain-mild order dated 12/29/22. -Hydrocodone-Acetaminophen 10 mg of Hydrocodone with 325 mg of Acetaminophen compounded together. Give one tablet by mouth four times a day for pain and/or fever order dated 1/8/23. -Both orders failed to have the parameters of not to exceed three grams of Acetaminophen in 24 hours from all sources. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During an interview on 6/13/24 at 8:07 A.M., Certified Medication Technician (CMT) A said: -Medications that contained Acetaminophen should have the parameters of not to exceed three grams of Acetaminophen in 24 hours from all sources. -When the parameters were not on the medication order he/she would inform the charge nurse. -The parameters were needed to be on the order because too much Acetaminophen could be toxic. -There were no parameters in the Acetaminophen orders for Residents #38, #52 and #54. -Resident #38, #52, and #54 should have had parameters in the Acetaminophen orders. During an interview on 6/13/24 at 8:57 A.M., CMT B said: -The parameters of not exceed three grams of Acetaminophen in 24 hours from all sources should be in the medication order of all medications that contained Acetaminophen. -When the parameters were not there, he/she would have told the charge nurse. -To much Acetaminophen can be toxic. During an interview on 6/13/24 at 9:00 A.M., Licensed Practical Nurse (LPN) A said: -The parameter of not to exceed three grams of Acetaminophen from all sources in 24 hours should be a part of the medication order. -When the parameters were not a part of the medication order, he/she would have notified the doctor, and received an order for the parameters to be added to the medications order. -More than three grams of Acetaminophen could be toxic. -There were no parameters in the Acetaminophen orders for Resident #38, #52, and #54. -There should have been parameters in the Acetaminophen orders for Resident #38, #52, and #54. During an interview on 8/23/23 at 8:37 A.M., the Director of Nursing (DON) said: -It was his/her expectation that all orders that contained Acetaminophen would have the parameter of not to exceed three grams of Acetaminophen in 24 hours from all sources. -It was his/her expectation that all nurses would have ensured that this parameter was added to all orders that contained Acetaminophen. -It was his/her expectation that when the parameter was missing on an order, the nurse that discovered it would have contacted the doctor and received the order to add the parameter. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-It was the responsibility of the Assistant Director of Nursing to audit all the new orders added to a resident's medical record. -He/she was unaware of the missing parameters for medications that contained Acetaminophen. -It was ultimately his/her responsibility to ensure that all medications that contained Acetaminophen had the parameter on all the orders.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 09895 Based on observation, interview, and record review, the facility failed to ensure one sampled resident (Resident #80) who had a diagnosis of Post-Traumatic Stress Disorder (PTSD - a mental health condition that is triggered by a terrifying event - either experiencing it or witnessing it; symptoms may include flashbacks, nightmares, severe anxiety, uncontrollable thoughts about the event and feelings of isolation) received trauma based interventions including ensuring the resident received meal service when he/she was in full view of staff during meal service, out of 19 sampled residents. The facility census was 92 residents. Review of Trauma-Informed Care Implementation Center (https://www.traumainformedcare.chcs.org/what-is-trauma-informed-care/), copyright 2021, showed: -Trauma-informed care shifts the focus from What's wrong with you? to What happened to you? -A trauma-informed approach to care acknowledges that health care organizations and care teams need to have a complete picture of a patient's life situation - past and present - in order to provide effective health care services with a healing orientation. -Adopting trauma-informed practices can potentially improve patient engagement, treatment adherence, and health outcomes, as well as provider and staff wellness. It can also help reduce avoidable care and excess costs for both the health care and social service sectors. -Trauma-informed care seeks to: --Realize the widespread impact of trauma and understand paths for recovery. --Recognize the signs and symptoms of trauma in patients, families, and staff. --Integrate knowledge about trauma into policies, procedures, and practices; and --Actively avoid re-traumatization. Review of the facility Trauma Informed Care policy, dated 2021, showed: -Trauma informed care is culturally sensitive and person-centered. -Caregivers are taught strategies to help eliminate, mitigate or sensitively address a resident's triggers (anything - a person, place, thing, or situation - that is a reminder of a past traumatic experience). -Strategies included to interact with all residents in a manner that is welcoming and kind without being intrusive. Review of the facility Dining Experience policy, dated 2021, showed: (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The dining experience will be person-centered with the purpose of enhancing each resident's quality of life and being supportive of each resident's needs during dining. -Residents will be involved in choosing where to eat and service staff notified of location selected. 1. Review of Resident #80's Face Sheet showed: -He/she was admitted to the facility on [DATE]. -He/she had a diagnosis of PTSD. Review of the resident's care plan, dated 3/12/24, showed: -He/she had prior trauma related to homelessness with triggers noted as unknown, had a diagnosis of PTSD, a potential psychosocial well-being problem related to anxiety (a feeling of worry, nervousness, or unease, typically about an imminent event or something with an uncertain outcome) and lack of motivation, he/she experienced loneliness and isolation and had a potential nutritional problem. -Goals included that he/she would have his/her physical and emotional needs met without increased emotional distress, he/she would have no indications of a psychosocial well-being problem and he/she would maintain adequate nutritional status. -Interventions included that staff would serve his/her ordered diet, explain and reinforce to him/her the importance of maintaining his/her diet and encourage him/her to comply. Review of the resident's Pre-Admission Screening and Resident Review (PASRR Level II, a person-centered evaluation that is completed for anyone identified by the Level I Screening as having, or suspected of having, a PASRR condition, including serious mental illness or related condition) Summary of Findings, dated 5/17/24, showed: -He/she did have a PASRR related disability of a serious mental illness. -His/her needs could be met in a nursing facility. -He/she did not have specialized services beyond those typically available in a nursing facility. -He/she had been homeless prior to admission to the facility and did not associate with his/her family. -His/her diagnoses included anxiety and depression. -He/she had a history of trauma - homelessness. and brain tumor surgery at age 14. -He/she did not require mental health specialized services and his/her needs could be met in a nursing facility. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she said he/she was not eating what he/she should be eating due to the brilliance of the kitchen not washing a banana that still had a label on it and was placed on top of his/her sausage and egg. -He/she received antidepressant medications (type of medicine used to treat clinical depression or prevent it recurring). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning), dated 6/11/24, showed: -He/she was cognitively intact. -He/she had little interest or pleasure in doing things, feeling down, depressed or hopeless, poor appetite or overeating, feeling bad about himself/herself, trouble concentrating, had thoughts he/she would be better off dead or of hurting himself/herself. -He/she had no behavioral symptoms. -He/she had anxiety, depression and PTSD. -He/she received antidepressant medication. Continuous observation on 6/13/24 from 12:05 P.M. to 12:25 P.M., showed: -The resident was seated in an open area just in front of the wide entryway to the dining room in full view of staff passing lunch trays in the dining room. -Staff in the dining room passed trays to all residents in the dining room and then passed hall trays to rooms on both sides of the nursing station directly across from the dining room, and passed by the resident with each hall tray delivery. -Following completion of staff passing hall trays at 12:25 P.M., the kitchen window rolling shade was pulled down. -The resident was not served a lunch tray. During an interview on 6/13/24 at 12:26 P.M., the resident said: -The kitchen had closed, and no one gave him/her lunch. -He/she had been where he/she always was during the lunch meal service. -The staff knew that was where he/she usually sat, everyone could see him/her, and the staff walked by him/her when they passed room trays. -The staff could see he/she did not get his/her lunch, they just did not care. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she guessed he/she was invisible, and no one spoke to him/her or got him/her a lunch meal and that happened often, staff just ignored him/her. During an interview on 6/13/24 at 12:31 P.M., Certified Nursing Assistant (CNA) B said: -The resident got a room tray. Observation on 6/13/24 at 12:32 P.M., showed: -There was no lunch tray in the resident's room. -The resident was not in his/her room. During an interview on 6/13/24 at 12:35 P.M., CNA B said: -The resident's meal card must not have been placed back in with the other residents' meal cards. -They used the meal cards in preparing and delivering meals. -The kitchen staff prepared the meals, and the direct care staff delivered the meals to the residents. -He/she did not see that the resident had not been served a meal. -He/she would get a meal for the resident. Observation and interview on 12/13/24 at 12:42 P.M., showed: -CNA B had a lunch meal on a tray and he/she said he/she was taking it to the resident's room. During an interview on 6/13/24 at 12:46 P.M., CNA B said, -He/she took the resident's lunch to him/her. -The resident refused his/her meal, saying he/she did not want his/her meal now. During an interview on 6/14/24 at 8:05 A.M., the resident said: -When staff walked past him/her, did not speak to him/her, and did not get him/her a meal, he/she felt anxious and alone and as if no one cared about him/her. -It reminded him/her of when he/she was a child and was bullied and made fun of and of being homeless and not knowing if he/she would have any food to eat - it made him/her feel alone and like no one cared about him/her. During an interview on 6/14/24 at 10:47 A.M., the Social Services Director said: -The resident did have PTSD. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident complained about the food at the facility. -The resident did not have problem behaviors at the facility. -The resident had trauma from being made fun of as a child due to having had a brain tumor and seizures and also he/she had been homeless prior to his/her facility admission. -He/she could see how not getting a meal when he/she was out where staff could see him/her at mealtime could trigger an emotional response, memories of being homeless and not having food, and being made fun of when a child. During an interview on 6/14/24 at 12:20 P.M., the Director of Nursing (DON) said: -The resident ate most of his/her meals in the dining room. -The facility had recently started a new meal service process that involved laminated meal cards. -At the end of the supper meal service, the meal cards were to be gathered to ensure all the cards had been collected. -When passing meals to residents, if the resident was not in the dining room, staff was to take the resident's meal to their room. -Normally if staff saw a resident without a meal, they asked if the resident got a meal tray and if they wanted a meal tray. -He/she would expect that the staff who normally served the meal trays would have noticed that the resident did not get his/her meal and get him/her his/her food. -The resident had a diagnosis of PTSD, and not being served a meal could be a trigger of his/her past trauma. -With the new system, there should not have been any resident tray missing and not served. -The CNA's served the trays and a licensed nurse oversaw the dining room and meal service. -The meal cards were the key to ensuring every resident was served their meal. -The CNA's and the licensed nurses were responsible for documenting each resident's meal intake for each meal.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 19916 Based on observation, interview and record review, the facility failed to ensure that dietary staff followed the recipe for pureed (cooked food, that has been ground, pressed, blended or sieved to the consistency of a creamy paste or liquid) eggs, which resulted in the eggs being unpalatable. This practice potentially affected two residents with pureed diets. The facility census was 92 residents. 1. Observation on 6/13/24 from 6:08 A.M. to 6:24 A.M., during the breakfast meal preparation, showed: -A disorganized recipe book on one of the tables with numerous amount of the pages which were not in order. -Dietary [NAME] (DC) A made pureed eggs with no recipe book open. -DC A added cold milk to the eggs and an unmeasured amount of thickener. -The state surveyor tasted the pureed eggs, and the eggs had a bland taste. -DC A did not taste the eggs himself/herself. -DC A placed the pureed eggs in the steam table. Review of the undated recipe for 100 servings of eggs showed: -Twelve 0.5 pounds (lbs.) portions of pasteurized liquid egg product. -Two tablespoons (Tbsp) of ground black pepper. -Two Tbsp. salt. -One 0.25 cup of melted margarine. -For pureed steps: Remove the desired number of servings and add nutritive liquid, milk, broth etc. Blend until desired consistency add approved thickener to achieve desired consistency if needed. During an interview on 6/13/24 at 6:42 A.M., DC A said: -He/she did not add salt or pepper to the eggs before cooking them. -He/she did not add margarine either. -The recipe book was disorganized which made it hard to find recipes. During an interview on 6/13/24 at 9:00 A.M., DC A said he/she was not trained in making the pureed foods correctly, because he/she was told not to add any salt by a previous Dietary Manager (DM). (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/14/24 at 9:18 A.M., DC B said: -He/she tasted all pureed foods except eggs and onions. -If he/she was not able to taste something with eggs and onions in it, he/she would ask one of the Dietary Aides to taste that food item. During an interview on 6/14/24 at 9:35 A.M., the Dietary Manager (DM) said: -He/she expected the cooks to taste everything they cook. -DC A confirmed to him/her that a previous DM said not to add salt to the foods.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19916 Based on observation and interview, the facility failed to maintain the floor under the deep fat fryer and the six burner stove free of a heavy grease buildup, maintain the wall mounted fan without dust; failed to identify an item in a 3 quart container in the reach-in fridge; failed to maintain the floors under the reach-in fridge and under the steam table free from debris and food particles; failed to refrigerate items which stated refrigerate after opening on the label; failed to maintain light fixtures and sprinkler heads in the kitchen, free of dust and grease; failed to store the utensils in a container free from food debris; failed to label two containers of a powdery substance; failed to maintain the lower spray wand of the dishwasher free from debris in the nozzles; failed to maintain the milk served in the Serenity kitchenette at a temperature close to or at 41 F (degrees Fahrenheit); failed to date the chicken with the date it was taken from the freezer; failed to clean the dishes from the previous night (6/12/24); failed to ensure the trash container in Serenity Court kitchenette was free of grime; failed to have enough dishes (silverware and coffee cups) to serve residents in the Serenity Court kitchenette; failed to ensure there was a thermometer which would be used for monitoring at the Serenity Court kitchenette; and failed to ensure that 7 of 14 cutting boards were in an easily cleanable condition. This practice potentially affected all residents. The facility census was 92 residents. 1. Observation on 6/10/24 from 10:51 A.M. to 11:11 A.M., during the initial kitchen tour, showed: -A buildup of grease and grime under the deep fat fryer. -A buildup of dust on the wall mounted fan. -An unidentified item in the reach-in fridge. -An unidentified item in a 3-quart container in the reach-in fridge. -A buildup of dust under the white reach-in fridge. -One bottle of beef paste, two containers of chicken base and one bottle of lemon juice which were opened, but not refrigerated according to label. -The presence of dust on the ceilings and on the sprinkler heads. -Utensils were stored in a container with food debris in it. -Two containers of a white powdery substance without a label. -The presence of grime, dishes and food debris under the steam table. -The presence of debris in the lower spray wand of the dishwasher. -The presence of grime and debris under the dishwasher. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 6/11/24 at 10:48 A.M., the facility Maintenance Director said the dietary department had not notified him/her about cleaning the sprinkler heads and the ceilings in the kitchen. 2. Observation on 6/13/24 from 5:52 A.M. to 9:40 A.M. during the breakfast meal preparation, showed: -A buildup of grease and grime under the deep fat fryer. -A buildup of dust on the wall mounted fan. -An unidentified item in the reach-in fridge. -An unidentified item in a 3-quart container in the reach-in fridge. -A buildup of dust under the white reach-in fridge. -One bottle of beef paste, two containers of chicken base and one bottle of lemon juice which were opened, but not refrigerated according to label. -The presence of dust on the ceilings and on the sprinkler heads. -Utensils were stored in a container with food debris in it. -Two containers of a white powdery substance without a label. -The presence of grime, dishes and food debris under the steam table. -The presence of debris in the lower spray wand of the dishwasher. -One box of chicken in the walk-in fridge, which was not dated with the date that box of chicken was taken from the freezer. -The presence of grime and debris under the dishwasher. -Dietary [NAME] (DC) A used a thermometer to check sausage without sanitizing the probe. -A buildup of grime on the floor of the walk-in fridge. -Seven cutting boards which were not easily cleanable because of numerous indentations and stains that could not be removed. During an interview on 6/13/24 at 6:02 A.M., Dietary Aide (DA) A said the substances in the two containers could be sugar and the containers should be labeled. During an interview on 6/13/24 at 8:39 A.M., the DM said: -The Assistant DM was the only one who cleaned the floor of the walk-in fridge. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The chicken should have been dated when it was taken from the freezer. -He/she could not tell how long the grease buildup behind the stove has been there. -The beef base and the lemon juice should have been refrigerated. -The containers of sugar should have been labeled. -The white reach-in refrigerator was the only fridge that was not cleaned. -He/she expected the dietary staff to sweep under the steam tables and behind the bread racks. -He/she had not had a chance to look at the all the cutting boards with numerous indentations, which rendered them not easily cleanable. -It has taken about a month to train all the dietary staff in cleaning the kitchen. -He/she spoke with the Regional Maintenance Director and the facility Maintenance Director about having the ceilings cleaned. -The nozzles of the dishwasher wands have not been cleaned in about 2 months because they do not have a regular dishwasher. 3. Observation on 6/13/24 from 7:10 A.M. to 8:04 A.M., during breakfast service at the Serenity Court kitchenette, showed: -Numerous unwashed dishes that were left from the night before. -One container of an unlabeled white substance. -Certified Nursing Assistant (CNA) C had to wait to deliver a tray to a resident because they were out of coffee cups. -The absence of a thermometer. -The presence of grime on the cover of the trash container. -The milk in the bottle on the counter had a temperature of 53.2 F after a small portion of milk was poured into a cup for measuring the temperature. -CNA A took a room tray from the kitchenette to resident room [ROOM NUMBER] without a plate cover. During an interview on 6/13/24 at 7:17 A.M., Certified Nurse's Assistant (CNA) D said the white powder in the container was thickener (a substance which can increase the viscosity of a liquid which is used to thicken sauces, soups, and puddings without altering their taste) but the label came off. During an interview on 6/13/24 at 7:36 A.M., DA A said the dietary department was out of plate covers. (continued on next page)

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	265358	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverbend Heights Health & Rehabilitation	1221 Highway 13 South Lexington, MO 64067

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 6/13/24 at 8:09 A.M., CNA C said they run out of coffee cups and silverware, and it was a usual occurrence. During an interview on 6/13/24 from 8:29 A.M. to 8:34 A.M., the DM said: -The dietary department was short of plate covers, bowls, coffee cups, silverware, and plates. -There was an extra thermometer and he/she needed to bring that thermometer to the Serenity kitchenette. -He/she forgot about the trash container in the Serenity kitchenette. -The dishes which were left in the Serenity kitchenette, should have been brought to the dishwashing room and washed. During an interview on 6/14/24 at 10:39 A.M., the Administrator said: -One of the reasons there may not be enough dishes, was it depended on the dietary staff and nursing staff picking up dishes in a timely manner after meals. -He/she was not sure what had happened to the plates because he/she had noticed an increase in the use of disposable paper/foam plates.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. 19916 Based on observation, and interview, the facility failed to ensure the walk-in fridge operated at a temperature of 41 F (degrees Fahrenheit) or below, and failed to maintain the automated dishwasher in good working order. This practice potentially affected all residents. The facility census was 92 residents. 1. Observation on 6/10/24 at 11:13 A.M., during the initial kitchen tour, showed the temperature of the walk-in fridge was 46.5 F (degrees Fahrenheit) after the thermometer was left in the walk-in fridge for about 10 minutes. Observation on 6/11/24 at 12:23 P.M., showed the temperature of the walk-in fridge was 46.4 F after the thermometer was left in the walk-in fridge for over an hour. During an interview on 6/11/24 at 12:24 P.M., the Maintenance Director said he/she had heard the walk-in fridge was not at the required temperature of 41 F, but he/she noticed the knob to control the temperature, was broken. During an interview on 6/13/24 at 8:29 A.M. the Dietary Manager (DM) said: -He/she had only been working for about a month. -The knob to control the temperature for the walk-in fridge was broken so he/she could not adjust the temperature of the walk-in fridge downward. During an interview on 6/14/24 at 9:33 A.M., the Assistant DM said it had been about 3 weeks since the walk-in fridge had not been operating at the correct temperature. During an interview on 6/14/24 at 10:16 A.M., the Maintenance Director said: He/she first found about the walk-in not operating at the proper temperature on Tuesday, 6/11/24, when he/she and the state surveyor looked at the temperature in the walk-in fridge and -There was not a knob on the controls to change the setting. During an interview on 6/14/24 at 10:41 A.M., the Administrator said he/she did not know about the walk-in fridge not having the proper temperature setting. 2. During an interview on 6/14/24 at 9:2 A.M., the DM said the following about the dishwasher: -One of the Dietary Aides (DA) delimed (to remove a buildup of lime from an area or something) the automated dishwasher. -The dish machine worked for 2-3 days. -The dishwasher was delimed again, and then it did not spray on the first cycle. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-It was about 3 weeks ago that he/she told corporate maintenance and the facility Maintenance Director. -The facility Maintenance Director tried to fix it during the week of May 27 2024. -The facility Maintenance Director said on the week of 6/10/24 that he/she would have to call a service person. During an interview on 6/14/24 at 10:16 A.M., the Maintenance Director said the following: -Dietary personnel told him/her that the dishwasher was not spraying on the first cycle. -He/she had not had a chance to look at it. -He/she would go and take a look at the automated dishwasher, but the repair may be beyond his/her expertise and he/she may have to call a service person to take a look at it. During a phone interview on 6/21/24 at 4:24 P.M., the Maintenance Director said on 6/20/24, they discovered the motor for the automated dishwasher was not working properly. 3. During a phone interview on 6/24/24, the Corporate Maintenance Director said: There was a calcium buildup in the left side pump of the dishwasher, which caused the dishwasher not to work properly. The walk-in fridge was frozen and he/she turned off the walk-in to defrost it and adjusted the temperature downward when he/she turned the walk-in fridge back on.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19916 Based on observation and interview, the facility failed to maintain the sewer pipe, in the area between the dry goods storage room and the walk-in refrigerator, in good repair to prevent drainage from backing up into the storage room and the walk-in refrigerator; failed to maintain the fans in the laundry room free of a heavy buildup of dust; failed to maintain the area under the vending machines in the Serenity dining room free from a heavy buildup of dust; and failed to ensure the restroom ceiling vent was securely attached to the ceiling in resident room [ROOM NUMBER]. This practice potentially affected an unknown number of residents who used the Serenity Unit dining room and other resident use areas in the facility. The facility census was 92 residents. 1. Observation on 6/10/24 at 11:07 A.M., showed a brownish substance with particles, backed up through the drains in the dry goods storage room and the walk-in refrigerator and the presence of a pungent smell of standing water. During an interview on 6/11/24 at 10:27 A.M., the Maintenance Director said the drains in the area between the walk-in fridge and the dry goods storage area are collapsed, which affected the ability of the water to drain properly because the drainage pipes underground broke. During an interview on 6/13/24 at 8:37 A.M., the Dietary Manager (DM) said: -The drainage in that area of the facility had been backing up for at least 4 years when he/she worked at the facility previously. -He/she asked the housekeeping supervisor to obtain a drain enzyme to take away the smell. During an interview on 6/13/24 at 9:48 A.M., the Administrator said: -He/she knew the drain backed up, but did not know why. -He/she thought that it was only that one time, which was a few weeks prior to the survey. 2. Observation on 6/10/24 at 2:01 P.M., with the Maintenance Director showed a heavy buildup of dust under the vending machines in the Serenity Unit dining room. During an interview on 6/10/24 at 2:02 P.M., the Housekeeping Director said he/she had not asked the vending machine company to come to the facility and move the vending machines so that his/her staff could clean under the machines. 3. Observation on 6/10/24 at 2:11 P.M., with the Maintenance Director, showed the fans on the clothes folding side and the washing side in the laundry, had a heavy buildup of dust on the blades. During an interview on 6/10/24 at 2:12 P.M., the Housekeeping Director said he/she cleaned the fans in December 2023 when he/she first started, but has not cleaned the fans since. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a phone interview on 6/21/24 at 12:36 P.M., the Housekeeping Director said he/she usually had the maintenance department clean the fans because they have the tools to take the fans apart. 4. Observation on 6/11/24 at 1:31 P.M., with the Maintenance Director, showed the restroom ceiling vent in resident room [ROOM NUMBER] was loose. During an interview on 6/11/24 at 1:32 P.M., the Maintenance Director said there were a few missing screws on that vent, which would have held it securely to the ceiling.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 19916 Based on observation and interview, the facility failed to maintain the area that was close to the window and the two-compartment sink, free of food debris and soiled dishes, which attracted ants to that area of the kitchen. This practice affected the kitchen. The facility census was 92 residents. 1. Observation on 6/13/24 at 6:16 A.M., 7:28 A.M., and 8:03 A.M., showed numerous dishes from the night before that were not washed and the presence of ants around the two compartment sink in the kitchen. During an interview on 6/13/24 at 8:43 A.M., after seeing the ants crawl in that area around the soiled dishes, the Dietary Manager (DM) said the dishes that were left at the window sill area should have been washed the previous night.