STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265379	A. Building B. Wing	06/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pinnacle Point Wellness & Rehabilitation	4700 NW Cliffview Drive Riverside, MO 64150

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 0689 Level of Harm - Minimal harm or potential for 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 interview and record review, the facility failed to ensure the health, safety, and welfare of Resident #1 was met when the facility provided the resident transportation to the bank and left him/her, returned but did not locate the resident and left without the resident. The resident did not receive his medications as ordered and slept outside in an alley. The resident borrowed a phone and called the facility to come pick him/her up the next morning. This affected one of seven sampled residents. The facility census was 114.On 06/29/26, the Administrator was notified of the past noncompliance which began on 06/17/26. Upon discovery, the facility administration immediately conducted an investigation, and corrective actions were implemented to include staff training regarding resident transportation. The noncompliance was corrected on 06/18/26. Review of the In-Service Training Report dated, 06/18/2026 included:Subject: Resident TransportationSummary of Meeting: 1.) If we transfer a resident, we are liable; 2.) We transfer for medical appointments; 3.) Working phone or way to contact facility for a ride. Review of the facility policy titled, Out on Pass, dated 08/2020, showed:-It is the policy of the facility to meet resident's physical and psychosocial needs to go out on pass;-The facility will make reasonable efforts to ensure resident safety and uphold resident rights;-A responsible person is considered to be a person who is over the age of 18 and can call for medical assistance if required;-Prior to the resident leaving on pass, a licensed nurse will assess the resident's physical and mental status and ensure that the resident has a supply of medications for the time period of the pass;-When the resident returns to the facility, a licensed nurse will re-assess the resident to determine the resident's condition and any medication returned after going out on pass;-The resident is encouraged to give the facility reasonable notice when anticipating going out on pass;-The resident will return to the facility at an agreed upon time, or else notify the facility of any unexpected delay in return to the facility. Review of the residents Face Sheet showed the following diagnoses: -Asthma;-Anemia;-Hypo-osmolality and Hyponatremia;-Alcohol Abuse; -Other Psychoactive Substance Abuse; -Polyneuropathy; - Essential (Primary) Hypertension; -Peripheral Vascular Disease; -Acute Sinusitis;-Other Abnormalities of Gait & Mobility; - History of Falling. Review of Resident #1's Quarterly Minimum Data Set (MDS) a federally required assessment tool completed by facility staff, dated 05/21/26, showed:-The resident was cognitively intact;-The resident had not exhibited any wandering habits;-Diagnoses of abnormalities of gait and mobility, hypertension (high blood pressure), and asthma. Review of the resident's care plan, revised on 05/26/26, showed:-The resident was at a moderate risk for falls and needed a safe environment with even floors free from spills and clutter, the call light in reach, glare-free light, and handrails on walls;-The resident had a history of being unhoused. Review of the resident's sign out sheet, dated 06/17/26, showed: The resident signed out on 06/17/26 at 9:30 A.M. and returned to the facility on [DATE] at 11:55 A.M. Review of the facilities Resident Transportation In-Service Training Report, dated 06/18/26, showed: -If the facility transferred a resident the facility was liable for that resident;-Residents required a working phone or a way to contact the facility for a ride to return to the facility. During an interview on 06/29/26 at 11:06 A.M., the resident said: -He/She had to go to the bank; facility transportation dropped him/her (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	off at the bank and he/she was going to give the transporter a call when he/she was done at the bank;-His/Her phone didn't have any minutes on it, and he/she was not able to get anyone to let him/her borrow a phone;-He/She laid down in an alley behind a fast-food restaurant that night, it was a little damp outside and the temperature was in the 60's;-He/She was able to borrow a phone from another customer at the fast-food restaurant the next morning to call the facility and get a ride back to the facility;-Facility staff were supposed to pick him/her up either at the bank or the fast-food restaurant on 06/17/26. During an interview on 06/29/26 at 1:26 P.M., the Director of Nursing (DON) said: -The facility usually only transported residents to medical appointments but was able to provide transportation to the bank for the resident on 06/17/26;-The resident was going to call the facilities transporter when he/she was done at the bank to get a ride back to the facility;-The transporter had another resident to drop off at another location then returned back to the bank to pick up the resident;-When the transporter returned to the bank the resident was not there, the resident had said that he/she might go to the fast-food restaurant after getting done at the bank and the transporter did not see the resident at the fast-food restaurant either;-The transporter when back to the bank and the fast-food restaurant a few times and did not find the resident;-Even though the resident was his/her own person the facility still needed to make sure he/she was in a safe situation;-The facility was responsible for the resident's safety;-This transportation was not done as safely as it could have been;-Moving forward that facility needed to ensure the resident had a way to contact the facility during any future transportation provided by the facility;-She provided education to administrative staff and the Transporter regarding the facilities liability when transporting a resident and ensuring that residents had a way to contact the facility for a ride back to the facility. During an interview on 06/29/26 at 1:26 P.M. the Assistant Director of Nursing (ADON) said:-The resident said he/she went to a fast-food restaurant after getting done at the bank but the employees would not let him/her stay inside the lobby;- He/She then went to a coffee shop, then to a different bank in that area;-Resident #1 did not take any medication;-She was concerned the resident was not able to be found;-The resident signed out at 9:55 A.M. on 06/17/26 and signed back into the facility at 11:55 A.M. on 06/18/26. During an interview on 06/29/26 at 1:48 P.M. the Transporter said:-She took the resident to the bank and made sure that the resident had his/her number to call her when he/she was done at the bank and ready to be picked up;-The resident said he/she would either be at the bank or the fast-food restaurant when he/she was done at the bank;-She did not receive a call from the resident, and went to the bank and the fast-food restaurant to look for the resident and was unable to find him/her;-She went back to the bank and the fast-food restaurant in between dropping off other residents for appointments and looked for Resident #1;-She let the facilities Administrator know that she was unable to find the resident four hours after she was unable to find him/her;-She was worried about the resident's safety while he/she was out and unable to be found;-She received education regarding the facilities liability when transporting a resident and ensuring that resident's had a way to contact the facility for a ride back to the facility. During an interview on 06/29/26 at 2:56 P.M. the Administrator said: -Facility transportation was able to take the resident to the bank and told him/her that he/she would have to wait to be picked up until other resident's had been dropped off at their appointments, the resident told the transporter that he/she would either be at the bank or at the fast food restaurant;-The transporter gave the resident a phone number to call when he/she was done and ready to be picked up;-The resident signed out of the facility before being transported to the bank;-She went to look around the area of the bank and the fast-food restaurant and was unable to find him/her;-The resident stayed outside around the fast-food restaurant that night;-She was not concerned about the resident's safety while the resident was unable to be found overnight; -The facility stopped looking for the resident around 8:00 P.M. on 06/17/26. -The facility contacted the police department but were unable to file a missing person's report due to the resident being his/her own person and the resident being missing for less than 24 hours;-She received education from the DON regarding the facilities liability when transporting a resident and ensuring that resident's had a way to contact the facility for a ride back to the facility. 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