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	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Nursing & Rehabilitation Center, LLC	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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37283 Based on record review and staff interview, the facility failed to ensure the Ombudsman was notified of two unplanned, facility-initiated hospital discharges for one (Resident (R) 263) of three residents reviewed for hospitalization . The facility census was 115. Findings include: Review of R263's Face Sheet tab of the electronic medical record (EMR) revealed he was admitted to the facility on [DATE] with diagnoses including spinal stenosis, osteomyelitis, and right leg below-the-knee amputation. 1. Review of R263's Discharge - return anticipated Minimum Data Set (MDS) assessment, with an assessment reference date [ARD] of 11/09/23 and located in the MDS tab of the EMR, indicated R263 experienced an unplanned discharge to the hospital on 11/09/23. Review of R263's Notice of Emergency Transfer of Resident, dated 11/09/23 and provided on paper, revealed the resident was transferred to the hospital because it was required by the resident's urgent medical needs. Review of R263's Nursing Departmental Notes, dated 11/10/23 at 1:56 AM and located in the Notes tab of the EMR, revealed, This resident received orders from the physician to be sent out to the hospital for immediate treatment due to wound infection. Resident was sent out via non emergent [sic] ambulance to . hospital. Review of the Detail Admission/Discharge Report, dated 01/29/24 and provided on paper with a handwritten title of, November Discharges revealed it was a list of monthly discharges provided to the Ombudsman. R263 was not included on the list, and the list did not include any residents sent to an acute care hospital. Review of R263's Nursing Departmental Notes, dated 11/18/23 at 7:39 AM and located in the Notes tab of the EMR, revealed R263 had been readmitted to the facility on [DATE] at 6:15 PM. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265379	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/19/2024

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/18/24 at 4:41 PM, the Social Services Director (SSD) stated she typically provided a monthly report of all discharges to the Ombudsman. The SSD stated the goal of sending the monthly notification was to make sure the Ombudsman was notified of everyone who experienced a facility-initiated discharge. During an interview on 04/18/24 at 4:58 PM, the SSD stated the Ombudsman had not been notified of R263's unplanned hospital discharge on 11/09/23. The SSD stated R263 did not pop up on the discharge list that month, and she needed to take an extra step when running the discharge report to ensure hospitalization s were included. 2. Review of R263's Discharge - return anticipated MDS assessment, with an ARD of 03/27/24 and located in the MDS tab of the EMR, indicated R263 experienced an unplanned discharge to the hospital on 03/27/24. Review of R263's Notice of Emergency Transfer of Resident, dated 03/27/24 and provided on paper, revealed the resident was transferred to the hospital because it was required by the resident's urgent medical needs. Review of R263's Nursing Departmental Notes, dated 03/27/23 and located in the Notes tab of the EMR, revealed, Resident is being sent to ER [emergency room] due to wound on left foot. Wound is non healing [sic], drainage, and with odor. Review of the Ombudsman Transfer/Discharge Tracker, dated March 2024 and provided on paper, revealed it was a list of monthly discharges faxed to the Ombudsman with a cover sheet indicating the fax was sent on 04/01/24. R263 was not included on the list, and the list did not include any residents sent to an acute care hospital. Review of R263's Nursing Departmental Note, dated 04/05/24 at 9:36 PM and located in the Notes tab of the EMR, revealed R263 was readmitted to the facility on [DATE] around 7:00 PM. During an interview on 04/18/24 at 4:41 PM, the SSD stated the Ombudsman had not been notified of R263's unplanned hospital discharge on 03/27/24, adding he did not pop up on the discharge list. The SSD stated she would include the resident on the next month's report and inform the Ombudsman of the omission.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37283 Based on record review and staff interview, the facility failed to ensure the accurate completion of the Minimum Data Set (MDS) assessment under the Pre-Admission Screening and Resident Review (PASARR) for two (Resident (R) 7 and R41) and under the Antipsychotic Medication section for one (R7) of 36 sampled residents. The facility census was 115. Findings include: 1. Review of R7's Face Sheet tab of the electronic medical record (EMR) revealed he was admitted to the facility on [DATE] with diagnoses including schizophrenia and anxiety disorder. A. Review of R7's PASRR/MI [Mental Illness] Level II Determination Sheet, dated 08/06/03 and located in R7's paper chart at the nurses' station, revealed R7 had a serious mental illness as defined by PASARR and required drug therapy and monitoring and provision of a structured environment. He was evaluated by Level II PASARR for a diagnosis of schizophrenia. Review of R7's admission Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 09/25/23 and located under the MDS tab of the EMR, revealed he had diagnoses of schizophrenia and anxiety but documented No to the question, Has the resident been evaluated by Level II PASRR [Pre-admission Screening and Resident Review] and determined to have a serious mental illness and/or mental retardation or a related condition? During an interview on 04/19/24 at 2:20 PM, the Social Services Director (SSD) stated R7 had a PASARR Level II evaluation due to a diagnosis of schizophrenia with recommendations for a structured environment and medication management. The SSD stated she did not complete the PASARR section of the MDS; the MDS Coordinator (MDSC) completed the section. During an interview on 04/19/24 at 3:00 PM, the MDSC stated she was not aware R7 had a PASARR Level II evaluation. She stated she would typically look in the paper chart, but added there were times she was unable to locate charts and completed the MDS without it. She stated R7 had been evaluated by PASARR Level II and the MDS was inaccurate. B. Review of R7's Medication Administration Record (MAR), dated March 2024 and provided on paper, revealed an order, which originated on 09/18/23, for olanzapine [an antipsychotic medication], 5 milligrams daily at bedtime for bedtime for a diagnosis of schizophrenia. The MAR documented R7 had received the olanzapine as ordered daily at bedtime. Review of R7's quarterly Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 03/18/24 and located under the MDS tab of the EMR, revealed he had diagnoses of schizophrenia and anxiety and exhibited rejection of care frequently. The MDS documented the resident was taking an antipsychotic medication and there was an indication noted. However, the follow-up question, Did the resident receive antipsychotic medications since . the prior OBRA assessment? was answered, No, Antipsychotics were not received. The MDS documented No to the question. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/19/24 at 2:20 PM, the SSD stated R7 had a diagnosis of schizophrenia and used antipsychotic medication. The SSD stated she did not complete the medication section of the MDS; the MDSC completed the section. During an interview on 04/19/24 at 3:00 PM, the MDSC stated she referred to the Physician Orders located in the paper chart to determine whether a resident was receiving an antipsychotic. She stated R7 was taking an antipsychotic medication, and she did not know why the MDS was answered with conflicting responses regarding antipsychotic use. The MDSC stated the MDS was inaccurate. 2. Review of R41's Face Sheet tab of the EMR revealed he was admitted to the facility on [DATE] with diagnoses including intellectual disabilities, schizophrenia, and major depressive disorder. Review of R41's PASRR Level II Evaluation Report, dated 07/13/23 and located in R41's paper chart at the nurses' station, revealed R41 had a serious mental illness as defined by PASARR but did not have intellectual disability as defined by PASARR and did not require specialized mental health services. He was evaluated by Level II PASARR for a diagnosis of schizophrenia. Review of R41's annual MDS assessment, with an ARD of 03/22/24 and located under the MDS tab of the EMR, revealed he had diagnoses of schizophrenia and anxiety but documented No to the question, Has the resident been evaluated by Level II PASRR [Pre-admission Screening and Resident Review] and determined to have a serious mental illness and/or mental retardation or a related condition? During an interview on 04/19/24 at 2:20 PM, the SSD stated R41 had a PASARR Level II evaluation due to a diagnosis of schizophrenia with no mental health recommendations. During an interview on 04/19/24 at 3:00 PM, the MDSC stated she was not aware R41 had a PASARR Level II evaluation. She stated she would typically look in the paper chart, but added there were times she was unable to locate charts and completed the MDS without it. She stated R41 had been evaluated by PASARR Level II and the MDS was inaccurate.

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F 0656 Level of Harm - Minimal harm or potential for 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** 37283 Based on staff interviews, record review, and review of the facility policy, the facility failed to develop a person-centered comprehensive plan of care to address the resident's chronic wounds and edema with measurable goals and plans for one of 29 sampled residents (Resident (R) 50). The facility census was 115. Findings include: Review of a policy provided by the facility titled, Comprehensive Person-Centered Care Plans undated, indicated . A Comprehensive Person-Centered Care Plan contains services provided, preference, ability, goals for admission and desired outcomes, and care level guidelines . For each problem, need, or strength a resident-centered goal is developed . Staff approaches are to be developed for each problem/strength/need . Review of R50's electronic medical record (EMR) titled, Admission Record, located under the Profile tab, indicated R50 was admitted to the facility on [DATE] with diagnoses including edema and stroke affecting the right side of the body. Review of R50's EMR titled Orders, located under the Orders tab, indicated R50 was ordered Lasix 40 milligrams (mg) with a start date of 10/26/23 and Bumex 4 mg twice daily with a start date of 10/26/23 for edema. Review of R50's EMR titled Progress Notes, located under the Progress Notes tab and dated 04/16/24, indicated R50 was seeing wound care for chronic wound/edema to bilateral lower legs. Review of R50's EMR titled Care Plan, located under the Care Plan tab, indicated no care plan for chronic edema or wounds to the bilateral lower legs. R50 was not interviewable. During an interview on 04/19/24 at 9:54 AM, the Administrator revealed Care plans should be updated accordingly. Information is gathered in morning meetings detailing resident care and the care plan should be changed if needed. During an interview on 04/19/24 at 1:42 PM, the Minimum Data Set Registered Nurse (MDSRN) 1 revealed the chronic edema and wound care should be care planned. I do the care plans, but nursing can enter care plans as well. I do not know how this was missed.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37283 Based on record review, resident and staff interview, facility policy review, the facility failed to administer physician ordered medications (glaucoma eye drops) as prescribed for one (Resident (R)44) of 29 residents sampled. The facility census was 115. Findings include: Review of the facility policy Medication Administration-General Guidelines dated 08/16 revealed . The resident's MAR/TAR [medication administration record/treatment administration record] is initialed by the person administering a medication, in the space provided under the date . Review of R44's Face Sheet, provided by the facility, revealed R44 was admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease and glaucoma. Review of R44's quarterly Minimum Data Set (MDS), located in the EMR under the MDS tab, with an Assessment Reference Date (ARD) of 01/11/24, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R44 was cognitively intact. Review of R44's physician orders dated 01/08/24 revealed timolol 0.5% eye drop, instill one drop into each eye daily at 8:00 AM, latanoprost 0.005% eye drop, instill one drop into each eye at 8:00 PM, Trusopt 2% eye drops, instill one drop into each eye twice a day at 12:00 PM and 8:00 PM, and Brimonidine 0.2% eye drop, instill one drop into both eyes twice a day at 12:00 PM and 8:00 PM. Review of R44's CMT Medication Administration Record for April 2024 revealed timolol 0.5% eye drop had blanks in the blocks under the dates of 04/02, 04/05, 04/07, 04/12, and 04/14; latanoprost 0.005% eye drop had blanks in the blocks under the dates of 04/08, 04/09, 04/11, 04/12, and 04/13; Brimonidine 0.2% eye drop had blanks in the blocks under the dates of 04/02 and 04/11; and Trusopt 2% eye drop had blanks in the blocks under the dates of 04/08, 04/09, 04/10, 04/11, and 04/14. During an interview on 04/19/24 at 2:30 PM, the interim director of nursing stated, If there is no documentation in the boxes below the dates, then I cannot prove the medications were given.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 37283

Based on observation, record review and interviews, the facility failed to ensure residents who smoked were assessed and that supervision was provided in accordance with the assessed needs. Residents were observed smoking, unsupervised outside of the designated areas. The facility failed to put a system in place to individually identify and determine if residents needed staff to maintain their smoking materials, care plan such needs, and implement a monitoring system for five of 22 residents that currently reside in the facility and smoke (Resident (R)11, R81, R17, R5, and R87). The facility also failed to develop a care plan for one of 22 residents that currently smoke (R11). The facility census was 115.

Review of the facility's policy Smoking dated 05/31/22, stated, It is not the intention of this facility to deprive residents of the pleasure of smoking, but rather offer a safe and comfortable environment to all residents living in the facility. Both smoking and non-smoking residents will be considered in the development of smoking locations and designated times.

Under the Procedure section of the smoking policy, it revealed the following:

l. All residents who smoke will be evaluated for his/her ability to smoke safely, the ability to handle smoking material and the level of supervision while smoking. The smoking Evaluation Tool will be completed upon admission, re-admission, quarterly, annually (sic) and as needed.

2. The facility staff will store smoking materials and identify designated times for smoking.

3. Assistance with lighting tobacco products, assistance to hold cigarettes, supervised smoking by staff and/or other protective/safety measures as determined appropriate by the Smoking Evaluation Tool will be provided.

4. Signs that prohibit smoking in the facility will be prominently placed at all building entrances that are used by residents, staff (sic) and visitors.

a. Staff will be informed of this policy at the time of hire.

b. Residents or their appointed representatives, as appropriate, will be informed of this policy upon admission to the facility.

c. This policy will be courteously communicated to visitors found smoking or using smoking materials in the building or in non-designated areas.

5. Smoking is only permitted in designated smoking areas with smoking times to be designated by the facility.

a. The designated smoking area will be provided with a fireproof ashtray in which all smoking material will be disposed of.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. No smoking material will be disposed of in waste cans, floors (sic) or any other inappropriate area. c. Ashtrays can only be emptied by staff into a fireproof metal container. d. No flammable liquid or combustible gases may be taken into the smoking areas. e. Use of oxygen in smoking areas and while smoking is not permitted. f. Smoking areas are to be maintained in such a manner that minimizes risk for fire hazards . 7. Violation of the smoking policy may result in discharge from the facility . 1. Review of R11's Face Sheet, provided by the facility, revealed R11 was readmitted on [DATE] with diagnoses including chronic pulmonary obstructive disease. Review of R11's quarterly Minimum Data Set (MDS), located in the EMR under the MDS tab, with an Assessment Reference Date (ARD) of 02/03/24, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, indicating R11 was moderately cognitively intact. Review of R11's care plan dated 08/22/23 revealed the resident had a problem indicating R11 is at risk for behaviors r/t [related to] being non-compliant at times. The goal indicated The resident will have no behaviors that are harmful to himself or others. Interventions were assist the resident to develop (sic) more appropriate methods of (sic) coping and interacting. Encourage the resident to express feelings appropriately (sic). If reasonable, discuss the residents (sic) behavior. Explain/reinforce why behavior is (sic) inappropriate and/or unacceptable. Observe for behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved (sic) and situations. There was no documentation nor development of a care plan to reflect R11 was a smoker. Review of the quarterly Smoking Evaluation Tool, dated 02/15/24, revealed under the Interview section of this tool Does the resident use oxygen? The answer documented was No. Under the Evaluation section of this tool revealed the area for BIMS Score was blank. The statement of Care plan reviewed and revised for appropriate supervision and smoking directions to include: General Supervision, Supervision and assist of one for smoking, Smoking apron, and Staff to light cigarette/cigar/pipe revealed no documentation to address these areas. The previous Smoking Evaluation Tool dated 11/17/23, revealed staff to store smoking materials, however on the tool dated 02/15/24, it did not reflect this documentation. During an interview on 04/19/24 at 1:05 PM, the Social Services Assistant stated, I just forgot to mark those areas, in regards to the incomplete smoking evaluation tool. 2. Review of R81's Face Sheet, provided by the facility, revealed R81 was admitted on [DATE] with diagnoses including dementia mild with agitation, psychosis, and major depressive disorder. Review of R81's quarterly MDS, located in the EMR under the MDS tab, with an ARD of 02/29/24, revealed the resident had a BIMS score of 14 out of 15, indicating R81 was cognitively intact. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R81's care plan, dated 08/22/23, revealed the resident had a problem indicating R81 is a smoker and is aware of the facility smoking policy. R81 is at risk for being non-compliant with storage of smoking materials. The goal indicated R81 will follow smoking policy and remain free from injury . The interventions reflected Resident has been educated on the scheduled smoking times and is aware the facility will hold all smoking and fire materials, evaluate quarterly and with change in condition as indicated, and Social Services to provide support as needed. Review of R81s Smoking Evaluation Tool dated 12/13/23 revealed under the Evaluation question of BIMS Score, there was no documentation. For the area noted under Evaluation-Care plan reviewed and revised for appropriate supervision and smoking directions to include General Supervision, Supervision and assist of one for smoking, and Smoking Apron, there was no documentation to reflect if the care plan had been reviewed and revised for smoking or what type of supervision R81 required while smoking. There was documentation which indicated staff was to hold smoking materials. Review of R81's Smoking Evaluation Tool dated 03/07/24 revealed under an Interview question Has the resident ever been offered resources to assist with quitting smoking there was no documentation noted. Under the Evaluation question of BIMS Score, there was no documentation. For the area noted under Evaluation-Care plan reviewed and revised for appropriate supervision and smoking directions to include General Supervision, Supervision and assist of 1 for smoking, and Smoking Apron, there was no documentation to reflect if the care plan had been reviewed and revised for smoking or what type of supervision R81 required while smoking. There was documentation which indicated staff was to hold smoking materials. Observation on 04/15/24 at 9:00 AM, showed R81 was smoking outside sitting on a brick ledge at the front of the facility. This was not the designated area to smoke for residents that need supervision. R81 stated, I only have half of a cigarette left. Observed three other residents with R81 smoking together as a group. There were no staff members present for supervision. On 04/16/24 at 9:00 AM and 5:30 PM, R81 was observed to be smoking while sitting on the brick ledge. Again, there were no staff members present for supervision. On 04/17/24 at 5:40 AM, R81 was observed putting in the code for the front door to open and ambulated outside to the front of the facility to smoke. R81 proceeded to sit down on the brick ledge and begin smoking a cigarette. During the interview with R81, the resident stated, I got my cigarettes and lighter from another person here that smokes. During an interview on 04/19/24 at 1:05 PM, the social services assistant (SSA) stated, R81 is a minimal supervised or unsupervised smoker. 3. On 04/16/24 at 11:30 AM, R17 was observed to be waiting at the front door in the electric scooter for the front desk receptionist to release the front door to open for R17 to go outside to the front parking lot. R17 stated, The ones that are supposed to come out here and supervise us when we are smoking, don't care about us. If they cared, they would come out here and supervise us. Review of R17's Face Sheet, provided by the facility, revealed R17 was admitted on [DATE] with diagnoses including peripheral vascular disease, chronic obstructive pulmonary disease, and bipolar disorder due to post traumatic stress disorder. Review of R17's quarterly MDS, located in the EMR under the MDS tab, with an ARD of 02/08/24, revealed the resident had a BIMS score of 15 out of 15, indicating R17 was cognitively intact. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R17's care plan, dated 01/01/21, revealed the problem as I [R17] am a smoker by choice. I sign myself out of the facility to smoke in the community. I am non-compliant with my smoking materials and refuse to get (sic) them to the facility for safe keeping. The goal for this problem revealed, I will smoke safely & (and) without incident in designated smoking areas . The interventions were Staff to accompany me [R17] during scheduled smoke breaks. I [R17] have been educated on the scheduled smoking times and I [R17] am aware that the facility will hold all smoking and fire materials. My social worker to provide support as needed. Facility staff to monitor me [R17] for (sic) safety. Evaluate me [R17] quarterly and with change in condition as indicated. Review of R17's Smoking Evaluation Tool dated 11/30/24 revealed under Evaluation R17 is to have General Supervision. Review of R17's Smoking Evaluation Tool dated 02/15/24 revealed under Evaluation the BIMS Score was left blank. R17 continues to be documented for General Supervision. There was noted documentation of Res [R17] is non-compliant with facility smoke policy at times. During an interview with R17 on 04/15/24 11:30 AM, the resident was asked where his smoking supplies were kept. R17 pointed to his basket on his scooter and observed three packs of cigarettes and a lighter attached to an elastic cord attached to the handle of the scooter. 4. Review of R5's Face Sheet, provided by the facility, revealed R5 was admitted on [DATE] with diagnoses including post-traumatic stress disorder which resulted in a gunshot wound causing traumatic brain injury, bipolar disorder, and post traumatic seizures. Review of R5's quarterly MDS, located in the EMR under the MDS tab, with an ARD of 01/19/24, revealed the resident had a BIMS score of 15 out of 15, indicating R5 was cognitively intact. Review of R5's care plan, dated 03/26/20, revealed a Problem which stated, I [R5] choose to smoke, and I am aware of the facility (sic) smoking policy. I [R5] do not always sign out and spend most of my [R5] time off facility property (sic) and return to facility for meals/meds [medicines]. I [R5] take my tobacco with me and leave the property. The Goal for this Problem stated, I [R5] will smoke in the designated smoking area and be free from injury. The Interventions for this Problem stated, Encourage and remind me [R5] of the proper protocol to sign out as needed, staff to accompany me during scheduled smoke breaks, I [R5] been educated on the scheduled smoking times and I [R5] am aware that the facility will hold all smoking and fire materials, facility staff to monitor for safety, evaluate quarterly and with change in condition as indicated, and my [R5] social worker to support as needed. Review of R5's Smoking Evaluation Tool, dated 02/08/24, revealed under Evaluation section the BIMS Score had no documentation. During an observation on 04/17/24 at 3:19 AM, R5 went outside in his electric wheelchair to smoke outside of the building on C hall. R5 stated, I always go out early before meds [medicines] come around. When asked who let R5 out, R5 stated, I have the code to go in and out. I keep my cigarettes in a locked box in my room. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Nursing & Rehabilitation Center, LLC	4700 NW Cliffview Drive Riverside, MO 64150

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with R5 on 04/17/24 at 7:20 AM, while R5 was out on the far-right side of the parking lot smoking a cigarette, R5 stated, The wind was blowing so hard yesterday morning that it blew the cigarette out of my mouth, and it [cigarette] was blown down the road. I went down the road to catch it in my wheelchair. An observation was made with the Social Services Director on 04/17/24 at 9:15 AM in which R5 stated, My lockbox is right under my bed. R5 showed the lockbox was at the right side at the head of the bed, and stated, When I am in here, my wheelchair sits in front of it so no one can see it. 5. Review of R87's Face Sheet, provided by the facility, revealed R87 was admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), and congestive heart failure. Review of R87's quarterly MDS, located in the EMR under the MDS tab, with an ARD of 03/07/24, revealed the resident had a BIMS score of 12 out of 15, indicating R5 was moderately cognitively impaired. Review of R87's care plan dated 09/06/22 revealed a Problem which stated, I [R87] smoke tobacco daily, I [R87] will remain safe while smoking. Per H&P (History and Physical) R87 smoked at home while using oxygen. Under the Goal section of the care plan, it revealed, I [R87] will be free from smoking related injuries . Interventions in the care plan revealed, Smoking cessation assistance will be provided should the desire to stop smoking be expressed, provide a schedule of supervised smoke times, smoking risk assessment following admission, significant change and quarterly, and must remove oxygen when going out to smoke. Review of R87's Smoking Evaluation Tool dated 03/14/24 revealed under the Evaluation section, the BIMS Score was not documented. The area which stated, Care plan reviewed and revised for appropriate supervision and smoking directions to include General Supervision, Supervision with assist of 1 for smoking, Smoking Apron, and Staff to light cigarette, cigars/pipe. There was documentation noted which stated, Remove O2 (oxygen) to smoke. On 04/17/24 at 5:00 AM, R87 was observed to be sitting in his wheelchair in the hallway of unit F. When asked where R87 keeps his cigarettes and lighter, R87 stated, I have to contemplate what I am going to tell you. I will tell you that I have cigarettes that I can get, I won't tell you how or where, but nevertheless they [cigarettes] are up there. 6. During an interview on 04/19/24 at 1:05 pm, the Social Services Assistant stated, I just forgot to document in those areas on this [smoking evaluation tool]. During an interview on 04/17/24 at 10:20 AM, the Executive Director was asked what general supervision meant when it was marked on the Smoking Evaluation Tool. The executive director stated, Someone needs to be supervising the residents to smoke and they need to smoke in the designated smoking area. Safe smokers can go smoke whatever time they want to. Those smokers can go out front to smoke. When asked if the front parking lot with the brick ledge was considered the facility's property, the area where the residents are smoking and the Executive Director stated, Yes, that is still our property. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the resident interviews, the residents were reluctant to speak to the survey team regarding where the smoking materials were really being stored. The residents had voiced concerns if they would tell us, then they might get their smoking privileges taken away and R17 stated, I have been smoking for 50 some years, and I can't stop now. This place gives me anxiety and I don't need anymore.

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F 0697

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide safe, appropriate pain management for a resident who requires such services.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 37283

Based on observation, resident and staff interview, record review and facility policy review, the facility failed to ensure pain medication (Hydrocodone) was available to be administrated to one of three residents (Resident (R)24). The facility census was 115.

Findings include:

Review of the facility's policy Medication Administration-General Guidelines dated August 2016, revealed . Medications are administrated in accordance with written orders of attending physicians .

Review of the facility's policy Pain Evaluation/Management dated January 2015 revealed the following:

A. Routine Pain Evaluations:

1. Upon admission/readmission the pharmacy/facility will provide a pain scale on the Medication Administration Record for the resident.

2. If a new episode of pain is noted report to the nurse and/or Executive Director.

3. Implement non-pharmacological interventions as appropriate.

4. If no relief or if the resident finds pain above acceptable levels notify the physician.

5. Notify physician if resident's response to their medication or treatment is not satisfactory to develop further interventions for relief of pain.

B. Completing Pain Management Evaluation Tool:

When to Evaluate:

. Upon admission and re-admission to the facility for all residents.

. Upon all new complaints of pain/discomfort from resident or resident's family.

. Upon a change of condition when indicated.

l. For residents cognitively intact, complete Section A of the tool. For cognitively impaired residents, complete Section B. Place in the medical record under Risk Evaluations.

2. After the evaluation is completed and if pain is identified, nursing will establish the problem on the resident's Plan of Care (to include non-pharmacological comfort measures as appropriate).

3. The physician will be called, and the results of the pain evaluation reviewed in order to

(continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	develop further interventions for relief of pain . Review of R24's Face Sheet, provided by the facility, revealed R24 was admitted on [DATE] with diagnoses including polyneuropathy, diabetes mellitus, rheumatoid arthritis, pain, and history of right femur fracture. Review of R24's quarterly Minimum Data Set (MDS), located in the EMR under the MDS tab, with an Assessment Reference Date (ARD) of 02/28/24, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating R24 was cognitively intact. Review of R24's care plan, provided by the facility, dated 06/07/22, revealed the resident had a problem indicating I [R24] is at risk for alterations of comfort r/t [related to] RA [rheumatoid arthritis], HX [history] of Femur [sic] Fx [fracture], neuropathy, depression [sic]. The Goal was documented as My [R24] pain will be managed and I [R24] will verbalize adequate pain relief . The Interventions were Monitor and record my [R24] pain as ordered and/or as needed. Administer medications as ordered. If pain or c/o [complaints of] pain increase notify my [R24's] physician. Therapy to eval [evaluate] and treat as needed. Review of R24's Pain Management Evaluation Tool, dated 08/31/23, revealed R24 has chronic pain in the right leg. When asked What makes the discomfort feel better/worse? It was documented R24 answered repositioning. When asked what is an acceptable level [pain] for you?, it was documented 2/10 [two out of 10]. When asked How long does the discomfort usually last?, it was documented R24 answered all day. Review of R24's physician orders, provided by the facility, dated 10/26/23, revealed Hydrocodone-Acetaminophen 5-325 mg [milligram] give one-tab [tablet] po [by mouth] BID [twice a day] .Dx [diagnosis] pain. This medication was ordered to be given at 8:00 AM and 8:00 PM. As well as an order for Tylenol 650 mg po every 8 hours, last dose dated 04/18/24 at 6:00 AM. During the Medication Administration observation on 04/18/24 at 8:24 AM, Licensed Practical Nurse (LPN) 6 stated, R24's pain medication [hydrocodone] will come this evening or tomorrow. At 8:40 AM, R24 asked LPN6 if her pain medication was here yet and LPN6 stated, It should be here this evening. LPN6 did not assess R24's pain at this time nor offer R24 another alternative for pain. LPN6 continued to state, I haven't had time to reorder medications for three weeks. Review of R24's Medication Administration Record (MAR), provided by the facility, dated for April 2024, revealed beginning on 04/11/24 at 8:00 AM through 04/19/24 at 8:00 AM, there were initials with circles around them for each administration time during this period. It was also documented on the MAR Pain Scale: 0=None, 1-3=Mild, 4-5=Moderate, 6-7=Severe, 8-10=Very Severe. Each shift was documented as 0. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 04/18/24 at 3:40 PM, R24 stated the pain was at a 5 (which represents moderate pain) most of the time because R24's pain medication had not come in yet for a week. Every time I [R24] ask, they say it's coming tomorrow, or the doctor was called. But I [R24] haven't gotten it. They don't care about what happens. When asked if the staff rate her [R24's] pain or ask pain level, she states, No, they just tell me the same story, but nothing happens. I get Tylenol in the mornings sometimes, but that doesn't help. I [R24] broke my femur eight months ago and it still hurts. When asked R24's acceptable level of pain, R24 stated 3. At the end of the conversation resident stated, I [R24] sure hope it will come soon. During this interview, R24 kept rubbing the right thigh back and forth. R24 stated, This helps a little when it gets to hurting a lot. During an interview on 04/18/24 at 4:46 PM, LPN5 stated, R24 has been out of her pain medication [hydrocodone] since April the eleventh. I have been working here for three weeks and I have never been taught how to reorder medications. When asked if the physician has been notified about the pain medication not being administrated as ordered, LPN5 stated, I don't know if I have to notify the doctor. During an interview on 04/19/24 at 9:30 AM, R24 stated, I [R24] asked this morning, and they [nurse] told me again it [pain medication] hasn't come in yet. During an interview on 04/19/24 at 2:30 PM, the Interim Director of Nursing (IDON) stated, I have not been told that she [R24] was out of her [R24's] pain medicine. This is the first I have heard of this. We have emergency pharmacies that we could have used and got her pain medication here in no time at all. When asked the process in ordering of the medications, IDON stated, The nurses check all the medications on Wednesday to see if they need to order any of them before the weekend comes so they will have it. But if the nurse sees that the medication will be out sooner, then they are to reorder the medication at that time and not wait so they don't run out of medication to give to the resident.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 37283 Based on interviews, record review, and facility policy review, the facility failed to complete a performance review of nurse aides at least once every 12 months and provide regular in-service education based on the outcome of the review. The facility censure was 115. Findings included: Review of the facility's policy titled, Human Resources Management Policy and Procedures dated 07/01/03 revealed, Upon hire and prior to performing any functions of their position, each new employee will be oriented within the first 40 hours of employment, in accordance with the State and Federal regulations, as well as with company policy and procedure. Application: Employees. Procedure: A. All employees will receive general orientation. B. All new employees, volunteers and independent contractors shall be required to attend training in Hazardous Communications. C. General Orientation should begin immediately upon hire of all new employees and be completed within the first 40 hours of employment; general orientation for CNAs must be completed with the first 16 hours of employment. In no case should an employee perform job duties before orientation to the job. D. An employee who is hired to fill positions in more than one specialty (i.e., a housekeeper and a laundry aide) must receive full orientation in each of the specialties. E. The Orientation Checklist or other state required orientation checklists will be completed by the employee and trainer and will be filed in the employee's personnel folder. F. Listed below is a summary of topics and federal criterion that are required to be trained during the initial orientation and annually by Department of Labor (OHA) regulations and can be found in the Safety and Loss Control Manual: 1. Hazard Communications. 2. Access to Employee Exposure & Medical Records. 3. Fire Safety & Disaster Plans. 4. Fire Alarm Systems. 5. Fire Extinguishers. 6. Lockout/tagout. 7. Personal Protection Equipment. 8. General lifting or transferring training. 9. Aggressive Behavior Training. 10. Slips, Trips & Falls training. 11. Blood borne Pathogens/HBV training materials are included in the Infection Control Manual. Review of 52 Certified Nursing Assistant (CNA) personnel files revealed the facility failed to complete a performance review of all nurse aides at least once every 12 months and provide regular in-service education based on the outcome of the review. During an interview on 04/19/24 at 1:50 PM, the Executive Director stated she did not have the CNAs competency evaluations, and that she provided all the information that she had.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37283 Based on observations, record review, and staff interview, the facility failed to ensure prescribed medications were administered at the prescribed time and were available for administration for eight of 13 residents (Resident (R)95, R62, R24, R41, R54, R263, R17, and R48) in the medication administration observation. These failures caused 29 medication errors out of 59 opportunities for error, or a medication error rate of 49. 15%. The facility census was 115. Findings include: Review of the facility policy Medication Administration-General Guidelines dated 08/16, revealed . Medications are administered in accordance with written orders of attending physicians . All current medications and dosage schedules are listed on the resident's medication administration record .and administered timely according to facility policy . Medications are administered within the identified block of time per facility defined parameters. One hour before and one hour after the scheduled time, except for orders relating to before, after, and during meal orders, which are administered as ordered. Unless otherwise specified by the physician, routine medications are administered according to the established medication administration schedule for the facility . 1. Review of R95's Face Sheet, provided by the facility, revealed R95 was admitted on [DATE] with diagnoses including osteoarthritis and chronic pain. Review of the R95's physician's order, provided by the facility, dated 11/20/23, revealed an order for salonpas 4% [percent] flex patch, apply patch to lower back in the AM (morning), wear for 12 hours and remove. The administration time for this medication was 8:00 AM. During the Medication Administration observation on 04/18/24 at 7:56 AM, Licensed Practical Nurse (LPN) 6 administered the physician ordered medications to R95 except for the salonpas patch. LPN6 did not ask R95 if he wanted or did not want this patch. During an interview on 04/18/24 at 11:00 AM, LPN6 stated, I didn't ask R95 if he wanted this patch because he usually refuses it anyway. When asked if LPN6 should have asked R95 if he wanted this patch this morning, LPN6 confirmed he should have spoken to R95 about applying this patch as ordered by the physician. 2. Review of R62's Face Sheet, provided by the facility, revealed R62 was admitted to the facility on [DATE] with diagnoses including bipolar disorder and anxiety. Review of R62's Physician Order Sheet (POS), provided by the facility, dated April 2024, revealed an order for buspirone HCL 10 mg (milligram) by mouth three times a day at 7:00 AM, 1:00 PM, and 7:00 PM. During the Medication Administration observation on 04/18/24 at 8:21 AM, LPN6 administered the above documented physician ordered medication to R62. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/18/24 at 11:00 AM, LPN6 confirmed the medication should had been given to R62 at 7:00 AM. During an interview on 04/19/24 at 2:15 PM, the interim director of nursing (IDON) stated, The medication was given late if it was an hour after the time the medication was scheduled to be given. The IDON confirmed the medication was given late to R62. 3. Review of R24's Face Sheet, provided by the facility, revealed R24 was admitted to the facility on [DATE] with diagnoses including history of right femur fracture and rheumatoid arthritis. Review of R24's POS, provided by the facility, dated April 2024, revealed an order for hydrocodone-acetaminophen 5-325 mg by mouth twice a day at 8:00 AM and 8:00 PM. During the Medication Administration observation on 04/18/24 at 8:24 AM, LPN6 did not administer the above documented physician ordered medication to R24 due the medication not being present in the facility. LPN6 stated, R24's pain medication [hydrocodone] will come this evening or tomorrow. At 8:40 AM, R24 asked LPN6 if her pain medication was here yet and LPN6 stated, It should be here this evening. LPN6 did not assess R24's pain at this time nor offer R24 another alternative for pain. LPN6 continued to state, I haven't had time to reorder medications for three weeks. I have had to ask other nurses to help me with this. During an interview on 04/19/24 at 2:30 PM, IDON stated, . The nurses check all the medications on Wednesday to see if they need to order any of them before the weekend comes so they will have it. But if the nurse sees that the medication will be out sooner, then they are to reorder the medication at that time and not wait so they don't run out of medication to give to the resident. 4. Review of R41's Face Sheet, provided by the facility, revealed R41 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes mellitus, hypertension, major depressive disorder, and mixed hyperlipidemia. Review of R41's POS, provided by the facility, dated April 2024, revealed orders for Humalog 100 unit/ml (milliliter), give per sliding scale AC (before meals) 120-180=4U, 181-220=6U, 221-260=8U, 261-300=10U, 301-350=12U, 351-400=14U, 401=16U to be given, at 8:00 AM, 12:00 PM, and 6:00 PM. During the Medication Administration observation on 04/18/24 at 9:08 AM, LPN6 administered the physician ordered medications to R41 except for the Humalog insulin which was not given. LPN6 stated, I have to get the insulins done. I will have to ask the other nurse to help me get to them. LPN6 confirmed that no insulins had been given thus far this morning. 5. Review of R54's Face Sheet, provided by the facility, revealed R54 was readmitted to the facility on [DATE] with diagnosis including type 2 diabetes mellitus, fluid retention, hypokalemia, and hypertension. Review of R54's physician orders, provided by the facility, dated 09/22/23, revealed an order for Novolog 100 unit/ml, administer 12 units subcutaneously before meals. This medication was to be administered at 8:00 AM. The physician orders, dated for April 2024 on the POS revealed orders for Coreg 12.5 mg by mouth twice a day at 8:00 AM and 8:00 PM. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the Medication Administration observation on 04/18/24 at 9:25 AM, PN6 administered the physician ordered medications to R54. During an interview on 04/19/24 at 11:00 AM, LPN6 confirmed R54 received Novolog insulin and Coreg late and was not given within the hour before and the hour after the scheduled time for administration to R54. 6. Review of R263's Face Sheet, provided by the facility, revealed R263 was admitted to the facility on [DATE] with diagnoses including osteomyelitis, resistance to multiple antimycobacterial drugs, and spinal stenosis. Review of R263's POS, dated April 2024, revealed orders for Megestrol 20 mg by mouth daily at 8:00 AM, pantoprazole DR (delayed release) 40 mg by mouth twice daily at 9:00 AM and 5:00 PM, and oxycodone IR five mg by mouth twice a day at 8:00 AM and 8:00 PM. During the Medication Administration observation on 04/18/24 at 10:31 AM, LPN6 administered the above documented physician ordered medications to R263. During an interview on 04/18/24 at 11:00 AM, LPN6 confirmed the above documented medications were not given within the hour after the scheduled time the medications were ordered to be given. 7. Review of R17's Face Sheet, provided by the facility, revealed R17 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes mellitus, right above the knee amputation, and chronic pain. R17 was also admitted to hospice services on 08/15/23. Review of R17's POS, dated April 2024, revealed orders for Ativan, one mg by mouth at 6:00 AM and 2:00 PM daily, and MS Contin ER 15 mg by mouth twice a day at 8:00 AM and 8:00 PM. During the Medication Administration observation on 04/18/24 at 10:41 AM, LPN6 administered the above documented physician ordered medications to R17. During an interview on 04/18/24 at 11:00 AM, LPN6 confirmed these medications administered to R17 were not given at the physician ordered time. 8. Review of R48's Face Sheet, provided by the facility, revealed R48 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes mellitus, anemia, and hypertension. Review of R48's POS, dated April 2024, revealed orders for ferrous sulfate 325 mg by mouth daily at 8:00 AM, finasteride five mg by mouth daily at 8:00 AM, metformin 500 mg by mouth twice a day at 8:00 AM and 8:00 PM, amlodipine besylate 10 mg by mouth daily at 8:00 AM-hold if BP less than 100/60 or heart rate less than 60, hydralazine 50 mg by mouth three times a day at 8:00 AM, 12:00 PM and 4:00 PM-hold for SBP (systolic blood pressure) less than 100 or HR less than 60, and carvedilol 3.125 mg by mouth twice a day-hold for SBP less than 100 or heart rate less than 60, to be given at 8:00 AM and 8:00 PM. During the Medication Administration observation on 04/18/24 at 10:35 AM, LPN6 administered the above documented physician ordered medications to R48. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Riverside Nursing & Rehabilitation Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/18/24 at 11:00 AM, LPN6 confirmed these medications administered to R48 were not given at the physician ordered time. 9. During an interview on 04/19/24 at 2:15 PM, the IDON stated, The residents that have . medication ordered should be given at the time the doctor has ordered for the medication to be given.

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	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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. 37283 Based on observation, interview, review of facility policy, the facility failed to ensure all items in the freezer were sealed closed, shelving and clean equipment were kept free from dust, and that dietary staff performed hand hygiene. These failures had the potential to affect all residents in the facility who consumed food from the kitchen. The facility census was 115. Findings include: Review of the facility's policy titled, Sanitizing Equipment and Food Contact Surfaces, undated, revealed Employees shall sanitize equipment and food contact surfaces utilizing the proper sanitizing solution . During an observation on 04/15/24 at 9:26 AM, the following observations in the kitchen were made with and verified by the Dietary Manager (DM): 1. The freezer contained one bag of hamburgers that were open to air. 2. There were eight plastic containers ready for use that were dirty on the inside with dried food particles. 3. There were two metal shelving units with dust collected on them that contained kitchen equipment and pans that were ready for use. 4. Observation of the tray line on 04/17/24 at 7:33 AM, revealed the metal containers of food from the kitchen were loaded into a hot box. The hot box was unplugged by Dietary Cook (DC) with bare hands and taken through two hallways to the dining room that contained a small room with the steam table. DC plugged in the hot box to remain hot and the containers of food were then put into the steam table. All extra food stayed in the hot box. The serving room did not have a sink or a sanitizing bucket. Serving utensils were observed to fall into the food tray and the DC picked them up using his hands. The DC dropped his pen on the floor, picked it up, and continued to serve food. DC did not wash his hands until he returned to the main kitchen after meal service was completed. During an interview on 04/17/24 at 9:02 AM, DC stated, I never thought about washing my hands. I guess I did touch the utensils when they fell in the food and I did pick my pen up off of the floor. During an interview on 04/19/24 at 9:16 AM, the DM stated, My expectations are to stay within regulations, make sure the residents are happy with the food, and that we honor their preferences and keep a clean kitchen. During an interview on 04/19/24 at 9:24 AM, the Administrator stated, The kitchen employees need to sanitize and wash their hands when processing and handling food.

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F 0843 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have an agreement with at least one or more hospitals certified by Medicare or Medicaid to make sure residents can be moved quickly to the hospital when they need medical care. 37283 Based on record review and staff interview, the facility failed to ensure a written transfer agreement with a hospital was in effect to assure residents of timely hospital admission when medically appropriate and necessary information would be exchanged between providers. This failure had the potential to affect all residents. The facility censure was 115. Findings include: On 04/18/24, the written transfer agreement(s) with the community hospital(s) was requested from the Executive Director. No written transfer agreement was provided. During an interview on 04/19/24 at 12:34 PM, the Executive Director stated, We don't have a written transfer agreement . it's not a requirement in Missouri . The community just understands that the residents will go to the hospital and be treated; we don't need to have a written agreement. The Executive Director stated she was unaware of a Federal requirement for a written transfer agreement. During an interview on 04/19/25 at 2:03 PM, the Executive Director stated she had never seen a written transfer agreement at the facility since she had been working there only a few months and was not able to find one. She stated she would immediately begin the process of obtaining a written transfer agreement with the community hospital.

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NAME OF PROVIDER OR SUPPLIER Riverside Nursing & Rehabilitation Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 4700 NW Cliffview Drive Riverside, MO 64150	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 37283 Based on interviews, and policy review, the facility failed to implement and maintain their established infection prevention and control program (IPCP) for surveillance, tracking, trending, and administration of corrective actions to prevent and control the spread of identified infections in the facility for the entire population of residents. The facility census was 115. Findings include: Review of the facility policy for IPCP indicated a critical component titled Surveillance for Healthcare Associated Infections developed to calculate baseline rates, detect outbreaks, track progress, and to determine trends to help prevent the development or spread of infection of healthcare associated infections (HAI), that develop in a resident who is cared for in any setting where healthcare is delivered, according to the Centers for Disease Control (CDC)Guidelines for Isolation Precautions, found at https://www.cdc.gov, to prevent the transmission of infectious agents in healthcare settings. The facility policy and procedures included completing a monthly infection control surveillance log utilizing identifying information of the resident and location within the facility, the infection onset date or onset of symptoms, the date and outcome of diagnostic tests, infection site or origin, culture and identify of the pathogen, and the date the infection was resolved. The surveillance action to generate comparisons to change behaviors, identify environmental factors, identify clusters of infections, symptoms, pathogens, and risk factors to minimize the infection rate in the facility was not implemented. During an interview on 04/16/24 at 1:46 PM, the Infection Preventionist (IP) stated she completed the IP certification process on 10/20/23 and she has been in the position of IP for one month; she stated she did not know the name of the previous IP or when/if the facility employed an IP for the past several months. She stated she was aware of the lack of documentation for tracking and trending for the facility infection prevention and control program and she was trying to improve her process and documentation. She stated she was familiar with the IPCP standards and procedure goals for infection prevention and control for the facility but was not there yet. She stated her expectation for the facility IPCP program included recording incidents of infections identified under the facility's IPCP, surveillance, tracking and trending, and the corrective actions taken by the facility. During an interview on 04/16/24 at 1:55 PM, the Corporate Nurse reported she was aware of the lack of documentation for the facility's infection prevention and control program and that the ongoing goal was to improve the program towards compliance with IPCP regulations, policies, and procedures.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 37283 Based on interviews, record review, and policy review, the facility failed to implement and maintain their infection prevention and control (IPCP) program critical element to monitor and evaluate antibiotic use and to track measures of usage in the facility for their entire population of residents. The facility census was 115. Findings include: Review of the facility's policy titled, Antibiotic Stewardship Program, updated 10/01/22, revealed their guidelines for monitoring antibiotic use included utilizing and collecting reports that summarized antibiotic susceptibility patterns, antibiotic reviews for appropriateness of administration of antibiotics, establish standards for clinical monitoring for adverse drug events from antibiotic use, and utilizing microbiology culture data to assess and guide future antibiotic selection. During an interview on 04/16/24 at 1:46 PM, the Infection Preventionist (IP) stated she was familiar with the IPCP standards and procedure goals for the antibiotic stewardship program for the facility, but was not there yet. She stated she could not provide previous or current documentation for the facility's ongoing review for antibiotic stewardship. She stated her expectation for the facility antibiotic stewardship program included tracking antibiotic usage and the outcome of the administered antibiotics. During an interview on 04/16/24 at 1:55 PM, the Corporate Nurse reported she was aware of the lack of documentation for the facility's antibiotic stewardship program and the ongoing goal was to improve the program towards compliance with IPCP regulations, policies, and procedures.