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	10/15/2024

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 44395 Based on observation, interview and record review, the facility failed to ensure residents were cared for in a dignified way when staff tugged on a residents shirt, ignoring the residents repeated requests for them to stop. Furthermore, staff treated the resident disrespectfully by yelling at the resident when the resident attempted to self propel his/her wheelchair up and down the halls of a secured care unit. This affected one of 21 sampled residents (Resident #85). The facility census was 103 Review of the facility provided Resident [NAME] of Rights dated 01/2023 showed: -Each resident has a right to a dignified existence, in a manner and in an environment that promotes maintenance or enhancement of his/her quality of life -The right to self determination, which the facility must promote and facilitate through support of resident choices about aspects of of his/her life in the facility. Including but not limited to activities, health care schedules and how he/she spends time. -The right to be free of abuse, neglect, exploitation, misappropriation Review of Resident #85's Quarterly Minimum Data Set (MDS: a federally mandated assessment tool completed by facility staff) dated 9/16/24 showed: -Brief Interview of Mental Status (BIMS) of 3, indicated significant cognitive impairment; -Makes himself/herself understood and was able to understand; -No behaviors; -Partial to moderate assist of staff for Activities of Daily Living (ADL's: tasks completed in a day to care for oneself); (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses of Dementia (a decline in mental abilities that affects a person's ability to perform daily activities and worsens over time) , Generalized anxiety disorder (a mental health condition that causes people to experience excessive and persistent worry about everyday things), Cerebral Infarction (Stroke: occurs when blood flow to part of the brain is stopped, causing injury), Hypertension(high blood pressure); -The resident resided on the locked special care unit (SCU). Review of the resident's undated Comprehensive Care Plan showed: -He/She needed assistance with ADL's due to dementia. Give verbal cues and break tasks into small steps. -He/She had dementia and anxiety. Encourage him/her to socialize with others. Provide a structured environment. Observations on 10/07/24 at 11:33 A.M. showed the resident was sitting in the hallway at the nurses station, he/she wore a red sweatshirt of a local sports team. At 11:39 A.M. Certified Nurse Aide (CNA) A grabbed hold of the resident's shirt at the front, lower 1/3. The CNA fisted the shirt, shaking it back and forth and told the resident he/she could not mess up the shirt that day. The resident said quit. CNA A continued to shake the shirt and the resident again said quit. CNA A continued to shake the residents shirt, said the resident could not mess up the shirt. The resident again said quit, swatted his/her hand at the CNA's hand and brushed the CNA's hand away. The CNA released the shirt, waved his/her hand away from the resident, replied well okay then and walked away. The resident remained sitting at the nurses station. At 12:16 P.M. the resident used his/her feet to propel up the hallway in his/her wheelchair (w/c). Licensed Practical Nurse (LPN) A yelled out at Resident #85; come back here, come back. The resident replied he/she did not need to come back, he/she hated just sitting there and there was nothing to do. The resident wheeled back to the nurses station. At 12:20 P.M. The resident was wheeling down the hall near the mailbox. LPN A yelled out, from the nurses station, calling the resident by name and said turn around now. The resident returned to the nurses station, asked LPN A if he/she called the resident. LPN A said no, he/she told the resident to come back because the resident didn't need to go that far. The resident replied that LPN A was ridiculous. At 12:41 P.M. the resident was in the dining room. A door alarm sounded. LPN A said to The resident, he/she needed to stay in the dining room because every time a door alarm went off LPN A thought it was The resident. The resident replied he/she did not do it. At 12:49 P.M. The resident was wheeling near the recreation room. LPN A yelled from the nurses station hallway for the resident to come back toward the nurses station and that he/she did not need to be down there. At 12:51 P.M. the resident was in the dining room and said it was loud and he/she did not want to be there. Staff did not assist the resident out of the dining room. During an interview on 10/7/24 at 12:51 P.M. LPN A said: -The resident will set off the secure door alarms if he/she travels too far up or down the hall; -He/She tried to keep all the residents in the middle of the hall and dining room areas instead of them going up and down the hall; -The residents are on a locked unit for their safety. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/7/24 at 11:42 A.M. CNA said: -He/She was playing with the resident when he/she grabbed and shook the resident's shirt; -He/She did not stop because he/she was just playing. During an interview on 10/10/24 at 6:25 P.M. with the Director of Nursing (DON) and the Administrator said: -The DON said she would not like her shirt to be shook. Someone shaking a resident's shirt and being asked to quit was absolutely a dignity issue. The purpose of the SCU was for resident's to receive specialized care to support their diagnosis. The residents might walk up and down the hall, and she would not expect staff to tell any resident to come back and stay there. She would expect staff to allow the resident to go anywhere on the unit as long as it was safe. -The Administrator said he agreed with the DON.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. 47195 Based on observation, interview, and record review, the facility failed to provide acceptable accommodations for one non English speaking resident (Resident #104) and failed to provide one resident appropriate seating for meal times when his/her chair put his/her at face at table height (Resident # 26). This affected two of 21 sampled residents. The facility census was 103. Facility did not provide a policy on accommodation of needs. Review of Resident [NAME] of Rights, revised 1/23, showed: -Each resident had a right to dignified existence, self-determination, and communication with and access to persons and services and outside the facility in a manner and in an environment that promotes maintenance or enhancement of (his or her) quality of life, regardless of diagnosis, severity of condition. -Informed in a language he/she can understand of his/her total health status, including but not limited to, his/her medical condition. -Reside and receive services in the facility with reasonable accommodation of residents needs and preferences except when to do so would endanger the health or safety of the resident or other residents. -Communicate with individuals and entities within and external to the facility. 1. Review of Resident #104's minimum data set (MDS), a federally mandated assessment tool completed by facility staff, dated 9/25/24, showed: -His/Her cognitive status was not measurable; -His/Her preferred language was Spanish; -He/She had no impairment to upper or lower extremities; -H/She was dependent on wheelchair; -He/She required substantial/maximal assistance with eating, oral hygiene; -He/She was dependent with toileting hygiene, bathing, dressing, mobility ; -Diagnoses included Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), Parkinson's Disease (a disorder of central nervous system that can cause symptoms of low movement, stiffness, and loss of balance) , repeated falls, headaches, and ototoxic hearing loss (inner ear damage that develops as a side effect of taking certain medications). Review of care plan, undated, showed: (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident was Spanish speaking and staff were able to communicate with him/her through Google translate; -He/She enjoyed listening to music such as traditional Spanish music; -Offer picture communication book to allow resident a chance to point at what he/she needs; -Provide an activity calendar in his/her room; -Offer picture/word communication board to the resident to show signs for snacks and fluids to alert resident to know what is happening; -Offer cueing for toilet, pain, nurse with pictures due to lack of communication due to Spanish speaking only; -He/She had difficulty hearing due to hearing loss; -Staff should speak in low, clear voice to increase resident's chance of hearing; -He/She can understood simple direct communication; -Resident hears better in right ear. Review of daily care guide, dated 10/8/24, showed: -He/She spoke Spanish; -Keep communication board pages with pictures in English and Spanish at his/her side in the wheelchair when he/she was up so staff can assist with his/her needs. Review of electronic medical record showed: -On 9/26/24, Physical Therapist A documented a physical therapy evaluation was completed after family requested physical therapy screen, and physical therapy was not recommended. The resident was at baseline function and did not progress with therapy due to language barrier and refusing to perform tasks in therapy. During an interview on 10/8/24 at 10:51 A.M., family representative Interview said: -Resident spoke Spanish and did not understand English; -He/She had translated short cues for therapy department with cues such as stand up and walk; -Resident understood short cues; -Facility staff mostly communicated with resident in English; -Family member went to facility daily to provide cares and showers to resident; (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident was the only Spanish speaking resident on the hall; -The facility staff did not make any accommodations for his/her language barriers. Observation on 10/7/24 at 10:07 A.M., showed resident was placed in alcove across from nurses station. Resident spoke Spanish to self. He/She was observed staring at the wall and pulling on his/her pants. He/She did not have a communication board with him/her in his/her wheelchair. Resident had no engagement items or Spanish music playing. Observation on 10/7/24 at 10:17 A.M. showed Licensed Practical Nurse (LPN) G obtained resident's foot pedals for wheelchair and applied to his/her wheelchair. LPN G talked to resident in English. Observation on 10/7/24 at 10:18 A.M. showed resident's room did not have any Spanish items. No activity calendar posted in room. Communication board observed in English was laying on a table in the resident's room. Observation on 10/7/24 at 2:35 P.M. showed resident was sat across from nurses station in an alcove. Resident was observed playing with his/her shirt. Resident did not have communication board with him. He/She had no engagement, no entertainment, and nothing in his/her hands. During continuous observation on 10/9/24 at 7:18 A.M.-9:04 A.M., showed resident was sat in alcove across from nurses station. He/She had no entertainment, no communication board, and no items in his/her hand. Observation on 10/9/24 at 9:11 A.M. showed Activity Director stopped and spoke to resident in English stating 'Papa are you okay?'. The staff member did not use a communication board, translator application or Spanish phrases when he/she interacted with the resident. Observation on 10/9/24 at 1:01 P.M. showed staff placed resident in alcove across from the nurses station with no communication board and no engagement activity. Observation on 10/9/24 at 1:12 P.M., showed Activity Director inquired with Shower Aide if resident has been provided incontinent care. Staff stated he/she did not know. Activity Director then said to resident in English 'come on, let's go'. The resident did not respond to the staff member and had blank stare. The staff member took the resident to his/her room. During a continuous observation on 10/9/24 from 6:55 P.M.-8:33 P.M. of B hall showed: -6:55 P.M. Facility staff wheeled the resident in his/her wheel chair to the alcove at the nurses station; - He/She tried to stand up; -7:02 P.M., Resident was speaking in Spanish and talking loudly, Certified Nurse Aide (CNA) E and CNA F talked to the resident in English and sat the resident back down in his/her wheelchair. Resident continued to talk loudly in Spanish. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-7:10 P.M., resident was sitting in the alcove across from nurses station attempting to stand up. CNA G went to the resident and said to him/her in English 'Come on Poppy, let's go'. Resident did not have his/her communication board. -8:09 P.M., showed resident was back in the alcove across from nurses station. Resident was speaking in Spanish and showing signs of agitation when he/she began to raise the tone of his voice and started speaking more rapidly. Registered Nurse (RN) A went to resident and asked resident in English if he/she wanted to go to bed. He/She then asked resident in English if resident wanted water. The resident had a blank stare and looked from staff to staff member back and forth. Resident did not have his/her communication board. Observation on 10/10/24 at 1:42 P.M. showed resident was in the dining room alone and attempted to stand up. The resident was chanting loudly in Spanish in front of the television. Television was on playing the news in English. During an interview on 10/8/24 at 11:27 A.M., Therapy Director said: -He/She had screened resident for therapy and determined resident was unsafe; -His/Her family had requested therapy multiple times but resident was too impulsive. During an interview on 10/9/24 at 1:22 P.M., LPN G said: -He/She used Google translate to communicate with resident; -Resident's family always came in evening if they needed help communicating with resident; -Resident had been talking a lot in Spanish; -Resident could not participate in activities, but Activities Director will take him/her to activities if there was music. During an interview on 10/9/24 at 1:45 P.M., CNA J said: -He/She found it hard to communicate with resident; -He/She told resident what he/she was doing in English; -He/She did not know Spanish; -Resident's family was in facility a lot and they helped communicate with resident; -He/She was not aware of a communication board; -When family is in facility they can get resident to relax and do more; -Resident was provided fidget toys for activities and taken on walks around building; (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident was sat at nurses station due to fall risk. During an interview on 10/9/24 at 7:14 P.M., RN A said: -It was his/her first time working on B-hall and his/her second day working in the facility building; -He/She was agency staff. During an interview on 10/9/24 at 8:13 P.M., CNA E said: -He/She had not been education about resident's communication board; -He/She did not know how to use Google translate; -He/She wanted to know how to communicate with resident; -He/She did not speak Spanish. During an interview on 10/9/24 at 8:15 P.M., CNA F said: -No staff members spoke Spanish that worked with resident; -He/She did not know resident had communication board; -He/She had not been taught how to communicate with resident. During an interview on 10/9/24 at 8:23 P.M., CNA G said: -He/She had not used resident's communication board to communicate with the resident; -He/She tried to communicate with resident in short phrases in Spanish; -He/She had tried using Google translate on his/her phone but it did not work with him/her. During an interview on 10/10/24 at 8:16 A.M., LPN G said: -He/She did comprehend some of what his/her family communicated to him/her in Spanish; -He/She had used Google translate with resident and Google translate only picked up one sensible thing from resident when he/she told him/her that he/she liked the music that LPN G had played. During an interview on 10/10/24 at 4:15 P.M., Activity Director said: -Resident did not appear he/she was interested in any activities; -He/She had not done activities for resident in Spanish; (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She had not spoken to resident's families to find out resident's history of activities that brought him/her joy; -Resident would act out by raising his voice and yelling, would try to get up out if his/her chair; -Resident should have a Spanish activity calendar in his/her room. During an interview on 10/10/24 at 6:25 P.M., Director of Nursing said: -He/She expected staff to communicate with resident who didn't have English as their primary language by using a communication board or translation device; -He/She expected staff to be educated on how to use communication boards or communication devices; -He/She would expect communication board to be in resident's primary language; -He/She expected activities or entertainment to be offered in resident's primary language. During an interview on 10/10/24 at 6:56 P.M., Administrator said: -He/She would expect some sort of accommodation for staff to be able to communicate with resident who did not speak with English as primarily language; -He/She expected staff working with resident to be educated on those accommodations and how to use them. During an interview on 10/16/24 at 10:41 A.M., Physical Therapist A said: -He/She completed the resident's initial physical therapy screening assessment when the resident was admitted to the facility; - The resident's family requested a second assessment that he/she completed on 9/26/24; -He/She set up therapy times so family could be present during therapy sessions; -Language was a barrier even when family was present; -Resident did respond to some prompts provided by family members during therapy sessions; -He/She did not know if the facility had a way to communicate with the resident outside of utilizing family members; -Therapy department had family write down sayings like larger steps, higher steps to utilize with resident in Spanish; -Therapy department staff had a really difficult time getting resident to progress even with family present providing prompts in Spanish. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	44395 2. Review of Resident #26's Quarterly MDS completed 8/9/24 showed: -BIMS of 4, indicated significant cognitive loss; -Substantial to maximum assistance of staff with Activities of Daily Living (ADL's: tasks completed in a day to care for oneself); -He/She is dependent on a wheelchair for mobility; -Height of 62 inches (in); -Diagnoses of osteoporosis (a disease that weakens bones), Dementia (a brain disease that causes loss of function such as thinking,remembering and reasoning that interferes with daily life), Ischemic Cerebral Infarction (damage to the brain from blocked blood flow). Review of the resident's comprehensive Care Plan showed no care plan for use of a wheelchair. Review of the resident's electronic medical record showed: -April 2024 the resident was seen by Skilled Therapy services for self feeding skills due to mobility and self propelling the w/c. -May 2024 the resident was seen by Skilled Therapy services for sitting balance and functional mobility. Observation on 10/07/24 at 11:05 A.M. showed the resident sitting in his/her w/c, slightly bent forward with a c shaped curve to his/her upper body. He/She was looking at a game card lying on the family style dining room table. His/Her w/c was very low to the ground. The table was at mid chest/breast height of the resident. The resident remained at the table for the noon meal. At 1:11 P.M. his/her meal was served . He/She attempted to raise his/her right hand from under the table, and picked up his/her fork from the table. He/She dropped the fork on the floor. He/She then began eating with his/her fingers. He/She did not complete his/her meal and staff removed the resident from the room. Observation on 10/08/24 at 6:41 AM the resident was sitting at the same dining room table. He/She had his/her head laid face down on the table. At 7:04 A.M. Certified Nurse Aide (CNA) H assisted the resident out of the dining room. During an interview on 10/8/24 at 6:45 A.M. CNA H said: -The wheelchair belongs to the resident. During an interview on 10/08/24 at 11:33 AM the Therapy Program Director said: -Skilled Therapy should measure each resident individually for wheelchairs; (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-She made recommendations for this resident to sit at an over bed table to eat, since he/she cannot reach the dining table; -She expects nurses to notify therapy if a wheelchair does not fit the resident, or if the resident has a problem with a chair, such as sitting chest height to a table. During an interview on 10/10/24 at 6:25 PM the Director of Nursing said: -He/She would expect staff to look into other options for a resident that sits chest height to the table; -She would expect Dietary and Skilled Therapy to be involved in care of Resident #26; -She was not aware that resident #26 sat at chest height to the dining room table.

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 46706 Based on interview and record review, the facility failed to provide the Notice of Medicare Non-Coverage (NOMNC) form CMS - 10123, to Medicare beneficiaries at least two days before the end of a Medicare covered Part A stay. This affected two out of 21 sampled residents (Resident #1 and #93). The facility census was 103. The facility did not provide the requested policy for Notice of Medicare Non-Coverage (NOMNC) form CMS - 10123. CMS Guidlines: Form CMS-10123, is given by the facility to all Medicare beneficiaries at least two days before the end of a Medicare covered Part A stay or when all of Part B therapies are ending. The NOMNC informs the beneficiaries of the right to an expedited review by a Quality Improvement Organization. 1. Review of Resident #1's medical record showed: -The resident had a Notice of Medicare Non-Coverage (NOMNC) issued that showed Medicare Part A benefits were ending on 8/20/24; -The NOMNC was signed by the resident on 8/20/24; -The resident's record showed the facilty failed to ensure the resident received the NOMNC at least at least two days before the end of a Medicare covered Part A stay. 2. Review of Resident #93's medical record showed: - The resident had a NOMNC issued that showed Medicare Part A benefits were ending on 9/3/24; -The NOMNC was signed by the resident on 9/3/24; -The resident's record showed the facilty failed to ensure the resident received the NOMNC at least at least two days before the end of a Medicare covered Part A stay. During an interview 10/10/24 at 4:40 P.M. the Business Office Manager said: -He/she was unaware the residents #1 and #93 did not receive the NOMNC at least two days before the end of their Medicare covered part A stay; -Residents should receive the NOMNC at least two days prior to the end of a Medicare covered Part A stay. During an interview on 10/10/24 at 06:56 P.M., the Administrator said: (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She could not recall the time frame for when the NOMNC form should be given to residents coming off of Medicare A; -He/She did not know who was responsible for providing the NOMNC form to the residents; -The NOMNC should not be given on the resident's last covered day.

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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** 44395 Based on observation and interview, the facility failed to ensure noise levels were at an acceptable level for two sampled residents (Resident #35 and #77). Additionally the facility failed to ensure housekeeping and maintenance services were provided to maintain a sanitary, orderly and comfortable interior throughout the facility. and failed to provide an adequate supply of linens. The facility census was 103. Review of the facility provided policy Resident [NAME] of Rights dated 1/2023 showed: -The facility residents have a right to a safe, clean, comfortable and homelike environment. Review of the facility provided policy Housekeeping Cleaning Procedures dated 6/2018 showed: -Spot clean walls/ damp wipe vertical surfaces/counters/ledges/sills; -Wipe walls weekly. Review of the facility provided policy Floor Care Cleaning Procedures dated 6/2018 showed: -Dust mop floor-remove gum, etc. with a putty knife; -Scrub edges with utility pad holder and/or scraper. The facility did not provide a policy on sound levels. 1. Review of Resident #35 Quarterly Minimum Data Set (MDS: a federally mandated assessment tool completed by facility staff) dated 7/11/24 showed: -Brief Interview of Mental Status of 99, indicated significant cognitive loss; -Adequate hearing; -Able to understand others and make himself/herself understood; -Dependent on staff for Activities of Daily Living (ADL's: tasks completed in a day to care for oneself); -Used a wheelchair for mobility; -Diagnoses of Anxiety disorder (a mental illness that causes a person to experience excessive and uncontrollable feelings of fear and anxiousness), Depression (a serious mental illness that can affect a person's thoughts, feelings, behavior, and sense of well-being), Mood disorder (a mental health condition that primarily effects your mental state), Alzheimer's Dementia (a disorder of the brain that gradually destroys thinking, memory and eventually the ability to complete daily tasks). (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 10/07/24 beginning at 11:05 A.M. showed the Special Care Unit (SCU) dining room/sitting room patio door was propped open with a brick and potted plant. The door alarm was beeping. Certified Nurse Aide (CNA) A said the door was alarming because the it was open and residents were at the dining table near the door. Resident #35 was sitting at the table with one side of his/her body positioned toward the door and the alarm. He/She had her hand up over his/her ear closest to the alarm. At 12:45 P.M. CNA A assisted the resident from the table down the hall. At 1:06 P.M. Resident #35 returned to the table. The door alarm continued to sound. The resident put his/her hand back over his/her ear. He/She had a distressed look with furrowed brow, on his/her face. 2. Observations beginning on 10/08/24 at 7:58 A.M. on the SCU showed: -Nursery room: the carpet was stained with grey dusty color debris, light fixtures had dead bugs and debris and baseboards had gray/black debris at floor edge; -room [ROOM NUMBER]: the entry door had scratches and large paint chips exposing the wood underneath, and drug against the floor when opening/closing. The bathroom floor grout was gray/black in color. The bathroom door had large chips and gouges in the paint. The room sink baseboard was chipped; -room [ROOM NUMBER] had a sticky floor, the entry door had gouges and chips in the paint, and there was dirt and rust on a ceiling access panel; -room [ROOM NUMBER] entry door had paint chips that exposed the wood underneath. The bathroom had non skid strips in front of the toilet that were peeled up and partially away from the tile. The bathroom grout was gray/black in color; -room [ROOM NUMBER] the baseboard was peeling away from the wall. The bathroom grout was gray/black in color. The bathroom door has chipped/scratched paint; -room [ROOM NUMBER] the privacy curtain had brown colored debris approximately 6 inches long on the front side; - room [ROOM NUMBER] the entry door had multiple paint chips exposing the wood underneath; -Dining/Sitting Room the baseboard had thick black gray crusty debris at the edge of the floor. There were multiple stained/scuffed floor tiles. The walls had multiple scuff marks. The ceiling light fixtures had dead bugs and debris. The door jam had scuffs and chips in the paint. The area rug had dust, debris and gray/brown stains. There were missing tile under the Packaged Terminal Air Conditioner (PTAC a type of self-contained heating and air conditioning system).The baseboard near the PTAC unit was peeling away from wall. The radio and radio stand had a layer of gray dust. There were pearl like beads on floor at edge of the wall. The windowsills had thick brown dust and debris. The chair rail mounted on the wall had a layer of dust at the top edge. The window blinds had dust and debris. The PTAC unit had black mold like substance in the vent, on the filter and the filter cover. An over bed table had laminate peeling off, with exposed pressboard; -room [ROOM NUMBER] had a large wall patch, unpainted. A large scuffed area at the door entrance. The baseboard was peeling away from the closet wall. The tile at the base of closet was cracked. The bathroom door had large scuffed areas with cracked laminate, exposing the wood underneath. The floor was sticky. The bathroom grout was gray/black in color; (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-room [ROOM NUMBER] the floor was sticky. The baseboard was peeling away from the wall and had crusty debris at the top of the board and wall. The PTAC had black mold like debris in the vent; -room [ROOM NUMBER] had dust and debris in the vent of the PTAC unit. There were two pencil sized holes in the bathroom door. The room entry door had scuffs and scratches in the paint. The baseboards had thick black/gray debris at the floor edge. 3. Observation on 10/09/24 at 8:16 P.M. showed the resident telephone room door had chipped finish exposing the wood underneath. There were multiple scuffs and gouges in the door. The floor was stained with brown/gray color. The baseboard was grimy with dust and dirt. There was dark crusty debris at the entry door threshold. During an interview on 10/10/24 at 4:13 PM Housekeeper A said: -There are floor technicians who are responsible for the hallways and general areas; -Housekeeping staff are responsible for cleaning the resident rooms, bathrooms and shower rooms; -Maintenance staff cleaned the lights, and completes high dusting in the hallways, such as the door corners; -Maintenance is responsible for patching and painting. During an interview on 10/10/24 at 4:42 P.M. the Maintenance Director said: -He worked in this facility for two years; -He was supervising the housekeeping department, but usually that department has their own supervisor; -The floor technicians are responsible for floor care, to include scraping debris off the floor, cleaning behind the doors and cleaning and/or scraping the baseboard edges; -Floors are stripped and waxed as resident rooms open up. General hallways and floors are done at night on a three week schedule; -Housekeeping staff are responsible for cleaning, and that included cleaning dead bugs and debris from the light fixtures; -Maintenance staff are responsible for upkeep of the building and repairs only; -PTAC units get cleaned twice a year; -Staff can fill out work orders for things that need repaired; -He did not have a list of repairs that need completed. During an interview on 10/10/24 at 6:25 P.M., the Director of Nursing (DON) said: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-She expected the building to be clean, and residents to be comfortable. 31102 4. Review of Resident #77's Quarterly Minimum Data Set (MDS), completed by facility staff and dated 8/9/24, showed: - Cognitive skills intact; - Independent with transfers; - Diagnoses included anxiety and depression. Review of the resident care plan, dated 4/4/2022, showed:- The resident had an alteration in sleep pattern related to insomnia (persistent problems falling and staying asleep); administer medications as ordered by the physician; observe for changes in sleep pattern inability to fall/stay asleep; provide a quiet restful environment. During an interview on 10/7/24 at 3:17 P.M., the resident said;- The staff take the smoking cart outside and roll it past his/her door and it is very loud; - There is something broken on it and it makes a loud clunking sound; - The smoking cart has been broken for over a month; - He/she has trouble sleeping at night and it has woken him/her up before. Observation on 10/8/24 at 7:14 A.M., showed: - Staff pushing the smoking cart down the hallway to the exit for the smoke break; - The front wheel looked like it was broken and it was made a very loud clunking sound. Observation on 10/8/24 at 10:05 A.M., showed:- Staff pushed the smoking cart down the end of the hall for the smoke break; - The smoking cart made a very loud clunking sound all the way down the hall. During an interview on 10/9/24 at 7:03 P.M., Licensed Practical Nurse (LPN) D said: - If something was broken he/she would call Maintenance and let them know and he/she would pass it on in report; - He/she was not for sure how long the smoking cart had been broken. During an observation and interview on 10/9/24 at 7:15 P.M., showed: - Staff brought the smoking cart back inside and it made a terribly loud clunking sound; (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Certified Nurse Aide (CNA) C said he/she has worked at the facility for a month. The smoking cart was really loud and had been like that since he/she has worked there. He/she had not reported it but you could hear the staff coming with it. Observation on 10/10/24 at 9:55 A.M., showed: - The surveyor was inside resident #77's room with the door closed and you could hear staff pushing the smoking cart past the room and it made a very loud clunking sound as it went past. During an interview on 10/10/24 at 10:07 A.M., LPN C said: - If something needs to be fixed or repaired, he/she writes up a departmental slip and places it in the maintenance box up front in the copy room; - He/she also reported it to the unit manager; - If it was not repaired, he/she would stay on it until it and follow up. During an interview on 10/10/24 at 4:42 P.M., the Maintenance Director said:- He/she used a notepad and wrote down things of high attention and would take care of those first; - He/she was aware of the wheel on the smoking cart being broken; - He/she ordered the replacement wheel this week. During an interview on 10/10/24 at 6:25 P.M., the Director of Nursing (DON) said: - Staff should report broken equipment; - Staff should notify the unit manager; - She was not aware of the wheel on the smoking cart being broken. 47195 5. Observation on 10/07/24 at 12:01 P.M. showed dining room had area above the television had been dry wall patched and sanded but not painted. A second area had not been painted where the wall was patched and sanded where the television previously hung. 6. Observation of B-wing hall on 10/7/24 at 10:29 A.M., showed: -room [ROOM NUMBER] had dry wall patches above the bed that had not been painted; -In the hallway between room [ROOM NUMBER] and 45 there was two 1 inch holes in the wall and paint was missing; -room [ROOM NUMBER] had gouges to the wall where drywall and paint had been scraped away by furniture; (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-room [ROOM NUMBER] had a broken outlet cover in the middle of the room. 7. Observation on 10/9/24 at 8:39 A.M. showed floor technician using floor machine on B-hall. The machine was making a loud squealing noise. During an interview on 10/10/24 at 4:43 P.M., Maintenance Director said: -He/She was responsible for facility repairs and upkeep; -He/She became aware of items requiring repair via the facility system; -He/She checked computer every morning for work orders; -Staff notify him also via cell phone of facility repairs needed; -The floor machine just started squeaking noise due to a rubber seal; -The walls in dining room were just patched; -Once drywall is patched it, he allowed it to sit for two to three days to allow the mud to dry; -He/She then should sand and paint the drywall patches;

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46706 Based on observation, interview and record review, the facility failed to ensure residents were free from physical restraints when the facility failed to obtain a physician's order, assess, monitor or care plan the use of a seat belt (a belt or strap used to secure a person to prevent injury) for one resident (Resident #11) and when the facility staff failed to unlock the wheels of a wheelchair for one resident (Resident #84) after the resident was observed pushing against the table with his/her hands, pushing back into the back of the wheelchair and yelling out repeatedly, He/She didn't want it. The facility census was 103. Review of the facility's Restraint Evaluation and Reduction policy, dated December 2023, showed in part: -All residents have the right to be free from restraints; -Physical restraints are identified as any manual method or physical devise attached to the resident's body that they cannot remove easily and restricts freedom of movement; -The following devices are considered a restraint and require an evaluation: o Seat belts; o Chairs; o Side rails; -A physician's order will be entered in the resident's record; -The resident's care plan will be updated. Review of the Missouri Resident [NAME] of Rights, provided through the state long term are ombudsman (a person who represents the interests of residents) program included Residents have the right to be treated with consideration, respect, and dignity, recognizing each resident' s individuality. 1. Review of Resident #11's, Quarterly Minimum Data Set (MDS, a federally mandated assessment tool completed by facility staff), dated 9/18/24, showed: -Severe cognitive impairment; -Dependent on staff for all ADL's, including mobility; -Always incontinent of bowel and bladder; -At risk for skin breakdown; (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident did not require the use of restraints; -Diagnoses included: Cerebral Palsy (a disorder that affects a person's ability to move, balance, and maintain posture), Quadriplegia (paralysis that affects all a person's limbs), and a seizure disorder. Review of the resident's care plan, revised 3/11/24, showed: -The resident requires ADL and mobility assistance; -The resident is at risk for skin breakdown; -The resident is at risk for injury from seizure activity; -The care plan did not address the use of a seat belt. Review of the resident's Physicians Order Sheet (POS) dated October 2024, showed: -No order for a seat belt was found. Review of the resident's record showed: -No evaluation for the use of the seatbelt was found; -Therapy notes dated 3/14/24 through 5/12/14 did not address the use of a seat belt and showed no assessment for the use of the seat belt. Observation on 10/10/24, at 10:35 A.M., showed: -The resident's hands were contracted; -The resident sitting in his/her power chair in the hall; -The resident had a seat belt fastened across his/her lap; -The resident attempted to use his/her right elbow to release the seat belt; -The resident could not release the seat belt. Observation on 10/10/24, at 10:48 A.M., showed: -The resident's hands were contracted; -The resident sitting in the hall in his/her power chair; -The resident had a seat belt fastened across his/her lap; -The resident pushed his/her arm to the waist but did not unlock the seat belt; (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident tried again to unlock the seat belt; -The resident could not release the seat belt. During an interview on 10/10/24 at 11:05 A.M., Certified Nurse Aide (CNA) K said: -The resident was dependent on staff for care; -He/She did not notice the resident used a seat belt; -He/she did not know if the resident could release the seatbelt on his/her own or not; -Residents should not have a seat belt if they cannot release it themselves. During an interview on 10/10/24 at 11:12 A.M., CNA N said: -He/she did not know the resident that well; -He/she did not know if the resident could release the seat belt without help; -Residents using belts should be able to unlock them with no help from staff. Observation and interview on 10/10/24 at 11:15 A.M., showed: - Licensed Practical Nurse (LPN) E said the resident can unlock the belt with his/her elbow by him/herself; -LPN E asked the resident to unlock the seat belt; -The resident could not unlock the seat belt; -LPN E said the resident should be able to unlock the seat belt with no help from staff. During an interview on 10/10/24 at 11:27 A.M., the Director of Therapy said: -He/she did not remember doing an assessment for a seat belt for the resident; -The resident's care plan should reflect they are using a seat belt; -The resident should have an assessment prior to getting the seat belt; -The resident must be able to release the seat belt with no help from staff. During an interview on 10/10/24 at 11:38 A.M., the [NAME] President of Operations said: -The resident's seat belt should have been discontinued; -The seat belt was not supposed to be in use; (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A physicians order is needed to evaluate for a seat belt and to have one; -In this case the seat belt was discontinued and should have been removed. During an interview on 10/10/24 at 06:25 P.M., the Director of Nursing (DON) said: -A physicians order is needed for a seat belt; -The resident should be evaluated for use of a seat belt; -The seat belt should be care planned; -In this case the seat belt was discontinued and should have been removed. During an interview on 10/10/24 at 06:25 P.M., the Administrator concurred with the DON's statements regarding the use of a seat belt for any resident. 44395 2. Review of Resident #84's MDS dated [DATE] showed: -BIMS score of 3, indicated significant cognitive loss; -No behaviors; -Dependent on staff for ADL's; -Uses wheelchair (w/c) for mobility; -Diagnoses of Anxiety Disorder (a feeling for fear, dread and uneasiness that can effect daily life), depression (a serious mental illness that can affect a person's thoughts, feelings, behavior, and sense of well-being), muscle weakness, dementia (a chronic condition that causes a loss of brain function, such as thinking, remembering, and reasoning, that interferes with daily life), chronic pain (long term pain) , Adult Failure to Thrive (a syndrome that describes a general decline in health that can affect older adults), and falls. Review of the resident's undated comprehensive Care Plan showed: -The resident resided on the locked Special Care Unit (SCU); -Redirect and reassure the resident as needed; -No care plan addressed the use of locked wheelchair brakes. Observation on 10/07/24 at 11:49 A.M. showed: -Resident #84 was sitting at the dining room table on the SCU; (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The wheels of his/her wheelchair were locked; -The resident was pushing his/her back into the back of the wheelchair, rocking the wheelchair slightly; -The resident was crying out 'we can't', repeatedly. Observation on 10/07/24 at 12:36 P.M. showed: -Resident #84 was sitting in his/her w/c with his/her back to the dining room table; -He/She was squirming his/her buttocks in the w/c, then lifted his/her buttocks off the w/c seat; -He/She complained of back pain; -LPN A unlocked the resident's wheels, turned the chair to face the dining table, and locked both w/c brakes; -The resident yelled out 'hey, hey, hey', while pushing back against the w/c. Then he/she began alternately patting and rubbing the table, yelling out 'hey' then mumbling. Observation on 10/07/24 at 1:09 P.M. the Activity Assistant unlocked the resident's wheelchair brakes and assisted the resident into the hall. Observation on 10/08/24 at 7:22 A.M. showed: -CNA H brought the resident to the dining room table and locked the right side wheelchair brake; -The resident began tapping and banging on the table. The resident said he/she 'didn't want it', repetitively; -The resident was pushing against the table with his/her hands and dragging his/her feet on the ground in stepping motion; -The resident moved back and forth in a circle saying he/she 'cannot go', repetitively; -At 7:38 A.M. CNA H unlocked the resident's brake. During an interview on 10/8/24 at 7:38 AM CNA H said: -Resident #84's wheels are locked so he/she stays put. During an interview on 10/09/24 at 8:12 PM Licensed Practical Nurse (LPN) E said: -Locked wheelchair brakes are a restraint; -Brakes should not be locked unless the resident can unlock or lock them themselves; (continued on next page)

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	265379	A. Building B. Wing	10/15/2024

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident #84 should not have his/her wheels locked. -He/She locked the wheels so the resident would stay at the table. During an interview on 10/10/24 at 6:25 PM with the Director of Nursing (DON) and the Administrator said: -The DON said locked wheelchair brakes are a restraint if the resident cannot unlock them. She would not expect staff to lock the wheels and not allow Resident #84 or any other resident down the hall; -The Administrator said he agreed with the DON.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 46706 Based on record review and interview, the facility failed to check the Family Care Safety Registry (FCSR, a registry that provides background information on people who work with children, seniors, and people with disabilities in Missouri) for three of the 10 sampled employees prior to them having contact with any resident. The facility census was 103. Review of the facilty's Abuse Prevention Policy, dated October 2022, showed in part: -The facilty is committed to protecting the residents from abuse; -The facilty conducts employee back ground checks; -The facilty will pre -screen all potential employees for a history of abusive behavior. 1. Review of Dietary Aide E's personnel file showed: -Date of hire 9/17/24; -A check of the FCSR dated 10/9/24; -The facilty failed to check the FCSR before the employee had contact with the residents. 2. Review of Licensed Practical Nurse (LPN) H's personnel file showed: -Date of hire 5/8/24; -A check of the FCSR dated 5/20/24; -The facilty failed to check the FCSR before the employee had contact with the residents. 3. Review of Certified Nurses Aide (CNA) O's personnel file showed: -Date of hire 10/1/24; -A check of the FCSR dated 10/9/24; -The facilty failed to check the FCSR before the employee had contact with the residents. During an interview on 10/10/24 at 4:20 P.M. the Human Resources Manager said: -He/she just started in the position a few weeks ago; -He/she is trying to get everything caught up; -Employees should have a criminal background screening before hire; (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The FCSR should be checked before any employee has contact with the residents. During an interview on 10/10/24 at 6:25 P.M. the Administrator said: -He/she expects that criminal background checks are completed before the employee is hired; -The FCSR should be checked before employees have contact with the residents.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44395 Based on observation, interview and record review, the facility failed to assure resident Minimum Data Set (MDS: a federally mandated Assessment tool completed by facility staff) assessments were completed accurately and timely for four of 21 sampled residents (Residents #72, #33, #84 and #39). The census was 103. Review of the facility provided policy, MDS Assessments dated 6/2023 showed: -The facility shall conduct interdisciplinary assessments using the MDS item sets. These assessments provide information on the resident's condition to facilitate development of an individualized plan of care as a means by which the facility can track changes in a resident's status. -Non-Medicare covered residents will be completed upon admission, discharge, quarterly and annually per Federal/State requirements. -Death in facility and entry tracking records will be completed per the Resident Assessment Instrument (RAI) instructions. 1. Review of Resident #72 Electronic Health Record showed: -admitted [DATE]; -Quarterly MDS assessment dated [DATE]; -Progress Notes dated 7/21/24 showed the resident discharged to another long term care facility; -No discharge MDS completed or submitted. 2. Review of Resident #84 Electronic Health Record showed: -admitted [DATE]; -Admission MDS was completed 5/19/24; -No MDS assessment completed and submitted in August, September or October. 3. Review of Resident #33 Electronic Health Record showed: -admitted [DATE]; -Admission MDS was completed on 3/6/24; -A Prospective Payment System (PPS: A method of Medicare reimbursement where the payment amount is fixed and predetermined.) MDS was completed on 5/15/24; (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident passed away in the facility 9/11/24; -No MDS assessment completed and submitted in August, September or October; -No Discharge assessment completed and submitted after death. 47195 4. Review of Resident #39's admission MDS, dated [DATE], showed: -He/She received dialysis. Review of Resident #39's quarterly MDS dated [DATE], showed: -He/She was cognitively intact; -He/She had clear speech, was able to make self-understood and understand others; -Dialysis was not marked; -Diagnoses included respiratory failure (condition when lungs can not get enough oxygen into blood or remove enough carbon dioxide), end stage renal failure (final stage of kidney disease in which kidneys can no longer function on their own), acute respiratory failure with hypercapnia (when body has too much carbon dioxide in the blood), obstructive sleep apnea (a sleep disorder that causes people to repeatedly stop or shallowly breathe while sleeping), chronic obstructive pulmonary disease (a lung disease that makes it difficult to breathe), and muscle weakness. Review of physician's orders, dated October 2024, showed: -Ordered 7/10/24, Dialysis every Monday, Wednesday, and Friday at 11:00 A.M. Pick up time 10-10:30 A.M. -Ordered 7/24/24, Check dialysis shunt for bruit (rumbling sound that indicates how well a dialysis access is working)/ thrill (a vibration felt over a dialysis fistula cause by blood flowing through it) every shift. Notify medical doctor if absent. Review of care plan, undated, showed, -He/She has end stage renal disease and was dependent on dialysis; -He/She would not have complications due to dialysis through next review date; -Check bruit and thrill as ordered by the physician; -Follow dialysis schedule as ordered; -Administer meds as ordered by physician. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/8/24 at 5:48 A.M., Resident said: -He/She received dialysis three times a week off site from facility; -He/She had a port (an access to the vein that was under the skin) located in his/her right arm crook; -He/She had the port for eleven years. During an interview on 10/9/24 at 1:22 P.M., Licensed Practical Nurse (LPN) G said: -Resident received dialysis. During an interview on 10/10/24 at 6:25 P.M., Director of Nursing said: -He/She expected dialysis to be reflected on a resident's MDS. 5. During an interview on 10/10/24 at 5:35 P.M., MDS Coordinator said: -He/She expected the MDS to reflect dialysis when a resident was receiving dialysis; -He/She has had difficulty getting Registered Nurse signatures, so several MDS submissions were late; -He/She was not aware of any discharged residents MDS that were not submitted; -He/She submitted Resident #72 and #33 on 10/10/24; -Death assessments should be submitted immediately; -He/She is not sure why Resident #84 did not have a current MDS. During an interview on 10/10/24 at 6:25 P.M., Director of Nursing said: -He/She expected MDS assessments to be completed and submitted timely. During an interview on 10/10/24 at 6:56 P.M., Administrator said: -He/She expected the MDS to reflect the resident's conditions. -He/She expected MDS assessments to be completed and submitted timely.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 47195 Based on observation, record review, and interview, the facility failed to develop and implement a comprehensive person-centered care plan for four of 21 sampled residents (Residents #39, #113, #26, #84) by not addressing care areas of resident side rail usage (Resident #39 and #113), use of a bilevel positive airway pressure device (bipap) (a noninvasive ventilator that helps people breathe by delivering pressurized air into airways) (Resident #39), and significant weight loss (Resident #26 and #84). The facility census was 103. Review of facility policy, comprehensive person centered care plans, revised March 2018, showed: -Each resident will have a person centered plan of care to identify problems, needs, strengths, preferences, and goals that will identify how the interdisciplinary team will provide care; -The interdisciplinary team along with the resident and/or resident representative will identify resident problems, needs, strengths, life history, preferences, and goals; -For each problem, need, or strength a resident-centered goal is developed. Goals should be measurable; -Staff approaches are to be developed for each problem/strength/needs; -The comprehensive person centered care plan can be reviewed and/or revised at quarterly intervals; -Upon a change in condition, the comprehensive person centered care plan will be updated; -An instant care plan can be completed with a change in resident condition if there is no care plan available or until the comprehensive person centered care plan is updated. 1. Review of Resident #39's quarterly minimum data set (MDS), a federally mandated assessment tool completed by facility staff, dated 9/13/24, showed: -He/She was cognitively intact; -He/She had clear speech, was able to make self-understood and understand others; -He/She was dependent on wheelchair for mobility; -He/She required partial/moderate assistance from staff with dressing, toileting, bathing, and mobility from sitting to lying; -He/She was independent with eating and oral care; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses included respiratory failure (condition when lungs can not get enough oxygen into blood or remove enough carbon dioxide), end stage renal failure (final stage of kidney disease in which kidneys can no longer function on their own), acute respiratory failure with hypercapnia (when body has too much carbon dioxide in the blood), obstructive sleep apnea (a sleep disorder that causes people to repeatedly stop or shallowly breathe while sleeping), chronic obstructive pulmonary disease (COPD) (a lung disease that makes it difficult to breathe), and muscle weakness. Review of care plan, undated, showed: -He/She was at risk for respiratory complications due to COPD and chronic respiratory failure; -Administer medications as ordered by physician; -Observed for signs and symptoms of breathing difficulty and report to physician; -Elevate head of bed as resident desires; -Continuous oxygen at 2 liters via nasal cannula; -BIPAP machine use was not care planned; -He/She was at risk for falls due to muscle weakness; -Keep bed in low position; -Bed mobility and use of side rails not care planned. Review of physician's orders, dated October 2024, showed: -Order started 7/24, 24, CPAP 20/EPAP (Bipap) 4/2 liters of oxygen at hour of sleep for chronic obstructive pulmonary disease; -Order started 7/24/24, as needed 2 liters of oxygen for COPD; -No orders for side rails. Review of daily care guide, dated 10/8/24, showed: -Oxygen at 2 liters nasal cannula continuous; -Bilateral assist rails. During an interview on 10/8/24 at 5:34 A.M. resident said: -He/She would like his/her bipap machine placed on him/her every night before he/she went to sleep; -Staff did not come in and apply it if he/she fell asleep; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-His/Her family had asked staff to see if they would place his BIPAP on him/her; -He/She sometimes fell asleep early and did not mean to; -He/She wanted staff to come place his/her BIPAP machine on even if it woke him/her up; -Staff did not care for his/her bipap machine by cleaning the mask, tubing, and filter. -He/She used the side rails to help reposition him/herself in bed and roll self over during personal cares. Observation on 10/8/24 at 5:34 A.M. in resident's room showed: -He/She had a BIPAP machine sitting on the table beside his/her bed; -Nasal cannula from machine was observed laying on the floor if his/her room; -He/She was laying in his/her bed and had side rails on both side of his/her bed. Observation on 10/9/24 at 7:37 A.M. showed resident was asleep in bed with side rails up on bed, he/she did not have BIPAP machine on but was wearing the oxygen concentrator. During an interview on 10/9/24/ at 1:22 P.M., Licensed Practical Nurse (LPN) G said: -Staff were supposed to put the BIPAP on the resident; -He/She knows the resident's family requested the BIPAP be put on him/her after shift change; -Night shift was responsible for maintaining and cleaning the BIPAP machines; -He/She used side rails to reposition self in bed and sit up. During an interview on 10/9/24 at 1:45 P.M., Certified Nurse Aide (CNA) J said: -The nurse applied resident's BIPAP machine; -Resident was awake when he/she left his/her shift after 10 P.M. so he/she did not know when it was usually applied; -Resident has side rails to help assist with rolling as he/she would grab and pull on the rails during cares. 2. Review of Resident #113's admission minimum data set (MDS), a federally mandated assessment tool completed by facility staff, dated 8/26/24, showed: -His/Her cognitive status was undetermined: -He/She had clear speech, was able to make self-understood and understand others; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She was dependent for self-care and indoor mobility; -He/She had impairment to one side of upper extremities; -He/She was dependent for all cares and mobility; -He/She used a wheelchair for mobility; -He/She had no falls prior to admission; -Restraints were not used; -Diagnoses included catatonic disorder (condition characterized by a person being awake but not responding to their environment or other people), gastrostomy (an opening into the stomach made surgically for the introduction of food), anxiety disorder, schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly). Review of care plan, undated, showed: -He/She was at risk of falls due to catatonic disorder, self-harm, and schizophrenia; -Keep bed in low position; -Fall mat to bedside; -He/She did not have side rails care planned. Review of physician's orders, dated October 2024, showed: -No orders for side rails. Review of daily care guide, dated 10/8/24, showed: -He/She was a two person assist with transfers with total lift; -Nothing noted on side rails or assist bars. Observation on 10/07/24 at 10:13 A.M. showed resident was laying in his/her bed and had a u shaped side rail on both sides of his/her bed. The bed was lowered to lowest position. Review of electronic medical record showed: -On 8/20/24 a side rail evaluation was completed showing resident had involuntary movements cause his/her weight to shift. No side rails were indicated on assessment. During an interview on 10/9/24/ at 1:22 P.M., LPN G said: -He/She did not know why resident had side rails on his/her bed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/9/24 at 1:45 P.M., Certified Nurse Aide (CNA) J said: -Resident had side rails because the resident will grab the side rail with one good arm and pull him/herself up in bed. 44395 3. Review of Resident #26's Quarterly MDS completed 8/9/24 showed: -BIMS of 4, indicated significant cognitive loss; -Substantial to maximum assistance of staff with Activities of Daily Living (ADL's: tasks completed in a day to care for oneself); -He/She is dependent on a wheelchair for mobility; -Height of 62 inches (in); -Diagnoses of osteoporosis (a disease that weakens bones), Dementia (a brain disease that causes loss of function such as thinking,remembering and reasoning that interferes with daily life), Ischemic Cerebral Infarction (damage to the brain from blocked blood flow). Review of the resident's electronic medical record showed: -April 2024 the resident was seen by Skilled Therapy services for self feeding skills due to mobility and self propelling the w/c. -May 2024 the resident was seen by Skilled Therapy services for sitting balance and functional mobility. -April 2024 weight of 109.9 pounds (lbs) -May 2024 weight of 109.6 lbs -June 2024 weight of 107.2 lbs -July 2024 weight of 106.1 lbs -August 2024 weight of 102.4 lbs -September 2024 weight of 102.4 lbs -October 2024 weight of 95 lbs -A 7.23% weight loss in 30 days from September to October or 7.4 lbs -A 10.46% weight loss in 90 days from July-September or 11.1 lbs (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A 13.56% weight loss in 6 months from April to October or 14.9 lbs Observation on 10/07/24 at 11:05 A.M. showed the resident sitting in his/her w/c, slightly bent forward with a c shaped curve to his/her upper body. He/She was looking at a game card lying on the family style dining room table. His/Her w/c was very low to the ground. The table was at mid chest/breast height of the resident. The resident remained at the table for the noon meal. At 1:11 P.M. his/her meal was served . He/She attempted to raise his/her right hand from under the table, and picked up his/her fork from the table. He/She dropped the fork on the floor. He/She then began eating with his/her fingers. He/She did not complete his/her meal and staff removed the resident from the room. Review of the resident's undated Comprehensive Care Plan showed: -He/She resided on the locked special care unit (SCU); -ADL deficit related to dementia, give him/her simple instructions; -He/She has Dementia and confusion that could cause oral intake and weight to fluctuate, obtain/update food preferences, diet as ordered and provide a cup with a lid; -No care plan for significant weight loss or interventions to combat weight loss. 4. Review of Resident #84's Admission MDS dated [DATE] showed: -BIMS score of 3, indicated significant cognitive loss; -No behaviors; -Dependent on staff for ADL's; -Uses wheelchair (w/c) for mobility; -Diagnoses of Anxiety Disorder (a feeling for fear, dread and uneasiness that can effect daily life), depression (a serious mental illness that can affect a person's thoughts, feelings, behavior, and sense of well-being), muscle weakness, dementia (a chronic condition that causes a loss of brain function, such as thinking, remembering, and reasoning, that interferes with daily life), chronic pain (long term pain) , Adult Failure to Thrive (a syndrome that describes a general decline in health that can affect older adults), and falls. Review of the resident's electronic health record showed: -May 2024 weight of 119.3 lbs -June 2024 weight of 118 lbs -July 2024 weight of 112.4 lbs -August 2024 weight of 101 lbs (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-September 2024 weight of 100.6 lbs -No October 2024 weight. -A 15.34 % Loss in 90 days May to August, or 18.3 lbs -Physician orders for : Med pass 120 milliliters (ml) twice a day, ordered 8/13/24. Boost breeze 250 ml twice a day ordered 5/13/24 (on admission). Regular diet. Review of the resident's undated comprehensive Care Plan showed: -The resident resided on the locked SCU; -Redirect and reassure the resident as needed; -The resident has memory deficit and confusion which could cause his/her intake to vary; -No care plan for significant weight loss, or interventions to mitigate weight loss. 5. During an interview on 10/10/24 at 5:34 P.M., MDS coordinator said: -He/She writes residents initial care plans; -If there are changes to the care plans he/she was notified during facility morning meeting; -The morning meeting was held every morning Monday through Friday; -The dietician completed care plan updates for significant weight changes; -He/She was responsible for updating care plans related to side rail usage and BIPAP usage. 6. During an interview on 10/10/24 at 6:25 P.M., Director of Nursing said: -He/She expected care plans to include BIPAP use and side rail use; -He/She expected significant weight loss and interventions implemented to be care planned. 7. During an interview on 10/10/24 at 6:56 P.M., Administrator said: -He/She expected care plans to be updated with specific care needs of the resident.

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	265379	A. Building B. Wing	10/15/2024

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Riverside Nursing & Rehabilitation Center, LLC	4700 NW Cliffview Drive Riverside, MO 64150

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46706 Based on observations, interviews and record review, the facility failed to ensure dependent residents who were unable to carry out activities of daily living (ADL's) received the necessary services to maintain good personal hygiene when staff failed to ensure they provided perineal care at least every two hours. This affected two of the 21 sampled residents, (Resident #11 and #19). The facility census was 103. Review of the Missouri Resident [NAME] of Rights, provided through the state long term are ombudsman (a person who represents the interests of residents) program included Residents have the right to privacy, to be treated with consideration, respect, and dignity, recognizing each resident' s individuality. Review of the facility's Incontinent Care Policy, review date January 2015, showed -Provide routine, preventative skin, perineal care after each incontinent episode. 1. Review of Resident #11's, Quarterly Minimum Data Set (MDS, a federally mandated assessment tool completed by facility staff), dated 9/18/24, showed: -Severe cognitive impairment; -Dependent on staff for all ADLs; -Always incontinent of bowel and bladder; -At risk for skin breakdown; -Diagnoses included: Cerebral Palsy a disorder that affects a person's ability to move, balance, and maintain posture), quadriplegia (paralysis that affects all a person's limbs), and seizure disorder. Review of the resident's care plan, revised 3/11/24, showed: -The resident requires ADL assistance; -The resident is at risk for skin breakdown; -The care plan did not address incontinence or incontinent care. During a continuous observation of the resident, beginning on 10/8/24 at 05:03 A.M., showed: -05:16 A.M., the resident was laying in his/her bed on his/her back; -05:23 A.M., Certified Nurse Aide (CNA) I looked in the resident's room, and did not reposition or assess the need for incontinent care for the resident; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-06:12 A.M., the resident was laying in his/her bed on his/her back; -06:15 A.M., the resident was laying in his/her bed on his/her back; -06:45 A.M., CNA I walked by the resident's room and did not reposition or assess the need for incontinent care for the resident; -07:02 A.M., CNA K and CNA N walked by and looked in the resident's room, and did not reposition or provide incontinent care for the resident; -07:38 A.M., the resident was laying in his/her bed on his/her back; -07:52 A.M.,CNA N walked by the resident's room, and did not reposition or assess the need for incontinent care for the resident; -07:02 A.M., CNA K and CNA N walked by and looked in the resident's room, and did not reposition or assess the need for incontinent care for the resident; -07:32 A.M., the resident was laying in his/her bed on his/her back; -07:45 A.M., the resident was laying in his/her bed on his/her back; -08:03 A.M., the resident is still laying in his/her bed on his/her back and staff did not assess the residents need for incontinent care or positioning. During an interview on 10/8/24 at 09:05 A.M., CNA K said: -The resident was dependent on staff for care. -The resident was incontinent of bowel and bladder. -He/She had not repositioned or provided incontinent care to the resident since arriving to work. -The resident should be provided incontinent care and repositioned at least every two hours; -He/She did not provide incontinent care to the resident every two hours. During an interview on 10/8/24 at 09:22 A.M., CNA N said: -He/She had not reposition or provided perineal care since arriving to work. -He/She was not sure the last time the resident had been changed; -The resident should be provided perineal care and repositioned at least every two hours. 2. Review of Resident #19's Quarterly MDS dated [DATE], showed: -Moderate cognitive impairment; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Dependent on staff for toileting and personal hygiene; -Always incontinent of bowel and bladder; -Diagnoses included Guillain-Barre syndrome (a neurological disorder that occurs when the body's immune system attacks the peripheral nervous system and causes weakness, tingling, loss of sensation, muscle pain, uncoordinated movement), high blood pressure, anxiety and depression. Review of the resident's care plan, revised 9/4/24, showed: -The resident had an ADL function impairment related to Guillain-Barre syndrome; -The resident is at risk for skin breakdown related to impaired mobility and incontinence; -The care plan did not address routine incontinent care. Continuous three hour observation beginning on 10/8/24 at 05:03 A.M., showed: -05:05 A.M., the resident was laying in bed and positioned on the right side. -05:28 A.M., Certified Nurse Aide (CNA) I looked in the resident's room, and did not reposition or assess the need for incontinent care for the resident; -06:15 A.M., the resident was laying on the right side, in bed, and the room had a strong smell of urine; -06:45 A.M., the resident was laying on the right side, in bed, and the room had a strong smell of urine; -06:55 A.M., CNA I walked by the resident's room and did not reposition or assess the need for incontinent care for the resident and a strong smell of urine was coming from the resident's room; -07:02 A.M., CNA K and CNA N walked looked in the resident's room, and did not reposition or assess the need for incontinent care for the resident; -07:03 A.M., a strong smell of urine was coming from the resident's room; -07:32 A.M., the resident was laying in bed on their back; -07:52 A.M.,CNA N walked by the resident's room, and did not reposition or assess the need for incontinent care for the resident; -08:12 A.M., the resident was laying in bed on their back and staff have not provided incontinent care for the resident. During an interview on 10/8/24 at 09:05 A.M., CNA K said: -The resident was dependent on staff for for incontinent care; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident was incontinent of bowel and bladder; -He/She had not repositioned or provided incontinent care to the resident since arriving to work. -The resident should be provided incontinent care and repositioned at least every two hours; -He/she did not smell urine in the resident's room; -He/She did not provide incontinent care to the resident every two hours. During an interview on 10/8/24 at 09:22 A.M., CNA N said: -He/She had not reposition or provided perineal care since arriving to work. -He/She was not sure the last time the resident had been changed; -The resident should be provided perineal care and repositioned at least every two hours. During an interview on 10/8/24 at 10:04 A.M., Licensed Practical Nurse (LPN) E said: -Dependent resident's should be repositioned every two hours; -Dependent residents should be checked for incontinence and provided perineal care every two hours; -He/She expects the CNA's to reposition the resident and provide perineal care at least every two hours. During an interview on 10/10/24 at 06:25 P.M., The Director Nursing (DON) said: -He/she expects incontinent residents to be provided incontinent care at least every two hours. During an interview on 10/10/24 at 06:28 P.M., the Administrator said: -Incontinent residents should be provided incontinent care at least every two hours.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 31102 Based on interviews and record review, the facility failed to assist one resident of the 21 sampled residents (Resident #82) with help in obtaining a hearing aide. The facility census was 103. Review of the facility's job description for the director of social services, dated 8/1/2012, showed, in part: - Under the direction of the Executive Director, the Social Services Director is responsible for monitoring the residents' mental and psycho-social needs and to provide the services to meet these needs in order to attain or maintain the highest practicable level of physical, mental, and psycho-social well-being; - Utilizes the Resident Assessment Instrument (RAI) process in conducting a psycho-social assessment; - Formulates a care plan which addresses the identified problems, needs, and concerns; - Documents progress toward goals, assessment updates, and interventions; - Reviews the resident's progress toward resolution of problems, needs, or concerns,; evaluates the effectiveness of the staff approaches, evaluates changes in the mental and psycho-social assessment; - Participates in the interdisciplinary assessment reviews and revisions; revises the residents' care plan according to residents' needs; - Coordinates the complaint/grievance program with appropriate disciplines and verifies that complaints/grievances are handled in a timely manner; - Coordinates appointments in the community for various health care visits and therapeutic needs; - Follows up as appropriate with supervisor, co-workers or residents regarding reported complaints, problems and concerns. 1. Review of Resident #82's Quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 8/22/24 showed: - Cognitive skills intact; - Hearing is adequate. Does not use a hearing aide. Able to make self understood; - Required assistance of set up and clean up with eating and oral hygiene; - Dependent on the assistance of staff with toilet use, showers, dressing, personal hygiene and transfers; (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Diagnoses included congestive heart failure (accumulation of fluid in the lungs and other areas of the body), high blood pressure and atrial fibrillation (afib- an irregular, often rapid heart rate that commonly causes poor blood flow). Review of the resident's care plan, dated 11/15/22 showed it did not address the resident's hearing issues or need for a hearing aide. Review of the resident's hearing aid evaluation report, dated 12/18/23, showed;- Diagnosis of bilateral sensorineural hearing loss (a type of hearing loss that affects both ears and occurs when the inner ear's hair cells or auditory nerve are damaged); - The resident preferred right ear fitting for the hearing aid. Review of the requested timeline documentation regarding Resident #82's hearing aid follow up included a piece of paper with some information that showed hand written notes to include the following: - 2/20/24 - mailed out information to the audiologist (health care professionals who identify, assess and manage disorders of hearing, balance and other neural systems); - 2/28/24 - still awaiting medicaid to approve; - 7/11/24 - still pending; - 8/7/24 - the audiologist is out today; - 8/15/24 - no answer. During an interview on 10/07/24 at 11:27 A.M., the resident said: - He/she had a hearing test two months ago at a local hospital but still does not have any hearing aides; - He/she had not talked to Social Services about it. During an interview on 10/09/24 at 01:26 P.M., the Social Services Director said: - It is generally the transportation person who schedules the appointments and follows up with them; - He/she does not document any information in the resident's chart about the the hearing aide; - It generally takes a couple of months before the resident can get their hearing aide; - Medicaid will only pay for one hearing aide. During an interview on 10/09/24 at 02:15 P.M., the transportation person said: - They are still waiting on Medicaid to approve the hearing aide;. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- He/she is the one who follows up to see where they are at; - He/she has the nurse chart about the hearing aide appointment because she/she did not have access to the charting; - Social Serviced does not document anything about the resident's hearing aide. During an interview on 10/10/24 at 6:25 P.M., the Director of Nursing (DON) said:- If the facility knows about the hearing aide, then they collaborate with Social Services and have transport schedule the hearing appointment; - Social Services should document where they are in the process of obtaining the hearing aide. During an interview on 10/10/24 at 6:56 P.M., the Administrator said;- He would expect the Social Services Director to have a bigger part in obtaining a hearing aide for the resident; - It was not up to transportation to do that; - He planned to follow up with social services regarding appointments.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44395 Based on observation, interview and record review the facility failed to treat significant weight loss for two residents (Resident #26 and #84) and failed to provide adequate hydration for 6 residents (Resident #26, #84, #35, #57, #94 and #4) of the 21 sampled residents. The facility census was 103. Review of the facility provided policy Hydration Cart dated 2016 showed: -Water or other fluids shall be offered to all residents throughout the day. Fluids are typically offered during meals, snacks. A hydration cart or location may be used to enhance access and encouragement of fluids for residents. -The Hydration Cart will be offered or refreshed each day at mid morning, mid afternoon and bedtime. -The cart or location will include fresh ice water and another beverage such as iced tea or lemonade. And may include snacks. -The cart or location will include fluids appropriate for those on thickened liquids. The facility did not provide a policy on weight loss or meal intake. 1. Review of Resident #26's Quarterly Minimum Data Set, (MDS A federally mandated assessment completed by the facility staff) dated 8/9/24 showed: -Brief Interview for Mental Status (BIMS) of 4, indicated significant cognitive loss; -Substantial to maximum assistance of staff with Activities of Daily Living (ADL's: tasks completed in a day to care for oneself); -He/She is dependent on a wheelchair for mobility; -Height of 62 inches (in); -Diagnoses of osteoporosis (a disease that weakens bones), Dementia (a brain disease that causes loss of function such as thinking,remembering and reasoning that interferes with daily life), Ischemic Cerebral Infarction (damage to the brain from blocked blood flow). Review of the resident's electronic medical record showed: -April 2024 the resident was seen by Skilled Therapy services for self feeding skills due to mobility; -May 2024 the resident was seen by Skilled Therapy services for sitting balance and functional mobility; (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-April 2024 weight of 109.9 pounds (lbs); -May 2024 weight of 109.6 lbs; -June 2024 weight of 107.2 lbs; -July 2024 weight of 106.1 lbs; -August 2024 weight of 102.4 lbs; -September 2024 weight of 102.4 lbs; -October 2024 weight of 95 lbs; -A 7.23% weight loss in 30 days from September to October or 7.4lbs; -A 10.46% weight loss in 90 days from July-September or 11.1lbs; -A 13.56% weight loss in 6 months from April to October or 14.9 lbs; -Physician order for regular diet. Ordered 1/29/24. No orders for appetite stimulant or supplements; -Progress Notes showed no notification of the physician for weight loss; - Nursing Progress Note dated 8/28/24 showed: resident observed for wt loss of 2.72 %, recommended resident receive appetite stimulant, and encourage to increase snacks. The physician increased remeron (a appetite stimulant medication) to 7.5 mg daily at bedtime; -Nursing Progress Noted dated 8/21/24 showed: the resident did not trigger for wt loss, monitoring because he/she was not eating unless he/she was cued; Review of Resident #26's activities of daily living (ADL) tracking record showed: - 9/30/24- 6:00 A.M.-2:00 P.M., the resident drank 100 milliliters (mls.); and consumed 50% of breakfast and lunch; - 9/30/24- 2:00 P.M.-10:00 P.M., the resident drank 100 ml ;consumed 50% of evening meal; - 9/30/24- 10:00 P.M.-6:00 A.M., the resident drank 120 ml's.; - 10/1/24- 6:00 A.M.-2:00 P.M., the resident drank 100 ml's.;and consumed 50% of breakfast and lunch; - 10/1/24- 2:00 P.M.-10:00 P.M., the resident drank 100 ml's.; and consumed 30% of evening meal; - 10/1/24- 10:00 P.M.-6:00 A.M., the resident drank 120 ml's.; (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 10/2/24- 6:00 A.M.-2:00 P.M., the resident drank 50 ml's; and consumed 50% of breakfast and lunch; - 10/2/24- 2:00 P.M.-10:00 P.M., the resident drank 50 ml's.; and consumed 30% of evening meal; - 10/2/24- 10:00 P.M.-6:00 A.M., the resident drank 120 ml's.; - 10/3/24- 6:00 A.M.-2:00 P.M., the resident drank 50 ml's; and consumed 50% of breakfast and lunch; - 10/3/24- 2:00 P.M.-10:00 P.M., the resident drank 50 ml's; and consumed 0% of evening meal; - 10/3/24- 10:00 P.M.-6:00 A.M., no documentation noted; -10/4/24-6:00 A.M.-2:00 P.M., no documentation noted; -10/4/24- 2:00 P.M.-10:00 P.M., the resident drank 240 ml's.; no documentation of % eaten; -10/4/24- 10:00 P.M.-6:00 A.M. the resident drank 120 ml's.; 10/5/24-6:00 A.M.-2:00 P.M., no documentation noted; -10/5/24- 2:00 P.M.-10:00 P.M., the resident drank 240 ml's.; no documentation of % eaten; -10/5/24- 10:00 P.M.-6:00 A.M. the resident drank 0 ml's.; 10/6/24-6:00 A.M.-2:00 P.M., no documentation noted; -10/6/24- 2:00 P.M.-10:00 P.M., no documentation noted; -10/6/24- 10:00 P.M.-6:00 A.M. the resident drank 120 ml's.; 10/7/24-6:00 A.M.-2:00 P.M., no documentation noted; no documentation of % eaten; -10/7/24- 2:00 P.M.-10:00 P.M., the resident drank 210 ml's.; consumed 100% of evening meal; -10/7/24- 10:00 P.M.-6:00 A.M. the resident drank 120 ml's Review of the resident's undated Comprehensive Care Plan showed: -He/She resided on the locked special care unit; -ADL deficit related to dementia, give him/her simple instructions; -He/She has Dementia and confusion that could cause intake and weight to fluctuate, obtain/update food preferences, diet as ordered and provide a cup with a lid; -No care plan for significant weight loss or interventions to combat weight loss. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 10/07/24 at 11:05 A.M. showed the resident sitting in his/her wheel chair, (w/c), at the dining room table, no fluids or snacks on the table. The resident was slightly bent forward with a c shaped curve to his/her upper body. His/Her w/c was very low to the ground. The table was at mid chest/breast height of the resident. Observation and interview on 10/07/24 at 11:56 A.M. showed: -The meal time fluid cart was delivered to the hall; -Certified Nurse Aide (CNA) G filled small Styrofoam cups with ice and water and gave to the resident; -CNA G said: dietary staff bring a cart of fluid at meal times, that is when fluids are passed. Observation on 10/07/24 at 1:11 P.M. showed his/her meal was served. He/She attempted to raise his/her right hand from under the table, and picked up his/her fork from the table. He/She dropped the fork on the floor. He/She then began eating with his/her fingers. Staff did not assist the resident with his/her meal and did not offer the resident fluids. He/She did not complete his/her meal and staff removed the resident from the room. Observation on 10/7/24 at 1:27 P.M. showed the resident had no fluids/ice water at bedside. Observation on 10/08/24 07:19 AM showed no fluids/ice water at bedside. Observation on 10/08/24 11:13 AM showed no fluids/ice water at bedside. Observation on 10/09/24 at 12:44 PM showed the resident was in the dining/activity room watching a movie. No snacks, water/drinks were available. No fluids/ice water at bedside. 2. Review of Resident #84's MDS dated [DATE] showed: -BIMS score of 3, indicated significant cognitive loss; -No behaviors; -Dependent on staff for ADL's; -Diagnoses of Anxiety Disorder (a feeling for fear, dread and uneasiness that can effect daily life), depression (a serious mental illness that can affect a person's thoughts, feelings, behavior, and sense of well-being), muscle weakness, dementia (a chronic condition that causes a loss of brain function, such as thinking, remembering, and reasoning, that interferes with daily life), chronic pain (long term pain) , Adult Failure to Thrive (a syndrome that describes a general decline in health that can affect older adults), and falls. Review of the resident's electronic health record showed: -May 2024 weight of 119.3 lbs; (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-June 2024 weight of 118 lbs; -July 2024 weight of 112.4 lbs; -August 2024 weight of 101 lbs; -September 2024 weight of 100.6 lbs; -No October 2024 weight; -A 15.34 % Loss in 90 days; May to August, or 18.3 lbs; -Physician orders for: Med pass 120 milliliters (ml) twice a day, ordered 8/13/24. Boost breeze 250 ml twice a day and Regular diet, both ordered upon admission 5/13/24. Review of the resident's undated comprehensive Care Plan showed: -The resident resided on the locked Special Care Unit (SCU); -Redirect and reassure the resident as needed; -The resident has memory deficit and confusion which could cause his/her intake to vary; -No care plan for significant weight loss, or resident specific interventions to combat weight loss. Review of Resident #84's ADL tracking record showed: - 9/30/24 6:00 A.M.-2:00 P.M., the resident drank 100 milliliters (ml's.); and consumed 75% of breakfast and lunch; - 9/30/24 2:00 P.M.-10:00 P.M., the resident drank 100 ml ; consumed 75% of evening meal; - 9/30/2410:00 P.M.-6:00 A.M., the resident drank 120 ml's.; - 10/1/24 6:00 A.M.-2:00 P.M., the resident drank 100 ml's.;and consumed 75% of breakfast and lunch; - 10/1/24 2:00 P.M.-10:00 P.M., the resident drank 100 ml's.; and consumed 75% of evening meal; - 10/1/24 10:00 P.M.-6:00 A.M., the resident drank 120 ml's.; - 10/2/24 6:00 A.M.-2:00 P.M., the resident drank 100 ml's; and consumed 75% of breakfast and lunch; - 10/2/24 2:00 P.M.-10:00 P.M., the resident drank 100 ml's.; and consumed 75% of evening meal; - 10/2/24 10:00 P.M.-6:00 A.M., the resident drank 120 ml's.; (continued on next page)

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	265379	A. Building B. Wing	10/15/2024

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 10/3/24 6:00 A.M.-2:00 P.M., the resident drank 100 ml's; and consumed 50% of breakfast and lunch; - 10/3/24 2:00 P.M.-10:00 P.M., the resident drank 100 ml's; and consumed 100% of evening meal; - 10/3/24 10:00 P.M.-6:00 A.M., the resident drank 120 ml's; -10/4/24 6:00 A.M.-2:00 P.M., the resident drank 240 ml's; and consumed 75% of breakfast and 50% of lunch; -10/4/24 2:00 P.M.-10:00 P.M., no documentation noted.; no documentation of % eaten; -10/4/24 10:00 P.M.-6:00 A.M. the resident drank 120 ml's.; 10/5/24 6:00 A.M.-2:00 P.M., no documentation noted, consumed 50% of evening meal; -10/5/24 2:00 P.M.-10:00 P.M., the resident drank 240 ml's.; no documentation of % eaten; -10/5/24 10:00 P.M.-6:00 A.M. the resident drank 120 ml's.; -10/6/24 6:00 A.M.-2:00 P.M., the resident drank 400 ml's; consumed 75% of breakfast, no documentation of % eaten of lunch; -10/6/24 2:00 P.M.-10:00 P.M., no documentation noted; -10/6/24 10:00 P.M.-6:00 A.M. the resident drank 0 ml's.; 10/7/24 6:00 A.M.-2:00 P.M., the resident drank 240 ml's; consumed 50% of breakfast, no documentation of % eaten of lunch; -10/7/24 2:00 P.M.-10:00 P.M., the resident drank 220 ml's.; no documentation noted of % eaten of evening meal; -10/7/24 10:00 P.M.-6:00 A.M. the resident drank 0 ml's. Observation and interview on 10/07/24 at 11:05 AM showed the resident was in the dining room at the dining room table. He/she had no fluid or snack. No fluids or ice water at bedside. At 1:15 P.M. his/her noon meal was served. The resident ate part of his/her meal then yelled out, that he/she could not do it. CNA G assisted the resident from the dining room. CNA G did not attempt to assist the resident with his/her meal. CNA G said the resident typically does not eat a full meal. The resident can feed himself/herself. CNA G did not ask the resident if he/she needed assistance because the resident can do it themselves. Observation on 10/08/24 at 6:05 A.M. showed the resident had no fluid/ice water at bedside. Observation on 10/08/24 11:13 AM showed no fluids/ice water at bedside (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 10/09/24 at 12:44 PM showed the Resident was in the dining/activity room watching a movie. No snacks, water/drinks were available. No fluids/ice water at bedside. 3. Review of Resident #35 Quarterly MDS dated [DATE] showed: -BIMS of 99, indicating severe cognitive impairment; -No behaviors; -Dependent on staff for ADL's; -Always incontinent of urine; -Diagnoses of Alzheimer's disease, Diabetes Mellitus, Anxiety, Hypertension, Chronic Urinary Tract Infection and Depressive Disorder. Review of the resident's Comprehensive Care Plan dated 6/11/23 showed: -Impaired thought process related to dementia. Provide instruction using a clear voice. Calmly talk to him/her and use reassurance. Intake may vary due to confusion. Review of the resident's October physician order sheets showed: -Regular diet; -Macrobid (antibiotic used to treat urinary tract infections)100 milligrams daily for chronic Urinary Tract Infection. Review of Resident #35's activities of daily living (ADL) tracking record showed:- -9/30/24- 6:00 A.M. - 2:00 P.M., the resident drank 100 milliliters (ml's.); - 9/30/24- 2:00 P.M. - 10:00 P.M., the resident drank 100 ml ; - 9/30/24- 10:00 P.M. - 6:00 A.M., the resident drank 120 ml's.; - 10/1/24- 6:00 A.M. - 2:00 P.M., the resident drank 100 ml's.; - 10/1/24- 2:00 P.M. - 10:00 P.M., the resident drank 100 ml's.; - 10/1/24- 10:00 P.M. - 6:00 A.M., no documentation noted - 10/2/24- 6:00 A.M. - 2:00 P.M., the resident drank 100 ml's; - 10/2/24- 2:00 P.M. - 10:00 P.M., the resident drank 100 ml's.; - 10/2/24- 10:00 P.M. - 6:00 A.M., the resident drank 120 ml's.; (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 10/3/24- 6:00 A.M. - 2:00 P.M., the resident drank 100 ml's; - 10/3/24- 2:00 P.M. - 10:00 P.M., the resident drank 80 ml's; - 10/3/24- 10:00 P.M. - 6:00 A.M., the resident drank 0 ml's. -10/4/24-6:00 A.M. -2:00 P.M., the resident drank 240 ml's; -10/4/24- 2:00 P.M. - 10:00 P.M., no documentation noted.; -10/4/24- 10:00 P.M. - 6:00 A.M. the resident drank 120 ml's.; 10/5/24-6:00 A.M. -2:00 P.M., no documentation noted, -10/5/24- 2:00 P.M. - 10:00 P.M., the resident drank 240 ml's.; -10/5/24- 10:00 P.M. - 6:00 A.M. the resident drank 120 ml's.; -10/6/24-6:00 A.M. -2:00 P.M., the resident drank 460 ml's; -10/6/24- 2:00 P.M. - 10:00 P.M., no documentation noted -10/6/24- 10:00 P.M. - 6:00 A.M. the resident drank 120 ml's.; 10/7/24-6:00 A.M. -2:00 P.M., no documentation noted -10/7/24- 2:00 P.M. - 10:00 P.M., the resident drank 240 ml's.; -10/7/24- 10:00 P.M. - 6:00 A.M. the resident drank 120 ml's.; Observation on 10/07/24 at 11:05 A.M. showed the resident sitting at the dining room table, no fluids or snacks on table,. Observation on 10/07/24 at 11:56 A.M. showed: -The meal time fluid cart was delivered to the hall; -Certified Nurse Aide (CNA) G filled a small Styrofoam cup with ice and water and gave to the resident. Observation on 10/7/24 at 1:27 P.M. showed the resident had no fluids/ice water at bedside. Observation on 10/08/24 07:19 AM showed no fluids/ice water at bedside. Observation on 10/08/24 at 11:13 AM no water at bedside. Observation on 10/09/24 at 12:44 PM showed the resident was in the dining/activity room watching a movie. No snacks, water/drinks were available. No fluids/ice water at bedside. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of Resident #57 Admission MDS dated [DATE] showed: -BIMS of 12 indicated minimal cognitive loss; -No behaviors; -Able to make needs known; -Set up to supervision of staff for ADL's; -Diagnoses of Dementia, Anxiety, Hypertension, Depression and Atrial Fibrillation (a rapid and irregular heart beat). Review of the resident's undated comprehensive care plan showed: -He/She was at risk for self care deficit, give simple one step directions , and provide assistance as needed. -He/She had the potential for weight change due to dementia ; obtain and monitor his/her weight, and obtain/update food preferences. Review of the ADL Tracking log book showed no tracking for Resident #57. Continuous observation on 10/08/24 starting at 6:12 AM showed -He/She asked CNA H for a drink of water; -CNA H said he/she would get the water and walked away from the resident; -The resident remained in the hallway talking with other staff and residents; -At 6:51 A.M. the resident again asked for water; -CNA H said he/she would get the water in awhile and proceeded down the hall; -The resident remained in the hall. No ice water/fluids at bedside; -The resident said he/she was so thirsty and needed a drink; -At 8:19 A.M. the Activity Director gave the resident a cup of water from the medication cart. During an interview on 10/8/24 at 8:22 A.M. CNA H said: -Resident #57 is very critical of everything. He/She complains all the time; -He/She just didn't have time yet to get the resident water and would get him/her something from the breakfast cart. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. During an interview on 10/09/24 08:13 PM LPN E said: -Residents #26 and #84 were not on hospice services; -He/She did not believe either Resident #26 or #84 had lost weight, however both residents have days they do not eat well; -The Interdisciplinary Team (IDT: a team of staff that includes dietary, the DON, Administrator, Social Services, Activity Director, etc) met weekly to review resident weights. If there was a wt loss, the IDT would get orders for interventions, update the care plan and notify the charge nurse; -The Charge Nurse would pass that information on to the CNA staff; -CNA staff are to pass snacks and ice water at least once a shift; -He/She expected snacks and drinks to be passed on the shift he/she worked; -There are some residents on special shakes; -Snacks should be given so the resident can travel around with them, such as sandwiches, cookies, crackers. 31102 6. Review of Resident #4's activities of daily living (ADL) tracking record showed: - 9/26/24- 6:00 A.M. - 2:00 P.M., the resident drank 240 milliliters (ml's.); - 9/26/24- 2:00 P.M. - 10:00 P.M., no documentation noted; - 9/26/24- 10:00 P.M. - 6:00 A.M., the resident drank 300 ml's.; - 9/27/24- 6:00 A.M. - 2:00 P.M., the resident drank 360 ml's.; - 9/27/27- 2:00 P.M. - 10:00 P.M., the resident drank 400 ml's.; - 9/27/24- 10:00 P.M. - 6:00 A.M., the resident drank 240 ml's.; - 9/28/24- 6:00 A.M. - 2:00 P.M., the resident drank 400 ml's.; - 9/28/24- 2:00 P.M. - 10:00 P.M., no documentation noted; - 9/28/24- 10:00 P.M. - 6:00 A.M., the resident drank 360 ml's.; - 9/29/24- 6:00 A.M. - 2:00 P.M., the resident drank 360 ml.; - 9/29/24- 2:00 P.M. - 10:00 P.M., the resident drank 360 ml.; (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 9/29/24- 10:00 P.M. - 6:00 A.M., the resident drank 260 ml's.; - 9/30/24- 6:00 A.M. - 2:00 P.M., the resident drank 360 ml.; - 9/30/24- 2:00 P.M. - 10:00 P.M., no documentation noted; - 9/30/24- 10:00 P.M. - 6:00 A.M., the resident drank 240 ml's.; - 10/1/24- 6:00 A.M. - 2:00 P.M., the resident drank 300 ml's.; - 10/1/24- 2:00 P.M. - 10:00 P.M., the resident drank 240 ml's.; - 10/1/24- 10:00 P.M. - 6:00 A.M., the resident drank 360 ml's.; - 10/2/24- 6:00 A.M. - 2:00 P.M., no documentation noted; - 10/2/24- 2:00 P.M. - 10:00 P.M., the resident drank 260 ml's.; - 10/2/24- 10:00 P.M. - 6:00 A.M., the resident drank 240 ml's.; - 10/3/24- 6:00 A.M. - 2:00 P.M., no documentation noted; - 10/3/24- 2:00 P.M. - 10:00 P.M., no documentation noted; - 10/3/24- 10:00 P.M. - 6:00 A.M., no documentation noted. Review of Resident #4's Annual MDS, dated [DATE], showed: - Cognitive skills intact; - Required staff assistance with set up and clean up for oral hygiene and eating; - Diagnoses included anemia (a condition that develops when your blood produces a lower-than normal amount of healthy red blood cells) and renal insufficiency (poor function of the kidneys that may be due to a reduction in blood-flow to the kidneys caused by renal artery disease). The facility did not provide the resident's POS for October 2024. Review of the resident's MAR, dated October 2024 showed: - Start date: 4/1/24 - regular diet with diabetic precautions. During an interview on 10/8/24 at 9:29 A.M., the resident said: - The staff have not passed any fresh ice water this morning; - He/she would like staff to pass fresh ice water every shift. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations from 10/7/24 through 10/8/24 at various times showed staff did not pass fresh water or ice. During an interview on 10/9/24 at 7:03 P.M., LPN D said: - The aides pass ice at 3:00 P.M., 6:00 P.M., and at 9:00 P.M.; - As far as he/she knows the ice gets passed to the residents. During an interview on 10/9/24 at 7:15 P.M., CNA C said: - Ice water gets passed two or three times a shift. It used to get passed at 3:00 P.M., 6:00 P.M., and 9:00 P. M., but it has changed to 10:00 A.M., 3:00 P.M., and 7:00 P.M. - It normally gets passed on his/her shift, it might be late, but it does get passed. During an interview on 10/10/24 at 6:25 P.M., the Director of Nursing (DON) said: - She expected ice water to get passed at a minimum of once a shift or as much as the resident wanted it; - It is the responsibility of all staff to pass fresh ice water; - They have Styrofoam cups with lids and straws; - All the residents should have a drink at bedside unless it's their preference; - Water should be passed other times than prior to a meal; - She would have to review the total on the ADL sheets to know if that was their total or just what they drank at meals.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47195 Based on observation, interview, and record review, the facility staff failed to assess residents for risk of entrapment from bed rails prior to installation and failed to ensure the bed's dimensions were appropriate for the resident's size and weight, and failed to obtain physician's orders for side rails for four of 21 sampled residents (Resident #39, #113, #54, and #104). The facility census was 103. The facility did not provide a policy on entrapment. 1. Review of Resident #39's quarterly minimum data set (MDS), a federally mandated assessment tool completed by facility staff, dated 9/13/24, showed: -He/She was cognitively intact; -He/She had clear speech, was able to make self-understood and understand others; -He/She was dependent on his/her wheelchair for mobility; -He/She required partial/moderate assistance from staff with dressing, toileting, bathing, and mobility from sitting to lying; -Diagnoses included respiratory failure (condition when lungs can not get enough oxygen into blood or remove enough carbon dioxide), end stage renal failure (final stage of kidney disease in which kidneys can no longer function on their own), and muscle weakness. Review of care plan, undated, showed: -He/She was at risk for falls due to muscle weakness; -Keep bed in low position; -Bed mobility and use of side rails not care planned. Review of physician's orders, dated October 2024, showed: -No orders for side rails. Review of daily care guide, dated 10/8/24, showed: -Bilateral assist rails. Observation on 10/8/24 at 5:34 A.M. in resident's room showed: (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident was laying in his/her bed with side rails up on both sides of his/her bed. During an interview on 10/8/24 at 5:34 A.M., Resident said: -He/She used his/her side rails to reposition self in bed. Review of side rail evaluation form showed: -On 7/24/24, resident was assessed for assist rail on both sides of bed for support with positioning, to turn in bed, and resident requested the rails. -On 9/13/24, resident was assessed for assist rails on both sides of bed for support with positioning, to turn in bed, and resident requested the rails. Review of bed entrapment evaluation, undated, showed: -Zone 1, recommended by FDA less than 120 mm (less than 4 and 3/4 inch), actual measurements 4 x 4 (unknown units of measurement) -Zone 2, recommended by FDA less than 120 mm (less than 4 and 3/4 inch), actual measurements 6 x 4 (unknown units of measurement); -Zone 3, recommended by FDA less than 120 mm (less than 4 and 3/4 inch), actual measurements 1 inch; -Zone 4, recommended by FDA less than 60 mm (less than 2 and 3.8 inch) and greater than 60 degree angle, actual measurements 6 x 4 (unknown units of measurement) and no degree angle documented. Did the facility complete the entrapment assessment? They did not complete it fully - and did not have full measurements in each of them. During an interview on 10/9/24 at 1:22 P.M., Licensed Practical Nurse (LPN) G said: -The resident used side rails to reposition self in bed and sit up. During an interview on 10/9/24 at 1:45 P.M., Certified Nurse Aide (CNA) J said: -Resident has side rails to help assist with rolling as he/she would grab and pull on the rails during cares. Observation on 10/10/24 at 8:31 A.M. showed Maintenance Director entering resident room with entrapment zone form. During an interview on 10/10/24 at 8:31 A.M., Maintenance Director said: -He/She had been asked to complete the entrapment evaluation this morning for the resident. 2. Review of which resident #113's admission MDS, dated [DATE], showed: (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She admitted to facility 8/20/24; -His/Her cognitive status was undetermined: -He/She had clear speech, was able to make self-understood and understand others; -He/She had impairment to one side of upper extremities; -He/She was dependent for all cares and mobility; -He/She used a wheelchair for mobility; -He/She had no falls prior to admission; -Restraints were not used; -Diagnoses included catatonic disorder (condition characterized by a person being awake but not responding to their environment or other people), gastrostomy (an opening into the stomach made surgically for the introduction of food), anxiety disorder, schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly). Review of care plan, undated, showed: -He/She was at risk of falls due to catatonic disorder, self-harm, and schizophrenia; -Keep bed in low position; -Fall mat to bedside; -Side rails were not care planned. Review of physician's orders, dated October 2024, showed: -No orders for side rails. Review of daily care guide, dated 10/8/24, showed: -He/She was a two person assist with transfers with total lift; -Nothing noted on side rails or assist bars. Observation on 10/07/24 at 10:13 A.M. showed resident was laying in his/her bed, he/she had a U shaped side rail on both sides of his/her bed. The bed was lowered to lowest position. Review of side rail evaluation form showed: (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 8/20/24 a side rail evaluation was completed showing resident had involuntary movements cause his/her weight to shift. Type of rails used showed none. No side rails was written on side rail committee recommendation section of the form. Review of bed entrapment evaluation, undated, showed: -Zone 1, showed 8 and 1/4 by 4 (unknown units of measurement); -Zone 2, showed 8 and 1/4 by 3 and 1/2 (unknown units of measurement); -Zone 3, showed 1 inch; -Zone 4, showed 3 and 1/2 (unknown units of measurement) and no degree angle documented. During an interview on 10/9/24/ at 1:22 P.M., LPN G said: -He/She did not know why the resident had side rails on his/her bed. During an interview on 10/9/24 at 1:45 P.M., CNA J said: -Resident had side rails because the resident will grab the side rail with one good arm and pull him/herself up in bed. Observation on 10/10/24 at 8:31 A.M. showed Maintenance Director entering resident room with entrapment zone form. During an interview on 10/10/24 at 8:31 A.M., Maintenance Director said: -He/She had been asked to complete the entrapment evaluation this morning for resident. 3. Review of Resident #54's quarterly MDS, dated [DATE], showed: -He/She was cognitively intact; -He/She had clear speech and was able to make self-understood and understand others; -He/She was dependent on wheelchair or walker; -He/She was independent with rolling left and right -He/She required supervision or touching assistance with transfers, mobility. -He/She had no falls with injury since prior assessment; -Diagnoses included: type 2 diabetes (condition in which body did not use insulin properly resulting in high blood sugar levels), renal failure (condition when the kidneys no longer filter waste and function properly), and anxiety (condition resulting in feeling of fear, dread, or uneasiness that can be normal in response to stress). (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of care plan, undated, showed: -He/She was at risk for pain due to amputation; -He/She was at risk for skin breakdown due to decreased mobility and surgical incision; -He/She had an activities of daily living deficit due to osteoarthritis; -Side rails were not care planned. Review of physician's orders, dated October 2024, showed: -No orders for side rails. Review of daily care guide, dated 10/8/24, showed: -Bilateral assist rails to aide in bed mobility and repositioning. Observation on 10/7/24 at 11:44 A.M. showed resident had resident had U-shaped cane rails on both sides of his/her bed. During interview on 10/8/24 at 10:27 A.M., resident said he/she had side rails to assist him with getting in and out of his/her bed and moving around in bed. Review of side rail evaluation form showed: -On 7/5/24, resident was to have assist rail to both sides of bed to assist with repositioning, increase independence, and resident requested use of side rails to increase independent mobility. Review of bed entrapment evaluation, undated, showed: -Zone 1, recommended by FDA less than 120 mm (less than 4 and 3/4 inch), actual measurements 4 and 1/2 by 5 and 1/2 (unknown units of measurement); -Zone 2, recommended by FDA less than 120 mm (less than 4 and 3/4 inch), actual measurements 3 and 1/8 and 4 and 1/2 (unknown units of measurement); -Zone 3, recommended by FDA less than 120 mm (less than 4 and 3/4 inch), actual measurements 1 inch; -Zone 4, recommended by FDA less than 60 mm (less than 2 and 3.8 inch) and greater than 60 degree angle, actual measurements 3 inches and no degree angle documented. During an interview on 10/10/24 at 8:16 A.M., LPN G said: -Resident's side rails were used to provide him/her with support to get out of his/her bed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 10/10/24 at 8:31 A.M. showed Maintenance Director entering resident room with entrapment zone form. During an interview on 10/10/24 at 8:31 A.M., Maintenance Director said: -He/She had been asked to complete the entrapment evaluation this morning for resident. 4. Review of Resident #104's quarterly MDS, dated [DATE], showed: -Cognitive status was not measured; -He/She had no impairment to upper or lower extremities; -He/She utilized a wheelchair; -He/She was dependent with toileting hygiene, bathing, dressing, mobility; Diagnoses included Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), Parkinson's Disease (a disorder of central nervous system that can cause symptoms of low movement, stiffness, and loss of balance) , repeated falls, headaches, and ototoxic hearing loss (inner ear damage that develops as a side effect of taking certain medications). Review of care plan, undated, showed: -He/She was at risk for falls or injuries due to impaired mobility and diagnosis of repeated falls, Parkinson's disease, and Alzheimer's; -C-rail to right side of bed for mobility; -Winged mattress in place to remind resident of boundaries of bed for safety. Review of physician's orders, dated October 2024, showed: -No orders for side rails. Review of daily care guide, dated 10/8/24, showed: -Assist rail to right side of bed. Observation on 10/7/24 at 10:07 A.M. showed: -Resident had winged mattress on his/her bed and two U shaped side rails on each side of his/her bed. Review of side rail evaluation form showed: -On 3/19/24, showed no side rails were indicated or initiated; (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 6/20/24, showed form was not completed; -On 9/3/24, showed form was not completed. Review of bed entrapment evaluation, undated, showed: -Zone 1, showed 3 and 1/2 by 4 (unknown units of measurement); -Zone 2, showed 3 and 3/4 by 4 (unknown units of measurement); -Zone 3, showed (unknown units of measurement); -Zone 4, showed 3 and 3/4 (unknown units of measurement) and no degree angle documented. During an interview on 10/9/24 at 1:45 P.M., CNA J said: -Resident was a two person transfer; -He/She did not know why resident had side rails on his/her bed. During an interview on 10/10/24 at 8:16 A.M., LPN G said: -He/She was not sure why resident had side rails on his/her bed but the resident had previously been more active; -He/She probably no longer needed side rails but they had not been removed from his/her bed. During an interview on 10/10/24 at 8:16 A.M., LPN G said: -Side rail evaluation was completed as part of admission paperwork; -Nurse determines via the side rail evaluation whether a resident would benefit from side rails; -He/She did not need a doctors order to implement side rails; -He/She did not know if side rail entrapment measurements were being done. During an interview on 10/10/24 at 8:31 A.M., Maintenance Director said: -He/She had been asked to complete the entrapment evaluation this morning for residents. -He/She was measuring mattresses and bed frames; -He/She goes to Supply Director if he/she is not sure if the mattress is right size to fit resident's bed; -He/She completes measurements every month of entrapment zones; (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She has a paper he/she documented every single room he completes side rail safety evaluation on and goes room to room; -Residents are assessed for side rails when they come into facility by nursing staff; -He/She will apply side rail if residents assessment shows they need them; -If resident asked him for side rails he/she would go to admission and social services and advise resident had asked for them; -He/She started doing rail safety audits back in April 2024. During an interview on 10/10/24 at 6:25 P.M., Director of Nursing said: -Side rails are assessed during admission assessment or with significant change in a residents status; -A physician order should be obtained prior to installation of side rails; -Distance should be assessed between mattress and side rails to ensure residents did not hurt themselves; -Assessments should also be completed to determine if residents need side rail on both sides of bed or just one; -Maintenance was responsible for completing entrapment measurements; -Measurements of mattress and bed frame should be completed any time bed is moved or a different mattress is applied to the bed. During an interview on 10/10/24 at 6:56 P.M., Administrator said: -He/She did not when entrapment assessments should be completed;

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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. 31102 Based on observations, interviews and record review, the facility failed to ensure staff administered medications with a medication error rate of less than 5%. Facility staff made five medication errors out of 26 opportunities for error, resulting in a medication error rate of 20%. This affected five of the 21 sampled residents, (Resident #4, #15, #43, #91 and #103). The facility census was 103. Review of the facility's policy for general guidelines for medication administration, dated 8/16, showed, in part: - Medications are administered as prescribed, in accordance with good nursing principles and practices and only be persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication; - Medications are administered in accordance with written orders of attending physicians, taking into consideration manufacturer's specifications and professional standards of practice; - 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; - The resident's medication administration record (MAR)/treatment administration record (TAR) is initialed by the person administering a medication, in the space provided under the date, and on the line for that specific medication dose following medication administration. Initials on each MAR/TAR are verified with a full signature in the space provided or on the signature log. The electronic (eMAR/eTAR) uses an electronic signature; - Placing an initial in the space provided on the MAR/eMAR and TAR/eTAR also indicates that the nurse who administered the medication is observing for side effects. Review of the facility's policy for insulin injections, dated 7/24 showed, in part:- Daily insulin injections are given with a physician's order. Injection sites will be rotated. Insulin will be given before meals unless otherwise ordered by the physician; - The policy did not indicate how long a resident should wait to eat a meal after receiving insulin. Review of the facility's policy for glucose monitoring (the process of measuring the amount of glucose, sugar, in your blood) via glucometer (a small, portable device that measures the amount of glucose, or sugar, in your blood); - The policy did not indicate how long the fingertip should air dry before staff obtained the resident's blood sugar. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Review of Resident #4's Annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff showed: - Cognitive skills intact; - Dependent on the assistance of staff for medication administration and glucose monitoring. - Diagnoses included chronic obstructive pulmonary disease (COPD, obstruction of air flow that interferes with normal breathing) and diabetes mellitus. The facility did not provide the resident's physician order sheet (POS). Review of the resident's medication administration record (MAR), dated October 2024, showed: - Start date: 4/3/24 - Check blood sugars daily for diabetes mellitus. Notify the physician for blood sugars less than 60 or greater than 400. Observation on 10/8/24 at 5:26 A.M., showed: - Licensed Practical Nurse (LPN) B cleaned the resident's finger tip with an alcohol wipe, did not let it air dry and obtained the resident's blood sugar. 2. Review of Resident #15's POS, dated October 2024 showed: - Check blood sugars daily at 6:00 A.M. for diabetes mellitus. Notify the physician for blood sugars less than 60 or greater than 400. Review of the resident's MAR, dated October 2024 showed: - Check blood sugars daily at 6:00 A.M. for diabetes mellitus. Notify the physician for blood sugars less than 60 or greater than 400. Observation on 10/8/24 at 5:59 A.M., showed: - LPN B cleaned the resident's finger tip with an alcohol wipe, allowed it to air dry for four seconds and obtained the resident's blood sugar. 3. Review of Resident #43's POS, dated October 2024 showed: - Start date: 8/22/23 - Check blood sugars before meals and at bedtime for diabetes mellitus. Notify the physician for blood sugars less than 60 or greater than 400. Review of the resident's MAR, dated October 2024 showed: - Check blood sugars before meals and at bedtime for diabetes mellitus. Notify the physician for blood sugars less than 60 or greater than 400. Observation on 10/8/24 at 6:03 A.M., showed: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- LPN B cleaned the resident's finger tip with an alcohol wipe, allowed it to air dry for six seconds and obtained the resident's blood sugar. During an interview on 10/8/24 at 6:09 A.M., LPN B said: - He/she should have let the finger tip air dry for 15 to 20 seconds before obtaining the blood sugar. During an interview on 10/10/24 at 6:25 P.M., the Director of Nursing (DON) said: - Staff should let the residents' finger tips air dry before obtaining the blood sugar; - She was not for sure how long the finger tip should air dry. 46706 4. Review of the facilty's policy Transdermal Drug Delivery System (Patch) Application Procedures, dated February 2018, showed in part: -To administer medication through the skin for continuous absorption while the patch in place through proper placement of the patch and care of the application sites; -Check MAR for correct medication, amount and time; -Remove patch from package and initial and date at this time; -Rotate placement sites; -Remove old patch before applying new patch; -Document on MAR (Medication Administration Record) Review of the manufacturer's guidelines for Salonpas 4% Patch (a patch used to treat pain), dated 2023 showed: -The patch should be applied to clean dry skin on the affected area; -Each patch should be removed after a maximum of eight hours of use. Review of the manufacturers guidelines for Humalog insulin (used to treat high blood sugar) dated 2023 showed: - Administer Humalog insulin 15 minutes before a meal. 5. Review of Resident #91's POS, dated October 2024 showed: -Start date: 8/23/24 Salonpas 4% Patch, apply 2 patches to right posterior shoulder, on in the A.M. and of at H.S. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's MAR, dated October 2024 showed: -Salonpas 4% Patch, apply 2 patches to right posterior shoulder, on in the A.M. and of at H.S.; -Documentation on 8/8/24 showed the patches were initialed by staff to indicate they were administered to the resident at 8:00 P.M. Observation and interview on 10/9/24 at 8:44 A.M., showed: -LPN E washed his/her hands and removed the new patches from the box and dated and initialed them; -The nurse entered the resident's room and removed the resident's clothing from the right shoulder; -There are two patches both dated 10/8/24 with no initials on the residents right shoulder; -The nurse removed the patches dated 10/8/24 from the resident's right shoulder; -The nurse said the old patches dated 10/8/24 should have been removed last night; -The nurse said the MAR showed that the patches were removed last night at 8:00 P.M., but the patches were still on the resident this morning; -The nurse said the physician's order should be followed. During an interview on 10/9/24 at 8:48 A.M., the resident said: -His/Her shoulder hurts; -The patches help; -He/she is supposed to have the patches taken off at night. 6. Review of Resident #103's POS, dated October 2024 showed: -Check blood sugars before meals and bedtime; for diabetes mellitus; -Humalog 100 units/ ml give at meal times per sliding scale; o less than 150 - 0 units; o 150 - 200 give 2 units; o 201 - 250 give 4 units; o 251 - 300 give 6 units; o 301 - 350 give 8 units; (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	o 351 - 400 give 10 units; -Notify the physician for blood sugars less than 60 or greater than 400. Review of the resident's MAR, dated October 2024 showed: -Check blood sugars before meals and bedtime; for diabetes mellitus; -Humalog 100 units/ ml give at meal times per sliding scale; o less than 150 - 0 units; o 150 - 200 give 2 units; o 201 - 250 give 4 units; o 251 - 300 give 6 units; o 301 - 350 give 8 units; o 351 - 400 give 10 units; -Notify the physician for blood sugars less than 60 or greater than 400. Continuous observation starting on 10/9/24 at 11:51 A.M., and ending on 10/9/24 at 12: 52 P.M., showed: -11:51 A.M., LPN E obtained the resident's blood sugar; -The resident's blood sugar was 246; -11:54 A.M.,The nurse administered and 4 units of Humalog insulin as directed by sliding scale; -11: 58 A.M.,The nurse left the resident's room; -12:15 P.M., The resident is setting in his/her room watching T.V., -12:33 P.M., The resident is setting in his/room and took a drink from a Styrofoam cup setting in the bedside table; -12:35 P.M. The resident continues to set in his/her room at the bedside table; -12:40 P.M., No staff have checked on him/her since he/she received the insulin; -12:42 P.M., The resident said he/she is hungry; -12:49 P.M., The Registered Dietitian (RD) brings the room trays to F hall and leaves the cart; (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-12:52 P.M., Certified Nurses Aide (CNA) K took the resident's tray to him/her and the resident began eating; -12:52 P.M., The facilty failed to provide the resident his/her meal within 15 minutes of administration of insulin as directed by the manufacture's guidelines. During an interview on 10/9/24 at 12:58 P.M., LPN E said: -The resident usally eats in the dining room; -He/she thought the resident had went to the dining room to eat his/her meal; -The resident receives fast acting insulin and should eat between 30 and 45 minutes; -The resident should not have went an hour after the insulin was given to eat a meal. During an interview on 10/10/24, at 6:25 P.M., the DON said: -Physician's orders should be followed: -When the order shows to remove patches at night the staff should remove the patches from the resident; -The patches from the day before should not be on the resident the next morning; -Humalog is a short acting insulin; -Humalog should be given no earlier than 10 minutes before a meal; -A resident should not be given a fast acting insulin and wait 45 minutes to an hour for a meal, that is too long.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 46706 Based on observations, interviews, and record review, the facility failed to ensure staff provided a safe and effective medication administration system that was free of significant medication errors when staff failed to provide a meal to a resident within 15 minutes after receiving fast acting insulin. This affected one out of 21 sampled residents, (Resident #103). The facility census was 103. Review of the facility's policy for general guidelines for medication administration, dated 8/16, showed, in part: - Medications are administered as prescribed, in accordance with good nursing principles and practices and only be persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication; - Medications are administered in accordance with written orders of attending physicians, taking into consideration manufacturer's specifications and professional standards of practice; - 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; - The resident's medication administration record (MAR)/treatment administration record (TAR) is initialed by the person administering a medication, in the space provided under the date, and on the line for that specific medication dose following medication administration. Initials on each MAR/TAR are verified with a full signature in the space provided or on the signature log. The electronic (eMAR/eTAR) uses an electronic signature; - Placing an initial in the space provided on the MAR/eMAR and TAR/eTAR also indicates that the nurse who administered the medication is observing for side effects. Review of the facility's policy for insulin injections, dated 7/24 showed, in part: - Daily insulin injections are given with a physician's order. Injection sites will be rotated. Insulin will be given before meals unless otherwise ordered by the physician; - The policy did not indicate how long a resident should wait to eat a meal after receiving insulin. Review of the manufacturers guidelines for Humalog insulin (used to treat high blood sugar) dated 2023 showed: - Administer Humalog insulin 15 minutes before a meal. 1. Review of Resident #103's Physician's Order Sheet (POS), dated October 2024 showed: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Check blood sugars before meals and bedtime; for diabetes mellitus; -Humalog 100 units/ ml give at meal times per sliding scale; o less than 150 - 0 units; o 150 - 200 give 2 units; o 201 - 250 give 4 units; o 251 - 300 give 6 units; o 301 - 350 give 8 units; o 351 - 400 give 10 units; -Notify the physician for blood sugars less than 60 or greater than 400. Review of the resident's Medication Administration Record (MAR), dated October 2024 showed: -Check blood sugars before meals and bedtime; for diabetes mellitus; -Humalog 100 units/ ml give at meal times per sliding scale; o less than 150 - 0 units; o 150 - 200 give 2 units; o 201 - 250 give 4 units; o 251 - 300 give 6 units; o 301 - 350 give 8 units; o 351 - 400 give 10 units; -Notify the physician for blood sugars less than 60 or greater than 400. Continuous observation starting on 10/9/24 at 11:51 A.M., and ending on 10/9/24 at 12: 52 P.M., showed: -11:51 A.M., Licensed Practical Nurse (LPN) E obtained the resident's blood sugar; -The resident's blood sugar was 246; -11:54 A.M.,The nurse administered and 4 units of Humalog insulin as directed by sliding scale; -11: 58 A.M.,The nurse left the resident's room; (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-12:15 P.M., The resident is setting in his/her room watching T.V., -12:33 P.M., The resident is setting in his/room and took a drink from a styrofoam cup setting in the bedside table; -12:35 P.M. The resident continues to set in his/her room at the bedside table; -12:40 P.M., No staff have checked on him/her since he/she received the insulin; -12:42 P.M., The resident said he/she is hungry; -12:49 P.M., The Registered Dietitian (RD) brings the room trays to F hall and leaves the cart; -12:52 P.M., Certified Nurses Aide (CNA) K took the resident's tray to him/her and the resident began eating; -12:52 P.M., The facilty failed to provide the resident his/her meal within 15 minutes of administration of insulin as directed by the manufacture's guidelines. During an interview on 10/9/24 at 12:58 P.M., LPN E said: -The resident usally eats in the dining room; -He/she thought the resident had went to the dining room to eat his/her meal; -The resident receives fast acting insulin and should eat between 30 and 45 minutes; -The resident should not have went an hour after the insulin was given to eat a meal. During an interview on 10/10/24, at 6:25 P.M., the Director of Nursing (DON) said: -Physician's orders should be followed: -Humalog is a short acting insulin; -Humalog should be given no earlier than 10 minutes before a meal; -A resident should not be given a fast acting insulin and wait 45 minutes to an hour for a meal, that is too long.

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	10/15/2024

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47195 Based on observation and interview, the facility failed to provide food that was palatable and attractive when hall trays were not served per resident food preferences and was not attractive. The deficient practice affected two of 21 sampled residents (Resident #85 and #52). The facility census was 103. The facility did not provide a policy for resident food preferences. 1. Review of Resident #85's Quarterly MDS, dated [DATE], showed: -He/She had severe cognitive impairment; -He/She required set up or clean up assistance with eating; -Diagnoses included: cancerous tumor, dementia, and anxiety. Review of care plan, undated, showed: -He/She was able to feed self but had dementia that may affect food intake and his/her weight; -Obtain/update food preferences; -Serve diet as ordered. Review of physician's orders, dated October 2024, showed: -Ordered 6/10/24, He/She was on a regular diet. During an observation on 10/9/24 at 1:10 P.M., showed: -Resident's rice was in form of ice cream scoop; -Resident observed having to cut rice with knife due to dry texture. During an interview on 10/9/24 at 1:10 P.M., Resident said: -Food was really dry. 2. Review of Resident #52's Quarterly MDS dated [DATE], showed: -He/She had moderate cognitive impairment; -He/She had clear speech and was able to make self-understood and understand others; -He/She required set up or clean up assistance with meals; (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses included stroke (damage to the brain from interruption of its blood supply) and dementia. Observation on 10/9/24 at 1:05 P.M., Resident showed: -Resident was sticking his/her fingers in his/her mouth to scoop out chewed up chicken; -Resident was served a plate of chicken, rice, bowl of carrots, and banana pudding; -Meal ticket showed carrots, pudding, roll, baked chicken, and buttered orzo, disliked rice and liver, regular diet. During an interview on 10/9/24 at 1:05 P.M., Resident #52 said: -Chicken was cooked to well done and was very dry -He/She was having so much trouble eating it; -He/She did not like rice. During an interview on 10/10/24 at 1:35 P.M., Dietary Manager said: -Food should be served at safe and palatable temperatures; -He/She was not aware of any current food complaints. During an interview on 10/10/24 at 6:56 P.M., Administrator said he/she expected food to be served palatable.

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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** 44395 Based on observation, interviews, and record review, the facility failed to ensure the walls, ceilings, and floors, of the facility were maintained in good repair. This had the potential to affect all residents. The census was 103. The facility did not provide a policy on upkeep and repair. 1. Observations beginning on 10/08/24 at 7:58 A.M. on the Special Care Unit (SCU) showed: -Hallway light fixtures had dead bugs, dust and debris; -Hallway hand rails were scratched and had scuff marks; -The Utility room door had large scratches and chipped paint; -room [ROOM NUMBER] entry door was scratched with large areas of chipped paint and drug against the floor when opening/closing; -room [ROOM NUMBER] entry door had chipped paint that exposed the wood underneath; -room [ROOM NUMBER] entry door was scratched with chipped paint; -room [ROOM NUMBER] entry door had multiple paint chips that exposed the wood underneath; -The Dining/Activity room baseboard had thick black/gray, crusty debris at edge of baseboard and floor; multiple stained and scuffed floor tiles; the walls had scuffs and gouges in the paint; light fixtures had dead bugs, dust and debris; door jam had scuffs and chips in the paint; missing and broken tile under the Packaged Terminal Air Conditioner (PTAC: is a ductless, self-contained unit that can heat and cool a small area); the baseboard at the edge of the PTAC was peeling away from the wall; windowsills had thick gray/brown dust and debris; the chair rail had a layer of dust on the top edge; window blinds were coated with gray dust and debris; the PTAC unit had black mold like substance on the vent and the filter; an over the bed table had peeling laminate covering that exposed the [NAME] underneath; -Nurse's station had chipped wood and paint exposing the wood underneath. The trim was cracked, leaving sharp edges. The floor had dark, black, crusty debris at the edge of the desk and the floor; -Hallway near the Activity Room exit door had large cobwebs with dead bugs, the window frame was chipped and rusted; -The sliding doors had dirt, debris, and cobwebs in them; -The PTAC had dirt, dust and debris in the vent; (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The patio exit had cracked tiles, dirt, debris, and cobwebs in the corners; the window had dead bugs and dust on the sill; the window frame was chipped and rusted with sharp edges exposed; -The second [NAME] entrance had multiple cracked tiles; cobwebs in corners; mini blinds were stained and coated with dust; the metal door frame was chipped and rusted with sharp edges; -Both sets of entrance doors are chipped with exposed wood underneath. During an interview on 10/10/24 at 4:13 PM Housekeeping Staff A said: -Maintenance does the high dusting up in the corners of the hallways and cleans the lights; -Floor technicians are responsible for the floors in the halls and common areas; -Repairs are completed by Maintenance. During an interview on 10/10/24 at 4:42 PM the Maintenance Director said: -He/She had been in that position for 2 years; -The floor techs was responsible for scraping the baseboard edge and getting behind any doors in the hallways; -Housekeeping was responsible for all dusting; -Maintenance does not clean the lights, housekeeping should clean the lights of dead bugs and debris; -Maintenance was only responsible for repair and upkeep of the facility; -Nurses use a texting system to notify him/her of any problems or repairs needed; -He/She was not behind on any reported concerns; -He/She had a project; as rooms open up they are refurbished such as; painted, door fixed, walls fixed, floor fixed; -The PTAC units are cleaned one hall at a time, once a quarter; -He/She was aware there were rusted door frames. Those require a contractor and one has not been contacted; -He/She was aware there was patching and painting to be done; -There is no written plan for repair and upkeep of the building. During an interview on 10/10/24 at 6:25 PM the Administrator said he expects the building to clean and in good repair.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44395 Based on observations, interviews and record review, the facility failed to maintain an effective pest control program to prevent gnats, flies and wasps in resident rooms, dining rooms, and hallways. The facility census was 103. The facility did not provide a pest control policy. 1. Observation on 10/07/24 at 9:18 AM showed multiple gnats in room [ROOM NUMBER]. 2. Observation on 10/07/24 at 11:05 A.M. showed multiple flies in the dining room. 3. Observation on 10/07/24 11:21 AM showed room [ROOM NUMBER]: -A fly strip hanging from the room divider with multiple dead flies on it; -Multiple flies and gnats in the room. 4. Observation on 10/07/24 at 11:30 AM Resident #18 said -There were flies in his/her room a lot; -There were multiple flies in room, landing on resident and crawling on the bed. 5. Observation on 10/08/24 at 7:58 A.M. on the Special Care Unit showed: -Two large wasps on the nursery room wall; -room [ROOM NUMBER] had multiple flies in the room, crawling on the resident, the bed and flying throughout the room. 6. Review of pest service invoices showed: -Outside in large fly control program date of service 7/31/24; -Outside in large fly control program date of service 8/28/24; -Outside in large fly control program date of service 9/25/24. During an interview on 10/10/24 06:25 P.M. the Administrator said: -There is a pest control program; -There should not be a fly strip in a resident's room; -Pest control will be notified of concerns.