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	11/20/2025

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to treat residents with dignity and respect when staff allowed Resident #64 to scream and yell obscenities in the hall and dining room while Resident #41 sat in the dining room, and when staff failed to acknowledge Residents #22 and #33 when they rang their call light and asked for a snack. This affected three of 24 sampled residents. The facility census was 119.Review of the facility's Resident Rights policy dated, January 2023 showed:-Each resident had the right to a dignified existence, in an environment that promotes maintenance or enhancement of his/her quality of life;-Each resident had the right to self determination, which the facility must promote and facilitate through the support of resident choice;-The resident had the right to a comfortable and home like environment.1. Review of Resident #41's admission minimum data set (MDS) a federally mandated assessment instrument completed by facility staff, dated 8/25/25 showed:-Moderate cognitive impairment;-Independent with Activities of Daily Living (ADLs);-Diagnosis included dementia, high blood pressure, and diabetes.Review of the resident's care plan dated 8/28/25 showed:-The resident had impaired cognitive function related to dementia;-The resident had the potential to be verbally aggressive;-Guide the resident away from sources of distress. 2. Review of Resident #64's quarterly MDS dated [DATE] showed:-Severe cognitive impairment;-Assistance of one staff member for ADLs;-Diagnoses included seizure disorder, traumatic brain injury, and anxiety.Review of the resident's care plan dated 8/2/25 showed:-The resident had a behavior problem;-Made negative statements to other residents;-Verbally aggressive;-Staff are to explain inappropriate behavior to the resident;-Staff are to intervene as necessary to protect the rights of others;-Staff are to divert resident's behavior by offering other tasks such as painting, coloring or journaling.Observation and interview on 09/30/25 at 1:12 P.M., showed:-Certified Nurse's Aide (CNA) D walked with Resident #64 up and down the hall and into the dining room of the memory care unit;-Resident #64 yelled out I hate you and Go to hell as he/she walked past the dining room;-Resident #64 continued to yell out and cry as he/she walked around the dining room with CNA D;-Resident #41 sat in the dining room and said out loud All the yelling that man/woman does gets on my nerves. It is the same thing every day, resident #64 gets up and starts yelling and cussing. It is very negative and hard to deal with every day;-Visitor A sat next to Resident #41 and said he/she came to visit Resident #41 at least three times per week;-Visitor A said Resident #64 is always shouting and yelling obscenities;-Visitor A said Resident #41's room is across from Resident #64's room and it keeps Resident #41 up at night;-Visitor A said the staff knew about the yelling;-CNA B was in the dining room;-Licensed Practical Nurse (LPN) C was at the nurse's station;-No staff explained the inappropriate behavior to Resident #64;-No staff intervened to protect the rights of other residents;-No staff attempted to divert Resident #64's behavior by offering other tasks such as painting, coloring or journaling.Observation and interview on 10/1/25 at 09:35 A.M. showed:-CNA D walked with Resident #64 up and down the hall;-Resident #64 yelled I wish I was dead, I am going to kill you;-CNA D walked with Resident #64 up and down the hall and into to the dining room;-Resident #41 sat in the dining room;-Resident #41 said the yelling is so negative, and so (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 - Some	is the cussing and foul language every day, how would you like to wake up to this, it is so hard to deal with day in and day out;-LPN C was at the medication cart at the nurses station;-CNA B was in the dining room;-No staff explained the inappropriate behavior to the resident;-No staff intervened to remove Resident #64 away from Resident #41;-No staff attempted to divert resident's behavior by offering other tasks such as painting, coloring or journaling.During an interview on 10/1/25 at 10:25 A.M., CNA D said:-Resident #64 yelled all the time and the other resident's became agitated;-Resident #41 complained about the yelling;-He/She was not aware of the interventions on how to redirect Resident #64.During an interview on 10/1/25 at 10:39 A.M., CNA B said:-Resident #64 always yelled and cussed;-The yelling upset the other residents;-The other residents tell Resident #64 to shut up;-The staff try to take Resident #64 into his/her room until he/she calms down.During an interview on 10/1/25 at 10:52 A.M., LPN C said:-Resident #64 yelled and cussed out loud several times daily;-Resident #64's disease process had progressed;-The yelling upset other residents daily;-The management knew about the behaviors of Resident #64;-More cognitively intact residents such has Resident #41 complain more;-The staff do the best they can to redirect Resident #64;-It was very agitating to the other residents.During an interview on 10/3/25 at 11:24 A.M., the Director of Nursing said:-Resident #64 had a history of yelling out;-The facility tried to redirect Resident #64 as needed:-She was not aware Resident #41 was upset about Resident #64's behavior;-She expected the interventions included on Resident #64's care plan to be followed;-She expected staff to ensure Resident #41's right to be free from Resident #64's yelling to be followed.During an interview on 09/3/25 at 11:45 A.M., the Administrator said:-Resident #41 had the right to be free from resident #64's yelling and cussing;-He expected staff to utilize the interventions on Resident #64's care plan to redirect the behavior.3. Review of Resident #22's quarterly MDS dated [DATE] showed:-Moderate cognitive impairment;-Set up help with eating and oral care;-Supervision with showers;-Diagnoses included Alzheimer's Disease, diabetes, and anxiety.Review of the resident's care plan dated 7/18/25 showed:-Dependent staff to meet physical and emotional needs;-The resident had an ADL self care deficit Alzheimer's Disease;-Encourage the resident to use call bell for assistance;-The resident had a diagnoses of diabetes. 4. Review of Resident #33's quarterly MDS dated , 7/18/25 showed:-Severe cognitive impairment;-Set up help with eating and oral care;-Dependent on staff for showers and toileting;-Diagnoses included, dementia, anemia, and low sodium in the blood.Review of the resident's care plan dated 8/2/25 showed:-Dependent on staff to meet physical and emotional needs;-The resident had an ADL self care deficit related to dementia;-Encourage the resident to use call bell for assistance;-The resident is at risk for dehydration.Observation on 9/1/25 from 11:11 A.M. to 11:39 A.M., showed:-11:11 A.M., Resident #22 sat in room his/her and yelled into the hall that he/she was hungry and wanted a snack and his/her roommate, Resident #33 wanted a snack also;-11:15 A.M., Resident #22 put his/her call light on and yelled out in the hall again he/she wanted a snack as CNA D walked by the residents' room.-11:13 A.M., Resident #33 yelled out into the hall he/she wanted a snack too;-11:18 A.M., CNA D walked by Resident #22's and #23's room and did not acknowledge the residents;-11:24 A.M., CNA D walked back by the residents' room again and did not give the residents a snack or acknowledge the residents;-11:25A.M., CNA D's pager was still going off as he/she walked past the room of Residents #22 and #23;-11:26 A.M., CNA D walked back by the residents' room to room [ROOM NUMBER] and shut the door without giving Residents #22 and #23 a snack;-11:27 A.M., LPN C walked into the residents' room and shut the call light off and the residents said they wanted a snack;-11:39 A.M., LPN C brought the drink cart to the residents' room, but no snacks.During an interview on 9/1/25 at 11:45 A.M., Resident #22 said:-He/She expected the staff to bring a snack if he/she wanted one;-He/She was a diabetic and needed a snack sometimes;-It made him/her feel disrespected when the staff did not acknowledge him/her.During an interview on 9/1/25 at 11:50 A.M., Resident #23 said:-The staff have a lot to do, but it would be nice if they could come in and at least say they would help him/her in a minute instead of walking by like they do not see him/her;-It made him/her feel like a burden when staff did not bring a snack. During an interview on 9/1/25 at (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11:52 A.M., CNA D said:-He/She had to take care of another resident first;-He/She was not aware Resident #22 and #23 wanted a snack;-Residents #22 and #23 have the right to a snack;-He/She should have acknowledged Residents #22 and #23 and told then he/she would come back.During an interview on 9/1/25 at 12:05 P.M., LPN C said:-When Resident #23 and #33 wanted a snack staff should have took a moment to give them one;-It is the resident's right to get a snack;-Staff should at least have told the residents it would be a moment;-He/She took only the drink cart into the residents' room, because lunch was going to be served in a few minutes.-She expected staff to acknowledge Resident #22 and #23 and give then a snack if they wanted one.During an interview on 09/3/25 at 11:45 A.M., the Administrator said:-He expected staff to answer Resident #22 and #23's call light and acknowledge them;-He expected to staff to get a snack and drink for Residents #22 and #23;-He expected staff to treat Resident #22 and #23 with dignity and respect.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review, the facility failed to inform residents and/or their responsible parties, in advance of the risks and benefits of proposed care, when the facility failed to obtain written consent before beginning psychotropic medications (medications that affect the mind, emotions, and behavior) for four residents (Resident #37, #5, #8, and #79) of the 24 sampled residents. The facility census was 119. Review of facility's Resident [NAME] of Rights policy, dated January 2023, showed: The facility residents have the right to be informed in advance of the risks and benefits of proposed care, of treatment alternatives or treatment options, and to choose the treatment option or alternative he or she prefers. 1.Review of Resident #37's care plan, dated 9/3/25, showed the resident used antidepressant medication for the treatment of depression and also used anti-anxiety medication for the treatment of anxiety. Review of the resident's physician order sheet, dated January of 2025 through February of 2025, showed:-The resident's order for Buspirone (anti-anxiety medication) 10mg (milligram) by mouth three times a day, began on 2/2/25;-The resident's order for Escitalopram (antidepressant medication) 20mg by mouth once a day, began on 1/8/25;-The resident's order for Modafinil (medication for narcolepsy) 100mg by mouth once a day, began on 1/8/25. Review of the resident's consent form for psychotropic medications, dated 8/28/2025, showed: the facility did not obtain verbal consent from the resident's representative until 8/28/25 for the resident to take psychotropic medications that was initiated on 1/8/25 and 2/2/25. 2. Review of Resident #5's care plan, undated, showed:-The resident was dependent on staff for meeting emotional, intellectual, physical, and social needs related to cognitive deficits;-The resident had impaired cognitive function related to Alzheimer's, dementia, and cerebral infarction (death of brain tissue cause by lack of blood flow);-The resident used antidepressant medication related to depression. Review of the resident's physician order sheet, for the month of August 2025, showed:-The resident's order for Trazodone HCl 25mg (an antidepression medication) by mouth, one time a day and began on 8/17/25.-The resident's order for Rivastigmine Transdermal Patch 4.6mg (a medication used for Alzheimer's disease) apply one patch every 24 hours, began on 8/22/25. Review of the resident's consent form for psychotropic medications, dated 8/28/25, showed: the facility did not obtain consent from the resident's representative prior to the start of Trazodone on 8/17/25 and Rivastigmine on 8/22/25. 3. Review of Resident #8's medication administration record (MAR) for the month of June 2025, showed the resident had a diagnosis of generalized anxiety disorder and depression. Review of the resident's physician order sheet for the month of November 2025, showed:-The resident's order for Buspirone 10mg three times a day, by mouth, began on 11/20/24;-The resident's order for Sertraline HCl 50mg (used to treat depression) one time a day, by mouth, began on 11/1/24. Review of the resident's consent form for psychotropic medications, dated 3/5/25, showed the facility did not obtain consent prior to the start of Buspirone and Sertraline from the resident or the resident's representative. Consent was not obtained until four months after the medication began. 4. Review of Resident #79's care plan, dated 9/3/25, showed the resident used antidepressant medication for the treatment of depression, psychotropic medications for behaviors, and anti-anxiety medications for anxiety. Review of the resident's physician order sheet for the months of January 2025 and February 2025, showed:-The resident's order for Escitalopram Oxalate 20mg daily by mouth, for the treatment of anxiety, began on 1/8/25;-The resident's order for Buspirone 10mg three times a day by mouth, for the treatment of depression, began on 2/2/25;-The resident's order for Modafinil 100mg daily by mouth, for the treatment of narcolepsy, began on 1/8/25. Review of the consent form for psychotropic medications, dated 8/28/25, showed the facility did not obtain consent from the resident's representative prior to taking Buspirone, Escitalopram, and Modafinil until 8/28/25. During an interview on 10/03/2025 at 10:49 A.M., the DON said the nurses or administration would call the family to obtain consent from the resident representative before a psychotropic medication was started. The DON was unaware consent was not being done prior to the (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administration of psychotropic medications. During an interview on 10/03/2025 at 11:14 A.M., LPN B said the nurse or unit manager was responsible for obtaining consent from the resident or family member before starting a psychotropic medication. During an interview on 10/03/2025 at 11:30 A.M., the corporate nurse said social services or nursing staff should obtain consent from the resident or the resident's family for psychotropic medications before the start of the medication. During an interview on 10/03/2025 at 11:35 A.M., the Administrator said nursing staff or social services should obtain consent from the resident or their family member before starting psychotropic medications.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections, when facility staff failed to utilize appropriate personal protective equipment (PPE) for two Residents (Resident #13 and #112) of 24 sampled residents. The facility census was 119. Review of the facility's Management of Communicable Diseases policy, dated, September 2019, showed: -Standard precautions (a set of evidence-based infection control practices designed to prevent the transmission of infections in healthcare settings which includes: hand washing, wearing gloves, gowns, masks, and regularly cleaning equipment) are intended to be applied to the care of all patients in all healthcare setting, regardless of the suspected or confirmed presence of an infectious agent; -The facility will establish guidelines to prevent the transmission of infections, communicable disease, and healthcare acquired infections. Review of the facility's Enhanced Barrier Precautions policy, dated April 2024, showed:- Enhanced Barrier Precautions (EBP) are indicated for residents with infections or for residents with wounds and/or indwelling medical devices during high-contact resident care activities as these residents are at an increased risk of being infected;- EBPs involve gown and glove use during high-contact resident care activities including, device care or use for central line, urinary catheter, feeding tube, tracheostomy, or ventilator;- EBPs are intended to remain in effect for the duration of the resident stay or until the wound is closed/medical device removed. 1.Review of Resident #112's Care Plan, undated, showed: -The resident had impaired cognitive function due to dementia; -The resident had a diagnosis of diabetes mellitus; -The resident had the potential of impairment to skin integrity due to diabetes, fragile skin. Review of the resident's physician order sheet for the months of September 2025 and October 2025, showed: -The resident had an order for blood sugar checks four times a day; -The resident had an order for insulin Aspart 5 units (a medication to help control blood sugar) to given subcutaneous (an injection under the skin into the fatty layer) before meals. Observation on 10/02/2025 at 11:06 A.M., showed Licensed Practical Nurse (LPN) B sanitized hands while walking into Resident #112's room then administered insulin subcutaneously without wearing gloves. During an interview on 10/03/2025 at 11:14 A.M., LPN B said: -Gloves are to be worn when administering insulin. He/she should have worn gloves; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-EBP supplies are worn with catheters, wounds, and feeding tubes, there is a sign placed on the door for residents who need EBP. 2. Review of the Resident #13's Comprehensive Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 8/22/25, showed:- Cognitive skills severely impaired;- Dependent on staff for transfers, toilet use, showers, dressing, and personal hygiene;- Diagnoses included: cerebral palsy (a group of movement disorders that affect a person's ability to control their muscles), aphasia (a language disorder that affects a person's ability to communicate effectively), and quadriplegia (a condition that causes paralysis in all four limbs). Review of the resident's care plan, revised 9/9/25, showed:- The resident was to have nothing by mouth due to diagnoses and was to receive nutrition by feeding tube;- Nursing staff would provide tube feeding and flushes as ordered by the physician;- The resident required EBP due to feeding tube;- Nursing staff would place EBP sign on the resident's door and apply personal protective equipment (PPE) for high contact care activities. Observation on 10/01/2025 at 11:56 A.M., showed: - An EBP sign on door to the resident's room and an EBP box hanging on the resident's room door that contained all supplies, such as gowns, gloves, and trash bags; - LPN A entered Resident #13's room to perform tube feeding; - A small handwritten sign above the resident's bedside table that stated to use EBP with high contact resident activities; - LPN A sanitized hands, grabbed wipes, applied gloves and wiped down the resident's bedside table;- LPN A let the table dry, sanitized hands, applied gloves, grabbed a graduate and syringe, and did not apply a gown and continued with the tube feeding process; During an interview on 10/1/25 at 11:59 A.M., LPN A said:- He/She should have put the gown on;- He/She was uncertain why a gown would be needed. 3. During an interview on 10/03/2025 at 8:48 A.M., Certified Nursing Aide (CNA) A said EBP should be used with indwelling devices like catheters and feeding tubes. During an interview on 10/03/2025 at 9:00 A.M., LPN A said EBP should be used anytime when performing cares with a resident with wound, an ostomy, feeding tub. During an interview on 10/03/2025 at 9:20 A.M., Registered Nurse (RN) A said:- Staff should utilize EBP when providing working with a resident's indwelling catheter;- EBP would be used depending on why its required for that resident. If because of a device like a feeding tube or catheter, staff should use EBP with high contact cares, during wound care, and if a highly contagious infection EBP would be used all the time. During an interview on 10/03/2025 at 10:03 A.M., the Corporate Nurse said staff should use EBP for residents with indwelling devices like feeding tubes and catheters and for extended high contact care. During an interview on 10/03/2025 at 12:52 P.M., the Director of Nursing said staff should use EBP when providing high levels of direct patient care like flushing a feeding tube or working with a catheter or wound.