STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265482	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River City Living Community	3038 West Truman Blvd Jefferson City, MO 65109

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42815 Based on interview and record review, facility staff failed to ensure one resident (Resident #1) remained free from sexual abuse, when Certified Nurse Assistant (CNA) A sexually assaulted the resident. The facility failed to protect the resident from further abuse when CNA D witnessed the assault, did not intervene, and did not report it immediately. CNA A worked an additional 18 overnight shifts after the sexual abuse was observed. The facility census was 52. The Administrator was notified on [DATE], of an Immediate Jeopardy (IJ) which began on [DATE]. The IJ was removed on [DATE] as confirmed by surveyor onsite verification. Review of the facility's policy titled, Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property Policy, undated, showed it is the policy of the facility each resident will be free from abuse, Review showed abuse can include verbal, mental, sexual, or physical abuse, misappropriation of resident property and exploitation, corporal punishment or involuntary seclusion. Residents will be protected from abuse, neglect, and harm while they are residing at the facility. An owner, licensee, Administrator, Licensed Nurse, employee or volunteer of a nursing home shall not physically, mentally or emotionally abuse, mistreat or neglect a resident. No abuse abuse or harm of any type will be tolerated, and residents and staff will be monitored for protection. Review of Resident #1's Annual Minimum Data Set (MDS), a federally mandated assessment tool, dated [DATE], showed a diagnosis of dementia. Review of the facility's investigation, dated [DATE], showed staff documented: -A report of an alleged sexual assault received, and an investigation started on [DATE] which allegedly occurred on [DATE] between 04:30 A.M. and 05:30 A.M. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-CNA D's written statement showed he/she witnessed CNA A having sexual intercourse with the resident. CNA D documented he/she witnessed it from the window outside the resident's room between 4:30 A.M. and 5:30 A.M. on [DATE]. CNA A entered the resident's room and walked to the resident's bedside and began to rub the resident's legs through the comforter. CNA A then bent down and kissed the resident on the mouth. CNA A then guided the resident out of bed and into the bathroom, they stopped in the doorway where CNA A and the resident hugged and kissed for a while then went into the bathroom and stayed for a while. CNA A left the bathroom and the resident ran out of the bathroom naked to his/her bed, laid in a fetal position, with his/her buttocks faced outward towards the edge of the bed. CNA A returned to the room with a wet towel and wiped the resident's private areas. CNA A then walked to the closet and got clothes out for the resident, walked back to his/her bed, raised the bed to his/her waist level, and began to perform sexual intercourse with the resident. CNA D documented when CNA A finished with sexual intercourse, CNA A cleaned the resident's private area with the wet towel. Review of the local law enforcement report, dated [DATE], showed the police officer documented: -On [DATE], a police officer responded to the facility at 1:43 P.M. for a report of a sexual offense. The officer documented the administrator said he/she was notified on [DATE] at 3:00 P.M. by CNA D of a sexual assault and CNA D had a video of the assault. The administrator told the officer he/she started an investigation on [DATE]. CNA D said he/she suspected CNA A of assaulting the resident for a while, but did not report it because he/she wanted proof before reporting. CNA D said he/she was in the courtyard recording through the window, witnessed CNA A enter the resident's room between 4:30 A.M. and 5:30 A.M. and observed CNA A rub the residents leg and bend down to kiss him/her. CNA D said he/she saw CNA A take the resident from his/her bed and headed to the bathroom, stopped at the bathroom entry and hugged and kissed passionately. CNA D said CNA A and the resident were in the bathroom for a while, when the CNA A left the room and the resident came out of the restroom naked, possibly with a T-shirt covering his/her chest area. CNA D said CNA A returned to the resident's room with a washcloth and wiped the resident's genitals from front to back multiple times. CNA D told the officer CNA A raised the resident's bed higher, unzipped his/her pants and penetrated the resident. CNA D told the officer CNA A penetrated the resident for a long time. CNA D said he/she did not know if CNA A penetrated the resident in his/her genital or anal area. CNA D said CNA A went to the restroom after the assault. CNA D said later in the morning he/she assisted the resident to the restroom and observed a blood like substance in the toilet. CNA D informed he/she had the video, but the video was dark. CNA D said he/she did not know how to find the date and time of occurrence, because he/she did not know how to search for it on his/her phone. CNA D said the resident thought CNA A was his/her deceased spouse and called the CNA by his/her spouse's name. Review showed the officer documented he/she spoke with the (Sexual Assault Nurse Examiner) SANE nurse on [DATE] around 3:30 P. M. and the nurse told the officer the resident had a bruise on his/her elbow, but the resident denied consent on anything further; -On [DATE], the family member said he/she was informed on [DATE] by facility staff the resident was assaulted. The family member said the resident had a diagnosis of dementia and would call other resident's at the facility by his/her deceased spouse's name. He/She said the resident was examined by the emergency room staff and by a SANE nurse. The family member said he/she left the resident in the examination room with the SANE nurse. The family member said he/she was called back to the room about fifteen minutes later to attempt to calm the resident. The family member said he/she did not believe the examination was conducted due to the short period of time before being called back to the room; (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-On [DATE], CNA D provided the detective with a copy of his/her written statement he/she provided to the facility. CNA D confirmed he/she had a video of the sexual assault on his/her phone. CNA D gave his/her cell phone to be downloaded for the investigation. CNA D said he/she had suspected CNA A of having inappropriate relations with nursing home residents for a while, but did not have proof of anything, so he/she did not report his/her concerns because he/she did not want to make false accusations and ruin CNA A's reputation. CNA D said he/she witnessed CNA A enter the resident's room the morning of [DATE]. CNA D said he/she was in the courtyard and could see into the resident's room and recorded the incident. He/She said the recordings were poor quality and CNA D contacted various businesses to find someone to enhance the quality of the video, but was unable to. CNA D said he/she was concerned the video's would delete after a month, so he/she reported the incident to the administrative staff at the facility; -On [DATE], the phone was examined and the detective was provided a thumb drive containing three files with three videos; -The videos were recorded on [DATE] at 4:34 A.M., 5:38 A.M., and 5:43 A.M.; -CNA A was arrested on [DATE] due to probable cause. Review of the resident's nurses note, dated [DATE] at 6:19 P.M., late entry, showed staff documented due to alleged sexual misconduct the resident was sent to the hospital for evaluation by the SANE nurse. Review showed the hospital staff notified the facility they were unable to complete the exam because the resident became combative and uncooperative. Resident returned to facility accompanied by family member. Review of the local police department Probable Cause Statement, dated [DATE], showed the detective documented: -CNA D told the detective he/she witnessed CNA A enter the resident's room and kiss the resident on the mouth while he/she laid on the bed. CNA A then led the resident towards the bathroom. CNA A and the resident hugged and kissed while they stood in the doorway of the bathroom, then both entered the bathroom, and remained for a while with the door closed. Both CNA A and the resident then exited the bathroom. The resident laid on the bed while CNA A engaged in sexual intercourse with the resident. CNA D said because of the resident's dementia, the resident would often think CNA A was his/her spouse and call CNA A by his/her spouse's name. CNA D said the sexual act was recorded on video and provided the video to law enforcement. -CNA A told the detective he/she was aware the resident had dementia and the resident was unable to care for himself/herself due to his/her mental state. CNA A admitted to having sexual intercourse with the resident. Review of CNA A's work schedule showed he/she worked from 3 P.M., to 7 A.M., on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. Review showed he/she worked 7 P. M., to 7 A.M. on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 9:23 A.M., the detective said CNA A admitted to having sexual intercourse with the resident. The detective said CNA A admitted he/she knew the resident had a diagnosis of dementia. The detective said CNA A said he/she cared for the resident, which is why he/she had sexual intercourse with the resident. The detective said CNA A told him/her the sexual intercourse with the resident only happened one time. During an interview on [DATE] at 3:11 P.M., CNA D said he/she witnessed CNA A enter the resident's room, rub the resident's leg, then lean down and kiss the resident. He/She said CNA A walked the resident to the bathroom and began kissing the resident in the doorway, before entering the bathroom. CNA A and the resident stayed in the bathroom for a little bit and then the CNA left the resident's room. He/She said the resident walked out of the bathroom with his/her shirt off, and used it to cover his/her upper body, and without pants or underwear. He/She said he/she videotaped the incident, but it was not clear, so he/she was going to take it to a professional to try and enhance the video. During an interview on [DATE] at 2:28 P.M., the Director of Nursing (DON) said staff are directed to remove the resident to an area of safety and immediately report to the charge nurse and then up the change of command. He/She said staff are directed to assess the resident, notify the physician and responsible party. During an interview on [DATE] at 2:27 P.M., the administrator said staff are directed to remove the resident to an area of safety and immediately report to the charge nurse and then up the change of command. He/She said staff are directed to assess the resident, notify physician, responsible party and the State agency, then begin the investigation. He/She said the staff are educated on abuse and neglect annually and upon hire. NOTE: At the time of the survey, the violation was determined to be at the immediate and serious jeopardy level J. Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the G level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action to be taken to address Class I violation(s). MO 00236810 MO 00236820

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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. 42815 Based on interview and record review, facility staff failed to implement abuse and neglect policies and procedures to ensure all staff providing care to residents were trained on the facility's abuse and neglect policy for two staff Certified Nurse Aides (CNA A and D) out of four sampled staff upon hire. The facility census was 52. 1. Review of the facility's policy titled, Screening Components, undated, showed all new employees and volunteers will receive training on the abuse policy prior to direct or indirect resident contact. All new employees/volunteers will be oriented to the Abuse Policy and made aware of their responsibility to report any suspected maltreatment as defined and described in this policy. Attendance at a yearly in-service on the Abuse Policy and on Resident Rights is mandatory for all employees/volunteers. 2. Review of CNA's A personnel records showed a hire date of 10/03/23. Review showed the personnel record did not contain documentation CNA A received abuse and neglect policy training prior to direct or indirect resident contact. 3. Review of CNA's D personnel records showed a hire date of 10/23/20. Review showed the personnel record did not contain documentation CNA D received abuse and neglect policy training prior to direct or indirect resident contact. During an interview on 05/29/24 at 3:11 P.M., CNA D said he/she did not know when he/she last attended an abuse in-service and did not know the timeframe to report abuse or neglect. 4. During an interview on 05/29/24 at 2:27 P.M., the current administrator said the staffing coordinator was responsible to conduct abuse and neglect training for all newly hired staff, including agency staff. He/She said the Director or Nursing (DON), or designee, was responsible to ensure agency staff and current staff receive abuse and neglect training on an annual basis. The administrator said he/she could not find documentation agency staff received training on abuse and neglect policies and procedures. The administrator said he/she did not know why agency staff was not trained on abuse and neglect policy and procedures when hired. During an interview on 05/29/24 at 2:27 P.M., the DON said the staffing coordinator was responsible to conduct abuse and neglect training for all newly hired staff, including agency staff. The DON said he/she, or designee, was responsible to ensure agency staff and existing staff received abuse and neglect training on an annual basis. The DON said he/she could not find documentation any agency staff received training on abuse and neglect policies and procedures. The DON said he/she did not know why agency staff were not trained on abuse and neglect policy and procedures when hired. During an interview on 06/06/24 at 9:49 A.M., the Staffing Coordinator said he/she was responsible to ensure newly hired and agency staff received abuse and neglect education as part of the orientation process. The staffing coordinator said he/she was not in his/her position when CNA A and CNA D were hired. The staffing coordinator said he/she did conduct an abuse and neglect in-service during orientation for agency staffing. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MO00236810 MO00236820

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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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 42815 Based on interview and record review, facility staff failed to report an allegation of sexual abuse for one resident (Resident #1) to the administrator on 4/17/24, after witnessing the event. The alleged perpetrator worked 18 additional shifts before the nurse aide reported what was seen to the administrator on 5/13/24. The administrator failed to report the allegation of sexual abuse to the Department of Health and Senior Services (DHSS) within the required two hour timeframe. The facility census was 52. The Administrator was notified on 06/26/24, of an Immediate Jeopardy (IJ) which began on 04/17/24. The IJ was removed on 05/30/24 as confirmed by surveyor onsite verification. 1. Review of the facility's policy titled, Investigation, undated, showed staff were directed to: -It is the policy of this facility that reports of abuse (mistreatment, neglect, or abuse, including injuries of unknown source, exploitation and misappropriation of property) are promptly and thoroughly investigated; -There are instances where an alleged violation of abuse, neglect, misappropriation of resident property and exploitation would be considered to a reasonable suspicion of a crime. In these cases, the facility is obligated to report to the Administrator, to the state survey agency, and to other officials in accordance with State Law; -The hotline (State Licensing Agency) will be notified by phone within two hours of the receipt of the report for the alleged offense, if serious bodily injury; -The facility shall complete the following report forms for the internal investigation, within twenty four hours to five days. 2. Review of Resident #1's Annual Minimum Data Set (MDS), a federally mandated assessment tool, dated 04/25/24, showed staff assessed the resident with a diagnosis of dementia. Review of the facility's investigation, dated 05/13/24, showed staff documented Certified Nurse Assistant (CNA) D reported on 05/13/24 at 2:30 P.M. CNA A sexually assaulted the resident on 04/17/24 between 04:30 A.M. and 05:30 A.M. Review showed staff documented they notified DHSS on 05/13/24 at 7:31 P.M. Review of CNA A's work schedule showed he/she worked from 3 P.M., to 7 A.M., on 4/17/24, 4/19/24, 4/23/24, 4/24/24, 4/25/24, 4/30/24, 5/6/24, 5/7/24, 5/8/24, and 5/9/24. Review showed he/she worked 7 P.M., to 7 A.M. on 4/20/24, 4/21/24, 4/26/24, 4/27/24, 5/4/24, 5/5/24, 5/11/24, and 5/12/24. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 05/29/24 at 3:11 P.M., CNA D said he/she witnessed CNA A enter the resident's room, rub the resident's leg, then lean down and kiss the resident. He/She said CNA A walked the resident to the bathroom and began kissing the resident in the doorway, before entering the bathroom. He/She said the resident walked out of the bathroom with his/her shirt off, covering his/her upper body, and without pants or underwear. CNA D said he/she videotaped the incident, but it was not clear, so he/she was going to take it to a professional to try and enhance the video. He/she did not intervene because he/she wanted to have proof and did not know that he/she could intervene. CNA D said he/she was not able to find anyone to enhance the video, so he/she decided not to wait any longer to report the incident and spoke with the administrator about the sexual abuse he/she witnessed approximately one month prior. CNA D said he/she waited to report because he/she wanted to have proof of the allegation before reporting the sexual abuse. CNA D said he/she did not know when he/she last attended an abuse in-service and did not know the timeframe to report abuse or neglect. During an interview on 5/14//24 at 9:30 A.M. the former administrator said he/she did not report within the two hour time frame because he/she had initially been told the allegation of sexual abuse had been reported and investigated. The administrator said he/she was later told the allegation of sexual abuse had not been reported, so he/she reported late. During an interview on 05/29/24 at 2:27 P.M., the current administrator said staff are directed to remove the resident to an area of safety and immediately report to the charge nurse and then up the change of command. He/She said staff are directed to assess the resident, notify physician, the responsible party and the State agency, then begin the investigation. He/She said the facility had two hours to report potential abuse to the State agency. During an interview on 05/29/24 at 2:27 P.M., the Director of Nursing said staff are directed to remove the resident to an area of safety and immediately report to the charge nurse and then up chain of command. He/She said staff are directed to assess the resident, notify physician and the responsible party and the State agency, then begin the investigation. He/She said allegations of abuse and neglect should be reported to the State agency within two hours. He/She said the incident occurred prior to his/her employment. NOTE: At the time of the survey, the violation was determined to be at the immediate and serious jeopardy level J. Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the D level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action to be taken to address Class I violation(s). MO00236810 MO00236820

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 42815 Based on interview and record review, facility staff failed to complete a thorough investigation when a staff member reported Certified Nurse Aide (CNA) A sexually assaulted one resident (Resident #1). The facility census was 52. 1. Review of the facility's policy titled, Investigation, undated, showed staff were directed to: -It is the policy of this facility that reports of abuse (mistreatment, neglect, or abuse, including injuries of unknown source, exploitation and misappropriation of property) are promptly and thoroughly investigated; -When an incident or suspected incident of abuse is reported, the Administrator or designee will investigate the incident with the assistance of appropriate personnel. The investigation will include: -Who was involved; -Residents' statements (for non-verbal residents, cognitively impaired residents or residents who refuse to be interviewed, attempt to interview resident first. If unable, observe resident, complete an evaluation of resident behavior, affect and response to interaction, and document findings); -Interviews obtained from three to four residents who received care from the alleged staff; -Involved staff and witness statements of events; -Observation of resident and staff behaviors during the investigation. 2. Review of Resident #1's Annual Minimum Data Set (MDS), a federally mandated assessment tool, dated 04/25/24, showed staff assessed the resident with a diagnosis of dementia. Review of the facility's investigation, dated 05/13/24, showed staff documented a report of an alleged sexual assault had been received and an investigation started on 05/13/24 which allegedly occurred on 04/17/24 between 04:30 A.M. and 05:30 A.M. Review of the investigation showed it did not contain documentation facility staff interviewed Resident #1 or any other residents. Staff did not document they observed the resident and staff behaviors during the investigation, or interviewed the charge nurse on duty the night of the incident. During an interview on 5/14/24 at 9:30 A.M. the former administrator said he/she did not start the investigation because he/she had initially been told the allegation of sexual abuse had been reported and investigated before. The administrator said he/she was later told the allegation of sexual abuse had not been reported, so he/she reported late and started the investigation. During an interview on 05/29/24 at 2:18 P.M , Registered Nurse (RN) C said staff are directed to ensure the safety of the resident, assess the resident, report to upper management, then begin investigation. He/She said he/she would follow direction provided by the upper management. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/30/24 at 2:48 P.M., the administrator, hired after the incident, said he/she or the Director of Nursing (DON) are responsible to investigate abuse. He/She said staff are directed to take witness statements, a description of the incident, staff involved, assessments and interview multiple staff and residents. He/She said he/she did not feel the investigation was complete, since no residents were interviewed. He/She said the charge nurse working the night of the incident should have been interviewed. During an interview on 05/30/24 at 2:48 P.M., the DON, hired after the incident, said he/she or the administrator are responsible to investigate abuse. He/She said staff are directed to take witness statements, a description of the incident, staff involved, assessments and interview multiple staff and residents. He/She said he/she did not feel the investigation was complete, since no residents were interviewed. He/She said the charge nurse working the night of the incident should have been interviewed. MO00236810 MO00236820