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	10/04/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43327 Based on observation, interview and record review, facility staff failed to develop a comprehensive person-centered care plan for each resident to meet the resident's medical, and nursing needs, when staff failed to address oxygen use and self-administration of medication for one resident (Resident #2) who received oxygen and kept medication at bedside, failed to address shower preferences for one resident (Resident #13), and failed to address falls for one resident (Resident #27) who had falls out six sampled residents. The facility census was 39. 1. Review of the facility's Care Plan Comprehensive policy, dated March 2015, showed: -The Interdisciplinary team (IDT) with input from the resident, family and/or legal representative will develop and maintain a comprehensive care plan for reach resident that identifies the highest level of functioning the resident may be expected to attain; -The comprehensive care plan will be based on a thorough assessment; -Assessment of each resident is ongoing process and the care plan will be revised as changes occur in the resident's condition; -The IDT is responsible for periodic review and updating of the care plans when a significant change in the resident's condition has occurred, at least quarterly, and when changes occur that impact the resident's care. 2. Review of Resident #2's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 08/20/24 showed staff assessed the resident as: -Long and short-term memory problem; -Did not use oxygen; -Received hospice service; -Diagnosis of dementia and heart failure. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's care plan, dated 10/01/24 did not contain direction for use of oxygen or ability to keep medication at bedside. Review of the resident's Physician Order Sheet (POS), dated October 2024, showed the POS did not contain an order for oxygen use or to keep medication at bedside. Observation on 10/01/24 at 10:21 A.M., showed the resident in bed with oxygen on and a bottle of multivitamins on the nightstand. Observation on 10/02/24 at 3:29 P.M., showed the resident in bed with oxygen on and a bottle of multivitamins on the nightstand. Observation on 10/03/24 at 7:55 A.M., showed a bottle of multivitamins on the nightstand. During an interview on 10:04/24 at 8:24 A.M., the MDS Coordinator said he/she was not aware the resident had medication at bedside. He/She said the resident was wearing his/her oxygen more often. He/She said the resident does get short of breath at times and will take it on and off his/herself. The MDS Coordinator said oxygen use and self-administration should be a part of the care plan. 3. Review of Resident #13's Admission MDS, dated [DATE], showed staff assessed the resident as: -Cognitively impaired; -Required supervision of staff during showers; -Diagnosis of dementia. Review of the resident's care plan, dated 09/24/24, did not contain direction for the residents shower preference or level of assistance required from staff. Observation on 10/01/24 at 2:07 P.M., showed the resident in his/her room. The resident's hair appeared greasy. Observation on 10/02/24 at 12:59 P.M., showed the resident in his/her room. The resident's hair appeared greasy. During an interview on 10/02/24 at 12:59 P.M., the resident said he/she has not had a bath or shower since being on isolation. He/She said he/she feels dirty and his/her head itched. During an interview on 10/02/24 at 1:07 P.M., the Director of Nursing (DON) said the resident had been on isolation since September 24, 2024. During an interview on 10/04/24 at 08:24 A.M., the MDS Coordinator said activities of daily living, including shower preferences should be a part of the care plan. He/She said there was miscommunication regarding the resident's ability for showers. He/She said the resident is still new to the facility and had not updated the care plan yet. 4. Review of Resident #27's Quarterly MDS, dated [DATE], showed staff assessed the resident as: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Cognitively impaired; -Functional limitation to both lower extremities; -Dependent on staff for toilet and bed-to-chair and chair-to-bed transfers; -Diagnosis of traumatic brain injury. Review of the resident's progress notes, dated 07/25/24 through 09/30/24 showed a documented fall occurred on 07/25/24, 09/18/24, 09/27/24 and 09/28/24. Review of the resident's care plan, dated 10/01/24 showed the care plan did not contain new interventions or care plan updates for fall prevention after the falls on 07/25/24, 09/18/24, 09/27/24 or 09/28/24. During an interview on 10/04/24 at 8:24 A.M., the MDS Coordinator said he/she usually updates falls in the care plan after the weekly at-risk meetings. He/She does not know why his/her care plan was not updated but should have been. X. During an interview on 10/04/24 at 8:24 A.M., the MDS Coordinator said care plans are updated daily after review of the daily report to include falls, new medications, changes in condition, alterations in mental status. He/She said it is his/her resposibility to make sure the care plans are udated but has been a struggle lately due to the need to help on the floor and recent additon of the infection prevention duties. Sometimes things just slip through the cracks. During an interview on 10/04/24 at 10:49 A.M., the DON said MDS completion and knowledge is his/her weak spot but knows care plans should be created in 48 hours after admission, updated with changes in condition such as falls, skin tears and at least quarterly or anytime requested by family and is the responsibility of the MDS Coordinator. The DON said it is his/her responsibility to monitor but has been busy with other things. During an interview on 10/04/24 at 10/04/24 at 11:48 A.M., the admninistrator said the MDS Coordinator should update care plans at minimum quarterly and with any change in resident status. He/She said care plans should include anything needed to care for the residents. He/She said the DON is responsible for monitoring the nursing department.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43327 Based on interview and record review, staff failed to maintain a professional standard of care when staff failed to obtain physician ordered blood work for four (Resident #1, #2, #4 and #5) of six sampled residents. The facility census was 39. 1. Review of the facility policies showed staff did not provide a policy for obtaining blood work. 2. Review of Resident #1's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 10/01/24, showed the resident had a diagnosis of diabetes. Review of the resident's Physician Order Sheet (POS), dated October 2024, showed the physician ordered a Hemaglobin A1C (measures average blood sugar over last two to three months) blood test to be obtained every three months on 05/28/24. Review of the resident's medical record showed the resident last Hemaglobin A1C blood test result on 05/30/24. Review showed the record did not contain a Hemaglobin A1C blood test as ordered in August 2024. 3. Review of Resident #2's Quarterly MDS, dated [DATE], showed a diagnosis of heart disease and diabetes. Review of the resident's POS, dated October 2024, showed the physician ordered a complete blood count ((CBC), blood test that can help diagnose conditions such as low iron, infection and leukemia), complete metabolic profile ((CMP) measures chemical balance in the blood), Depakote level (a measure of anti-seizure medication in the body), and Hemaglobin A1C every three months. Review of the resident's medical record did not contain documentation a three-month CMP, CBC, Depakote level, or hemaglobin A1C was obtained as ordered. 4. Review of Resident #4's Quarterly MDS, dated [DATE], showed a diagnosis of hypertension. Review of the resident's POS, dated October 2024, showed the physician ordered a CBC and CMP to be obtained every three months on 05/28/24, . Review of the resident's medical record, showed the record did not contain a CBC or CMP for September 2024 as directed by the physician order. 5. Review of Resident #5's Quarterly MDS, dated [DATE], showed a diagnosis of hypertension, heart failure and lung disease. Review of the resident's POS, dated October 2024, showed the physician ordered a CBC, CMP and Depakote level to be obtained every three months on 06/04/24. Review of the resident's medical record, showed the record did not contain a CBC, CMP or Depakote level for September 2024 as ordered by the physician. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. During an interview on 10/04/24 at 9:00 A.M., Registered Nurse (RN) D said once a laboratory (lab) order is recieved, the order is transcribed into the electronic health record and the contracted lab website. When the lab technicians come onsite to draw blood, the technicians review the orders and obtain the blood. When the bloodwork results are returned to the facility, the physician is called by the charge nurse for emergent issues and faxed for non-emergent issues with a copy of the results inserted into a physician folder to sign off on weekly. He/She is not sure who uploads the documents into the computer but the results should be available for those that need the results to refer to and does not know why residents #1, #2, #4 or #5's blood work has not been done or uploaded into the system. RN D said he/she thinks the Director of Nursing (DON) is responsible to make sure the overall lab process is completed properly. During an interview on 10/04/24 at 10:49 A.M., the DON said he/she was not aware the blood work was not completed as ordered on resident #1, #2, #4, or #5. He/She said he/she feels there is a disconnect between the agency nurses and the facility process. He/She said he/she is new to the DON role at the facility and needs to go through and do a lab audit to ensure no other residents have been affected by missed blood work. During an interview on on 10/04/24 at 11:48 A.M., the administrator said he/she just recently hired a medical record staff member to upload documents which should help with keeping the electronic health record up to date. He/She was not aware there was issues with the blood work getting completed but would expect nursing to follow up on all physician orders.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40424 Based on observation, interviews, and record review, facility staff failed to provide an ongoing activity program on the weekends and evenings and failed to provide a program that met the needs of two dependent residents (Resident #6, and #1). The facility census was 39. 1. Review of the facility's Activity, Volunteer and Recreational Services, dated March, 2012, showed the facility provides an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical , mental, and psychosocial well-being of each resident. The activity program must be directed by a qualified professional (Activity Director) who is directly responsible to the Administrator. 2. Review of the facility's activity calendar, dated September 2024, showed the weekend activities as follows: -On 09/07/24 10:00 A.M. bible study, 1:00 P.M. snack time, and 2:00 P.M. puzzles; -On 09/14/24 10:00 A.M. bible study, 1:30 P.M. snack time, and 2:30 P.M. color me pretty; -On 09/21/24 10:00 A.M., bible study, 1:30 P.M. snack time, and 2:30 P.M. story time; -On 09/28/24 10:00 A.M. bible study, and 3:00 P.M., movie time. Review of the facility's activity calendar, October 2024, showed the weekend activities as follows: -On 10/05/24 10:00 A.M. bible study and 3:00 P.M. puzzles; -On 10/12/24 10:00 A.M. bible study and 2:30 P.M. read; -On 10/19/24 10:00 A.M. bible study and 2:30 P.M. crossword; -On 10/26/24 10:00 A.M. bible study and 2:30 P.M. music. 2. Review of Resident #6's Quarterly MDS, dated [DATE], showed staff assessed the resident as follows: -Mild cognitive impairment; -Activity preferences not assessed. Review of the resident's care plan, dated 09/27/24, showed the care plan did not contain the resident's activity preferences. During an interview on 10/02/24 at 3:06 P.M., the resident said there are no real organized activities on the weekends and he/she would really enjoy having the activities because there is not much to do. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/04/24 at 8:00 A.M., Certified Medication Technician (CMT) C said weekend activities are sometimes done on Saturdays but mostly it's just games or coloring. Staff sometimes do nail polish with the resident. He/She said the staff are expected to do the activity with the residents but just don't have time. 3. Review of Resident #1's Annual Minimum Data Set (MDS), a federally mandated assessment tool, dated 03/31/24 showed staff assessed the resident as comatose with diagnosis of persistent vegetative state. Review of the residents medical record showed the facility Observation Detail Section F form, dated 09/07/24, showed: -The preference for customary routine and activities was not assessed; -The staff assessment of daily and activity preferences was not assessed. Review of the resident's care plan, dated 10/01/24, showed staff documented: -Likes to look out the window during the day when awake; -Have access to the outside view when possible; -Place in wheelchair three times a week and out of his/her room and about facility per family request; -Keep curtain/shades open in room; -Have lights to remain on during cloudy days; -Have radio turned to gospel music during the day; -Is a Baptist; -Always enjoyed watching television especially football and basketball; -Enjoys Christian music and sitting outside but not in the sun; -Has a great sense of humor and loves a good joke; -Provide one-on-one sessions; -Provide activities that resembles his/her prior lifestyle; -Vary the environment when possible. Observation on 10/01/24 at 10:29 A.M., showed the resident on his/her back in bed with the curtains closed and the room dark. A sign hung on the wall by the bed stated the resident is able to blink twice for yes and once for no. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 10/02/24 at 3:09 P.M., showed the resident in bed with the curtains closed and the room dark. Observation on 10/03/24 at 7:38 A.M., showed the resident in bed. Staff entered the room, administered the resident's medication, left the room and did not turn on television or gospel music for the resident. During an interview on 10/04/24 at 9:08 A.M., the Director of Nursing (DON) said the resident's family wants the room curtains to remain open when care not provided to let the resident look outside. During an interview on 10/04/24 at 8:24 A.M., Registered Nurse (RN) A said the resident enjoys looking out the window, so staff should keep the window shades open during the day and closed at night. He/She likes to watch everyone and should be taken out of room once in a while. During an interview on 10/04/24 at 10:29 A.M., the Activity Director said he/she will take the resident outside when the nursing staff get him/her out of bed. He/She said the resident has not been out of bed this week. The resident will listen to gospel and enjoys staff talking to him/her. He/She said if there was more regular staff and not as much agency, there might be more consistency with the resident getting out of bed. During an interview on 10/04/24 at 11:48 A.M., the Administrator said activities should be available during the day, evenings and weekends. He/She said the lack of activity director training and use of agency staff has made activities participation difficult. The agency staff may not know that activities are to be done. 43327

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the activities program is directed by a qualified professional. 43327 Based on interview and record review, the facility staff failed to ensure the activities program was directed by a qualified professional. The census was 39. 1. Review of the facility's Activity, Volunteer and Recreational Services, dated March, 2012, showed the facility provides for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical , mental, and psychosocial well-being of each resident. The activity program must be directed by a qualified professional (Activity Director) who is directly responsible to the administrator. During an interview on 10/04/24 at 10:29 A.M., the Activity Director said he/she was not certified and was not aware he/she needed to be certified. He/She said he/she has been in the position since February 2024. During an interview on 10/03/24 at 09:13 A.M., the administrator said the activity director is not certified, but should be. He/She was not aware the director was not certified until asked to provide the certification.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 43327 Based on observation, interview and record review, facility staff failed to ensure nursing staff had the appropriate skills and competencies to meet the care needs for the residents by not providing in-services, re-evaluating and documenting skills and competencies on a regular basis for each employee and failed to ensure nurse aides received the required 12 hours in-service education annually. The facility census was 39. 1. Review of the facility's Orientation and Training policy, dated April 2011 showed: -Each department head is responsible for the job-specific training required. -The policy did not include how often the education should be provided, how the education is to be documented or a list of inservices to include: abuse and neglect, dementia care, resident rights, communication, behavioral health or specialized resident needs to include: gastrostomy tube (tube placed into the stomach to deliver nutrition and/or hydration) use and care of, tracheostomy (artificial opening of the neck to help the person breath) use and care of, hospice/palliative care, enhanced barrier precautions, oxygen use and storage, ostomy (opening or stoma in the body to allow waste to exit a different way), emergency preparedness, weight loss and nutrition, and chemotherapy (cancer treatment). Review of the Facility Assessment, dated 08/30/24, showed staff identified: -Staff should receive initial training upon hire, ongoing professional development, and periodic competency assessments; -Certified Nurse Aides (CNA's) ongoing education focuses on enhancing skills in areas such as dementia care, infection control, and resident rights; -Licensed Practical Nurses (LPN's) ongoing education includes updates on medication management, wound care advancements, and palliative care practices; -Registered Nurses (RN's) ongoing education includes advanced clinical skills, leadership development, and specialized areas such as geriatric care and chronic disease management; -Staff are encouraged to participate in regular in-service training sessions, workshops, and online courses to stay current with best practices, regulatory changes, and emerging trends in long-term care. Topics include infection control, new therapeutic approaches, advancements in medical technology, and updates on regulatory requirements; -Competency assessments may include hands-on demonstrations, written exams, and peer evaluations covering critical areas such as medication administration, emergency response, and specialized care techniques; (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Staff training programs and competency assessments include: initial training, continuing education, skill competency assessments, specialized training, and leadership development; -Regular performance evaluations help identify areas where individual staff members may excel or need improvement; -Some residents have unique care needs, such as those requiring wound care for pressure ulcers, or tube feeding; -A subset of the resident population may be receiving palliative or hospice care; -The resident population may include individuals from diverse cultural and religious backgrounds, each with specific needs regarding diet, activities and spiritual care. It is crutial for the facility to provice culturally competent care; -Many residents have dietary restrictions or specific nutritional needs; -To effectively meet the diverse care needs of the resident population, staff members must possess a wide range of competencies that are essential for ensuring that residents receive high-quality person-centered care and include: wound care, dementia care, medication administration, palliative and end of life care, behavioral health management, infection prevention and control, rehabilitation and therapy services, nutrition and dietary management and emergency preparedness. Review of the facility's in-service annual training showed: -07/10/24 in-service topic: F600, F607, F609, and F610 training regarding abuse and neglect to include reporting, definitions, examples, timeframes for reporting. The inservice included directions for resident money and photographs/videos of residents. Staff documented the inservice started at 09:00 A.M., and did not contain an end time or length of training; -07/15/24 in-service topic: COVID-19 (a disease caused by a novel coronavirus) Personal Protective Equipment (PPE): Donning (application of). The training form did not contain a start or end time or length of training; -09/10/24 in-service topic: Influenza/COVID-19 vaccines, drug testing and infection. Staff documented the in-service started at 09:00 A.M., and did not contain an end time or length of training; -09/10/24 in-service topic: Wound care/skin assessments. Staff documented the in-service start time at 09:10 A.M., and did not contain an end time or length of training; -The annual training did not contain documentation of skills and competencies to meet the care needs for the residents or documentation of the required 12-hour nurse aide training. Review of the facility's Matrix for Providers (a federally required resident population assessment tool), undated, showed the following resident specialized care needs: -Seven residents required hospice services; (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-One resident required tracheostomy care and use; -Two residents required wound care; -Two residents received nutrition and hydration using a gastrostomy tube; -Two residents had weight loss. Observation during initial tour on 10/01/24, showed the resident population included the following specialized services: gastrostomy tubes, tracheostomies, ostomies, chemotherapy treatments, oxygen use, enhances barrier precautions, COVID-19 isolation, dependent care, dementia/behavioral needs and residents who smoked cigarettes. During an interview on 10/03/24 at 2:36 P.M., the administrator said he/she is unable to locate any further staff trainings. During an interview on 10/04/24 8:11 A.M., Certified Medication Technician (CMT) D said he/she did not receive any training on oxygen, COVID, dementia care, abuse and neglect, hand hygiene/PPE or transfer technique. CMT D said he/she is relying on his/her past experience to know how to handle those situations. During an interview on 10/04/24 at 8:24 A.M., RN A said he/she received some training on hire such as watching a couple of videos, other than that he/she said staff are thrown out with a CNA. He/She said tracheostomy care, ostomy care, gastrostomy tube care and use are things he/she learned in school but not at the facility. He/She was not able to identify a spare tracheostomy tube should be kept at the bedside of a resident who had a tracheostomy. During an interview on 10/04/24 8:30 A.M., CNA G said he/she did not receive any training on oxygen, COVID 19, dementia care, abuse and neglect, hand hygiene/PPE or transfer technique. CNA G said he/she is relying on his/her own knowledge in her current position. During an interview on 10/04/24 at 9:00 A.M., RN D said he/she worked in a intensive care unit (ICU) before and knows how to care for residents with a tracheostomy and gastrostomy tube. He/She has not received any training at the facility and in most facilities, the management staff expect agency staff to know everything when they arrive at the building and are just put into an empty position. During an interview on 10/04/24 at 10:49 A.M., the Director of Nursing (DON) said when staff are hired or an agency staff works, the staff member is paired with someone from the facility. He/She said there is a written report at the nurse station that gives guidance and direction for individual care needs and a binder that includes specific trainings for all staff and agency staff to review at the nurse station. There is a consistency problem related to the amount of agency staff the facility uses but if the agency staff says they don't' know how to do something, they will be shown by on the spot training. He/She said agency does their own competencies with their staff so the facility does not do them and the facility just assumes they are competent to perform safe care. He/She said he/she is responsible to ensure staff are appropriately trained to care for residents and obtain the required trainings. He/she said he/she has only been at the facility a few months and has not started tracking the hours, but the trainings will be laid out in a calendar for each employee. (continued on next page)

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

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/04/24 at 11:48 A.M., the administrator said he/she is responsible for everything in this building and has only been here a few months. CNA's are required to have 12 hours of training a year and just recently the facility has been given a list of yearly trainings to be completed from the corporate office. He/She does not know what was done prior to his/her starting at the facility.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 45564 Based on observation, interview and record review, facility staff failed to serve food in accordance with the nutritionally calculated menus to all residents. The facility census was 39 with a capacity of 87. 1. Review of the facility's Food Preparation and Distribution policy, dated May 2015, showed measured utensils are used to serve proportions as described on menu. 2. Review of the facility menus, undated (Week 2, Day 10), showed the menus directed staff to provide the residents on regular diets six ounces of stroganoff, 1/2 cup (four ounces) of noodles and 1/2 cup of vegetable blend at the lunch meal. Observation on 10/01/24 at 12:41 P.M., showed [NAME] I served the residents a #6 scoop (5.3 ounces) of stroganoff, three ounces of noodles, and three ounces of mixed vegetables. Observation showed the portions were less than the menu directed portions. 3. Review of the facility menus, undated (Week 2, Day 10), showed the menus directed staff to provide the residents on pureed diets one #6 (5.3 ounces) scoop of stroganoff, one #10 (3.2 ounces) scoop of noodles, and one #16 scoop of pureed bread at the lunch meal. Observation on 10/01/24 at 12:41 P.M., showed [NAME] I served the two residents who received pureed meals one #10 (3.2 ounce) scoop of stroganoff, one #12 (2.6 ounces) of noodles and did not serve the residents pureed bread. Observation showed the portions were less than the menu directed portions. During an interview on 10/02/24 at 8:53 A.M., [NAME] I said the cook was responsible for setting serving utensils on the serving line. [NAME] I said cooks look at the menu for correct portion sizes. [NAME] I said the facility did not have a 1/2 cup scoop so he/she used a three ounce scoop. [NAME] I said he/she was not sure how many ounces were in 1/2 cup so he/she was not sure if he was under serving the residents. [NAME] I said he/she did not know why he/she served the incorrect portion sizes. [NAME] I said no bread was pureed for the lunch meal because the other cook forgot. During an interview on 10/02/24 at 9:00 A.M., the dietary manager (DM) said the cooks should serve food in accordance with menus and he/she is responsible to ensure the full meal is served. The DM said he/she did not know why staff did not serve the correct serving sizes. During an interview on 10/03/24 at 3:20 P.M., the administrator said the DM was responsible for ensuring staff served correct portions according to the menus. The administrator said he/she was not aware residents were not served correct portion sizes.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45564 Based on observation, interview and record review, facility staff failed to store food in a manner to prevent potential contamination and outdated use. This failure has the potential to affect all residents. The census was 39 with a capacity of 87. 1. Review of the facility's Safe Food Handling policy, dated May 2015 showed all food, including bulk items, should be tightly sealed with an identifying label and date. 2. Observation on 10/01/24 at 10:01 A.M., showed the reach in refrigerator contained: -A plastic container of pineapple which was not in its original container and was undated; -A plastic container of hot dogs which was undated; -An opened and undated bag of lettuce; -An opened and undated container of tuna salad; -A cardboard flat of eggs which contained five broken eggs; -A zipper bag of meat, dated 09/01/24, and labeled use until gone which was open to the air; -A zipper bag of cooked hot dogs, labeled with a use by date of 09/29/24; -A one gallon container of soy sauce which was open to the air. Observation on 10/01/24 at 10:06 A.M., showed the left side of the 3-door reach in freezer contained two bags of beef patties and one bag of fish which were open to the air and undated. Observation on 10/01/24 at 10:18 A.M., showed the dry goods storage room contained: -An opened and undated bag of pasta elbows; -An opened and undated bag of cookie crumbs; -An opened and undated bag of tortilla chips; -A zipper bag dated 08/05/24 and open to the air contained an opened bag of gravy mix. During an interview on 10/02/24 at 8:53 A.M., [NAME] I said the cooks were responsible for making sure all food items were labeled, dated and not open to the air. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 10/01/24 at 10:27 A.M., the Dietary Manager (DM) said all open items should be labeled and dated. The DM said open canned items were good for seven days and cooked items were good for three days. The DM said no food items should be open to the air. The DM said he/she and the cooks were responsible for food storage. During an interview on 10/03/24 at 3:20 P.M., the administrator said the DM was responsible for ensuring all food items were labeled and dated. The administrator said food items should not be stored open the air. The administrator said prepared food items were good for three days.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40424 43327 Based on observation, interview, and record review, facility staff failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment when staff failed to store oxygen and nebulizer equipment in a manner to prevent spread of infection for six residents (Resident #1, #2, #3, #5, #13 and #15) of seven sampled residents who used oxygen, when staff failed to cleanse a suction machine for one (Resident #1) of one sampled resident who required as needed suctioning and when staff failed to use appropriate hand hygiene during wound care for two residents (Resident #27 and #36) of three sampled residents with wounds. The facility census was 39. 1. Review of the facility's Oxygen Administration policy, dated March 2015 showed: -Label humidifier with date and time opened; -The policy did not contain direction or guidance on oxygen tubing or nebulizer tubing storage in resident rooms. Review of the facility's Suctioning policy, dated March 2015, showed the policy did not contain direction for when to cleanse the suction machine. 2. Review of Resident #1's Quarterly Minimum Data Set (MDS), dated [DATE], showed staff assessed the resident as: -Comatose; -Required tracheostomy (artificial opening to aide in breathing) care and to be suctioned; -Diagnosis of respiratory failure and stroke. Review of the resident's Physician Order Sheet (POS), dated October 2024, showed the physician the following orders: -Ipatropium-albuterol (medication used to open the airway) solution for nebulization, 0.5 mg-3 mg/3 mL, 3 mL vial twice a day as needed via tracheostomy; -Change tracheostomy tubing and mask weekly; -Suction as needed for secretions, shortness of air or respiratory distress. Observation on 10/01/24 at 10:29 A.M., showed the resident's nebulizer tracheostomy mask and a nebulizer mask uncovered face down on the nightstand. The tubing and/or mask did not contain a date. The suction machine on an overbed table with yellow contents inside. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 10/02/24 at 3:09 P.M., showed the resident's nebulizer tracheostomy mask and a nebulizer mask uncovered face down on the nightstand. The tubing and/or mask did not contain a date. The suction machine on an overbed table with yellow contents inside. Observation on 10/03/24 at 7:38 A.M., showed the resident's nebulizer tracheostomy mask and a nebulizer mask uncovered face down on the nightstand. The tubing and/or mask did not contain a date. The suction machine on an overbed table with yellow contents inside. During an interview on 10/04/24 at 9:00 A.M., Registered Nurse (RN) D said the resident gets suctioned periodically. The contents should be dumped and equipment cleansed after each episode. He/She had not noticed the suction machine contained contents and does not know when the last time the resident was suctioned. RN D said suction machine contents can build up with germs and will start to smell if not cleansed after each use. 3. Review of Resident #2's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Long and short-term memory problems; -Did not require oxygen; -Diagnosis of heart disease. Review of the resident's POS, dated October 2024, did not contain an order for oxygen use or maintenance of the tubing. Observation on 10/01/24 at 10:21 A.M., showed an oxygen concentrator tubing curled up around the bedframe and nasal prongs touched the floor. The tubing did not contain a date or placed into a dated plastic container. Observation on 10/02/24 at 3:29 P.M., showed the resident wore oxygen via nasal cannula. The tubing did not contain a date. Observation on 10/03/24 at 7:55 A.M., showed an oxygen concentrator tubing on the bed and not stored in a plastic container or dated. 4. Review of Resident #3's Annual MDS, dated [DATE], showed staff assessed the resident as: -Cognitively impaired; -Used oxygen; -Diagnosis of irregular heartbeat. Review of the resident's POS, dated October 2024, showed the physician order as follows: -Oxygen at 2 liters as needed for shortness of breath; -Change oxygen tubing monthly. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 10/01/24 at 10:53 A.M., showed oxygen tubing on the oxygen concentrator not in a plastic container. Observation on 10/02/24 at 3:22 P.M., showed undated oxygen tubing on the oxygen concentrator undated and not in a plastic container. Observation on 10/03/24 at 7:58 A.M., showed undated oxygen tubing on the oxygen concentrator undated and not in a plastic container. 5. Review of Resident #5's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Moderately impaired cognition; -On oxygen; -Diagnosis of heart failure and lung disease. Review of the resident's POS, dated October 2024, showed the physician order as follows: -Ipatropium-albuterol solution for nebulization, 0.5 mg-3 mg/3 mL, 3 mL vial daily as needed and fpur times a day; -Change nebulizer and oxygen tubing weekly. Observation on 10/01/24 at 10:42 A.M., showed a nebulizer machine on the floor next to the residents bed. Observation on 10/01/24 at 11:32 A.M, showed the resident in the television room with oxygen on via nasal cannula. The oxygen tubing did not contain a date. Observation on 10/02/24 at 3:15 P.M., showed the resident in the television room with oxygen on via nasal cannula. The oxygen tubing did not contain a date. Observation on 10/02/24 at 3:26 P.M., showed the resident's nebulizer machine on the floor next to the bed. Observation on 10/03/24 at 7:56 A.M., showed the resident's nebulizer machine on the floor next to the bed. 6. Review of Resident #13's Admission MDS, dated [DATE], showed staff assessed the resident as: -Cognitively impaired; -Diagnosis of lung disease. Review of the resident's POS, dated October 2024, showed an order for oxygen to be used at two liters as needed at bedtime. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 10/02/24 at 12:59 P.M., showed the oxygen tubing on the resident's bed undated and not stored in a dated plastic container. During an interview on 10/02/24 at 1:07 P.M., the Director of Nursing (DON) said the resident did have oxygen in his/her room but is not wearing it. He/She only needed it when he/she was ill. 7. Review of Resident #15's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Severely cognitively impaired; -No oxygen; -Diagnosis of heart disease. Review of the resident's POS, dated October 2024, showed an order to change oxygen tubing weekly. Observation on 10/01/24 at 10:50 A.M., showed the residents oxygen nasal prongs on the floor. The humidifier and tubing did not contain a date and the tubing not stored in a plastic container. Observation on 10/02/24 at 3:25 P.M., showed the residents oxygen nasal prongs on the floor. The humidifier and tubing did not contain a date and the tubing not stored in a plastic container. Observation on 10/03/24 at 07:57 A.M., showed the residents oxygen nasal prongs on the floor. The humidifier and tubing did not contain a date and the tubing not stored in a plastic container. 8. During an interview on 10/04/24 at 8:02 A.M., Certified Medication Technician (CMT) E said tubing should be put in a plastic bag and not left on the floor. The tubing is changed every Sunday. During an interview on 10/04/24 at 8:12 A.M., Certified Nurse Aid (CNA) F said oxygen tubing is changed and dated weekly. He/She said it is not always getting done and was not sure why. During an interview on 10/04/24 at 09:00 A.M., RN D said he/she did not have any training regarding the facility protocol for oxygen storage but the tubing should not be on the floor and the nebulizers should not be on the floor so that germs don't collect on them. He/She did not know about dating the tubing or storage bags. He/She said tubing for oxygen and nebulizers should be changed at least weekly and usually done on the weekends. During an interview on 10/04/24 at 9:11 A.M., RN A said oxygen tubing should be stored in a bag and changed weekly and the bag should be dated. During an interview on 10/04/24 at 10:49 A.M., the DON said oxygen tubing, nebulizer tubing and tubing storage bags should be dated when tubing is changed weekly by the nurses. There should be an order for oxygen and to change the tubing weekly. Nebulizer machines should not be on the floor and suction machines should be cleansed after each use. He/She said he/she just recently obtained an assistant and will now be able to do more frequent rounds with the MDS nurse and assistant. Failing to store oxygen equipment properly and clean the suction machines can lead to buildup of germs that cause infections. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 10/04/24 at 11:48 A.M., the administrator said oxygen masks and tubing should be stored in a dated bag when not in use and changed per physician order by the nurses to keep bacteria out of them. 9. Review of the facility's hand hygiene policy, dated March 2015, showed the policy did not contain direction on when to perform hand hygiene or use/change gloves. Review of the facility's Wound Care and Treatment policy, dated March 2015, showed: -Hand washing must be done as outlined in the guidelines; -Apply gloves, remove soiled dressing, remove gloves and wash hands; -Apply clean gloves, apply clean dressing after cleansing and label the dressing with initials, date and time; -Wash hands. 10. Review of Resident #27's Quarterly MDS, dated [DATE] showed staff assessed the resident as: -Cognitively impaired; -At risk for developing pressure injuries; -Diagnosis of anoxic brain damage (brain cell damage due to lack of oxygen). Observation on 10/02/24 at 9:17 A.M., showed RN D applied a gown and gloves and entered the resident room to perform wound care. He/She removed the dressing from the resident's right heel wound, cleansed the wound, applied a clean dressing and secured it with tape. With the same soiled gloves, RN D cleansed the posterior calf wound, applied a clean dressing and secured it with tape. With the same soiled gloves, he/she gathered his/her trash and unused supplies, removed his/her gloves and gown and exited the room. He/she did not perform hand hygiene until after he/she exited the room. During an interview on 10/02/24 at 9:26 A.M., RN D said he/she should have performed hand hygiene and changed his/her gloves between dirty and clean and between wounds to decrease risk of infection spread but was nervous and does not like to be watched. 11. Review of Resident #36's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Cognitively impaired; -At risk for developing pressure injuries; -Presence of one stage III (a full thickness tissue loss that extends into deeper tissue and fat, but does not expose bone, tendon, or muscle) unhealed pressure wound; -Received pressure ulcer care; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Diagnosis of cerebral palsy, pressure ulcer to sacrum. Observation on 10/02/24 at 9:36 A.M., showed RN D applied a gown and gloves and entered the resident's room to provide wound care. He/She removed the dressing from the resident's sacrum, cleansed the wound, applied a clean dressing and secured it with tape. He/She did not perform hand hygiene between dirty and clean tasks. During an interview on 10/02/24 at 9:44 A.M., RN D said he/she should have performed hand hygiene and changed his/her gloves between dirty and clean tasks. He/She said he/she knows how to do his/her job but does not like being watched. 12. During an interview on 10/04/24 at 8:24 A.M., the Infection Preventionist said nurses should wash their hands prior to performing wound care, if soiled, and between glove changes to prevent contamination of wounds and the spread of germs. During an interview on 10/04/24 at 10:49 A.M., the DON said hand hygiene should be performed between dirty and clean tasks, between different areas of the body and before leaving the room to decrease spread of infections and germs. During an interview on 10/04/24 at 11:48 A.M., the administrator said hand hygiene should be performed between patients, when they leave a room, before care, and between glove changes or when removing gloves to keep bacteria out of the wounds or spreading of germs.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 43327 Based on interview and record review, the facility staff failed to implement an effective and complete antibiotic stewardship program when staff failed to track residents on antibiotics for various infections in the facility, by not completing a current and ongoing antibiotic log of residents with active infections. The facility census was 39. 1. Review of the facility's Antibiotic Stewardship Program, undated, showed: -The Infection Preventionist (IP) will be the hub of the Antibiotic Stewardship Program. They will have the knowledge and expertise to effectively develop, implement and monitor the Antibiotic Stewardship Program; -The IP/designee will be responsible to audit the clinical assessment documentation at the time of the antibiotic prescription; -The IP/designee will be responsible for auditing of the completeness of antibiotic prescribing documentation to include dose, route, start date, end date, days of therapy and indication; -The IP/designee will track antibiotic resistant infections; -A blank Long Term Care Surveillance definitions for infections form; -A blank infection line listing showed resident name, age, sex, room number, infection site, pathogen/lab date, date of symptoms, date of treatment, appropriate, and resolved. 2. Review of the Antibiotic Tracking three-ring binder, dated September 2023 and an email dated August 2024, showed the most recent line blank. During an interview on 10/02/24 at 01:45 P.M., the IP said he/she has only been in the role of IP since the end of August. He/She said the DON usually tracks the antibiotic justification and the IP just looks at the length of treatment and for adverse effects. During an interview on 10/04/24 at 08:19 A.M., the DON said the he/she is responsible for the antibiotic stewardship program. He/She said he/she currently does not track antibiotics but was sent a form to use from the corporation. He/She said he/she was going to start tracking the antibiotics this month and will only track residents with active infections being treated with antibiotics. He/She said there are a lot of things that need addressed right now and just has not started this process yet but it is on his/her list. During an interview on 10/04/24 at 11:48 A.M., the administrator said the antibiotic stewardship program is the responsibility of the IP and believes it is reviewed during the weekly risk meetings. He/She was not aware the program had not been implemented.

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43327 Based on interview and record review, the facility staff failed to document the administration or refusal of the pneumococcal (lung inflammation caused by bacterial or viral infection) vaccine for three (Resident #1, #4, and #37) of five sampled residents. The facility census was 39 residents. 1. Review of the facility's Immunization policy, undated, showed: -A physician order, consent to receive signed by the resident and/or legal representative, information sheet included with the consent to administer pneumococcal vaccine, includes general information, risks and side effects and the resident will be monitored for fever up to 72 hours; -The schedule for administration will be determined according to the pharmacy and Centers for Disease Control (CDC) recommendations; -A copy of the consent is to be placed in the resident's medical record, with documentation of the administration of the vaccine according to physician orders. Review of the CDC's Pneumococcal Vaccine Timing for Adults dated 09/12/24, showed: -Adults greater than or equal to [AGE] years old who have not received a prior vaccine should receive a PCV20 or PCV21 vaccine or PCV15 with a PPSV23 in greater than or equal to one year later; -Adults greater than or equal to [AGE] years old who received a PPSV23 at any age should receive a PCV20, PCV21 or PCV15 after or equal to one year later; -Adults greater than or equal to [AGE] years old who received a PCV13 at any age should receive a PCV20 or PCV21 or PPSV23 after or equal to one year later; -Adults greater than or equal to [AGE] years old who received a PCV13 at any age and a PPSV23 at less than [AGE] years old should receive a PCV20 or PCV21 or PPSV23 after or equal to five years later. 2. Review of Resident #1's medical record showed: -Age 69; -admitted to the facility on [DATE]; -Staff documented they administered the pneumococcal vaccine on 11/17/2005 and did not indicate which vaccine was administered; -The record did not contain documentation the resident received or refused the PCV20, PVC21 or PPSV23 pneumococcal vaccine. (continued on next page)

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	10/04/2024

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

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Missouri Immunization Record provided by the facility, dated 06/20/24, showed a pneumococcal vaccine due on 09/09/2020. 3. Review of Resident #4's medical record showed: -Age 87; -admitted to the facility on [DATE]; -The record did not contain documentation the resident received or refused any pneumococcal vaccine. Review of the Missouri Immunization Record provided by the facility, dated 06/20/24, showed a pneumococcal vaccine due on 04/14/2002; 4. Review of Resident #37's medical record showed: -Age 83; -admitted to the facility on [DATE]; -The record did not contain documentation the resident received or refused any pneumococcal vaccine. Review of the Missouri Immunization Record provided by the facility, dated 06/20/24, showed a pneumococcal vaccine due on 02/17/2006. 5. During an interview on 10/02/24 at 03:29 P.M., the Director of Nursing (DON) said immunizations is a work in process and has been a struggle. He/She is not sure of the process prior to him/her at the facility. During an interview on 10/03/24 at 02:46 P.M., the Infection Preventionist said he/she has been responsible for the vaccine status of residents since the end of August. He/She said he/she has only looked at new admissions and did not have a system for looking a long-term residents who may be due for a vaccine. He/She said vaccine consents and education should be a part of the admission process. During an interview on 10/04/24 at 11:48 A.M., the administrator said the infection preventionist is in charge of the vaccine and tracking with consents signed on admission. He/She is not sure how the process is being tracked to keep residents up to date.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 43327 Based on interview and record review, the facility staff failed to ensure provision and documentation of education regarding the benefits, risks, potential side effects associated with the COVID-19 (a disease caused by a novel coronavirus) vaccine for facility staff. The facility census was 39 residents. 1. Review of the facility's Immunization policy dated 02/26/22 showed the policy did not contain direction for COVID-19 vaccine for facility staff. Review of the facility's COVID-19 for LTC policy dated 05/15/23 showed the policy did not contain direction for COVID-19 vaccine for facility staff. 2. During an interview on 10/02/24 at 09:36 A.M., the administrator said the business office manager quit on 10/02/24. The business office does the new hire paperwork to include review of COVID-19 status for employees. During an interview on 10/02/24 at 01:45 P.M., the Infection Preventionist said he/she is new to the role since August. He/She said he/she believes the business office obtains staff COVID-19 information on hire and he/she only tracks the resident information. He/She does not know if any education is provided. During an interview on 10/03/24 at 09:10 A.M., the administrator said the facility does not document education regarding the COVID-19 benefits, risks and potential side effects and/or offer or alert staff to how to obtain the vaccine.