

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265743	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/30/2025
NAME OF PROVIDER OR SUPPLIER  Riverview at the Park Care and Rehabilitation Cent		STREET ADDRESS, CITY, STATE, ZIP CODE  1100 Progress Parkway Sainte Genevieve, MO 63670	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on observation, interview, and record review, the facility nursing staff failed to contact the physician in a timely manner for one resident (Resident #1) of five residents sampled when experiencing a change in condition resulting in a hospitalization. The facility census was 100. Based on observation, interview, and record review, the facility nursing staff failed to contact the physician in a timely manner for one resident (Resident #1) of five residents sampled when experiencing a change in condition resulting in a hospitalization. The facility census was 100. Review of the facility's revised policy titled, Change in Resident's Condition or Status, dated 02/2021, showed: -The nurse will notify the resident's attending physician or physician on call when there has been a significant change in the resident's physical/emotional/mental condition based on the judgment of the clinical staff. - A significant change of condition is a major decline or improvement in the resident's status that will not normally resolve itself without interventions by staff or by implementing standard disease related interventions (is not self-limiting) and impacts more than one area of the residents' health status; 1. Review of Resident #1's Quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/09/25, showed: - Cognitively intact; - Requires partial to moderate assist with activity of daily living, including ambulation, and transfers; - Eating requires meal set up only; - Occasionally incontinent of bowel and bladder; - Diagnoses included coronary artery disease (occurs when plaque buildup (atherosclerosis) narrows the heart's arteries, restricting blood, oxygen, and nutrient flow, leading to symptoms like chest pain (angina), shortness of breath, and fatigue, and can ultimately cause a heart attack or heart failure), Anemia (a common blood disorder where your blood lacks enough healthy red blood cells or hemoglobin, impairing its ability to carry oxygen, leading to fatigue, weakness, pale skin, shortness of breath, and dizziness, often caused by iron deficiency, blood loss, or chronic conditions), Cancer, High blood pressure, Orthostatic hypotension (a sudden drop in blood pressure when standing up from sitting or lying down, causing dizziness, lightheadedness, or fainting due to reduced blood flow to the brain), Peripheral arterial disease ( a circulatory condition where narrowed arteries reduce blood flow to your limbs, most commonly the legs, due to plaque buildup (atherosclerosis), causing pain, cramping, and numbness during activity), Diabetes with polyneuropathy (nerve damage from long-term high blood sugar), Depression, dysphagia (difficulty swallowing food or liquids). Review of the resident's plan of care, dated 12/10/25 showed: - The resident required substantial assist with ambulation and wheeled walker.- The resident required partial assist tray set up, like opening packets or cartons and cutting up food. The resident able to feed self. - The resident required partial assist with toileting and is occasionally incontinent of bowel and bladder. Review of Resident #1's progress notes showed:- On 12/13/25 at 3:40 P.M. Resident continues to be alert to self only and confused in general, unable to comprehend how to feed self or cut own food, will stare blankly at food or other residents who are eating. Not bearing weight, staff having to use Hoyer Lift (a mechanical lift to move position) for</p> <p>(continued on next page)</p>

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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>transfers for safety. Resident continues to be incontinent of bowel and bladder, urine dark amber and strong in odor, skin color is pale;- On 12/14/2025 at 4:54 P.M., Resident has been lethargic (sluggish, drowsy, and lacking energy or enthusiasm, describing a state of extreme tiredness, inactivity, and apathy, often with reduced mental alertness, that goes beyond normal tiredness and can signal an underlying health issue), remains in bed with eyes closed this shift, responds to painful stimuli only. Able to administer fever reducing medications 4:30 P.M. Resident not eating or drinking this shift. Temperature noted at 4:00 P.M. 99.7;- On 12/14/2025 8:39 Resident was unable to swallow medications this evening, Held all per nurse; - On 12/15/2025 at 11:40 A.M., resident noted to be unresponsive this morning, new order received to send to emergency room for evaluation. - No documentation of notifying the resident's physician or physician on call 12/13/25 or 12/14/25. During an interview on 12/30/25 at 12:30 P.M., Licensed Practical Nurse (LPN) A said he/she was the one that documented Resident #1 was unresponsive on 12/15/25. That information had been reported to him/her. LPN A said he/she did not work 12/13/25 or 12/14/25. LPN A said he/she would have expected a nurse to contact a resident's physician if a resident suddenly can no longer feed themselves or bear weight as they had before. During an interview on 12/30/25 at 12:40 P.M., LPN B said on the morning of 12/15/25, he/she visited the resident with the wound nurse practitioner. LPN B said the resident felt warm like a fever and was not responding to verbal commands or painful stimulation. LPN B said he/she reported the information to the nurse. That nurse is no longer employed at the facility. During a phone interview on 12/30/25 at 12:50 P.M., Resident #1's Primary Care Physician (PCP) said no one notified him/her of any status changes for Resident #1 until 12/15/25. The PCP said he/she expected staff to notify him/her immediately of any notable changes to one of his/her patients. The PCP said he/she would consider going from being able to feed oneself to not, in addition to a mental status change a reason to notify his/her office immediately. During an interview on 12/30/25 at 1:15 P.M., the Director of Nursing said based on the documentation in Resident #1's medical record, he/she would have expected the nursing staff to notify the physician on the resident change in condition prior to 12/15/25. COMPLAINTS: 2693690 &amp; 2693979</p>		