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 _____	C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CITY LIVING COMMUNITY	3038 WEST TRUMAN BLVD JEFFERSON CITY, MO 65109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, facility staff failed to ensure services provided met professional standards of practice when staff failed to document and complete neurological checks for three residents (Resident #1, #2, and #3) of four sampled residents who had unwitnessed falls. The facility's census was 40. 1. Review of the facility's Event Investigation policy, dated March 2015, showed staff are directed to identify any injuries after a resident sustains an event, and directed staff to document the type of event, such as a fall, and a mental/neurological status after the event. Review of the facility's post-fall flow chart, undated, showed staff are directed as follows: -Charge nurse initiates a fall event in the electronic medical record (EMR). Describe if "witnessed" or "observed on floor", "neurological checks initiated" or "neurological checks not initiated"; -Charge nurse enters initial vital signs, progress note, and any other orders: complete "neurological checks" on paper form then scan and upload into the EMR; -The policy did not indicate the time frame for staff to complete neurological checks after a fall.	F 658		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Danette Patton | TITLE: LNHA | (X6) DATE: 2-28-2025

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.

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 _____	C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CITY LIVING COMMUNITY	3038 WEST TRUMAN BLVD JEFFERSON CITY, MO 65109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 1	F 658		

2. Review of Resident #1's Quarterly Minimum Data Set (MDS), a federally mandated assessment, dated 01/10/25, showed staff assessed the resident with mild cognitive impairment and had two or more non-injury falls since admission.

Review of the facility's fall incident report, dated 12/13/24 through 02/13/25, showed the resident had an unwitnessed fall on 01/08/25 and 01/30/25.

Review of the resident's progress notes, dated 01/08/25, showed staff documented the resident was found laying on floor next to his/her bed. Review showed staff did not document neurological checks were initiated.

Review of the resident's progress notes, dated 01/30/25, showed staff documented the resident rolled out of bed and found on fall mat.

Review of the resident's EMR showed the record did not contain documentation staff completed the neurological checks after the resident's unwitnessed fall on 01/08/25 and 01/30/25.

3. Review of Resident #2's Quarterly MDS, dated 11/27/24, showed staff assessed the resident with severe cognitive impairment, and had two or more non-injury falls since admission.

Review of the facility's fall incident report, dated 12/13/24 through 02/13/25, did not show documentation of the resident's fall on 01/15/25.

Review of the resident's progress notes, dated 01/15/25, showed staff documented the resident found laying on floor next to his/her bed,

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 _____	C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CITY LIVING COMMUNITY	3038 WEST TRUMAN BLVD JEFFERSON CITY, MO 65109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 2	F 658		

assessed by the nurse, and transferred to bed. Review showed staff did not document neurological checks were initiated.

Review of the resident's EMR showed the record did not contain documentation staff completed the neurological checks after the resident's unwitnessed fall on 01/15/25.

4. Review of Resident #3's Quarterly MDS, dated 12/19/24, showed staff assessed the resident with severe cognitive impairment, and did not have any falls since admission.

Review of the facility's fall incident report, dated 12/13/24 through 02/13/25, showed the resident had an unwitnessed fall on 01/02/25.

Review of the resident's progress notes, dated 01/02/25, showed staff documented the resident had an unwitnessed fall.

Review of the resident's EMR showed the record did not contain documentation staff completed the neurological checks after the resident's unwitnessed fall on 01/02/25.

5. During an interview on 02/13/25 at 11:50 A.M., the Director of Nursing (DON) said he/she expects staff to document an event note with a nurse's note in the EMR and initiate a neurological assessment for any resident who had an unwitnessed fall or a fall with head injury, and if the resident is not sent to a hospital for evaluation, staff should complete the neurological checks for up to 72 hours. He/She said up until about a week prior, staff were directed to complete the neurological assessments on paper and upload to the residents' EMR. He/she said

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 _____	C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CITY LIVING COMMUNITY	3038 WEST TRUMAN BLVD JEFFERSON CITY, MO 65109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 3	F 658		

staff should have completed neurological checks for residents #1, #2, and #3 after each documented unwitnessed fall or documentation the resident was "found". He/She said he/she is now responsible to oversee and audit post-fall documentation and completed neurological assessments.

During an interview on 02/13/25 at 2:08 P.M., Licensed Practical Nurse (LPN) A said staff are directed to document an event note, a nurse's note in the EMR, and complete neurological checks if a resident had an unwitnessed fall. He/She said the neurological checks are completed and documented on paper for up to 72 hours.

During an interview on 02/13/25 at 3:07 P.M., the administrator said he/she expects staff to complete neurological checks for 72 hours on any resident who had an unwitnessed fall since staff would be unsure if the resident sustained a head injury. He/She said the neurological checks were being completed on paper and scanned to the residents' EMR. He/She said the previous DON was responsible for post-fall audits and to ensure the neurological assessments were completed until he/she resigned on 01/10/25.

Duiring an interview on 2/25/25 at 1:33 P.M., the DON said that he/she had just started his/her position recently. He/She said the guidance to complete the neurological checks for 72 hours comes from the facility software program which directs the nursing staff to complete neurological checks for 72 hours after a fall where the resident hits their head or if the fall is unwitnessed.

During an interview on 2/25/25 at 2:15 P.M., the

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 _____	C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CITY LIVING COMMUNITY	3038 WEST TRUMAN BLVD JEFFERSON CITY, MO 65109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 4 Physician said he/she would expect staff to complete neurological checks after a resident fall if the resident hit their heads or if the fall was unwitnessed. He/She said the neurological checks should be completed for three days.	F 658		
	MO00248703			
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, facility staff failed to provide the services of a Registered Nurse (RN) for at least eight consecutive hours per day, seven days per week. The facility's census was 40. 1. Review of the facility's policies showed the facility did not provide a policy for RN coverage. 2. Review of the facility's time-keeping records for consecutive hours worked by an RN for December 2024, showed the facility did not have	F 727		

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 _____	C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CITY LIVING COMMUNITY	3038 WEST TRUMAN BLVD JEFFERSON CITY, MO 65109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 727	Continued From page 5	F 727		

an RN for at least eight consecutive hours a day in the building on Tuesday, 12/31/24.

Review of the facility's time-keeping records for consecutive hours worked by an RN for January 2025, showed the facility did not have an RN for at least eight consecutive hours a day in the building on the following dates:

-Saturday, 01/04/25;
-Sunday, 01/05/25;
-Saturday, 01/11/25;
-Sunday, 01/12/25:
-Saturday, 01/18/25;
-Sunday, 01/26/25.

Review of the facility's time-keeping records for consecutive hours worked by an RN for 02/01/25 through 02/12/25, showed the facility did not have an RN in the building on Saturday, 02/01/25 or Sunday, 02/02/25.

During an interview on 02/13/25 at 2:48 P.M., the Director of Nursing (DON) said he/she was aware of the requirement to have an RN in the building at least eight consecutive hours daily, but he/she had only been at facility for eight days and did not know who was responsible to ensure the RN coverage was being met prior. He/She said the administrator is currently responsible for scheduling RNs.

During an interview on 02/13/25 at 3:07 P.M., the administrator said he/she was aware of the requirement to have an RN in the building at least eight consecutive hours daily. He/She said the previous DON was responsible for scheduling RNs and when the DON resigned in January, another staff was helping with the RN schedules,

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 _____	C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CITY LIVING COMMUNITY	3038 WEST TRUMAN BLVD JEFFERSON CITY, MO 65109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 727	Continued From page 6 but he/she was ultimately responsible to ensure there was eight hours of RN coverage daily. The administrator said he/she realized there were several days without eight consecutive hours of RN coverage. He/She said on 02/01/25 and 02/02/25, the RN that was scheduled did not show up to work, and he/she did not have a back-up plan for RN coverage on those dates. MO00248703	F 727		

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04826	A. BUILDING: _____ B. WING _____	C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CITY LIVING COMMUNITY	3038 WEST TRUMAN BLVD JEFFERSON CITY, MO 65109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4040	19 CSR 30-85.042(35)(B) SNF RN-Day Shift, LPN/RN eve/nights Licensed Nursing Requirements; Skilled Nursing Facility. (B) A registered nurse shall be on duty in the facility on the day shift. Either a licensed practical nurse (LPN) or a registered professional nurse (RN) shall be on duty in the facility on both the evening and night shifts. II This regulation is not met as evidenced by: Class II Please refer to F727	A4040		
A4075	19 CSR 30-85.042(66) Nursing Care per Res Condition Each resident shall receive personal attention and nursing care in accordance with his/her condition and consistent with current acceptable nursing practice. I/II This regulation is not met as evidenced by: Class II Please refer to F658	A4075		

Missouri Department of Health and Senior Services
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Danielle Patton — LNHA — 2-28-2025

PLAN OF CORRECTION

Provider/Supplier Name:	River City Living Community
Street Address, City, Zip:	3038 West Truman Blvd Jefferson City, MO 65109
Date of Survey:	Completed 02/13/2025

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		
ID PREFIX TAG	**PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)**	**COMPLETION DATE**
	This Plan of Correction (POC) is submitted under State and Federal Law. The submission of this POC does not constitute an admission on the part of River City Living Community (the facility) as to the accuracy of the surveyor's findings or the conclusions drawn therefrom. The Facility's submission of this POC does not constitute the submission of River City Living Community that the findings cited are accurate, constitute a deficiency, or that the scope and severity regarding the deficiencies cited are correctly applied. The POC is intended to constitute the facility's credible letter alleging compliance. Compliance has been and will be achieved no later than the last completion date listed in the POC. Compliance will be maintained as provided in the POC. Date of Alleged Compliance: March 10, 2025	03/10/2025
F 658	The facility will ensure complete neurological checks are completed after unwitnessed falls for all residents that have an unwitnessed fall, including resident #1, #2 and #3. All residents that fall are considered at risk of the alleged deficient practice. All licensed nurses have been inserviced by the DON regarding completing neurological checks per facility policy for any resident that has an unwitnessed fall or a fall with a head injury. The DON will monitor the fall documentation daily when scheduled to ensure documentation is completed each shift, as required. Corrective action will be implemented immediately, if/when discovered. The DON will provide a quarterly fall report to the QAA committee and will follow recommendations and guidance as given by the Medical Director.	03/10/2025

	Date of Alleged Compliance: March 10, 2025	
F 727	The facility will ensure a Registered Nurse is scheduled at least eight consecutive hours per day, seven days per week. All residents are considered at risk of the alleged deficient practice. All registered nurses have been inserviced regarding working a full eight-hour shift, excluding the lunch break. The DON and Administrator will monitor the RN hours daily when scheduled to ensure compliance is achieved and maintained. Corrective action will be implemented immediately, if and when discovered. The DON will provide a quarterly staffing report to the QAA committee and will follow recommendations and guidance as given by the Administrator. Date of Alleged Compliance: March 10, 2025	03/10/2025
A 4040	Refer to F 727	03/10/2025
A 4075	Refer to F 658	03/10/2025

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.