STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265361	A. BUILDING _____ B. WING _____	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERDELL CARE CENTER	1121 11TH STREET BOONVILLE, MO 65233

(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 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and	F 584		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kayla Warren	Administrator	12/31/24

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
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F 584	Continued From page 1 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, facility staff failed to provide a comfortable and homelike environment for residents, when staff failed to maintain walls, ceilings, and floors. The facility census was 46. 1. Review of the facility's Homelike Environment policy, date February 2021, showed residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting to include a clean, sanitary, and orderly environment. 2. Observation on 12/10/24 at 10:30 A.M., showed resident occupied room 111's bathroom contained multiple areas of black stains in the tile around the toilet. Observation showed the tiles lifted from the floor. Observation on 12/10/24 at 11:10 A.M., showed resident occupied room 111's bathroom contained multiple areas of black stains in the tile around the toilet. Observation showed the tiles lifted from the floor. The wall by the sink with damaged sheetrock which exposed metal edges at the corner joint. 3. Observation on 12/10/24 at 10:39 A.M., showed resident occupied room 112's bathroom had a sticky dried yellow substance on the bathroom tile, and the room contained a strong	F 584		

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	265361	A. BUILDING _____ B. WING _____	12/13/2024

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F 584	Continued From page 2 odor. 4. Observation on 12/10/24 at 10:45 A.M., showed resident occupied room 113's bathroom tiles broken with exposed concrete below with sharp edges and had a strong odor. 5. Observation on 12/11/24 at 11:07 A.M., showed resident occupied room 109's ceiling near the window patched contained cracks, brown stains, and black material which protruded from a hole. 3. During an interview on 12/13/24 at 8:17 A.M. Certified Medication Technician A said if they see damage in the building there is a maintenance log to write it down. He/She said they also try to tell the Maintenance Director in person. During an interview on 12/13/24 at 8:22 A.M., Housekeeper I said he/she tells the housekeeping supervisor if damage is found. During an interview on 12/13/24 at 8:25 A.M., the Maintenance Director said he/she looks at the repair log to learn what repairs are need. Staff are to write the repair needs in the log. He/She said they were aware of the damage to walls and the flooring in the rooms. The maintenance director said he/she has been working around the building trying to keep up. During an interview on 12/13/24 at 9:27 A.M., the administrator said damage to the rooms could be a risk to residents. He/She said the facility has been too full to move residents when repairs are being done. The administrator said the Maintenance Director is responsible for making sure the repairs are finished.	F 584		

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	265361	A. BUILDING _____ B. WING _____	12/13/2024

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F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review, the facility staff failed to propell two residents (Resident #7, and #44) when staff did not use wheelchair footrests. Facility staff failed to provide safe mechanical lift transfers for three residents (Resident #15, #21, and #33), and failed to store hazardous materials in a safe manner in one shower room, one dining room and one storage cabinet. The facility census was 46. 1. The facility did not provide a policy for wheelchair safety. 2. Review of Resident #7's Annual Minimum Data Set (MDS), a federally mandated assessment tool, dated 10/01/24, showed staff assessed the resident as: -Cognitively intact; -Independent wheelchair; -Diagnosis of cerebrovascular accident, bipolar, schizophrenia, and macular degeneration. Observation on 12/10/24 at 2:59 P.M., showed Certified Nurse Aid (CNA) E propelled the resident in a wheelchair from the nurses desk to	F 689		

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F 689	Continued From page 4	F 689		

the Physical Therapy room. Observation showed the wheelchair did not contain foot rests and the residents feet slid along the floor while being propelled.

During an interview on 12/10/24 at 3:01 P.M., CNA E said he/she couldn't find the foot rests for the wheelchair and had to propel the resident without them. He/She said it is safer with footrests on the wheelchair.

3. Review of Resident #44's quarterly MDS, dated 11/04/24, showed staff assessed the resident as:

-Severe cognitive impairment;
-Substantial assistance wheelchair;
-Diagnosis of dementia, and anxiety.

Observation on 12/11/24 at 9:18 A.M., showed the administrator propelled the resident from the nurses desk to the resident's room. Observation showed the wheelchair did not contain footrests. Observation showed the residents foot on and off the floor while being propelled.

4. Review of the facility's Lifting Machine, Using a Mechanical policy, dated 2001, showed staff the purpose of the procedure is to establish the general principles of safe lifting using a mechanical lifting device it is not a substitute for manufacturer's training or instructions and make sure the lift is stable and locked.

5. Review of Resident #15's Quarterly MDS, dated 11/20/24, showed staff assessed the resident as:

-Cognitively intact;

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	265361	A. BUILDING _____ B. WING _____	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERDELL CARE CENTER	**1121 11TH STREET BOONVILLE, MO 65233**

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F 689	Continued From page 5 -Dependent on staff for all transfers; -Diagnosis of stroke. Observation on 12/11/24 at 01:05 P.M., showed NA D and CNA E transferred the resident from the wheelchair with a mechanical lift and the leg base of the lift open, NA D raised the resident from the wheelchair, closed the leg base, pushed the resident over the bed and lowered the resident onto the bed. During an interview on 12/12/24 at 01:43 P.M., NA D said the leg base should be open wide to keep the lift stable. NA D said when using a mechanical lift the legs should be open to the widest position for stability otherwise the lift could tip over. He/She said he/she did not think about it. 6. Review of Resident #21's Quarterly MDS, dated 10/15/24, showed staff assessed the resident as: -Severely cognitively impaired; -Dependent on staff for all transfers; -Diagnosis of dementia. Observation on 12/10/24 at 10:43 A.M., showed License Practical Nurse (LPN) C and the housekeeping supervisor transfered the resident from the wheelchair with a mechanical lift and the leg base of the lift open. LPN C raised the resident from the wheelchair, closed the leg base, pushed the resident over the bed and lowered the resident onto the bed. During an interview on 12/13/24 at 08:15 A.M., LPN C said mechanical lift training is done by therapy and nursing at least every three to four	F 689		

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F 689	Continued From page 6 months. He/She said staff should keep the leg base open during the transfer for stability but the room size makes it difficult. LPN C said the leg base should be kept open or the lift could go off balance and the resident could fall. 7. Review of Resident #33's quarterly MDS, dated 11/04/24, showed staff assessed the resident as: -Severe cognitive impairment; -Transfer total dependence; -Diagnosis of dementia. Observation on 12/11/24 at 10:00 A.M., showed CNA J and LPN C used a mechanical lift to transfer the from a wheelchair to a bed. LPN C operated the lift while CNA J steadied the resident. LPN C opened the legs of the mechanical lift and positioned it over the wheel chair. LPN C removed the wheelchair, closed the legs of the lift, pivoted the lift towards the bed, pushed the lift over the bed and lowered the resident. During an interview on 12/11/24 at 10:15 A.M., LPN C said the legs of the lift can not be opened because of the lack of space in the room. He/She said the legs should be open for stability and resident safety. 8. During an interview on 12/13/24 at 09:15 A.M., the Administrator said during mechanical lift transfers, staff should keep the leg base open for the stability of the machine. He/She said staff are trained on the operation of the lifts by the therapy department. The DON is responsible for the oversight of the nursing staff. During an interview on 12/13/24 at 09:30 A.M.,	F 689		

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F 689	Continued From page 7 the DON said for safety reasons, staff should keep the leg base open during transfers with a mechanical lift for better balance. He/She said staff are trained during on the floor assistance and observations. The DON said the ADON and DON do daily hall checks for issues. 9. The facility did not provide a policy for the storage of hazardous materials. Observation on 12/10/24 at 11:42 A.M., showed the 100 hall shower room unattended and door unlocked. Observation showed the shower room cabinet unlocked with an open disposable razor container. Observation showed staff were not present in the hallway by the unlocked door. Observation on 12/11/24 at 9:18 A.M.,showed the 100 hall shower room unattended and door unlocked. Observation showed the shower room cabinet unlocked with an open disposable razor container. Observation on 12/11/24 at 9:57 A.M., showed the 300 hall resident dining room contained two bottles of nail polish remover in a plastic bin. Observation showed unattended residents sat in the dining room. 10. During an interview on 12/12/24 at 1:52 P.M., CNA K said wheelchairs should have the footrest on before a resident is pushed because it could injure the resident without the footrest. Mechanical lifts should be closed during transfers. He/She said hazardous chemicals and razors should be locked to prevent resident access for their safety. During an interview on 12/12/24 at 1:43 P.M.,	F 689		

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F 689	Continued From page 8 LPN F said staff should not push residents in a wheelchair without the footrests on. There could be injuries if the footrests are not on the wheelchair. Mechanical lifts should be done with the legs spread to the widest position or a resident could be injured. All hazardous materials or razors should be locked when not in use. During an interview on 12/13/24 at 9:19 A.M., the Administrator said residents should not be pushed without the footrests on or they could be injured. The administrator said staff are educated on this wheelchair safety. He/She said all hazardous chemicals or razors should be locked for resident safety.	F 689		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 761		

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	265361	A. BUILDING _____ B. WING _____	12/13/2024

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RIVERDELL CARE CENTER	1121 11TH STREET BOONVILLE, MO 65233

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F 761	Continued From page 9	F 761		

Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, facility staff failed to store medications in one out of two medication storage rooms in a safe and effective manner. The facility census was 46.

1. Review of the facility's policy titled "Medication Labeling and Storage", dated February 2023, showed if the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items. The nursing staff is responsible for maintaining medications storage and preparation areas in a clean, safe, and sanitary manner.

2. Observation on 12/11/24 at 10:17 A.M., showed the 100 hall medication storage room contained the following:

-One bottle of Aspirin 325 milligram (mg) with an expiration date of 09/24;
-One bottle of Magnesium Oxide 400 mg with an expiration date of 09/24;
-Three bottles of Vitamin D 10 mg with an expiration date of 09/24;
-One Diclofenac Sodium topical Gel 100 gram tube with an expiration date of 04/24.

During an interview on 12/13/24 at 8:16 A.M., Certified Medication Technician (CMT) A said expired or damaged medication are returned to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265361	A. BUILDING _____ B. WING _____	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERDELL CARE CENTER	1121 11TH STREET BOONVILLE, MO 65233

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F 761	Continued From page 10 the pharmacy or destroyed. During an interview 12/13/24 at 8:34 A.M., Licensed Practical Nurse (LPN) B said the night shift nurse is responsible for monitoring the medication storage room. Expired medications should be returned to the pharmacy or destroyed by facility staff and then reordered. All nurses and CMT's are to check for medication issues. During an interview on 12/13/24 at 9:26 A.M., the administrator said the Director of Nursing (DON) and the CMT's are responsible for monitoring the medication storage room. There should not be any expired medications in the room because of the risk to resident's health. During an interview on 12/13/24 at 9:43 A.M., the DON said all nursing staff are responsible for medication storage and for checking for expired medications. The medications should be destroyed due to the risk to the residents if they received the expired medications.	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265361	A. BUILDING _____ B. WING _____	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERDELL CARE CENTER	**1121 11TH STREET BOONVILLE, MO 65233**

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F 812	Continued From page 11 safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, facility staff failed to ensure the dish washer machine operated according to manufacturer's instructions in a manner adequate to prevent cross contamination of kitchen wares. The facility census was 46. 1. Review of the facility's Sanitization policy, revised November 2022, showed dishwashing machines are operated according to manufacturer's instructions. General recommendations for low temperature dishwashers (chemical sanitization) are wash temperature of 120 degrees Fahrenheit (F) and final rinse with 50 parts per million (ppm) hypochlorite (chlorine). Review of the facility's Dish Machine - PPM Sanitizer Record Logs for the period of 10/01/24 through 12/12/24 showed staff documented morning and afternoon machine temperatures of 98 degrees F on all days. Observation on 12/10/24 at 10:20 A.M., showed the front of the dish machine contained a label which indicated minimum wash and rinse temperatures of 120 degrees F. Observation on 12/10/24 at 11:06 A.M., showed Dietary Dish Aide M ran a food processor bowl,	F 812		

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	265361	A. BUILDING _____ B. WING _____	12/13/2024

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F 812	Continued From page 12	F 812		

lid, and blade through the dish machine. Observation showed the maximum water temperature reached was 101 degrees F.

Observation on 12/10/24 at 11:10 A.M., showed the Dietary Manager (DM) used a food processor to puree chicken and broth. Observation showed the DM rinsed the food processor parts, added the parts to a dish machine rack, and ran the items through the dish machine. Observation showed the maximum water temperature reached was 109 degrees F.

Observation on 12/10/24 at 11:23 A.M., showed Dietary Dish Aide M ran a food processor bowl, lid, and blade through the dish machine. Observation showed the maximum water temperature reached was 102 degrees F.

Observation on 12/10/24 at 12:20 P.M., showed Dietary Dish Aide M prewashed and ran a rack of dishes through the dish machine. Observation showed the maximum water temperature reached was 106 degrees F.

Observation on 12/12/24 at 9:03 A.M., showed a test run of the dish machine indicated a maximum temperature of 104 degrees F. Observation showed the dish machine temperature gauge and a calibrated digital thermometer indicated the same temperature during the test run.

During an interview on 12/12/24 9:01 A.M., Dietary Dish Aide M said he/she checked the dish machine water temperature in the morning and afternoon. He/She said the dish machine water temperature should be 98 to 100 degrees F. He/She said he/she documented water

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265361	A. BUILDING _____ B. WING _____	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERDELL CARE CENTER	**1121 11TH STREET BOONVILLE, MO 65233**

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F 812	Continued From page 13	F 812		

temperatures on the dish machine log. He/She said he/she was trained to check water temperatures and sanitizer concentrations by the previous DM.

During an interview on 12/12/24 9:16 A.M., Cook L said the dish machine temperature usually ran around 98 degrees F. Cook L said the water temperature should be between 98 and 100 degrees F. Cook L said staff checked water temperatures daily and notified the vendor if there was a problem. Cook L said the vendor never said anything about the dish machine water temperature.

During an interview on 12/12/24 at 9:12 A.M., the DM said he/she was responsible for making sure the dish machine operated correctly and staff were trained on proper use and function. The DM said he/she was not aware the dish machine water was not getting hot enough. The DM said he/she thought the water temperature should be 110 degrees F.

During an interview on 12/12/24 at 10:50 A.M, the maintenance director said he/she used the dish machine temperature gauge to observe water temperatures. The maintenance director said the dish machine gauge never reached 120 degrees and that was okay because the machine used low temperature sanitizer chemicals. The maintenance director said he/she had read the instructional signage on the dish machine but he/she never thought about it.

During an interview on 12/12/24 at 11:40 A.M., the administrator said the facility used a low temperature dish machine but he/she did not know the specific water temperature of the

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	265361	A. BUILDING _____ B. WING _____	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERDELL CARE CENTER	**1121 11TH STREET BOONVILLE, MO 65233**

(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 812	Continued From page 14 machine. The administrator said the DM was responsible for ensuring staff followed the dish machine manufacturer's instructions. The administrator said he/she was not aware the dish machine was not being operated in accordance with manufacturer's instructions.	F 812		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other	F 880		

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F 880	Continued From page 15 persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, facility staff failed to develop and implement complete policies and procedures for	F 880		

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F 880	Continued From page 16 the inspection, testing and maintenance of the facility's water systems to inhibit the growth of waterborne pathogens and reduce the risk of an outbreak of Legionnaire's Disease (LD- a serious type of pneumonia (lung infection) caused by Legionella bacteria, which places all residents of the facility at risk of exposure which could lead to illness. Facility staff failed to use appropriate infection control procedures to prevent the spread of bacteria or other infectious causing contaminants when staff failed to position an indwelling catheter of one resident (Resident #11) out of two sampled residents off the floor. The facility census was 46 1. Review of the Centers for Medicare and Medicaid Services (CMS) Quality, Safety and Oversight (QSO) 17-30, dated 06/02/17 and revised on 07/06/18, showed: The bacterium Legionella can cause a serious type of pneumonia called LD in persons at risk. Those at risk include persons who are at least 50 years old, smokers, or those with underlying medical conditions such as chronic lung disease or immunosuppression. Outbreaks have been linked to poorly maintained water systems in buildings with large or complex water systems including hospitals and long-term care facilities. Transmission can occur via aerosols from devices such as showerheads, cooling towers, hot tubs, and decorative fountains. Facilities must have water management plans and documentation that, at a minimum, ensure each facility: -Conducts a facility risk assessment to identify where Legionella and other opportunistic	F 880		

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F 880	Continued From page 17 waterborne pathogens (e.g. Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas, nontuberculous mycobacteria, and fungi) could grow and spread in the facility water system; -Develops and implements a water management program that considers the ASHRAE industry standard and the CDC toolkit; -Specifies testing protocols and acceptable ranges for control measures, and document the results of testing and corrective actions taken when control limits are not maintained. Review of the facility's Legionella Water Management Plan, reviewed 09/27/24, showed: -The plan introduction indicated the name of another facility; -The portion of the plan related to responsible personnel indicated the name of another facility; -The plan indicated maintenance personnel were to dismantle, clean and descale all showerheads and spray nozzles quarterly; -The water heaters will be flushed every six months; -The written description of the building water system indicated water entered the facility from a municipal water line from a town which is located more than 90 miles from the facility; -The written description of the building water system indicated the facility had three separate water systems, which consisted of six water heaters; -The plan table of contents indicated the plan contained a building water system flow diagram. Review showed the plan did not contain a flow diagram. Observation on 12/11/24 during the Life Safety Code tour showed the facility contained three	F 880		

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F 880	Continued From page 18 water heaters. Observation showed two water heaters located in the mechanical room near the laundry room and one water heater in the 300-hall mechanical room. Review of the facility's Legionella control measures for the period of January 2024 through November 2024 showed the documentation did not include: -Semiannual water heater flushes; -Quarterly shower head and spray nozzle cleaning and descaling. During an interview on 12/12/24 at 10:50 A.M., the maintenance director said he/she was responsible for Legionella control in the facility. The maintenance director said the Legionella plan should include an accurate description of the facility water system. The maintenance director said he/she never cleaned shower heads because he/she thought staff cleaned them. The maintenance director said the facility contained three water heaters and he/she did not know why the Legionella plan indicated six water heaters. The maintenance director said he/she did not flush water heaters. The maintenance director said he/she reviewed the Legionella plan, but never read the plan thoroughly. During an interview on 12/12/24 at 11:40 A.M., the administrator said the Legionella Water Management plan was in place when he/she started. The administrator said he/she and maintenance staff were responsible for ensuring the Legionella plan was accurate and was followed. The administrator said the Legionella plan should have accurate facility water system descriptions. The administrator said he/she was	F 880		

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F 880	Continued From page 19 not aware of all required components of a water management plan. 2. Review of the facility's Urinary Catheter Care policy, dated 2001, showed the policy did not contain direction for positioning of an indwelling catheter off the floor. 3. Review of Resident #11's MDS, dated 09/24/24, showed staff assessed the resident as: -Cognitively intact; -Dependent on staff for toilet hygiene; -Used an indwelling catheter; -Diagnosis of stroke and urine retention. Observation on 12/10/24 at 10:27 A.M., showed the resident in bed. His/Her indwelling catheter on the floor. Observation on 12/11/24 at 09:05 A.M., showed the resident in bed. His/Her indwelling catheter on the floor. Observation on 12/12/24 at 09:03 A.M., showed the resident in bed. His/Her indwelling catheter on the floor. During an interview on 12/11/24 at 09:05 A.M., the resident said he/she has had the catheter a long time. He/She said the staff hook the catheter to the bed when he/she lays down. During an interview on 12/12/24 at 01:55 P.M., Certified Nursing Assistant (CNA) G said catheters should be hooked to the bed below the bladder and never touch the floor because the floor is dirty and could get bacteria inside the bag.	F 880		

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F 880	Continued From page 20 During an interview on 12/13/24 at 08:15 A.M., the Assistant Director of Nursing (ADON) said catheter bags should be kept off the floor for infection control reasons. During an interview on 12/13/24 at 08:30 A.M., the Infection Preventionist said residents with catheters should be kept off the floor because the floor is dirty and could cause an infection. The Infection Preventionist said there is training for infection control and the DON and ADON complete staff competencies of pericare during actual resident care. During an interview on 12/13/24 at 09:15 A.M., the Administrator said catheters should not be laid on the bed or on the floor due to risk for infections. He/She said the DON is responsible to oversee the process. During an interview on 12/13/24 at 09:30 A.M., the DON said catheters should not be placed on the floor due to bacteria potential. He/She said there has not been catheter training lately and is his/her responsibility to ensure staff are following proper procedure. He/She said the ADON and DON complete daily hall checks.	F 880		

Missouri Department of Health and Senior Services

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	14428	A. BUILDING: _____ B. WING _____	12/13/2024

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RIVERDELL CARE CENTER	1121 11TH STREET BOONVILLE, MO 65233

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A3001	19 CSR 30-85.032(2) Substantially Constructed/Maintained The building shall be substantially constructed and shall be maintained in good repair. New facilities shall comply with the requirements in accordance with the provisions found in 19 CSR 30-85.012. Existing licensed facilities shall meet and maintain the facility's physical plant in accordance with the construction standards in effect at the time of initial licensing, unless there is a specific rule governing the subject cited in this section or in 19 CSR 30-85.022, except that those facilities licensed between 1957 and 1965 shall not increase the capacity of any room or the total capacity of the facility without meeting new construction requirements. Existing licensed facilities with plans approved after April 8, 1972 and prior to January 1, 1999, shall comply as Existing Health Care Occupancies with NFPA 101, 2000 edition. Facilities whose physical plant requirement plans are approved on or after January 1, 1999, shall comply as New Health Care Occupancies with NFPA 101, 2000 edition. II/III This regulation is not met as evidenced by: Class III Please refer to F584	A3001		
A4064	19 CSR 30-85.042(55) Medication Storage Facilities shall store all external and internal medications at appropriate temperatures in a safe, clean place and in an orderly manner apart from foodstuffs and dangerous chemicals. A facility shall secure all medications, including those refrigerated, behind at least one (1) locked door or cabinet. Facilities shall store containers of discontinued medication separately from current	A4064		

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A4064	Continued From page 1 medications. II/III This regulation is not met as evidenced by: Class III Please refer to F761	A4064		
A4074	19 CSR 30-85.042(65) Protective Oversight, Voluntary Leave Each resident shall receive twenty-four- (24-) hour protective oversight and supervision. For residents departing the premises on voluntary leave, the facility shall have, at a minimum, a procedure to inquire of the resident or resident's guardian of the resident's departure, of the resident's estimated length of absence from the facility, and of the resident's whereabouts while on voluntary leave. I/II This regulation is not met as evidenced by: Class II Please refer to F689	A4074		
A4086	19 CSR 30-85.042(77) Infection Control/Communicable Disease Residents shall be cared for by using acceptable infection control procedures to prevent the spread of infection. The facility shall make a report to the division within seven (7) days if a resident is diagnosed as having a communicable disease, as determined by the Missouri Department of Health and listed in the Code of State Regulations pertaining to communicable diseases, specifically 19 CSR 20-20.020, as amended. I/II	A4086		

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A4086	Continued From page 2 This regulation is not met as evidenced by: Class II Please refer to F880	A4086		
A7083	19 CSR 30-87.030(81) Machine Chemical Sanitization, PPM Measured Machines (single-tank, stationary-rack, door-type machines and spray-type glass washes) using chemicals for sanitization may be used provided that-the temperature of the wash water is not less than one hundred twenty degrees Fahrenheit (120°F), the wash water is kept clean, chemicals added for sanitization purposes are automatically dispensed; utensils and equipment are exposed to the final chemical sanitizing rinse in accordance with manufacturers ' specifications for time and concentration, the chemical sanitizing rinse water temperature is not less than seventy-five degrees Fahrenheit (75°F) nor less than the temperature specified by the machine ' s manufacturer; chemical sanitizers used shall meet the requirements of 21 CFR 178.1010 (Revised 2005), Food and Drug Code of the United States Food and Drug Administration, Department of Health and Human Services and a test kit or other device that accurately measures the parts per million concentration of the solution is available and is used. II/III This regulation is not met as evidenced by: Class III Please refer to F812	A7083		

PLAN OF CORRECTION

Provider/Supplier Name:	Riverdell Care Center
Street Address, City, Zip:	1121 11th Street Boonville, MO. 65233
Date of Survey:	12/13/2024
PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	265361

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 is prepared and executed because it is required by the provision of the state and federal regulations and not because Riverdell Care Center agrees with the allegations and citations listed the statement of deficiencies. Riverdell Care Center maintains that the alleged deficits do to, individually and collectively, jeopardize the health and safety of the residents, not are they of such character as to limit our capacity to render adequate care as prescribed by the regulation. This plan of correction shall operate as Riverdell Care Center written credible allegation of compliance. By submitting this plan of correction, Riverdell Care Center does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation, or position, and Riverdell Care reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding.	

F584	What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice; No residents were found to have affected by the alleged deficient practice. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; Facility resident have the potential to be affected by the alleged deficient practice. Room 111's bathroom contained multiple areas of black stains in the tile around the toilet, tile will be purchased and will be installed when product arrives. Room 111's wall by the sink with damaged sheetrock which exposed metal edges at the corner joint has been repaired. Room 112's bathroom had a sticky dried yellow substance on the bathroom tile has been cleaned up. Room 113's bathroom tile broken with exposed concrete below with sharp edges and had a strong order has been deep cleaned and repaired. Room 109's ceiling near the window patched contained cracks, brown stains, and black material which protruded from a hole has been repaired. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; The Administrator and/ or Desingee will provide education to facility staff to include; Registered Nurses, Licensed Practical Nurses, Certfied Medication Technicians, Certfied Nursing Assistants, Nursing Assistance, Maintenance, Housekeeping on reporting crack tiles and keeping a home life enviroment. The Maintenance Director will meet with facility staff to identify areas of concern and correct identification concerns immediatley with Maintenance work orders. How the corrective action(6) will be monitored to ensure the deficient practice will to recur, i.e., what quality assurance program will be put into place. Maintenance Director and/ or Designee will audit 5 residetnt rooms and 1 common area five times a week for two weeks, weekly times three weeks and monthly thereafter until deemed no longer necessary by the committee. Maintenance Director and/or Designee will present audit finding from the managment audit monthly at the Quality Assurance Performance Improvement meeting monthly times three months, quarterly times one quarter, and randomly thereafter until deemed no longer necessary by the committee	1/15/25

F689	What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice; Resident #7 did not have any adverse reactions from the alleged deficient practice. Facility staff have been educated on not propelling resident without wheelchair footrests in place. Resident #44 did not have any adverse reactions from the alleged deficient practice. Facility staff have been educated on not propelling resident without wheelchair footrests in place. Resident #15 did not have any adverse reactions from the alleged deficient practice. Facility staff have been educated on properly using a mechanical lift during transfers. Resident #21 did not have any adverse reactions from the alleged deficient practice. Facility staff have been educated on properly using a mechanical lift during transfers. Resident #33 did not have any adverse reactions from the alleged deficient practice. Facility staff have been educated on properly using a mechanical lift during transfers. Razors and hazard chemicals have been properly removed and stored in a secure location on December 16, 2024. Facility staff have been educated on properly storing razors and hazard chemicals. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken; Facility residents have the potential to be affected by the alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; The Administrator and/ or Designee will provide education to facility staff to include; Registered Nurses, Licensed Practical Nurses, Certified Medication Technicians, Certified Nursing Assistants and Nursing Assistants to include; Wheelchair safety while wheelchair is in motion, Operating a mechanical lift during transfers, and proper storage of hazardous chemicals. The Director of Nursing and/or Designee management audit action rounds will be completed five times a week for two weeks, weekly times three weeks and monthly thereafter until deemed no longer necessary by the committee. The Management action rounds will include monitoring for; wheelchair safety, mechanical lift during transfers safety, and proper storage of hazardous chemicals. How the corrective action(s) will be monitored to ensure the deficient practice will to recur, I.e., what quality assurance program will be put into place.	01/15/25

	The Director of Nursing and/or Designee will present audit findings from the management audit monthly at the Quality Assurance Performance Improvement meeting monthly times three months, quarterly times one quarter, and randomly thereafter until deemed no longer necessary by the committee. Areas of concern will be addressed at time of discovery for further interventions.	

F761	What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice; One bottle of Aspirin 325 milligram (mg) with an expiration date of 9/24 was disposed of on 12/16/24. One bottle of Magnesium Oxide 400mg with an expiration date of 9/24 was disposed of on 12/16/24 Three bottles of Vitamin D 10 mg with an expiration date of 9/24 was disposed of on 12/16/24 One Diclofenac Sodium topical Gel 100 gram tube with an expiration date of 04/24 was disposed of on 12/16/24 How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken; Facility residents have the potential to be affected by this alleged deficient practice. What measures will be put into Place or what systemic changes you will make to ensure that the deficient practice does not recur; The Administrator and/or Designee will provide education to facility Registered Nurses, Licensed Practical Nurses, Certified Medication Technicians on checking for expired medications. The Director of Nursing and/or Designee management audit action rounds will be completed weekly times four weeks, bi-weekly times two weeks and then monthly thereafter until deemed no longer necessary by the committee. The management action rounds will include monitoring for expired medication and date of disposal. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The Director of Nursing and/or Designee will present audit findings from the management audit monthly at the Quality Assurance Performance Improvement meeting monthly time three months, quarterly times one quarter, and randomly thereafter until deemed no longer necessary by the committee. Area of concern will be addressed at time of discovery for further interventions.	1/15/25

F812	What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice. No residents were found to have been affected by the alleged deficient practice. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken; All residents can be affected by the the alleged deficient practice. Maintenance turned up the water heater 01/02/25 and the dish machine came up to temperature. The two visitor bathrooms is temporary out of service until plumber comes in to place a mixing valve due to water temps being to high. There is a visitor bathroom that can be used still. Starting 01/02/25 to ensure the safety of the increase water heater turn up we will be randomly auditing 5 random rooms daily 5 times a week times two weeks to ensure safety of temperatures in range. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur; The Administrator and/or Designee will provide education to facility staff to include Dietary Manager, Cooks, Dish-aides, and Maintenance on the following; Temperature checks on dish machine and the accurate temperature and if not in compliance who to report to. Action rounds (checking daily temperature logs) will be completed by the Dietary Manager/ Designee five times a week for two weeks, weekly times two weeks and monthly times one quarter to ensure temperature of dish washer stays in proper limits. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e, what quality assurance program will be put into place place. Action rounds (checking daily temperature logs) will be completed by the Dietary Manager/ Designee five times a week for two weeks, weekly times two weeks and monthly times one quarter to ensure temperature of dish washer stays in proper limits. The Dietary Manager and/or Designee will review audit findings monthly in the Quality Assurance Performance Improvement meeting monthly times three months, quarterly times one quarter and randomly thereafter until deemed no longer necessary. Area of concern will be addressed at time of discovery for further interventions.	1/15/25

F880	What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice; No residents were found to have been affected by the alleged deficient practice on the Legionella Bacteria. Resident #11 did not have any adverse effects from the alleged deficient practice on her indwelling catheter. A new water management plan will be created by 1/15/25 How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken; Facility residents have the potential to be affected by the alleged deficient practice. Facility residents with catheters have the potential to be affected by the alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; The Regional Director of Consulting will provide education to the facility Administrator and Maintenance Director on the development, implementation and inspection and maintenance of the water management program. The water management program will be updated to reflect the facilities water systems for the growth of waterborne pathogens and prevention of Legionella Disease. The policy will be updated as well to reflect identification situation that can lead to the growth of legionella, control measures, testing protocols, acceptable ranges for control measures and what corrective action to be taken when control limits are not maintained. Maintenance and Administration will develop a home specific water plan for the facility. The Maintenance Director and/or Designee will tour the facility monthly documenting the following; any identified area of growth of waterborne pathogens, identification of situations that can lead to the growth of legionella, control measures, testing concerns if any completed, and control measures out of range if any. This will be completed, weekly time two weeks, monthly times three months and quarterly time one or until deems safe. The Administrator and/ or Designee will provide education to facility Registered Nurses, Licensed Practical Nurses, Certified Medication Technicians, Certified Nursing Assistants, and Nursing Assistance on catheter placement of bag for safety of infections. Actions rounds will be completed by the Director of Nursing and/ or Designee five times a week for two weeks, weekly times two weeks and monthly times one quarterly validating the placement	1/15/25

	Of catheter bags. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The Maintenance Director and/or Designee will turn in completed water management audits monthly at the Quality Assurance Performance Improvement meeting. This will be completed monthly time one quarter and ongoing. The Director of Nursing and/or Designee will review audits in the monthly Quality Assurance Performance Improve meeting monthly times one quarter and randomly thereafter until deemed no longer necessary by the the committee. Areas of concern will be addressed at time of discovery for further interventions.	
K291	What corrective action(s) will be accomplished for the one resident found to have been affected by the deficient practice. The occupants from the 200 wing was found to have been affected by the alleged deficient practice. Mainline protection was called on December 30, 2024 to conduct an annual emergency lights testing on all exterior emergency lights. Mainline will be in to complete testing on January 2, 2025. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; Facility residents have the potential to be affected by the alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; The Administrator and/or designee will provide education to the Maintenance Director on ensuring that all emergency lights have an annual 90-minute testing. How the facility plans to monitor its performance to make sure the solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. The Maintenance Director will bring results of the the annual emergency light testing to the QAPI meeting and will review if any actions that need to be addressed.	1/15/25

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.

PLAN OF CORRECTION

Provider/Supplier Name:	Riverdell Care Center
Street Address, City, Zip:	1121 11th Street Boonville, MO. 65233
Date of Survey:	12/13/2024

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	265361

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
A3001	Please refer to F584	01/15/25
A4064	Please refer to F761	01/15/25
A4074	Please refer to F689	01/15/25
A4086	Please refer to F880	01/15/25
A7083	Please refer to F812	01/15/25

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.