STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175298	A. Building B. Wing	10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverbend Post Acute Rehabilitation	7850 Freeman Avenue Kansas City, KS 66112

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42966 The facility reported a census of 98 residents. The sample included eight residents; one resident was reviewed for misappropriation of property. Based on record review and interviews, the facility failed to ensure Resident (R) 3 remained free from misappropriation of funds when $300.00 was identified as missing from R3's wallet, which was stored in the facility safe, upon discharge. This deficient practice had the risk for financial instability and loss of dignity for R3. Findings included: - R3 admitted to the facility on [DATE] and discharged [DATE]. The Diagnoses tab of R3's Electronic Medical Record (EMR) documented diagnoses of bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods) and major depressive disorder (major depressive disorder). The Admission Minimum Data Set (MDS) dated [DATE] documented R3 had a Brief Interview for Mental Status (BIMS) score of six which indicated severe cognitive impairment. The Cognitive Loss/Dementia (progressive mental disorder characterized by failing memory, confusion) Care Area Assessment (CAA) dated 09/01/22, documented R1 had an alteration in cognition and was at risk for complications. The Care Plan dated 08/19/22, documented R3 had an alteration in cognition and was at risk for complications. The Care Plan directed staff identified themselves at each interaction, faced R3, and made eye contact. (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Investigation dated 10/24/22, documented there was a discrepancy in the amount of money checked in upon admission for R3 and the amount of money provided at discharge from the facility. Administrative Staff C went to the safe to obtain R3's belongings with Licensed Nurse (LN) G and noted the amount of money in R3's wallet was not the same amount as noted upon admission. The money counted upon admission was counted by Administrative Staff B and Administrative Staff C with Administrative Staff CC as a witness and was found to be $2,500.00. The money counted upon discharge on 10/18/22 was counted by Administrative Staff C and LN G and was found to be $2,200.00. Administrative Staff A gained access to the safe on 10/13/22 to obtain R3's house keys for his guardian and Consultant G in preparation for moving to his new facility on 10/18/22. It was noted that in the safe, R3 had a freezer bag with his personal items and a wallet that had a post-it note with the amount of $2,500.00 written on it attached to the wallet. The wallet was not in the freezer bag of belongings but was placed in the freezer bag on 10/13/22. Administrative Staff B and Administrative Staff C were the two individuals that had access to the safe for resident trust funds and had been in and out of the safe for those purposes weekly. A Debt Acknowledgement Form (IOU) was provided to R3 for the $300.00 to be paid within 30 days of 10/18/22 and was accepted without frustration by R3. In a Witness Statement on 10/19/22 at 10:57 AM, Administrative Staff C stated on 08/22/22, Administrative Staff CC opened the black box up at the front office and discovered a wallet with a large amount of cash in it. Immediately, Administrative Staff C and Administrative Staff CC counted the cash together and both counted $2,500.00. Administrative Staff C wrote the amount on a sticky note, both staff initialed the sticky note, and the sticky note was placed on the wallet with a rubber band. Administrative Staff C stated she kept the wallet locked in her office until Administrative Staff B came in, at which time they both counted the money again at $2,500.00. Administrative Staff B initialed the sticky note and locked the wallet up in the safe. Administrative Staff C stated she had not had any further contact with the wallet until 10/18/22. She stated the only other time during that time period that she had contact with the safe was on 10/07/22 when she locked the cash box back in the safe. In a Witness Statement on 10/19/22 at 11:35 AM, Administrative Staff CC stated she counted $2,500.00 in the wallet and initialed the sticky note on the wallet. She stated a rubber band was wrapped around the wallet and given to Administrative Staff B and Administrative Staff C who then placed it in the safe. In a Witness Statement on 10/19/22, LN G stated R3 was discharging home and had money locked in the safe. Upon Administrative Staff C opening the safe, LN G observed a bag that contained R3's wallet, ring, watch, and inhaler. There was a sticky note on the wallet stating wallet had $2,500.00 cash in with a date and signatures of staff that counted the money when placed in the safe. Before discharge, LN G counted $2, 200.00 in front of Administrative Staff C then recounted a second time with same amount counted. Administrative Staff C counted the money from the wallet and counted $2,200.00. Upon finding there was missing money, Administrative Staff A and Administrative Nurse D were notified. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a Witness Statement on 10/19/22, Administrative Staff B stated it was reported to her at approximately 11:00 AM on 10/18/22 that R3 was preparing to discharge from the facility and had asked for his belongs out of the safe. Upon admission, R3 had a wallet with $2,500.00 in it and wanted it kept in the safe while he was in the facility. Administrative Staff B, Administrative Staff C, and Administrative Staff CC counted the money and verified there was $2,500.00 in it, initialed a sticky note and attached it to the wallet with a rubber band around it. She stated she had not opened the wallet since the day it was placed in the safe. Administrative Staff B stated anyone can get a key to any office in the building by going to the maintenance office and getting a key out of the key cabinet. She stated the code to the safe was written in a password book and on her cork board in her office. On 10/26/22 at 02:41 PM, Administrative Staff C stated Administrative Staff CC had opened the drop box outside the office and discovered a wallet with a generous amount of cash in there. As soon as Administrative Staff CC brought the wallet to her, they counted it and signed a sticky note with the amount, date, and signatures. When Administrative Staff B came in 10 to 15 minutes later, Administrative Staff B and Administrative Staff C both counted the money again and Administrative Staff B initialed the sticky note then placed it in the safe. Administrative Staff C stated she had not had any further contact with the wallet until R3 discharged . On 10/26/22 at 02:49 PM, Administrative Staff A stated he had accessed the safe a week before R3's discharge to get his keys for Consultant G and knew the wallet was in there. He stated the code to the safe had now been reset and only he knew it until the segregation of duties was redistributed. Administrative Staff A stated the facility planned to pay R3 back the $300.00 within 30 days of 10/18/22. The facility's Abuse: Prevention of and Prohibition Against policy, last revised January 2021, directed each resident had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. The policy defined misappropriation as the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent. The facility failed to ensure R3 remained free from misappropriation of funds when $300.00 was identified as missing from R3's wallet, which was stored in the facility safe, upon discharge. This deficient practice had the risk for financial instability and loss of dignity for R3.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40688 The facility identified a census of 98 residents. The sample included eight residents with one reviewed for discharge. Based on interviews and record review, the facility failed to issue a written discharge/transfer notice to Resident (R)1's legal representative when the facility transferred R1 to the Emergency Department (ED) on 06/27/22. When the facility issued the discharge notice, dated 10/18/22, the notice failed to contain all the required information. This deficient practice placed R1 at risk for impaired resident rights and decreased psychosocial wellbeing. Findings included: - The Entry Tracking Record documented R1 admitted to the facility on [DATE]. R1's Electronic Medical Record (EMR) recorded diagnoses of major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), anxiety, Wernicke's encephalopathy (degenerative brain disorder caused by the lack of vitamin B1), and schizoaffective disorder (combination of symptoms of schizophrenia [a serious mental disorder in which people interpret reality abnormally] and mood disorder, such as depression). The Quarterly Minimum Data Set (MDS) dated [DATE] recorded R1 had Brief Interview for Mental Status score of nine which indicated moderately impaired cognition and no signs of acute mental status changes. The MDS recorded R1 had no behaviors in the look back period. R1 was independent with transfers, locomotion on and off the unit, and toileting. He required supervision and assistance from one staff with walking and required limited assistance of one staff member for personal hygiene. He was occasionally incontinent of bladder and frequently incontinent of bowel. The MDS recorded R1 had no pain and received no pain medication. R1 received an antidepressant (medication used to treat depression) and an antipsychotic (medication used to treat mental disorder such as schizophrenia) for all seven of the look back days. The MDS recorded the resident did not want to discuss the possibility of leaving the facility and returning to the community to live. (continued on next page)

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Discharge Assessment-Return Not Anticipated documented R1 discharged on [DATE] to an acute care facility (psychiatric hospital option was present but not selected). The assessment recorded staff identified R1 had a memory problem and moderately impaired decision making; R1 required supervision and cues with decisions. The assessment documented R1 had disorganized thinking continuously without fluctuation. The staff interview for mood was not completed. The assessment recorded R1 did not have psychosis (mental disorder characterized by a disconnection from reality) but did have physical behaviors and verbal behaviors directed towards others one to three days of the look back period. The impact of the behaviors on other residents, and on R1, was not answered on the assessment. The section regarding a change in behavior or other symptoms was left blank. The assessment recorded R1 required supervision with bed mobility, transfers, dressing, toileting and personal hygiene. R1 was independent with walking on and off the unit, locomotion on and off the unit, and eating. R1 received an antidepressant and antipsychotic medication for all seven of the look back days. The assessment documented there was an active discharge plan for the resident to return to the community. The questions regarding who participated in the planning were left blank. The assessment recorded a referral was made to the local contact agency. R1's Care Plan recorded a focus revised on 10/02/20 which directed R1 wished to remain long term care. A Nursing note under the Progress Notes tab in R1's EMR recorded on 06/24/2022 at 01:30 PM, Social Services X, Administrative Nurse D and the nurse called R1's guardian to discuss an incident the previous night. R1's representative was shocked and stated that R1 had never had any physical aggression towards anyone in his life. The note recorded staff discussed that the facility was looking at sending R1 to an acute inpatient psychiatric hospital that day and informed R1's representative that R1 was served a misdemeanor summons by the police. R1's representative stated that he shared power of attorney and he would relay all of the information to R1's other representative. A Social Services note dated 06/24/22 at 01:39 PM recorded Social Services would mail the original ticket that R1 received from police after the incident earlier that morning. The note recorded R1's power of attorney was aware the ticket would be in the mail. A Nursing note dated 06/26/22 at 03:21 PM documented admission was notified the acute inpatient psychiatric hospital was unable to accept R1 due to s staffing shortage. The facility was looking at other options. The record lacked evidence this information was provided to R1's representative. A Social Services note dated 06/27/22 at 03:17 PM recorded Social Services X received notification R1 would discharge to an acute hospital ED at 04:00 PM for a psych stay due to the incident that happened early on 06/24/22. The note further recorded R1 may be diverted to a different hospital dependent on how many patients the intended hospital ED received from a recent train derailment. The note documented Social Services X tried to call R1's representative but was unable to get ahold of him so a message was left. The note indicated Social Services X would continue to try to call. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Discharge Summary-Nursing note dated 06/27/22 at 03:19 PM recorded R1 was picked up by EMS [emergency medical services] non-emergency and was being transferred to the hospital emergency room to be admitted to the hospital's psych center. The summary recorded discharge instructions were provided to the resident or his representative regarding R1's diagnosis. R1's final diagnosis at discharge was recorded as behavior's [sic], physical aggression towards others. The summary again recorded R1 was discharged to the acute hospital emergency room for psych stay. The summary recorded the State Long Term Care Ombudsman was notified and the Kansas Department of Aging and Disability Services (KDADS) was notified. The address and phone number for KDADS was not listed, and the services provided by KDADS were marked not applicable (NA). A Social Services note dated 06/27/22 at 03:30 PM recorded Social Services X spoke with R1's representative and notified him R1 was discharged to the acute hospital emergency room for a psych stay. The note recorded the representative thanked Social Services X for the information. A Nursing note dated 06/28/22 at 04:54 PM recorded the hospital notified the facility three psychiatric evaluations were completed on R1 and none indicated anything wrong. The note recorded the hospital stated they were sending R1 back to the facility. The note recorded the facility stated it was not an appropriate place to handle that type of resident due to the lack of experienced staff for the behaviors. The note recorded the [unidentified]admission person said there was nowhere else to send R1. The note recorded R1's representative did not want him to return to the facility and the facility awaited an answer from the hospital regarding what the hospital was doing with R1's admission. Review of the non-emergency medical transportation service invoice revealed R1 was sent non- emergently to the hospital via the transportation service on 06/27/22. R1's clinical record and documents provided by the facility during the survey lacked documentation of further conversations with R1's representative regarding the transfer to the ED. The facility and R1's clinical record lacked evidence a written notice of discharge was provided to the resident's representative in a practicable amount of time as required by the regulation at the time of discharge. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Notice of Proposed Transfer/discharge date d 10/18/22 (113 days after the transfer/discharge on 06/27/22) documented the discharge location as the acute hospital. The notice recorded the reason for the discharge notice was the safety of individuals in the facility was endangered due to the clinical or behavioral status of the resident [R1] and further cited the reason the safety of others in the facility was endangered was due to the 06/24/22 incident; R1 broke the handle off a hospital cup and used the jagged edge to attack his roommate. R1's roommate was found with multiple cuts and scratches all over his body, including long, bleeding scratches on his bilateral legs. The notice directed if R1 and/or his representative believed the transfer/discharge was inappropriate and involuntary they had the right to appeal. The appeal could be filed in writing to, or by calling, the listed agencies. The notice listed KDADS and the physical address as well as the main phone number. The notice further identified the State Long Term Care Ombudsman (LTCO) and a street address and phone number. The notice lacked information regarding how to file an appeal, or who would be available to assist the resident/representative in filing an appeal. The notice lacked information on how to contact the Office of Administrative Hearing (OAH). The notice lacked instruction on how to contact all appropriate agencies electronically and lacked information, including the phone number, on how to file a formal complaint with the appropriate state agency. The notice lacked information (was left blank) regarding the State Advocacy Agency for Persons with Mental Health Disorders (despite R1's diagnosis of schizoaffective disorder). The notice recorded it was sent to the OAH Judge, both R1's representatives and the LTCO. The notice lacked evidence it was provided to the facility listed as discharge location. On 10/26/22 Social Services X was no longer employed by the facility and unavailable for interview. On 10/26/22 at 01:07 PM, Regional Consultant GG stated R1's case was in front of a judge because the hospital felt like R1 should be able to return to the facility, but the facility felt that due to the situation on 06/24/22 and the fact the other involved resident remained in the facility, it was not appropriate for R1 to return to the facility. On 11/07/22 at 08:54 AM, R1's representative stated the facility gave R1, who was unable to make his own decisions or understand what was happening some discharge paperwork. R1's representative further stated he learned of the 06/27/22 transfer (to the ED) at 12:35 AM on 06/28/22 when the ED contacted him about R1. The facility policy Discharge or Transfer revised 01/2022 documented for planned discharges to other healthcare facilities, the facility would obtain orders for discharge from the physician, keep the resident/family involved with all the discharge planning, complete the transfer/discharge form. The facility would document the entire process in the nursing notes. The policy directed the facility would provide a safe, organized, structured transfer and/or discharge to hospital, other healthcare facility, or home that would meet the residents highest practical level of medical, physical, and psychosocial wellbeing. The facility failed to issue a written discharge/transfer notice to R1's legal representative when the facility non-emergently transferred R1 to the ED on 06/27/22. When the facility issued the discharge notice, dated 10/18/22, the notice failed to contain all the required information. This deficient practice placed R1 at risk for impaired resident rights and decreased psychosocial wellbeing.

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F 0626 Level of Harm - Actual harm Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40688 The facility identified a census of 98 residents. The sample included eight residents with one reviewed for discharge. Based on interviews and record review, the facility failed to allow Resident (R)1 to return to the facility after the facility non-emergently transferred him to the Emergency Department (ED) for a psychiatric evaluation, on 06/27/22. The facility further failed to allow R1 to return to the facility pending and during the appeals process as required. As a result of this failure, R1 remained in an inpatient hospital setting since the transfer on 06/27/22, greater than four months, as the hospital could not find alternative placement. Due to these failures, cognitively impaired R1, who was unable to make decisions, remained homeless. R1, with history of depression (persistent feeling of sadness and loss of interest) and anxiety, was unable to attend activities, deprived of a homelike environment, socially isolated from peers, and unable to leave the acute hospital for therapeutic leave to spend time with his family due to his inpatient status. Findings Included: - The Entry Tracking Record documented R1 admitted to the facility on [DATE]. R1's Electronic Medical Record (EMR) recorded diagnoses of major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), anxiety, Wernicke's encephalopathy (degenerative brain disorder caused by the lack of vitamin B1), and schizoaffective disorder (combination of symptoms of schizophrenia [a serious mental disorder in which people interpret reality abnormally] and mood disorder, such as depression). The Quarterly Minimum Data Set (MDS) dated [DATE] recorded R1 had Brief Interview for Mental Status score of nine, which indicated moderately impaired cognition and no signs of acute mental status changes. The MDS recorded R1 had no behaviors in the look back period. R1 was independent with transfers, locomotion on and off the unit, and toileting. He required supervision and assistance from one staff with walking and required limited assistance of one staff member for personal hygiene. He was occasionally incontinent of bladder and frequently incontinent of bowel. The MDS recorded R1 had no pain and received no pain medication. R1 received an antidepressant (medication used to treat depression) and an antipsychotic (medication used to treat mental disorder such as schizophrenia) for all seven of the look-back days. The MDS recorded the resident did not want to discuss the possibility of leaving the facility and returning to the community to live. (continued on next page)

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F 0626 Level of Harm - Actual harm Residents Affected - Few	The Discharge Assessment-Return Not Anticipated documented R1 discharged on [DATE] to an acute care facility (psychiatric hospital option was present but not selected). The assessment recorded staff identified R1 had a memory problem and moderately impaired decision making; R1 required supervision and cues with decisions. The assessment documented R1 had disorganized thinking continuously without fluctuation. The staff interview for mood was not completed. The assessment recorded R1 did not have psychosis (mental disorder characterized by a disconnection from reality) but did have physical behaviors and verbal behaviors directed towards others one to three days of the look back period. The impact of the behaviors on other residents, and on R1, was not answered on the assessment. The section regarding a change in behavior or other symptoms was left blank. The assessment recorded R1 required supervision with bed mobility, transfers, dressing, toileting and personal hygiene. R1 was independent with walking on and off the unit, locomotion on and off the unit, and eating. R1 received an antidepressant and antipsychotic medication for all seven of the look back days. The assessment documented there was an active discharge plan for the resident to return to the community. The questions regarding who participated in the planning were left blank. The assessment recorded a referral was made to the local contact agency. R1's Care Plan recorded a focus revised on 10/02/20 which directed R1 wished to remain long term care. A Nursing notes under the Progress Notes tab in R1's EMR recorded on 06/24/2022 at 01:30 PM, Social Services X, Administrative Nurse D, and the nurse called R1's guardian to discuss an incident the previous night. R1's representative was shocked and stated R1 had not shown physical aggression towards anyone in his life. The note recorded staff discussed the facility was looking at sending R1 to an acute inpatient psychiatric hospital that day and informed R1's representative that R1 was served a misdemeanor summons by the police. R1's representative stated that he shared power of attorney and he would relay all of the information to R1's other representative. A Nursing note dated 06/26/22 at 03:21 PM documented admission was notified the acute inpatient psychiatric hospital was unable to accept R1 due to staffing shortage. The facility was looking at other options. The record lacked evidence this information was provided to R1's representative. Review of the non-emergency medical transportation service invoice revealed R1 was sent non- emergently to the hospital via the transportation service on 06/27/22. A Nursing note dated 06/28/22 at 04:54 PM recorded the hospital notified the facility three psychiatric evaluations were completed on R1 and none indicated anything wrong. The note recorded the hospital stated they were sending R1 back to the facility. The note recorded the facility stated it was not an appropriate place to handle that type of resident due to the lack of experienced staff for the behaviors. The note recorded the hospital admission person said there was nowhere else to send R1. The note recorded R1's representative did not want him to return to the facility and the facility awaited an answer from the hospital regarding what the hospital was doing with R1's admission. R1's clinical record lacked evidence or documentation R1's representative would not allow R1 to return to the facility. (continued on next page)

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F 0626 Level of Harm - Actual harm Residents Affected - Few	The hospital Social Work Services assessment dated [DATE] recorded R1 had mental illness, and homelessness. The note documented R1 was formerly at a long-term care (LTC) facility but was kicked out due to assaulting a roommate. The LTC facility later recanted the severity of the assault (stabbing down to scratching) and would take R1 back for an additional $15.00 a day for a private room. The LTC facility then changed their mind and asked for $30.00 a day. R1's legal guardians contacted Medicaid. A court hearing was scheduled in October. New placement was sought, and multiple referrals sent, but no facilities accepted R1. The hospital Length of Stay Note dated 09/02/22 recorded the case manager spoke with R1's representative regarding discharge planning. The social worker made mass referrals to Kansas facilities, but R1 was likely to return to [the former nursing home] after a hearing on 10/11/22. The note recorded R1's discharge plan was a facility; anticipated discharge date was greater than seven days. The note recorded the medical reason for the hospitalization was NA and recorded specialty consults were also NA. The hospital Social Work Free Text Note dated 09/06/22 recorded the social worker received a call from facility staff Administrative Staff E. Administrative Staff E reported Social Services X was no longer at the facility so Administrative Staff E would assist. The note recorded the facility did want R1 to return but believed the court would make the facility take R1 back after the hearing in October. Administrative Staff E hoped to find placement before that but needed the hospital to complete a Kansas Level II Pre-Admission Screening and Resident Review (PASARR). Review of the Notice of Proposed Transfer/discharge date d 10/18/22 (113 days after the transfer/discharge on 06/27/22) documented the discharge location as the acute hospital. The notice recorded the reason for the discharge notice was the safety of individuals in the facility was endangered due to the clinical or behavioral status of the resident [R1] and further cited the reason the safety of others in the facility was endangered was due to the 06/24/22 incident; R1 broke the handle off a hospital cup and used the jagged edge to attack his roommate. R1's roommate was found with multiple cuts and scratches all over his body, including long, bleeding scratches on his bilateral legs. The notice directed if R1 and/or his representative believed the transfer/discharge was inappropriate and involuntary they had the right to appeal. The appeal could be filed in writing to, or by calling, the listed agencies. The notice listed KDADS and the physical address as well as the main phone number. The notice further identified the State Long Term Care Ombudsman (LTCO) and a street address and phone number. The notice lacked information regarding how to file an appeal, or who would be available to assist the resident/representative in filing an appeal. The notice lacked information on how to contact the Office of Administrative Hearing (OAH). The notice lacked instruction on how to contact all appropriate agencies electronically and lacked information, including the phone number, on how to file a formal complaint with the appropriate state agency. The notice lacked information (was left blank) regarding the State Advocacy Agency for Persons with Mental Health Disorders (despite R1's diagnosis of schizoaffective disorder). The notice recorded it was sent to the OAH Judge, both R1's representatives and the LTCO. The notice lacked evidence it was provided to the facility listed as discharge location. R1's clinical record lacked evidence the facility evaluated R1's status at the time the discharge notice was issued. The facility was unable to provide any documentation or evidence of evaluations of R1's status at the time the discharge notice was issued and only referred to the 06/24/22 event. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175298	A. Building B. Wing	10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverbend Post Acute Rehabilitation	7850 Freeman Avenue Kansas City, KS 66112

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

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F 0626 Level of Harm - Actual harm Residents Affected - Few	An Inpatient Social Work Referral Note dated 10/21/22 recorded mass referrals were sent to approximately 150 Kansas facilities, and denials were received. Review of R1's acute hospitalization notes lacked documentation of behavioral events, physical aggression, or the need for inpatient psychiatric services. On 10/26/22 the facility was unable to provide documentation of assessment of R1's current status as related to returning to the facility. The facility was further unable to provide evidence of attempted placement in other facilities. A statement from Administrative Staff A written and provided on 10/26/22 noted there was no written correspondence between the facility and the hospital regarding the transfer of R1 back to the facility. There were a series of phone calls from an [unidentified] hospital staff member in the psych department. The conversations were regarding the status and psychological wellbeing of R1 and his decreased need to be admitted to a psychiatric facility. The statement noted that Consultant GG and Administrative Staff A stated the facility was not capable of caring for R1 due to the nature of the incident that occurred between R1 and his roommate. The statement recorded Consultant GG and Administrative Staff A asked the [unidentified] hospital staff member for a psychological evaluation for R1 and the hospital staff member hung up on them. The statement recorded later phone calls were made to R1's representative regarding R1's status and the conversations were regarding R1 and his current needs at that time. The statement recorded the facility and R1's representative had still not to come to an agreement at the time of the statement and continued to work through the process. On 10/26/22 at 03:34 PM, Administrative Staff E stated the facility started to try to find placement for R1 immediately after the event on 06/24/22. R1 was placed in a private room with a one to one sitter and staff tried to get multiple places to accept R1. Administrative Staff E stated the hospital was able to take R1, so he was sent non-emergent EMS for a psych evaluation through the hospital ED. She said she spoke with the hospital and the hospital (unable to identify the hospital staff) said just send R1 through the ED, and he can admit through the ED. She said that hospital was the only place that would accept R1 that day due to the train wreck [derailment] on 06/27/22. She further reported the hospital tried to find a place for R1. She stated the facility worked on finding placement for R1. Administrative Staff E stated she was pretty sure R1 was still at the hospital. She stated she tried to call the hospital about a week after R1 transferred but the hospital had no information for her. She stated she assumed R1 was in the psychiatric unit. She further revealed the facility had not received a referral or updated packet from the hospital regarding R1's status. (continued on next page)

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F 0626 Level of Harm - Actual harm Residents Affected - Few	On 10/27/22 at 10:50 AM in a telephone interview, Social Work Consultant II confirmed R1 was dropped off at the acute hospital ED due to a behavioral episode reported by the facility. consultant II stated R1 was evaluated and was found to have no need for inpatient psychiatric health services. Consultant II confirmed that during R1's stay at the acute hospital, which was currently over months and ongoing, R1 had no behaviors, no aggression and no actions which warranted an inpatient psychiatric stay and had not been admitted for psychiatric or behavioral health reasons. Consultant II confirmed the facility refused to allow R1 to return to the facility and based on the facility's initial allegation that r1 tried to stab his roommate, which was later downgraded to scratching, no other facility would accept R1. She stated R1 remained on the medical/surgical unit, awaiting placement. Consultant II reported the hospital continued to try to find placement for R1 and worked with R1's representative to find a safe discharge for R1. Consultant II reported the hospital was unaware the facility issued an involuntary discharge notice on 10/18/22 as it was discussed the facility would allow R1 to return if a payment for a private room could be arranged. On 11/07/22 at 08:54 AM, R1's representative state he learned of the transfer on 12:35 AM on 06/28/22 from the ED. He stated he had not spoken with anyone from the facility at that point regarding the transfer on 06/27/22. R1's representative stated he knew about the incident that occurred on 06/24/22 and was shocked to learn of it because R1 had no history of been physically aggressive with other residents in the facility. R1's representative stated R1 was currently in the hospital. He said R1 did not do much of anything except sleep all day. R1 did like to watch television but because R1 had impaired memory it was hard for R1 to remember what he liked. R1's representative stated when R1 was in the facility, R1's family could come and take R1 out to the lake and out to enjoy R1's favorite foods which always made R1 happy. The current situation, with R1 inpatient at the hospital, did not allow R1 and the family to go on family outings. R1's representative stated he tried to get to the hospital as much as possible to try to visit with R1, but it was more difficult and R1's mother was unable to visit as much as desired. R1's representative stated he hoped R1 could return to the facility and resume his normal activities. R1's representative did express some concern that the facility may retaliate or not provide supportive cares for R1 due to extended battle and court proceedings. R1's representative stated he was unsure how the situation had impacted R1 because R1's mental illness made it difficult for R1 to express how he was feeling and R1 reacted to things differently due to the mental illness and his impaired memory. The facility policy Discharge or Transfer revised 01/2022 documented for planned discharges to other healthcare facilities, the facility would obtain orders for discharge from the physician, keep the resident/family involved with all the discharge planning, complete the transfer/discharge form. The facility would document the entire process in the nursing notes. The policy directed the facility would provide a safe, organized, structured transfer and/or discharge to hospital, other healthcare facility, or home that would meet the residents highest practical level of medical, physical, and psychosocial wellbeing. The facility failed to allow R1 to return to the facility after he was transferred non emergently on 06/27/22 to the Emergency Department (ED) for a psychiatric evaluation. The facility further failed to allow R1 to return to the facility pending and during the appeals process as required. As a result of this failure, R1 remains in an inpatient hospital setting since the transfer on 06/27/22, greater than four months, as the hospital was unable to find alternative placement. R1 is now homeless, unable to attend activities, deprived of a homelike environment, and socially isolated from peers in his inpatient status. R1 is unable to leave the acute hospital for therapeutic leave to spend time with his family due to his inpatient status. (continued on next page)

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F 0626 Level of Harm - Actual harm Residents Affected - Few	The scope and severity were determined to be actual harm based on the reasonable person concept due to the circumstances of R1's mental illness and inability to self-identify and express his feelings.