Printed: 11/24/2024 Form Approved OMB No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175298	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/26/2022
NAME OF PROVIDER OR SUPPLIER Riverbend Post Acute Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 7850 Freeman Avenue Kansas City, KS 66112	
For information on the nursing home's	plan to correct this deficiency, please con	tact 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	**NOTE- TERMS IN BRACKETS F The facility reported a census of 98 reviewed for misappropriation of pr Resident (R) 3 remained free from R3's wallet, which was stored in the financial instability and loss of dign Findings included: - R3 admitted to the facility on [DA' The Diagnoses tab of R3's Electron (major mental illness that caused properties depressive disorder (major depressive disorder (major depressive disorder (major depressive Status (BIMS) score of six which in The Cognitive Loss/Dementia (properties) and the Care Plan dated 08/19/22, door 1985 the	TE] and discharged [DATE]. nic Medical Record (EMR) documented people to have episodes of severe high	ONFIDENTIALITY** 42966 residents; one resident was terviews, the facility failed to ensure 00 was identified as missing from ficient practice had the risk for d diagnoses of bipolar disorder and low moods) and major had a Brief Interview for Mental by failing memory, confusion) Care on in cognition and was at risk for

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

FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID:

Facility ID: 175298

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175298	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/26/2022
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	ion)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	checked in upon admission for R3 Administrative Staff C went to the samount of money in R3's wallet wa upon admission was counted by Ac CC as a witness and was found to counted by Administrative Staff C access to the safe on 10/13/22 to for moving to his new facility on 10 personal items and a wallet that ha wallet. The wallet was not in the free Administrative Staff B and Administresident trust funds and had been in Acknowledgement Form (IOU) was was accepted without frustration by In a Witness Statement on 10/19/2 Staff CC opened the black box upon Immediately, Administrative Staff C was the sticky note was placed on the volocked in her office until Administrative Staff C stated she had not had any time during that time period that she box back in the safe. In a Witness Statement on 10/19/2 safe. Upon Administrative Staff C watch, and inhaler. There was a stand signatures of staff that counted 200.00 in front of Administrative Staff C counted the	and the amount of money provided at a safe to obtain R3's belongings with Lice is not the same amount as noted upon diministrative Staff B and Administrative be \$2,500.00. The money counted upon and LN G and was found to be \$2,200.00 betain R3's house keys for his guardian /18/22. It was noted that in the safe, R3 and a post-it note with the amount of \$2,8 bezer bag of belongings but was placed trative Staff C were the two individuals in and out of the safe for those purpose is provided to R3 for the \$300.00 to be pay R3. 2 at 10:57 AM, Administrative Staff CC counted to rote the amount on a sticky note, both wallet with a rubber band. Administrative staff B came in, at which time they intialed the sticky note and locked the way further contact with the wallet until 10/12 at 11:35 AM, Administrative Staff C counted to the wallet. She stated a rubber be staff B and Administrative Staff C who staff C then recounted a second time with money from the wallet and counted \$2 and Administrative Nurse D were not staff C and Administrative Nurse D were not	discharge from the facility. Insed Nurse (LN) G and noted the admission. The money counted a Staff C with Administrative Staff on discharge on 10/18/22 was 200. Administrative Staff A gained and Consultant G in preparation 3 had a freezer bag with his 500.00 written on it attached to the d in the freezer bag on 10/13/22. That had access to the safe for as weekly. A Debt and within 30 days of 10/18/22 and stated on 08/22/22, Administrative let with a large amount of cash in it. The cash together and both counted staff initialed the sticky note, and a staff initialed the sticky note, and a staff C stated she kept the wallet by both counted the money again at wallet up in the safe. Administrative 18/22. She stated the only other 07/22 when she locked the cash a stated she counted \$2,500.00 in and was wrapped around the then placed it in the safe. The and had money locked in the other that contained R3's wallet, ring, and \$2,500.00 cash in with a date are defore discharge, LN G counted \$2, h same amount counted.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11:00 AM on 10/18/22 that R3 was of the safe. Upon admission, R3 ha in the facility. Administrative Staff E and verified there was \$2,500.00 in around it. She stated she had not constant the stated and the stated around it. She stated she had not constant the stated around it. She stated she had not constant the stated around it. She stated anyone can get a key getting a key out of the key cabinet her cork board in her office. On 10/26/22 at 02:41 PM, Administ outside the office and discovered a Administrative Staff CC brought the date, and signatures. When Admin Administrative Staff C both counted placed it in the safe. Administrative discharged. On 10/26/22 at 02:49 PM, Administ discharge to get his keys for Consultad now been reset and only he known been	2, Administrative Staff B stated it was repreparing to discharge from the facility and a wallet with \$2,500.00 in it and wards, Administrative Staff C, and Administrative it, initialed a sticky note and attached opened the wallet since the day it was ply to any office in the building by going it. She stated the code to the safe was determined to the state of the safe was determined to the state of the safe was determined to the safe wallet to her, they counted it and significant it is stative Staff B came in 10 to 15 minuted the money again and Administrative Staff C stated she had not had any further staff A stated he had accessed ultant G and knew the wallet was in the new it until the segregation of duties ware R3 back the \$300.00 within 30 days of and Prohibition Against policy, last review abuse, neglect, misappropriation of an as the deliberate misplacement, explangings or money without the resident's stained free from misappropriation of further stated in the facility safe, upon disch of dignity for R3.	y and had asked for his belongs out ated it kept in the safe while he was rative Staff CC counted the money it to the wallet with a rubber band placed in the safe. Administrative to the maintenance office and written in a password book and on aff CC had opened the drop box in there. As soon as led a sticky note with the amount, less later, Administrative Staff B and Staff B initialed the sticky note then other contact with the wallet until R3 the safe a week before R3's re. He stated the code to the safe as redistributed. Administrative Staff for 10/18/22. Sed January 2021, directed each resident property, and exploitation, or wrongful temporary or consent.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the rebefore transfer or discharge, include **NOTE-TERMS IN BRACKETS For the facility identified a census of 9 discharge. Based on interviews an notice to Resident (R)1's legal reproperty (ED) on 06/27/22. When the facility all the required information. This dedecreased psychosocial wellbeing. Findings included: - The Entry Tracking Record docur R1's Electronic Medical Record (Eldisorder characterized by persister impairment in daily life), anxiety, Wof vitamin B1), and schizoaffective disorder in which people interpret round the MDS recorded R1 had no beholocomotion on and off the unit, and walking and required limited assistincontinent of bladder and frequent no pain medication. R1 received an antipsychotic (medication used to the service of	sident, and if applicable to the resident ling appeal rights. HAVE BEEN EDITED TO PROTECT Company in the sample included eight direcord review, the facility failed to issue the sesentative when the facility transferred in its visued the discharge notice, dated 10 deficient practice placed R1 at risk for improved the session of the se	representative and ombudsman, ONFIDENTIALITY** 40688 residents with one reviewed for use a written discharge/transfer R1 to the Emergency Department (18/22, the notice failed to contain apaired resident rights and ATE]. essive disorder (mental health in activities, causing significant to brain disorder caused by the lack schizophrenia [a serious mental such as depression). Brief Interview for Mental Status of acute mental status changes. Independent with transfers, assistance from one staff with thygiene. He was occasionally rided R1 had no pain and received eat depression) and an renia) for all seven of the look back	

AND PLAN OF CORRECTION 17529 NAME OF PROVIDER OR SUPPLIER Riverbend Post Acute Rehabilitation For information on the nursing home's plan to con (X4) ID PREFIX TAG SUMM (Each of the control of the	ROVIDER/SUPPLIER/CLIA		
Riverbend Post Acute Rehabilitation For information on the nursing home's plan to condition (X4) ID PREFIX TAG F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few The D facility R1 had decision staff in disord directers reside others transfer locome.		(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/26/2022
Riverbend Post Acute Rehabilitation For information on the nursing home's plan to contain (X4) ID PREFIX TAG SUMM (Each of the contained of	NAME OF PROVIDED OR SURPLIED		P CODE
For information on the nursing home's plan to contain the following plan the followin			
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few The D facility R1 ha decisic staff in disord directe reside other stransfelocom		Kansas City, KS 66112	
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few The D facility R1 hard decisions staff in disord directer reside others transfel locom	For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state surv		
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The as R1's C A Nurs Service night. anyon inpatie summ the inf A Soc that R was as A Nurs psychi option A Soc would early c many Service note in	Discharge Assessment-Return y (psychiatric hospital option val da memory problem and motions. The assessment documenterview for mood was not coder characterized by a disconred towards others one to three ents, and on R1, was not answaymptoms was left blank. The fers, dressing, toileting and penotion on and off the unit, and even of the look back days. The ent to return to the community issessment recorded a referration of the look back days. The ent to return to the community issessment recorded a focus recreasing note under the Progress cas X, Administrative Nurse D R1's representative was shown in his life. The note recorder the psychiatric hospital that dans by the police. R1's representative to R1's other representation to R1's other representative was the intensity of the police after the ware the ticket would be in the string note dated 06/26/22 at 0 piatric hospital was unable to a first the properties of the police of the properties of the police	I Not Anticipated documented R1 disch was present but not selected). The assederately impaired decision making; R1 ented R1 had disorganized thinking completed. The assessment recorded R1 nection from reality) but did have physic edays of the look back period. The important of the look back period. The important of the assessment and the section eassessment recorded R1 required supportant of the section of the assessment and the property of the look back period. The important of the look back period. The important of the section of the assessment recorded R1 required support of the look back period. The section of the look back period and there was a second of the local contact agency and was made to the local contact agency evised on 10/02/20 which directed R1 was not and the nurse called R1's guardian to color and the nurse called R1's guardian to color and the nurse called R1's guardian to color and the nurse called R1's representative the sentative stated that R1 had never had sent at the facility was lead and informed R1's representative the sentative stated that he shared power of the incident earlier that morning. The notice mail. 13:21 PM documented admission was maccept R1 due to s staffing shortage. The this information was provided to R1's et this information was provided to R1's all ED at 04:00 PM for a psych stay due to the content of the local content of the	arged on [DATE] to an acute care essment recorded staff identified required supervision and cues with nationally without fluctuation. The did not have psychosis (mental cal behaviors and verbal behaviors pact of the behaviors on other regarding a change in behavior or pervision with bed mobility, with walking on and off the unit, and antipsychotic medication for an active discharge plan for the lated in the planning were left blank. Which is a minimum of the previous any physical aggression towards booking at sending R1 to an acute at R1 was served a misdemeanor of attorney and he would relay all of the facility was looking at other representative. Des X received notification R1 to the incident that happened arent hospital dependent on how ment. The note documented Social

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[emergency medical services] non- be admitted to the hospital's psych the resident or his representative re as behavior's [sic], physical aggres the acute hospital emergency room Ombudsman was notified and the landified. The address and phone no were marked not applicable (NA). A Social Services note dated 06/27 representative and notified him R1 The note recorded the representati A Nursing note dated 06/28/22 at 0 evaluations were completed on R1 stated they were sending R1 back appropriate place to handle that typ note recorded the [unidentified]adn recorded R1's representative did no the hospital regarding what the hos Review of the non-emergency med to the hospital via the transportation R1's clinical record and documents conversations with R1's representation	provided by the facility during the survitive regarding the transfer to the ED. The discharge was provided to the residen	to the hospital emergency room to urge instructions were provided to gnosis at discharge was recorded ain recorded R1 was discharged to d the State Long Term Care bility Services (KDADS) was the services provided by KDADS dices X spoke with R1's emergency room for a psych stay. Information. The facility three psychiatric the note recorded the hospital cility stated it was not an enced staff for the behaviors. The elese to send R1. The note the facility awaited an answer from the lack of the send R1 was sent non- emergently are lacked documentation of further the facility and R1's clinical record

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Evel of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 06/27/22) documented the disch the discharge notice was the safety behavioral status of the resident [R endangered was due to the 06/24/2 edge to attack his roommate. R1's including long, bleeding scratches obelieved the transfer/discharge was could be filed in writing to, or by cal address as well as the main phone Ombudsman (LTCO) and a street at of file an appeal, or who would be a notice lacked information on how to instruction on how to contact all apphone number, on how to file a forr information (was left blank) regarding (despite R1's diagnosis of schizoaff R1's representatives and the LTCO discharge location. On 10/26/22 Social Services X was On 10/26/22 at 01:07 PM, Regiona hospital felt like R1 should be able 06/24/22 and the fact the other invorteturn to the facility. On 11/07/22 at 08:54 AM, R1's represented of the 06/27/22 transfer R1. The facility policy Discharge or Transhealthcare facilities, the facility wou involved with all the discharge plan the entire process in the nursing no structured transfer and/or discharge residents highest practical level of the facility failed to issue a written non-emergently transferred R1 to the street of the process in the nursing residents highest practical level of the facility failed to issue a written non-emergently transferred R1 to the street of the street of the process in the nursing residents highest practical level of the facility failed to issue a written non-emergently transferred R1 to the street of the process in the nursing residents highest practical level of the facility failed to issue a written non-emergently transferred R1 to the street of the process in the nursing residents highest practical level of the facility failed to issue a written non-emergently transferred R1 to the street of the process in the nursing residents highest practical level of the facility failed to issue a written non-emergently transferred R1 to the street of the street of the street of the street of the process in the nursing residents highest practical level	Transfer/discharge date d 10/18/22 (11 harge location as the acute hospital. The of individuals in the facility was endand 1] and further cited the reason the safe 22 incident; R1 broke the handle off a horommate was found with multiple cuts on his bilateral legs. The notice directed in inappropriate and involuntary they halling, the listed agencies. The notice list number. The notice further identified the address and phone number. The notice available to assist the resident/represer to contact the Office of Administrative H propriate agencies electronically and legal complaint with the appropriate stating the State Advocacy Agency for Persfective disorder). The notice recorded in the notice lacked evidence it was provided in the facility for the notice lacked evidence it was provided in the facility for the state of the facility for the state of the facility of the ED) at 12:35 AM on 06/28/22 whose the facility of the ED) at 12:35 AM on 06/28/22 whose the facility of the ED at 12:35 AM on 06/28/22 whose the facility work in the facility of the ED on 06/27/22. When the facility work in the facility is the ED on 06/27/22. When the facility is in all the required information. This definated psychosocial wellbeing.	e notice recorded the reason for gered due to the clinical or sty of others in the facility was pospital cup and used the jagged and scratches all over his body, dif R1 and/or his representative do the right to appeal. The appeal ted KDADS and the physical nee State Long Term Care alacked information regarding how notative in filing an appeal. The earing (OAH). The notice lacked acked information, including the eagency. The notice lacked acked information, including the eagency. The notice lacked acked information including the eagency are not to the OAH Judge, both ovided to the facility listed as a unavailable for interview. In front of a judge because the set that due to the situation on the twas not appropriate for R1 to who was unable to make his own R1's representative further stated when the ED contacted him about a planned discharges to other physician, keep the resident/family form. The facility would document all provide a safe, organized, or home that would meet the sellbeing. The representative when the facility sued the discharge notice, dated	

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F 0626 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS IN The facility identified a census of 9 discharge. Based on interviews and facility after the facility non-emerge evaluation, on 06/27/22. The facility appeals process as required. As a transfer on 06/27/22, greater than these failures, cognitively impaired history of depression (persistent feactivities, deprived of a homelike ehospital for therapeutic leave to spirindings Included: - The Entry Tracking Record docur R1's Electronic Medical Record (Eldisorder characterized by persister impairment in daily life), anxiety, Wof vitamin B1), and schizoaffective disorder in which people interpret romains in which people interpret romains in the MDS recorded R1 had no beholocomotion on and off the unit, and walking and required limited assistincontinent of bladder and frequent no pain medication. R1 received an antipsychotic (medication used to total services).	AVE BEEN EDITED TO PROTECT Company to the service of the sample included eight of record review, the facility failed to allow the transferred him to the Emergency of further failed to allow R1 to return to the result of this failure, R1 remained in an four months, as the hospital could not five failed to allow the facility of the facility of sadness and loss of interest) and interest of the facility on the faci	onfidentiality** 40688 residents with one reviewed for ow Resident (R)1 to return to the Department (ED) for a psychiatric the facility pending and during the inpatient hospital setting since the ind alternative placement. Due to so, remained homeless. R1, with and anxiety, was unable to attend so, and unable to leave the acute tient status. ATE]. Ressive disorder (mental health in activities, causing significant the brain disorder caused by the lack schizophrenia [a serious mental such as depression). Brief Interview for Mental Status is of acute mental status changes. Independent with transfers, assistance from one staff with hygiene. He was occasionally reded R1 had no pain and received eat depression) and an renia) for all seven of the look-back

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F 0626 Level of Harm - Actual harm Residents Affected - Few	facility (psychiatric hospital option of R1 had a memory problem and modecisions. The assessment docum staff interview for mood was not codisorder characterized by a discondirected towards others one to thre residents, and on R1, was not answother symptoms was left blank. The transfers, dressing, toileting and pelocomotion on and off the unit, and all seven of the look back days. The resident to return to the community The assessment recorded a referra R1's Care Plan recorded a focus read A Nursing notes under the Progres Services X, Administrative Nurse Dight. R1's representative was shown is life. The note recorded staff dispsychiatric hospital that day and in by the police. R1's representative sinformation to R1's other represent A Nursing note dated 06/26/22 at Copsychiatric hospital was unable to a options. The record lacked evidence Review of the non-emergency medito the hospital via the transportation. A Nursing note dated 06/28/22 at Coevaluations were completed on R1 stated they were sending R1 back appropriate place to handle that typnote recorded the hospital admission R1's representative did not want his hospital regarding what the residence was not an expense and the residen	D3:21 PM documented admission was reaccept R1 due to staffing shortage. The ce this information was provided to R1's dical transportation service invoice reven service on 06/27/22. D4:54 PM recorded the hospital notified and none indicated anything wrong. To the facility. The note recorded the fape of resident due to the lack of experies on person said there was nowhere else m to return to the facility and the facility.	required supervision and cues with ntinuously without fluctuation. The I did not have psychosis (mental cal behaviors and verbal behaviors pact of the behaviors on other regarding a change in behavior or pervision with bed mobility, with walking on and off the unit, and antipsychotic medication for an active discharge plan for the ated in the planning were left blank. It is an an antipsychotic medication for an active discharge plan for the ated in the planning were left blank. It is an an active discharge plan for the ated in the planning were left blank. It is shown to be a served an incident the previous residual aggression towards anyone in the served a misdemeanor summons and he would relay all of the incified the acute inpatient is representative. The facility was looking at other is representative. The facility three psychiatric the note recorded the hospital cility stated it was not an enced staff for the behaviors. The is to send R1. The note recorded the valued of a waited an answer from the

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F 0626 Level of Harm - Actual harm Residents Affected - Few	homelessness. The note documen due to assaulting a roommate. The scratching) and would take R1 bac changed their mind and asked for swas scheduled in October. New plate R1. The hospital Length of Stay Note of regarding discharge planning. The to return to [the former nursing hom was a facility; anticipated discharge reason for the hospitalization was In the hospital Social Work Free Tex facility staff Administrative Staff E. facility so Administrative Staff E. facility screening and Resident Review (F. Review of the Notice of Proposed on 06/27/22) documented the discharge resident [Rendangered was due to the 06/24/2 edge to attack his roommate. R1's including long, bleeding scratches believed the transfer/discharge was could be filed in writing to, or by can address as well as the main phone Ombudsman (LTCO) and a street of the file an appeal, or who would be anotice lacked information on how to contact all apphone number, on how to contact all apphone number, on how to file a for information (was left blank) regardicespite R1's diagnosis of schizoaf R1's representatives and the LTCO discharge location.	assessment dated [DATE] recorded R ted R1 was formerly at a long-term care LTC facility later recanted the severity k for an additional \$15.00 a day for a p \$30.00 a day. R1's legal guardians con acement was sought, and multiple reference to the case management was sought, and multiple reference to the case management was sought, and multiple reference to the case management was greater than seven days. The NA and recorded specialty consults we at Note dated 09/06/22 recorded the soc Administrative Staff E reported Social should assist. The note recorded the facility take R1 back after the hearing in the but needed the hospital to complete a PASARR). Transfer/discharge date d 10/18/22 (11 harge location as the acute hospital. They of individuals in the facility was endared in a further cited the reason the safe 22 incident; R1 broke the handle off a recommate was found with multiple cuts on his bilateral legs. The notice directes in inappropriate and involuntary they had ling, the listed agencies. The notice directes in inappropriate and involuntary they had ling, the listed agencies. The notice list address and phone number. The notice available to assist the resident/represent contact the Office of Administrative H propriate agencies electronically and legal complaint with the appropriate stating the State Advocacy Agency for Perifective disorder). The notice recorded in the state Advocacy Agency for Perifective disorder). The notice recorded in the facility evaluated R1's status at the ordinal complaint with the appropriate stating the State Advocacy Agency for Perifective disorder). The notice recorded in the facility evaluated R1's status at the ordinal complaint with the appropriate stating the State Advocacy Agency for Perifective disorder). The notice recorded in the facility evaluated R1's status at the ordinal complaint with the appropriate stating the State Advocacy Agency for Perifective disorder). The notice recorded in the facility evaluated R1's status at the ordinal complaint with the appropria	e (LTC) facility but was kicked out of the assault (stabbing down to rivate room. The LTC facility then tacted Medicaid. A court hearing rals sent, but no facilities accepted ager spoke with R1's representative (ansas facilities, but R1 was likely the recorded R1's discharge plan ne note recorded the medical re also NA. Cial worker received a call from Services X was no longer at the ty did want R1 to return but n October. Administrative Staff E a Kansas Level II Pre-Admission 3 days after the transfer/discharge the notice recorded the reason for the sty of others in the facility was nospital cup and used the jagged and scratches all over his body, dif R1 and/or his representative dif the right to appeal. The appeal the State Long Term Care to lacked information regarding how thative in filing an appeal. The earing (OAH). The notice lacked acked information, including the eagency. The notice lacked sons with Mental Health Disorders the was sent to the OAH Judge, both ovided to the facility listed as
	R1's clinical record lacked evidenc issued. The facility was unable to p time the discharge notice was issu	provide any documentation or evidence	of evaluations of R1's status at t

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175298	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/26/2022
NAME OF PROVIDER OR SUPPLIER Riverbend Post Acute Rehabilitation		STREET ADDRESS, CITY, STATE, ZI 7850 Freeman Avenue Kansas City, KS 66112	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact 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)		on)
F 0626 Level of Harm - Actual harm Residents Affected - Few	An Inpatient Social Work Referral N 150 Kansas facilities, and denials of Review of R1's acute hospitalization or the need for inpatient psychiatric On 10/26/22 the facility was unable to returning to the facility. The facility facilities. A statement from Administrative St correspondence between the facility were a series of phone calls from a conversations were regarding the admitted to a psychiatric facility. The facility was not capable of carin his roommate. The statement record hospital staff member for a psychol The statement recorded later phone conversations were regarding R1 a R1's representative had still not to a through the process. On 10/26/22 at 03:34 PM, Administ immediately after the event on 06/2 tried to get multiple places to accept was sent non-emergent EMS for a hospital and the hospital (unable to admit through the ED. She said that train wreck [derailment] on 06/27/2, the facility worked on finding placer at the hospital. She stated she tried no information for her. She stated set in the stated se	Note dated 10/21/22 recorded mass referenceived. n notes lacked documentation of beha	vioral events, physical aggression, ent of R1's current status as related ace of attempted placement in other en of R1 back to the facility. There in the psych department. The if and his decreased need to be and Administrative Staff A stated and that occurred between R1 and is Staff A asked the [unidentified] al staff member hung up on them. We regarding R1's status and the statement recorded the facility and is statement and continued to work to try to find placement for R1 with a one to one sitter and staff hospital was able to take R1, so he ED. She said she spoke with the and R1 through the ED, and he can did accept R1 that day due to the did to find a place for R1. She stated ed she was pretty sure R1 was still R1 transferred but the hospital had unit. She further revealed the

			No. 0936-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175298	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/26/2022
NAME OF PROVIDER OR SUPPLIER Riverbend Post Acute Rehabilitation		STREET ADDRESS, CITY, STATE, ZI 7850 Freeman Avenue Kansas City, KS 66112	P CODE
For information on the nursing home's	For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.		agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0626 Level of Harm - Actual harm Residents Affected - Few	at the acute hospital ED due to a bevaluated and was found to have rethat during R1's stay at the acute he behaviors, no aggression and no a admitted for psychiatric or behavior to return to the facility and based owas later downgraded to scratching medical/surgical unit, awaiting placement for R1 and worked with the hospital was unaware the facility the facility would allow R1 to return On 11/07/22 at 08:54 AM, R1's repthe ED. He stated he had not spok 06/27/22. R1's representative state to learn of it because R1 had no his representative stated R1 was curreall day. R1 did like to watch television what he liked. R1's representative to the lake and out to enjoy R1's fainpatient at the hospital, did not allowed he tried to get to the hospital as mumother was unable to visit as much facility and resume his normal active representative stated he was unsuit difficult for R1 to express how he wand his impaired memory. The facility policy Discharge or Train healthcare facilities, the facility would involved with all the discharge plan the entire process in the nursing not structured transfer and/or discharge residents highest practical level of the facility failed to allow R1 to retit the Emergency Department (ED) for the facility pending and during the inpatient hospital setting since the to find alternative placement. R1 is environment, and socially isolated.	chone interview, Social Work Consultary ehavioral episode reported by the facility on need for inpatient psychiatric health hospital, which was currently over montications which warranted an inpatient psyral health reasons. Consultant II confirms in the facility's initial allegation that r1 trigg, no other facility would accept R1. Shement. Consultant II reported the hospital's representative to find a safe discrity is sued an involuntary discharge notice if a payment for a private room could be resentative state he learned of the transen with anyone from the facility at that and he knew about the incident that occurs for of been physically aggressive with entity in the hospital. He said R1 did not into but because R1 had impaired memistated when R1 was in the facility, R1's vorite foods which always made R1 had ow R1 and the family to go on family outled as possible to try to visit with R1, but he as desired. R1's representative did express scares for R1 due to extended battle and rehow the situation had impacted R1 because feeling and R1 reacted to things different in the facility of the properties. The policy directed the facility word to hospital, other healthcare facility, comedical, physical, and psychosocial were to hospital, other healthcare facility, comedical, physical, and psychosocial were to hospital, other healthcare facility of the payment of the facility after he was transferred appeals process as required. As a resultance of the facility after he was transferred appeals process as required. As a resultance of the facility of the payment of the facility after he was transferred appeals process as required. As a resultance of the facility of the payment of the facility after he was transferred to the facility of the payment of the facility after he was transferred to the facility of the payment of the facility of	ity. consultant II stated R1 was services. Consultant II confirmed his and ongoing, R1 had no ychiatric stay and had not been med the facility refused to allow R1 ited to stab his roommate, which he stated R1 remained on the itial continued to try to find harge for R1. Consultant II reported to en 10/18/22 as it was discussed to arranged. Inster on 12:35 AM on 06/28/22 from point regarding the transfer on the iteration of anything except sleep ory it was hard for R1 to remember a family could come and take R1 out ppy. The current situation, with R1 utings. R1's representative stated by the hoped R1 could return to the some concern that the facility may do court proceedings. R1's representative stated with the some concern that the facility may do court proceedings. R1's representative stated with the facility may do court proceedings. R1's representative stated with the facility may do court proceedings. R1's representative stated with the facility may do court proceedings. R1's representative the facility would document and physician, keep the resident/family form. The facility would document and provide a safe, organized, or home that would meet the sellbeing. The facility would document would meet the sellbeing. The facility would was unable ties, deprived of a homelike to leave the acute hospital was unable ties, deprived of a homelike to unable to leave the acute hospital was unable ties, deprived of a homelike to unable to leave the acute hospital was unable ties.

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