

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/22/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175219	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/14/2024
NAME OF PROVIDER OR SUPPLIER KAW RIVER CARE AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 750 BLAKE STREET EDWARDSVILLE, KS 66111		
(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 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation KS00191760 and KS00191852..	F 000			
F 550 SS=D	The 2567 was sent electronically on 11/22/24. Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F 550			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

11/22/2024

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.

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F 550	Continued From page 1 §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: The facility identified a census of 32 residents. The sample included six residents. Based on record review, observations, and interviews the facility failed to provide care and services that promoted resident dignity for Resident (R) 1. This placed R1 and other residents in the vicinity at risk for impaired dignity and decreased quality of life. Findings included: - The Electronic Medical Record (EMR) documented R1 admitted to the facility on 01/28/22 with a diagnosis of encephalopathy (diseases of the brain that cause altered mental state and confusion). The EMR recorded R1 had diagnoses of cognitive communication deficit, (problems with communication that have an underlying cause in cognitive deficit rather than a primary language or speech deficit), amnesia, (a partial or total loss of memory), and acute kidney failure (a loss of kidney function caused by illness, infections, or injury). The "Quarterly Minimum Data Set (MDS)," dated 09/20/24, documented R1 had a Brief Interview	F 550			

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F 550	Continued From page 2 for Mental Status score of 11 indicating moderate cognitive impairment. The MDS documented R1 exhibited behaviors of yelling at staff and rejection of care one to three days of the assessment period. The "Activities of Daily Living (ADL) Care Area Assessment (CAA)" dated 06/20/24 recorded R1 had functional limitations related to medical conditions as well as physical deconditioning. R1 required some assistance with most ADLs including bathing, transfers, and mobility. R1 used a wheelchair for mobility. The "Psychosocial CAA" dated 06/20/24, documented a care plan would be developed due to R1 sometimes yelling at staff members as well as at other residents. R1 sometimes just wanted to be left alone. R1 's "Care Plan" revised 06/28/24 recorded R1 had a history of verbal aggression, refusing care, and physical aggression when agitated. The care plan directed staff to assist R1 in developing appropriate methods of coping and interacting such as: approaching R1 and speaking calmly, diverting R1 's attention, and providing opportunities for positive interaction. A "Nurse Progress Note," dated 11/14//24 at 01:20 PM documented: that a Certified Nurse Aide (CNA) asked R1 if she wanted a shower, and R1 said no. R1 proceeded to the dining room, where another resident told R1 to put on a smile and R1 stated, "I don't like that little black [expletive]." A facility incident report documented on 11/14/24 at 01:10 P.M., CNA O and CNA N asked R1 if she	F 550			

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F 550	Continued From page 3 wanted her shower. R1 said, " No, get the [expletive] out of here before I call the police." The aides left R1 's room. Shortly afterward, R1 wheeled into the dining room where another resident told R1 to put a smile on her face. R1 then looked towards CNA O and said, " I don ' t like that little [expletive]." CNA O told R1 " You cannot call me that, I wasn ' t named that." R1 then said, "Shut up black [expletive]." At that point, CNA O raised her voice and told R1 that it was unacceptable and that she could not speak to her like that. Both were bickering back and forth until one of the medication aides and the social services director stepped in. CNA O was asked to provide a statement along with other staff present and was placed on immediate suspension pending the investigation of verbal abuse towards a resident. Observation on 11/14/24 A 1:10 P.M. revealed CNA O in the facility dining room. CNA O stated to R1 "You cannot call me a black [expletive], I will not allow you to disrespect me like that, That is not my name. My name is [CNA O]. If you call me that again I am going to take you to your room." CNA O then continued talking to staff and other residents in a loud voice saying that R1 called her a black [expletive] and repeated this four times. The loud exchange drew the attention of staff and other residents until the Social Services X intervened. On 11/14/24 at 01:47 P.M. R1 sat in a wheelchair in the dining room, dressed appropriately and eating a hamburger, Jello, and lemonade. R1 had a stern, angry, countenance, and was resistant to talk, stating "I don ' t like people." R1 became more conversational over time and did not recall or did not want to discuss, the earlier altercation	F 550			

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F 550	Continued From page 4 with CNA O. CNA N ' s "Witness Statement" from 11/14/24 recorded that CNA N took R1 ' s lunch to the room. R1 refused, and when CNA N returned the tray was outside the room and R1 asked another resident, "What the hell was she looking at?" CNA N documented that R1 then called an aide black [expletive]. CNA M ' s "Witness Statement" from 11/14/24 documented that at approximately 01:15 P.M., R1 was heard arguing with another resident, but nothing escalated. A few moments later CNA M heard R1 and CNA O arguing. CNA M noted that she then went to Social Services X. CNA O ' s "Witness Statement" from 11/14/24 documented that R1 looked at CNA O and said she didn ' t like that little [expletive]. CNA O noted she told R1 that she could not call CNA O a [expletive] since CNA O was not "named that." CNA O noted that R1 then told CNA O to shut up and called her black [expletive]. CNA O said she told R1 that was unacceptable and told R1 that she could remove herself from the dining room. CNA O noted that Social Services X then entered the area. Social Services X ' s "Witness Statement" from 11/14/24 documented that after receiving the story of what happened, she asked CNA O to move from the dining room and explained to CNA O that, as professionals, staff should remove themselves from the situation. CNA O refused and said, "My mama gave me a name and it isn ' t black [expletive]." Social Services X documented she asked R1 to return to her room and R1 stated she wanted to leave the facility and	F 550			

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F 550	Continued From page 5 move somewhere else. CNA O continued saying she was tired of people making excuses and saying people like R1 behavior. Social Services X wrote that she reminded CNA O it is the staff 's job to act professionally in all situations. Social Services X spoke to Administration A about the incident immediately. Interviewed on 11/14/24 at 02:20 P.M. CNA M stated the R1 often yelled at staff when they came in her room, and just wanted to be left alone, but then other times was cooperative. CNA N said if she had been in that situation she would have just ignored it and told the charge nurse. Interviewed on 11/14/24 at 02:20 PM Licensed Nurse (LN) H said she did not witness the incident but heard the commotion and then saw Social Services X intervene. On 11/14/24 at approximately 2:00 P.M. Administrative Staff A acknowledged receiving a report from Social Services X. Administrative Staff A collected written witness statements and placed CNA O on suspension pending a full investigation. The facility's "Exercise of Rights/ Resident Rights" policy revised 11/2024, recorded: Our residents have the right to be treated with respect and dignity and care that promotes maintenance or enhancement of his or her quality of life recognizing each resident individuality, Specifically, Staff shall treat cognitively impaired residents with dignity and respect and sensitivity, for example, a) addressing the underlying motives or root causes for behavior and b) not challenging or contradicting the residents' beliefs or statements. The policy further recorded the	F 550			

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F 550	Continued From page 6 facility will not hamper, compel by force, treat differently, or retaliate against a resident for exercising his or her rights. The facility failed to provide care and services that promoted resident dignity for R1. This placed R1 and other residents in the vicinity at risk for impaired dignity and decreased quality of life.	F 550			