

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

PRINTED: 07/10/2025
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 06/25/2025
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	F 000	Past noncompliance: no plan of correction required.		
F 600 SS=G	The following citations represent the findings of complaint investigation KS00196147, KS00196008, KS00195980, and KS00195898. The 2567 was sent electronically on 07/10/25. Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: The facility had a census of 36 residents. The sample included three residents reviewed for abuse. Based on observation, record review, and interview, the facility failed to ensure that cognitively impaired Resident (R) 1 remained free from injuries of unknown origin. On 06/07/25, R1 sustained a second-degree burn (potentially painful burn which affects the first and second layer of the skin) of unknown origin to his left arm and shoulder. This deficient practice also placed R1 at risk for further injuries, pain, abuse, neglect, and/or mistreatment.	F 600	Past noncompliance: no plan of correction required.		

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

TITLE

(X6) DATE

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 600	Continued From page 1 Findings included: - The Electronic Medical Record (EMR) for R1 documented diagnoses of vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), cerebrovascular disease (a group of conditions that affect the circulation of blood to the brain, causing limited or no blood flow to affected areas of the brain), generalized muscle weakness, flaccid hemiplegia affecting left non-dominant side (paralysis of one side of the body), unsteadiness on feet, cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), and other reduced mobility. The 03/31/25 "Quarterly Minimum Data Set" (MDS) documented R1 had a Brief Interview for Mental Status (BIMS) score of seven, which indicated severe cognitive impairment. The MDS documented R1 required substantial to maximal assistance for toileting hygiene, bathing, lower body dressing, and personal hygiene. R1 required partial to moderate assistance with moving from a seated to a standing position, chair-to-bed transfers, toilet transfers, tub or shower transfers, and walking 10 feet. The MDS documented that R1 used a wheelchair and was independent in his ability to self-propel. The 07/08/24 "Cognitive Loss / Dementia Care Area Assessment" (CAA) documented R1 had a cognitive deficit and some difficulty making decisions regarding tasks of daily life. The CAA documented R1 was modified independent (the	F 600			

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F 600	Continued From page 2 ability to perform daily tasks independently, but with some level of support or needing extra time or cues) with decision making. The 07/08/24 "ADL Functional/Rehabilitation Potential" CAA documented R1 had functional limitations related to medical conditions as well as physical deconditioning. R1 required some assistance with most activities of daily living (ADL). R1's "Care Plan" with an initiated date of 01/02/17, documented R1 had impaired cognitive function or impaired thought processes due to dementia, impaired decision making, neurological symptoms, and past cerebrovascular accident (CVA-stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain). R1's "Care Plan" with an initiated date of 01/06/17, documented R1 sometimes had behaviors that included yelling, screaming, shouting, anxiety, withdrawal, obsessing over things, insomnia (inability to sleep), paranoia (a thought process believed to be heavily influenced by anxiety or fear to the point of irrational thinking), delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), verbal and physical aggression, refusing medications, history of wandering, and rejecting care. R1's "Care Plan" with an initiated date of 03/05/25, documented R1 was at high risk for falls related to gait and balance problems, being unaware of safety needs, left-sided neglect, decreased cognition, non-compliance, and hemiparesis/hemiplegia (weakness and paralysis on one side of the body).	F 600			

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F 600	Continued From page 3 R1's June 2025 "Medication Administration Record/Treatment Administration Record" (MAR/TAR) documented a "9" for the dayshift behavior monitoring, on 06/06/25, which indicated to refer to the nurse's notes. R1's EMR recorded a "Nursing" note dated 06/06/25 at 04:13 PM that documented R1 continued on behavior monitoring. R1 was resistant to care, and cussed at the nurse while they attempted to help R1 get ready for the day. The note documented R1 did not want to get ready for the day. The note further documented R1 was resistant to the Certified Nurse Aide (CNA) giving him care, and R1 complained of pain. The note further documented the nurse assessed R1, and his area of pain kept changing. R1 refused any intervention offered. The note lacked mention of what interventions were offered or the location(s) of R1's pain. R1's June 2025 MAR/TAR documented an order for Ativan (an antianxiety medication) 0.5 mg PRN for anxiety for 14 days. The order lacked a specified frequency. The MAR/TAR lacked evidence the Ativan was offered or administered on 06/06/25. The "Pain Level Summary" in R1's EMR for 06/06/25 at 04:29 PM documented R1's pain as four out of 10. R1's June 2025 MAR/TAR documented an order for acetaminophen 325 mg two tablets PRN for mild pain every six hours. The MAR/TAR lacked evidence the acetaminophen was offered or administered on 06/06/25. R1's June 2025 MAR/TAR documented an order	F 600			

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F 600	Continued From page 4 to place a splint on the resident's left arm each morning at 09:00 AM and an order to remove the splint each evening at 08:00 PM. The MAR/TAR noted a "1" indicating the resident refused the 09:00 AM splint application on 06/06/25, though 08:00 PM splint removal was noted as completed. A "Nursing" note dated 06/07/25 at 02:07 PM documented R1 continued on behavior monitoring. The note documented R1 was resistant to the CNAs giving him care, and R1 complained of pain. The note further documented the nurse assessed R1, and his area of pain kept changing. R1 accepted Tylenol (acetaminophen) and Ativan (an antianxiety medication) and said it was effective. R1's "Pain Level Summary" on 6/07/25 at 01:33 PM documented R1's pain was eight out of 10. R1's clinical record lacked documentation related to the area(s) of R1's pain. R1's MAR/TAR on 06/07/25 at 01:33 PM documented R1 received both acetaminophen and Ativan, and both were noted as effective. A "Nursing: Medication Note" dated 06/07/25 at 02:08 PM documented R1 started on Ativan 06/04/25/ R1 has not had any adverse or allergic reactions. R1's behavior had improved. R1 was stable. R1's June 2025 MAR/TAR documented a "0" for behavior monitoring both shifts on 06/07/25, which indicated the resident had no behaviors. R1's June 2025 MAR/TAR documented a "1" indicating the resident refused the 09:00 AM splint application on 06/07/25, and the 08:00 PM	F 600			

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F 600	Continued From page 5 splint removal recorded a "6" which indicated the resident was hospitalized. A "Nursing Transfer Note" dated 06/07/25 at 05:10 PM documented R1 had been resistant to care since 06/06/25. R1 was combative and cursed at the staff when they tried to give him care. R1 also complained of pain but did not want any interventions at the time. The note recorded on that day documented the resident was still resistant to care and complaining of pain, but the resident did not want the nurse to bother him. In the afternoon, he complained of pain to the aide, who notified the nurse, and Tylenol and Ativan were administered after having to explain for five minutes the benefit of the resident taking the medication. The note recorded that upon reassessment, R1 stated he was not feeling pain. When the CNAs provided care for R1, they found R1 had an alteration on his left arm from his shoulder to his elbow. The skin was sloughed off, and there were multiple blisters. The note documented the skin alteration was not present the previous day (06/06/25) when the nurse tried to apply R1's brace. The nurse notified the on-call provider and received instructions to send R1 to the hospital. Staff notified administrative staff, and R1 was transported to the hospital. A "Nursing" note dated 06/07/25 at 08:00 PM documented R1 returned to the facility via stretcher transport and was transferred into bed with the assistance of four staff members. R1 was alert and confused, which was his baseline. R1 reported a burning pain in his left upper arm rated six out of 10. R1 had a dressing in place on his left upper arm. R1 stated he did not remember how he sustained the burn to his left upper arm.	F 600			

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F 600	Continued From page 6 R1's hospital "ED [Emergency Department] Provider Notes" dated 06/07/25 documented R1 was brought by Emergency Medical Services (EMS) from the nursing home for a burn on his left upper arm. The note documented nursing home staff reported that R1 had spilled coffee on his arm. They did not notice any blistering or wounds until today. The hospital record further documented, under the final diagnosis section, R1 had a second-degree burn to multiple sites on his shoulder and arm. The facility's investigation, dated 06/10/25, documented on 06/07/25 at approximately 04:54 PM, Administrative Staff A was notified of an injury involving R1. R1 sustained an injury of unknown origin to his left shoulder. The area appeared bright red, with clear evidence of skin sloughing (dead tissue, usually cream or yellow in color) and a partial skin tear. R1 was a known fall risk due to cognitive impairment. In the days leading up to the incident and on the day it occurred, R1 had become increasingly combative toward staff and refused care on multiple occasions. When questioned, R1 was unable to explain how the injury occurred or what may have caused it. R1 was sent to the hospital for evaluation. Medical staff confirmed the injury was consistent with a burn and noted visible evidence of skin sloughing at the affected site. The facility investigation further documented that witness statements were obtained from clinical staff on duty on the day of the incident. The maintenance department conducted a full inspection of the resident's room and found no environmental hazards or equipment that could have caused a burn. A review of the resident's meals and linens showed no evidence of food or beverage spills.	F 600			

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F 600	Continued From page 7 The resident was checked on consistently throughout the day and had not received a shower within the 48 hours prior to the incident. The investigation lacked a conclusion of how R1 sustained the burn. An unnotarized "Witness Statement" from Certified Nurse Aide (CNA) M, dated 06/07/25, documented CNA M was doing a routine check and change for R1 with CNA N, CNA O, and CNA P at 04:30 PM. CNA M documented R1 was combative, uncooperative, and refusing care. CNA M documented they went to change R1's sheets and shirt due to them being wet and noticed the skin peeling off of R1's left arm. CNA M documented they called the nurse into R1's room to assess the situation and then called EMS. CNA M documented the CNAs left the room as EMS arrived. An unnotarized and undated "Witness Statement" from Licensed Nurse (LN) H documented she saw R1 lying in bed from 06/07/25 to 06/08/25, for the 12-hour shift, on R1's left side. LN H documented there were no complaints from R1, and his eyes were closed. LN H documented they did not notice anything out of the ordinary about R1. An unnotarized and undated "Witness Statement" from CNA N documented while attempting to complete rounds, at roughly 04:30 PM, CNA N recorded R1's skin was peeling as staff attempted to turn R1 as they cleaned him up for dinner. CNA N documented R1 had been combative and refused care earlier in the day. CNA N documented she went to get the nurse on duty and informed her that R1 had a wound. The nurse came to examine R1, and the nurse felt it	F 600			

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F 600	Continued From page 8 best to call EMS as the nurse believed R1's wound may possibly be a burn. An unnotarized "Witness Statement" from CNA O, dated 06/07/25, documented CNA O and three other aides went to check and change R1 at 04:30 PM due to him being combative and uncooperative. CNA O documented as staff went to change R1's sheets and shirt, because they were wet, they noticed the skin of R1's left arm was peeling off. The nurse was called into R1's room to assess the situation and then called EMS. An unnotarized and undated "Witness Statement" for Certified Medication Aide (CMA) R documented the last time she saw R1, before R1 went to the hospital on 06/07/25, was the day before at about 08:30 PM, during evening medication pass. CMA R documented at that time, CMA R gave R1 his night medication and did not notice any changes in his condition at that time. An unnotarized and undated "Witness Statement" for CNA P documented staff were doing a routine check and change on R1 at about 04:30 PM when they noticed R1 was not acting like himself. CNA P documented she and three other aides were caring for R1; they noticed R1 had what looked like burns on his left upper arm. CNA P documented one of the CNAs got the nurse, and the nurse took it from there. An unnotarized and undated "Witness Statement" for LN G documented the witness statement was attached. (The attachment was the printed "Nursing Transfer Note" dated 06/07/25, as listed above).	F 600			

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F 600	Continued From page 9 The facility provided investigation did not include a witness statement for CNA Q. On 06/24/25 at 01:55 PM, observation of a photo of R1's burn on Administrative Nurse D's work phone revealed R1 in the photo. The picture was taken from the left side of R1's body. A large red area was observed on the outer portion of R1's left arm. The red area started just below R1's left shoulder and continued to about the level of his elbow. There was a thin layer of skin that had separated from the reddened site and appeared to have sloughed off, exposing the red tissue beneath. On 06/25/25 at 09:17 AM, R1 slept in bed, on his back. With his left side towards the wall. He had the blanket pulled up to his neck. On 06/24/25 through 06/26/25, LN H and CMA R were unavailable for interviews. On 06/24/25 at 06:31 PM, CNA M stated she went in with the other CNAs during breakfast to check and change R1. CNA M stated that R1's brief was wet, and he lay on his left side. CNA M stated R1 was "super combative," and he was punching and kicking at the CNAs. CNA M stated staff were able to change R1's brief despite the punching and kicking, but were unable to change his other clothing due to him being combative. She stated they backed off due to him being combative and came back later. CNA M stated they tried to check on R1 throughout the day, but he was still combative. She stated staff went in just after lunch, and R1's shirt was wet, and they decided they could not leave him in his wet shirt. CNA M stated they tried to turn R1, then they saw	F 600			

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F 600	Continued From page 10 his arm and notified the nurse. CNA M stated that each time they went into R1's room, the CNAs went in as a group. She stated they went in several times between breakfast and lunch, and his brief was dry until they checked him just after lunch. CNA M stated she believed staff checked on R1 at least four times between breakfast and lunch. She stated R1 was not acting like himself as he was not moving while he was in bed and would not move off his left side. CNA M stated she believed R1 was acting strange, so they checked on him more often. On 06/25/25 at 08:05 AM, CNA O stated she had gone in to check and change R1 with CNA M, CNA N, and CNA P on 06/07/25. CNA O stated R1 was lying on his left side and using his right arm and leg to kick and punch at staff. CNA O stated R1 would not move his left arm and kept saying it hurt. She stated they were going to change R1's clothing and brief. She stated they were going to change R1's sheets as they were soiled. CNA O stated they were only able to change R1's brief due to him being combative, and that he stayed on his left side the whole time. She stated they asked R1 if they could hold his hands so they could change his brief, and he eventually let them. She stated they told the nurse R1 complained of pain, and LN G went in to check R1. CNA O stated the CNAs went in a few times between breakfast and lunch to check on R1. CNA O stated that after lunch, they went in to check him again, and R1 had tears in his eyes and kept saying his left leg hurt. She stated R1 told her to please call somebody, but he would still not come off of his left side. CNA O stated it was unlike R1 to lay in bed all day, as he was normally up and out of bed. CNA O stated R1 does have a history of refusing care, but she had	F 600			

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F 600	Continued From page 11 never seen him punch or kick someone prior to this. CNA O stated he would normally refuse and tell staff to get out of his room, but his being combative and the pain he was reporting, she had not witnessed from R1 before. CNA O stated the last time they checked on R1, he had three draw sheets and three chucks under him, and they were all soiled and wet. She stated it looked like someone had placed a clean one over a wet one; however, they were all wet, and his brief was saturated. She stated it looked like the previous CNAs just stuffed more under him. CNA O stated R1 had blisters that had not popped yet on his left arm. She stated she initially thought something hot may have been spilled on him when she saw the burn; however, she did not see anything that looked like a coffee spill on his clothing or in his bed. CNA O stated R1 was not his normal self that day and kept saying he did not want staff to touch him because he hurt. She stated R1 was not acting this way the day before and was out of his room, in his wheelchair, moving around on 06/06/25. CNA O stated she believed the nurse went in to see R1 at least twice on 06/07/25. On 06/25/25 at 08:39 AM, CNA P stated she went in with the other CNAs to help provide care for R1. CNA P stated R1 was on his left side and kept saying his arm hurt. CNA P stated that at breakfast, when they tried to change him, R1 was being combative, so they changed his brief and backed off. She stated they had checked on him a few times between breakfast and lunch on 06/07/25, and it looked like something was not right with him because he was in bed all day. CNA P stated R1 was usually up during the day and gets up to use the bathroom. CNA P stated it was not normal for him to lay in bed on one side all day. CNA P stated she thought R1 was in too	F 600			

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F 600	Continued From page 12 much pain to get up, and he would yell for them to stop when they attempted to move him to provide care. CNA P stated that when they went in after lunch to change R1, they noticed his shirt was wet and he had food all over his bed. CNA P stated that when they went to turn him, they noticed the burn, and they went to get the nurse. CNA P stated none of the CNAs grabbed R1's arms or legs to hold him down or to pull on him when they went to provide care. On 06/25/25 at 09:24 AM, CNA N stated she went in with CNA P, CNA O, and CNA M to change R1. CNA N stated she was on orientation at the time, so she did not physically touch R1. CNA N stated that she saw R1 lying on his left side on 06/07/25 when they checked on R1. She stated R1 did not want anyone to touch him because he was in pain. CNA N stated she did not see any of the CNAs grab R1's arms or legs to hold him while they provided care. CNA N stated R1 was being combative, but they were able to get him to calm down enough, and he let them change his brief in the morning and roll him to clean him up around lunch. CNA N stated they saw the burn during the lunch brief change, and everyone gasped when they saw it. On 06/26/25 at 01:06 PM in an interview with CNA Q via phone, CNA Q stated she worked the night of 06/06/25 and stated she had helped R1 off the toilet three times that evening. CNA Q stated R1 often got out of bed to use the bathroom by himself, and could usually get up alone, but that night he was not himself. She stated R1 usually wanders a lot, but was not wandering as much that night. CNA Q stated R1 appeared weaker and was having a hard time standing up from the toilet. She stated she helped	F 600			

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F 600	Continued From page 13 him pull his brief up and got him back into bed, but he was struggling. CNA Q stated R1 kept leaning on the sink and sitting back down on the toilet when she was helping him. CNA Q stated she reported what she saw to the other CNAs and nurse and was told the nurse was aware of it. CNA Q stated both LN H and the following morning, LN G stated they knew about R1's pain and situation, and R1 was fine. CNA Q stated R1 was normally very fidgety, even when he was asleep, he would not sleep for long. CNA Q stated that when she went in to help R1 that night, he complained of leg pain, and she noticed he was having a harder time using his leg when she helped him back to bed from the bathroom. CNA Q stated R1 was typically up and down, in and out of the bathroom on his own, but that night R1 was a lot more still, was not moving much, and was quieter. CNA Q stated she thought it may have been related to his pain. CNA Q stated she did not see any burns to R1's left arm at any point during her shift. CNA Q stated R1 has never been combative with her and would check on him by herself at times; however, if she needed to change the resident or reposition him, she would ask other CNAs to assist her. CNA Q stated she did receive an all-employee in-service after the incident, on 06/09/25. On 06/24/25 at 03:53 PM, LN G stated she worked on day shift 06/06/25 and 06/07/25 and stated she did not see a burn on R1's arm 06/06/25. LN G stated the CNAs came to get her and told her it appeared R1 had an area that looked like it had been burned on his arm. LN G stated she got wound cleaner to clean the site, but was careful not to displace tissue. She stated she sent a picture to leadership and the on-call provider and sent R1 to the hospital. LN G stated	F 600			

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F 600	Continued From page 14 R1 was very combative while trying to dress his burn. LN G stated R1 had been lying in urine when they found the burn, and he had multiple wet sheets under him. LN G stated the facility had a big in-service related to job duties for nurses and CNAs. LN G stated they increased rounds for R1 after the burn was found, and nurses were supposed to do rounds and make sure CNAs were doing their rounds. LN G stated R1 never should have had that burn. LN G stated R1 was not lying directly on his mattress and was lying on sheets. She stated R1 moves around a lot, is usually restless, has a lot of falls, and moves in bed a lot. On 06/25/25 at 08:44 AM, LN G stated that R1 refused to allow her to place a splint on his left arm on 06/06/25. R1 refused the splint on 06/07/25 and refused to let her touch the resident. LN G said R1 lay on his left side and was resistant to care. LN G stated that R1 could have gotten the injury overnight because R1 refused the splint, and she had not seen his left side until the CNAs got her when the CNAs found the burn. On 06/24/25 at 01:50 PM, Administrative Staff A stated the facility had maintenance inspect R1's room for any leaks, drips from the ceiling, and chemicals, and also inspected his bed. Administrative Staff A stated the facility changed to a hypoallergenic sheet and detergent; the resident was placed on more frequent checks. Administrative Staff A stated housekeeping checked linens and found no evidence of coffee or food spilled on R1's clothing. Administrative Staff A stated they thought it possible could have been a friction burn as staff saw R1 lying on his left side for most of the day. Administrative Staff A	F 600			

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F 600	Continued From page 15 stated R1 did not stay still, and it could have been friction from the mattress. Administrative Staff A stated he was told by one of the CNAs that the blanket had slid down the mattress when they found him, and as much as R1 moved around, it was hard to keep blankets on him. Administrative Staff A stated R1's family typically gave R1 a shower, but his family had not been to the facility recently, and there was no evidence R1 had a shower 48 hours leading up to discovering the burn. Administrative Staff A stated he reviewed camera footage for the day and did not see R1 leave his room that day, but went on to say that he did not keep track of who entered R1's room and when. On 06/24/25 at 01:55 PM, Administrative Nurse D stated he was out of town when the burn was discovered but R1 was sent out immediately when the burn was discovered. Administrative Nurse D stated he was not sure what happened, but saw the photos of the burn. Administrative Nurse D stated he had worked with burns in an Intensive Care Unit (ICU) in the past and had never seen a friction burn that resembled the burn R1 had on his arm. Administrative Nurse D stated there was blistering, and his thought was it may have been from hot fluid; however, he stated the facility did not serve fluids that hot to residents. Administrative Nurse D stated R1 was combative with staff, and it usually took multiple staff to assist him. Administrative Nurse D stated that if R1 was in bed, he usually tried to crawl out. On 06/25/25 at 10:19 AM, Administrative Nurse D R1 was usually in his wheelchair, going back and forth in the halls. Administrative Nurse D stated that if a nurse performed an assessment, then ideally, he would want to know what area was	F 600			

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F 600	Continued From page 16 assessed. Administrative Nurse D stated the facility had provided education related to documentation. Administrative Nurse D stated if the CNAs saw R1 lying on his left side for a long period of time, and the resident reported he was in pain, it should trigger the CNAs to report to the nurse. Administrative Nurse D stated he expected the CNAs to alert the nurse so the nurse could assess the resident. Administrative Nurse D stated that if it was uncommon for a resident to favor one side, he would want to know what was going on with that side and why the resident did not want to get off of it. He stated a general assessment should be done, and then a more in-depth assessment if the resident complained of pain. Administrative Nurse D stated he expected the nurses to physically move the resident onto their back to take a look at the resident's side if they complained of pain, were favoring it, and did not want to get off of it. Administrative Nurse D stated he believed care in pairs would prevent abuse, neglect, or exploitation, as it would have meant two people had decided to participate in that, and he did not see that happening, but stated the care in pairs was more for staff protection due to behaviors. On 06/25/25 at 11:30 AM, Administrative Staff A stated R1's baseline was for him to be out of bed and moving around a lot. Administrative Staff A stated that one of the reasons R1 was a high fall risk was because he was always moving. He stated that R1 never stays still; he was always moving. Administrative Staff A described R1 as being "squirmy." Administrative Staff A stated that if a nurse was notified of R1's pain and did not want to move from his left side, he expected the nurses to document it and attempt to reposition him. Administrative Staff A stated the nurse tried	F 600			

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F 600	Continued From page 17 to give R1 pain medication, but he continued to refuse. Administrative Staff A stated that if R1 was doing something outside of his normal behavior, he expected the nurse to document and contact the provider on call of the situation; however, he did not believe R1 was doing anything out of the ordinary on 06/07/25, as it was normal for R1 to favor one side. Administrative Staff A stated he did not know if R1 had moved back and forth between staff checking on him and would have no way of knowing if R1 had just returned to his left side before staff checked on him each time. Administrative Staff A stated he expected the nurses to assess for pain and have done a physical assessment. Administrative Staff A stated that the things the nurse assessed should have been documented if the nurse was able to complete the assessment without R1 refusing or being combative. Administrative Staff A stated that providing care in pairs did not mean there was no possibility that abuse could take place, as anything is possible. Administrative Staff A stated it would be impossible to know what any person was going to do or not do, but with R1's history, they did not want staff going into his room alone. Administrative Staff A stated steps the facility took to protect the residents during the investigation were to switch detergents, contact the maintenance director, and have him inspect the resident rooms to ensure they were safe. Administrative Staff A stated nurses performed wound checks on other residents to ensure there were no other wounds beyond what was already documented. Administrative Staff A stated they had an all-staff in-service related to resident care. Administrative Staff A stated education provided to staff included the need for two-hour checks and changes for CNAs, and having nurses perform random rounding checks to make sure	F 600			

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F 600	Continued From page 18 CNAs were completing their rounds. Administrative Staff A stated they were not documenting the rounds by the CNAs or nurses, and were going on what the expectation was from the education provided. Administrative Staff A stated they randomly followed up with residents to make sure staff were completing their rounding. Administrative Staff A stated LN H worked the night shift. The facility's "Abuse Prevention Program, Recognizing Signs and Symptoms of Abuse/Neglect (Identification)" policy, with an effective date of 10/2024, documented "Abuse" is defined as willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. "Neglect" is defined as failure to provide goods and services as necessary to avoid physical harm, mental anguish, or mental illness. Injury of unknown origin is defined as suspicious related to the source of the injury is not observed or the extent or location is unusual, or related to the number of injuries, either at a single point or over time. On 06/09/25, the facility completed corrective actions, which included an all-staff in-service with a topic titled "Resident Care Checklist". The Inservice topics included the following: resident rounding every two hours, checking for incontinence, repositioning, monitoring for signs of distress, documentation, accurately documenting all care provided during rounds, noting any changes in resident condition, completing incident reports for any accidents or altercations, nurse oversight, nurse verifies CNA rounds completed and documented, the nurse conducts random resident checks during shift,	F 600			

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F 600	Continued From page 19 communication and reporting, report any issues or concerns regarding resident care to the supervisor, notify nurse of any resident altercations and accidents, report any CNA, CMA or nurse not fulfilling their duties, general care standards, maintain residents' dignity and privacy at all times, ensure residents have access to water, call light and personal items, and preventing and identifying abuse, neglect, or unusual behavior. The corrective actions were completed prior to the onsite survey therefore, the deficient practice was cited as past noncompliance at a scope and severity of "G" (isolated, actual harm).	F 600			