STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175219	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kaw River Care and Rehab	750 Blake Street Edwardsville, KS 66111

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41713 The facility identified a census of 37 residents. The sample included 12 residents. Based on observation and interview, the facility failed to ensure that residents ' rights and dignity were respected by staff when staff failed to provide a dignity bag for Resident (R) 12's indwelling catheter (tube placed in the bladder to drain urine into a collection bag) bag. This placed R12 at risk for decreased self-esteem and decreased self-worth. Findings: - R12 ' s Electronic Medical Record (EMR) documented diagnoses of multiple sclerosis (MS - progressive disease of the nerve fibers of the brain and spinal cord), seizures (violent involuntary series of contractions of a group of muscles), respiratory failure (a condition in which your blood does not have enough oxygen), and pneumonia (a lung infection that causes inflammation and fluid buildup in the air sacs, making it difficult to breathe). R12 ' s Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of one, which indicated severely impaired cognition. The MDS documented R12 functional limitation in range of motion with impairment on both sides of the upper and lower extremities. The MDS documented R12 was dependent on staff for all activities of daily living and functional abilities. The MDS documented R12 had an indwelling catheter (tube placed in the bladder to drain urine into a collection bag). The MDS documented R12 had pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and/or friction). The MDS documented R12 required a gastrostomy tube (G-tube: tube surgically placed through an artificial opening into the stomach) for his nutritional needs. The MDS documented R12 required supplemental oxygen therapy. R12 ' s Urinary Continence Care Area Assessment (CAA) dated 10/25/24 documented he had a suprapubic catheter (urinary bladder catheter inserted through the abdomen into the bladder) due to neurogenic bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system). R12 ' s Care Plan, revised 12/06/24, directed staff to keep the catheter bag below the level of the bladder. The plan of care documented staff were directed to provide routine catheter care. The plan of care documented staff were to observe the catheter tubing for kinks. The plan of care lacked staff direction to provide a dignity bag to cover the catheter collection bag. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/05/25 at 08:10 AM, R12 laid in bed with the head of the bed elevated. R12 ' s catheter collection bag was hung on the right side of his bed and was visible from the hallway. The collection bag lacked a dignity bag. On 05/06/25 at 07:09 AM, R12 laid in bed with the head of the bed elevated. R12 ' s catheter collection bag was hung on the right side of his bed and was visible from the hallway. The collection bag lacked a dignity bag. On 05/07/25 at 10:24 AM, Licensed Nurse (LN) I stated she would expect a dignity bag to cover R12 ' s catheter bag, or the bag should be placed on the opposite side of his bed, where it would not be visible from the hallway. On 05/07/25 at 10:53 AM, Certified Nurse Aide (CNA) M stated that the catheter bags should be covered with a dignity bag when the resident was out of their rooms. CNA M stated the bag should be hung on the side of the bed opposite the doorway or be covered with a dignity bag. On 05/07/25 at 11:02 AM, Administrative Nurse D stated that a dignity bag should cover catheter bags when the resident was out of his room. Administrative Nurse D stated the catheter bag should have a dignity bag to cover it while in the room or placed on the opposite side of the bed away from the doorway. The facility's Exercise of Rights/Residents' Rights policy dated 11/24 documented that Residents have the right to a dignified existence, self-determination, and communication with access to persons and services inside and outside the facility. Residents have the right to be treated with respect and dignity and care that promotes maintenance or enhancement of the resident's quality of life, recognizing each resident ' s individuality. Residents have equal access to quality care, regardless of diagnosis, severity of condition, or payment source.

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41713 The facility identified a census of 37 residents. The sample included 12 residents, with five residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 11, had a time limit of 14-days for his as-needed (PRN) antianxiety (a class of medications that calm and relax people) medication order for Ativan (lorazepam: benzodiazepine medication used to treat anxiety, insomnia (trouble sleeping), severe agitation, and active seizures (violent involuntary series of contractions of a group of muscles)including status eplielticus), and further failed to ensure R32 had a time limit of 14-days for PRN anti-anxiety Ativan with a physician indication of use. This defiant practice placed R11 and R32 for potentially unnecessary psychotropic (alters mood or thought) medication administration. Findings Included: - R11's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of overactive bladder, psychotic disorder (a severe mental illness characterized by a significant impairment in an individual's ability to distinguish between reality and fantasy), substance dependence, delusional disorders (a mental illness where individuals experience one or more non-bizarre delusions for at least a month, without other signs of psychosis like hallucinations or disorganized thinking), major depressive disorder (major mood disorder that causes persistent feelings of sadness), epilepsy (brain disorder characterized by repeated seizures), mood effective disorder (characterized by significant disturbances in mood, encompassing a range of conditions from depression to mania), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), hypertension (high blood pressure), lack of coordination, muscle weakness, repeated falls, cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), reduced mobility need for assistance with personal care, flaccid (weak and flabby) hemiplegia (paralysis of one side of the body) effecting left nondominant side, pain, and vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain). The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of seven, which indicated severely impaired cognition. The MDS documented R11 had impairment on one side of his body. The MDS documented R11 required set up and clean up by staff for eating, and substantial to maximum assistance for dressing and toileting. The MDS documented R11 received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) and an antidepressant (a class of medications used to treat mood disorders) during the observation period. R11 Psychotropic Drug Use Care Area Assessment (CAA) dated 07/08/24 documented R11 used high-risk medications, which could contribute to decreased functionality and less motivation to progress with goals. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R11 ' s Care Plan dated 10/27/23 documented R11 was at risk for adverse reactions related to taking medications with Black Box Warning (BBW - the highest safety-related warning that medications can have assigned by the Food and Drug Administration) drugs for patients for whom alternative treatment options were inadequate. Staff were to limit dosages and durations to the minimum required. Staff were to follow patients for signs and symptoms of respiratory depression and sedation. R11 ' s EMR under Orders revealed the following physicians ' orders: Ativan oral tablet 0.5mg (Lorazepam), give one tablet by mouth every eight hours as needed for anxiety, dated 05/01/25. R11 ' s Ativan PRN order lacked a 14-day discontinuation date. On 05/05/25 at 07:05 AM, R11 laid on his back in bed, with his right leg hanging off the bed. On 05/06/25 at 08:51 AM, R11 was sitting on the side of his bed. On 05/07/25 at 10:24 AM, Licensed Nurse (LN) I stated that physicians were not putting in their orders. LN I stated that the nurse taking off the order should be checking the order for accuracy. She stated that, as needed (PRN), psychotropic medications should have a 14-day stop date. On 05/07/25 at 11:02 AM, Administrative Nurse D stated the nurse on duty was responsible for ensuring all orders were entered correctly. He stated R11 ' s PRN Ativan should have had 14 14-day stop date. The facility ' s Free from Chemical Restraints, Unnecessary Psychotropic Medication policy, dated 04/2025, documented chemical restraints shall only be used for the safety and well-being of the residents and only after other alternatives have been tried unsuccessfully. Chemical restraints shall only be used to treat the residents ' medical symptoms and never for discipline or staff convenience. - R32 ' s Electronic Medical Record (EMR) documented diagnoses of hemiplegia and hemiparesis (weakness and paralysis on one side of the body) following a cerebral vascular incident (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), insomnia (inability to sleep), delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), major depressive disorder (major mood disorder that causes persistent feelings of sadness), displaced closed fracture (traumatic bone break where two ends of the bone separate out of their normal positions without a break in the skin), and history of falling. R32 ' s Annual Minimum Data Set (MDS) dated [DATE] documented she had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R32 had impairment on one side of her upper and lower extremities. The MDS documented R32 required substantial assistance to being totally dependent on staff for her functional abilities and activities of daily living (ADL). The MDS documented R32 had no history of falls since the previous assessment. The MDS documented R32 had a recent surgery that required skilled nursing care. The MDS documented R32 had received an antidepressant (a class of medications used to treat mood disorders), a hypnotic (medications that depress the central nervous system, leading to relaxation, sedation, and sleep induction), and an opioid (a class of controlled drugs used to treat pain) during the lookback period. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R32 ' s Psychotropic Drug Use Care Area Assessment (CAA) dated 01/03/25 documented she used psychotropic medications for depression and to aid in sleep. R32 ' s Behavioral CAA dated 01/03/25 documented she had frequent behavior issues, such as hostile and abusive language towards staff and refusal of care. R32 ' s Care Plan, revised 01/07/25, directed staff to administer medications as ordered. The plan of care documented staff were to monitor and document any side effects and the effectiveness of the medications. R32 ' s Orders tab of the EMR documented a physician ' s order dated 05/01/25 for Ativan (an antianxiety agent) to give 0.5 milligrams (mg) for anxiety at bedtime as needed. This order lacked a 14-day stop date. On 05/07/25 at 08:48 AM, R32 laid in her bed with her curtains drawn and the light off. On 05/07/25 at 10:24 AM, Licensed Nurse (LN) I stated that physicians were not putting in their orders. LN I stated that the nurse taking off the order should have checked the order for accuracy. She stated that, as needed (PRN), psychotropic medications should have a 14-day stop date. On 05/07/25 at 11:02 AM, Administrative Nurse D stated the nurse on duty was responsible for ensuring all orders are entered correctly. He stated R11 ' s PRN Ativan should have had 14 14-day stop date. The facility ' s Free from Chemical Restraints, Unnecessary Psychotropic Medication policy, dated 04/2025, documented chemical restraints shall only be used for the safety and well-being of the residents and only after other alternatives have been tried unsuccessfully. Chemical restraints shall only be used to treat the residents ' medical symptoms and never for discipline or staff convenience.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41713 The facility identified a census of 37 residents. The sample included 12 residents. Based on observation, record review and interview, the facility failed to report to the State Agency (SA) as required when a Resident (R) 32 had a fall that resulted in a major injury. This placed R32 at risk for ongoing neglect and abuse. Findings included: - R32 ' s Electronic Medical Record (EMR) documented diagnoses of hemiplegia and hemiparesis (weakness and paralysis on one side of the body) following a cerebral vascular incident (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), insomnia (inability to sleep), delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), major depressive disorder (major mood disorder that causes persistent feelings of sadness), displaced closed fracture (traumatic bone break where two ends of the bone separate out of their normal positions without a break in the skin), and history of falling. R32 ' s Annual Minimum Data Set (MDS) dated [DATE] documented she had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. R32 had impairment on one side of her upper and lower extremities. R32 required substantial assistance to being totally dependent on staff for her functional abilities and activities of daily living (ADL). R32 had no history of falls since the previous assessment. R32 had a recent surgery that required skilled nursing care. R32 ' s Falls Care Area Assessment (CAA) dated 01/03/25 documented R32 had an actual fall with a major injury (hip fracture) because she attempted to transfer without waiting for adequate staff assistance. R32 had hemiparesis following a CVA. R32 ' s Care Plan, revised 1/07/25, directed staff that she had an actual fall on 10/19/24, and staff were to use a gait belt with two-person assistance for transfers. R32's plan of care directed staff to provide cares in pairs. R32 ' s care plan lacked a new intervention that was initiated post-fall on 12/20/24. R32 ' s Progress Notes tab of the EMR documented an Event Note: Fall Related by Licensed Nurse (LN) J, dated 12/20/24. The note stated the Certified Nurse Aide (CNA) came to the nurse stating R32 fell on to the floor. On entering R32 ' s room, she was on the floor with her legs facing the bed. R32 hit her head as she fell to the floor. R32 was being transferred from the bed to her wheelchair, R32 grabbed the armrest of a wheelchair, and when R32 stood up, she lost her balance attempting to pivot around into the wheelchair. R32 complained of a headache. The provider, director of nursing (DON), and family representative were called and notified of incident. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Event Note: Fall Related in R32 ' s EMR dated 12/20/24 at 07:44 PM documented a late entry addendum to the Fall note on 12/20/24 at 06:00 PM. The CNA stated to the nurse, as the nurse walked into R32 ' s room, that she was transferring R32 from the bed to her wheelchair. R32 fell when she lost her balance. The CNA lowered R32 to the floor. R32 ' s head was facing the bed, with her legs under the lower side of her bed. R32 stated her foot hurt. Upon assessment, there was no shortening of either leg and no turning in or out of either foot. The two CNAs transferred R32 back into bed using the Hoyer (total body mechanical lift) lift. An Event Note: Fall Related in R32 ' s EMR dated 12/21/24 at 02:35 AM documented R32 on fall follow-up with neurological checks. R32 stated she did not hit her head when she fell , but that her left leg really hurts. Later, R32 complained her whole body was hurting and that she did hit her head and stated she wanted a pain pill and not Tylenol (a nonsteroidal pain medication). An Alert Note in R32 ' s EMR dated 12/21/24 at 09:16 AM documented R32 complained of leg pain and called emergency medical services (EMS) on her own. The provider, DON, and family representative were notified. R32 stated that this pain stemmed from the fall she had yesterday, and it had been hurting her all night, and she needed something stronger than Tylenol. R32 told the emergency services technicians (EMT) that she wanted something stronger than Tylenol and that was all she had been given for her pain management. R32 was transported to the hospital by EMS. An Alert Note in the EMR dated 12/21/24 at 12:15 PM documented Licensed Nurse (LN) G spoke with the hospital emergency department (ER). The ER stated that R32 was going to be admitted for a hip fracture. The ER stated it was a surprise about the hip fracture because R32 yelled about being in pain, then she would fall asleep. R32 ' s on-call provider, DON, and family representative were notified. A SPN: Admission Note dated 12/24/24 at 03:33 PM in R32 ' s EMR documented R32 arrived at the facility at 02:45 PM by facility transportation. R32 came back to the facility in a bad mood and refused to go to her room to be assessed. R32 refused three times and stated she wanted to stay in her wheelchair for dinner. R32 stated that the hospital nurses and CNAs had been mean to her and rude to her, which was why she was in a bad mood. R32 remained in her wheelchair in the dining room, sleeping in her wheelchair. R32 was told that if she lay down, the staff would get her back up for dinner, and R32 refused to lie down for admission assessment. This nurse would pass the information on to the night shift to do the skin assessment on the resident. R32 remained in her wheelchair in the dining room, sleeping in her wheelchair. A After Visit Summary in the Misc. tab of the EMR dated 12/24/24 documented a hospital stay from 12/21/24 to 12/24/24 for a hip fracture. A left hip percutaneous pinning (a surgical procedure where pins or screws are inserted through small incisions in the skin to hold the broken bone fragments together) surgery was performed on 12/22/24. Discharge instructions included activity as tolerated and were instructed by physical therapy. R32 to follow up with the orthopedic surgeon in two weeks. An Event Note: Fall Related dated 12/26/24 at 01:18 PM in R32 ' s EMR documented the Interdisciplinary Team (IDT) met to discuss R32 ' s fall on 12/20/24. R32 had threatened the new CNA N to transfer her by herself. CNA N lowered R32 to the floor. CNA N stated R32 did not hit her head, but R32 stated she had. The root cause was determined that R32 needed a two-person assist with transfers using a gait belt. R32 ' s care plan was reviewed, and it was to provide care in pairs. R32 had been sent to the hospital for a hip fracture. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A typed Fall Incident Statement received on 05/07/25 by CNA N documented: On 12/20/24, it was a very busy shift. CNA N noticed that R32 had her call light on, so she knocked and entered R32 ' s room to ask how she could be assisted. R32 told CNA N she wanted to get up and get dressed. CNA N helped her get dressed, and when it was time to transfer R32 from the bed to the wheelchair, CNA N expressed to R32 that she was not confident transferring her alone. R32 expressed the urgency and strongly insisted that she be assisted immediately. CNA N stated she felt pressured by R32 because she was not confident in transferring R32 alone, but R32 insisted CNA N did it anyway, so then CNA N proceeded to try to help her. During the transfer, the R32 became unsteady. CNA N attempted to prevent the fall by guiding R32 safely to the floor, to minimize the impact, and ensuring R32 did not hit her head or any nearby objects. CNA N immediately looked for the nurse and called for help. The nurse assessed the R32, and all the appropriate protocols were followed. Later, two other CNAs, along with CNA N, assisted the R32 into her wheelchair. CNA N continued helping R32 while doing this, R32 and I talked about the situation that had just occurred. CNA N then took R3 to the dining room. CNA N said it was her fault for not thinking the situation through and failing to assert herself when CNA N should have told R32, not yet, or waited and called for another CNA. CNA N said it was a very busy time, and she could not find anyone else to help, so she simply followed what R32 instructed her to do because she felt pressured. CNA N stated she had learned her lesson and would make it a priority to follow all transfer protocols in the future to ensure the safety of the residents. A witness statement was requested by Licensed Nurse (LN) J regarding this incident, but was not received as requested. The facility failed to report R32 ' s fall, which resulted in a major injury to the SA. On 05/07/25 at 08:48 AM, R32, laid in her bed, stated that on the day of the accident, only one staff member assisted her while she was transferred. R32 stated the CNA did not use a gait belt while she assisted with the transfer from her bed to the wheelchair. On 05/07/25 at 08:50 AM, Administrative Staff A stated this fall was not called into the state, as the resident was able to tell us exactly what happened, and the situation that occurred that caused the fall. Administrative Staff A stated that, also, when the incident happened, there was no concern over any injuries, due to R32 ' s reporting of mild pain. Administrative Staff A stated it was not until the day after the incident that R32 notified us of the severe pain and was sent to the hospital for evaluation. The facility's Accident and Incidents-Investigating and Reporting policy, dated 10/24, documented all accidents or incidents involving residents, employees, or vendors occurring on the facility's premises shall be investigated and reported to the Administrator. The Nurse Supervisor shall promptly initiate and document an investigation of the accident or incident. The facility would strive to be in compliance with current rules and regulations governing accidents and incidents involving a medical device.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26768 The facility had a census of 37 residents, with 12 sampled, including two residents reviewed for hospitalization . Based on interview and record review, the facility failed to provide a Bed Hold Notice to Resident (R) 18 or her representative, upon transfer and admission to a hospital. This deficient practice placed R18 at risk for not being permitted to return and resume residence in the nursing facility. The facility further failed to provide a written notification of transfer to R12 or the resident's representative as soon as practicable, which included the required information. Findings included: - R18's Electronic Medical Record documented diagnoses of chronic obstructive pulmonary disease (COPD - progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), acute and chronic respiratory failure with hypoxia (inadequate supply of oxygen), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), anxiety disorder (mental or emotional disorder characterized by apprehension, uncertainty and irrational fear), and congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid). R18's Annual Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate impairment of cognition. The MDS documented R18 was dependent on or required staff assistance with most activities of daily living. The MDS documented R18 received numerous medications. R18's Care Plan, dated 04/14/25, directed staff to administer medications as ordered, monitor for side effects, and assess effectiveness. R18's medical record documented R18 was hospitalized on [DATE] and again on 04/30/25. The facility lacked documentation R18 or her representative were provided the bed hold policy or notice at those times. On 05/06/25 at 04:05 PM, R18 was in her room in a wheelchair. R18 stated she had two mice (one white, one gray) that visited her, and she had named them. She talked about other residents and staff, and after talking, she decided to take her concerns to the facility administrator. On 05/06/25 at 09:30 AM, Administrative Staff A reported that the facility should have provided R18 a Bed Hold Notice when she was hospitalized on [DATE] and 04/30/25. The facility's Bed Hold policy, dated 04/2025, stated the facility would inform residents prior to a transfer for hospitalization of the bed hold policy. When emergency transfers were necessary, the facility would provide the resident and their representative with information concerning the bed hold policy per state law. 41713 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Kaw River Care and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 750 Blake Street Edwardsville, KS 66111	

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- R12 ' s Electronic Medical Record (EMR) documented diagnoses of multiple sclerosis (MS - progressive disease of the nerve fibers of the brain and spinal cord), seizures (violent involuntary series of contractions of a group of muscles), respiratory failure (a condition in which your blood does not have enough oxygen), and pneumonia (a lung infection that causes inflammation and fluid buildup in the air sacs, making it difficult to breathe). R12 ' s Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of one, which indicated severely impaired cognition. The MDS documented R12 functional limitation in range of motion with impairment on both sides of the upper and lower extremities. The MDS documented R12 was dependent on staff for all activities of daily living and functional abilities. The MDS documented R12 had an indwelling catheter (tube placed in the bladder to drain urine into a collection bag). The MDS documented R12 had pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and/or friction). The MDS documented R12 required a gastrostomy tube (G-tube: tube surgically placed through an artificial opening into the stomach) for his nutritional needs. The MDS documented R12 required supplemental oxygen therapy. R12 ' s Discharge MDS dated [DATE] documented an unplanned discharge to an acute hospital with a return anticipated. R12 ' s Entry MDS dated [DATE] documented a re-entry to the facility from an acute hospital. The facility failed to provide the required written notification of transfer to R12 and or his representative for this facility-initiated discharge. R12 ' s Discharge MDS dated [DATE] documented an unplanned discharge to an acute hospital with a return anticipated. R12 ' s Entry MDS dated [DATE] documented a re-entry to the facility from an acute hospital. The facility failed to provide the required written notification of transfer to R12 and or his representative for this facility-initiated discharge. R12 ' s Discharge MDS dated [DATE] documented an unplanned discharge to an acute hospital with a return anticipated. R12 ' s Entry MDS dated [DATE] documented a re-entry to the facility from an acute hospital. The facility failed to provide the required written notification of transfer to R12 and or his representative for this facility-initiated discharge. R12 ' s Discharge MDS dated [DATE] documented an unplanned discharge to an acute hospital with a return anticipated. R12 ' s Entry MDS dated [DATE] documented a re-entry to the facility from an acute hospital. The facility failed to provide the required written notification of transfer to R12 and or his representative for this facility-initiated discharge. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Kaw River Care and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 750 Blake Street Edwardsville, KS 66111	

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R12 ' s Discharge MDS dated [DATE] documented an unplanned discharge to an acute hospital with a return anticipated. R12 ' s Entry MDS dated [DATE] documented a re-entry to the facility from an acute hospital. The facility failed to provide the required written notification of transfer to R12 and or his representative for this facility-initiated discharge. R12 ' s Discharge MDS dated [DATE] documented an unplanned discharge to an acute hospital with a return anticipated. R12 ' s Entry MDS dated [DATE] documented a re-entry to the facility from an acute hospital. The facility failed to provide the required written notification of transfer to R12 and or his representative for this facility-initiated discharge. R12 ' s Discharge MDS dated [DATE] documented an unplanned discharge to an acute hospital with a return anticipated. R12 ' s Entry MDS dated [DATE] documented a re-entry to the facility from an acute hospital. The facility failed to provide the required written notification of transfer to R12 and or his representative for this facility-initiated discharge. R12 ' s Nutrition Care Area Assessment (CAA) dated 10/25/24 documented he required a G-tube for all nutritional and hydration needs. R12 ' s Care Plan, revised on 04/06/25, directed staff to give all medications as directed. The plan of care directed staff to position R32 with the head of the bed elevated to 30 to 40 degrees as needed to facilitate breathing. The plan of care directed staff to provide breathing treatments as ordered and ensure prompt treatment of any respiratory infections. On 05/06/25 at 08:13 AM, R12 laid on his bed, the head of the bed was elevated, with his enteral feeding infusing through his G-tube. R12 had his supplemental oxygen on via nasal cannula (NC - a hollow tube to assist with providing supplemental oxygen). On 05/07/25 at 08:15 AM, Administrative Staff A stated that the prior social services person had not been doing all the bed holds and providing the written notification of transfer as required. Administrative Staff A stated that going forward, he would ensure that both the bed holds and the required written notification were provided upon any discharge. The facility's Transfer and or Discharge, Including Against Medical Advice, Discharge Notification policy, dated 04/25, documented the facility had established transfer and discharge criteria based upon applicable federal requirements. The facility would provide a resident and or the resident's representative with a thirty-day written notice of an impending transfer or discharge when specific criteria had not been reached.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41713 The facility identified a census of 37 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to ensure staff developed and implemented a comprehensive care plan for Resident (R) 29 that included staff direction for activities of daily living (ADL) care. This placed R29 at risk of impaired care due to uncommunicated care needs. Findings included: - R29 ' s Electronic Medical Record (EMR) documented diagnoses of hypertension (HTN - elevated blood pressure), cerebral infarction (stroke), tracheostomy status (opening through the neck into the trachea through which an indwelling tube may be inserted), and gastrostomy status (G-tube: tube surgically placed through an artificial opening into the stomach). R29 ' s Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R29 used a walker or a wheelchair to assist with mobility. The MDS documented R29 required partial to moderated assistance from staff for toileting, bathing, and personal hygiene. The MDS documented R29 had a tracheostomy. R29 ' s Functional Abilities Care Area Assessment (CAA) dated 03/09/25 documented she had decreased functional abilities due to impaired strength and mobility. R29 ' s Care Plan, revised on 05/04/25, directed staff to administer medications as ordered. R29's plan of care directed staff to converse with R29 while providing care. R29 ' s care plan lacked staff direction for her activities of daily living (ADL) care and functional ability assistance. On 05/06/25 at 11:45 AM, R29 wheeled herself out of her room in her wheelchair. On 05/07/25 at 10:24 AM, Licensed Nurse (LN) I stated all nurses were to put interventions in the care plan for each fall. She stated the intervention was communicated to all staff during staff huddles. On 05/07/25 at 10:53 AM, Certified Nurse's Aide (CNA) M stated she did not have access to the care plan. She stated she would ask her nurse, or her nurse would let her know if there were special instructions for each resident she was to care for. On 05/07/25 at 11:02 AM, Administrative Nurse D stated that the administrative staff meet each week, and if there had been a fall, the team discussed interventions. He stated the intervention for the fall was put into the care plan during the meeting. The facility's Comprehensive Care Plan policy, dated 03/25, documented an individualized comprehensive person-centered care plan that included measurable objectives and time frames to meet the resident's medical, nursing, mental, cultural, and psychological needs was developed for each resident. The care plan should describe the resident's nursing, medical physician and mental and psychosocial preferences, they should have specific, measurable objectives and time frames with a goal.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 37 residents. The sample included 12 residents, with one resident reviewed for respiratory care. Based on observation, record review, and interviews, the facility failed to revise the comprehensive care plan to include interventions for falls for Resident (R) 11. This defiant practice placed R11 at increased risk for future falls. Findings included: - R11 ' s Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of Overactive bladder, Psychotic disorder (a severe mental illness characterized by a significant impairment in an individual's ability to distinguish between reality and fantasy), substance dependence, delusional disorders (a mental illness where individuals experience one or more non-bizarre delusions for at least a month, without other signs of psychosis like hallucinations or disorganized thinking), major depressive disorder (major mood disorder that causes persistent feelings of sadness), epilepsy (brain disorder characterized by repeated seizures), mood effective disorder (characterized by significant disturbances in mood, encompassing a range of conditions from depression to mania), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), hypertension (high blood pressure), lack of coordination, muscle weakness, repeated falls, cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), reduced mobility need for assistance with personal care, flaccid (weak and flabby) hemiplegia (paralysis of one side of the body) effecting left nondominant side, pain, and vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain). The Quarterly Minimum Data Set (MDS) for R11, dated 03/31/25, recorded a Brief Interview for Mental Status (BIMS) score of seven, which indicated severely impaired cognition. The MDS documented R11 required setup and clean up when eating. The MDS documented R11 needed substantial to maximum assistance from staff for dressing and toileting. The MDS documented R11 was frequently incontinent and had one fall with injury. R11's Falls Care Area assessment dated [DATE] documented R11 had a fall with a skin tear to his left calf of his leg. R11's Care Plan revised on 08/05/24, documented staff would offer bathroom assistance to R11 when doing rounds when he was awake. R11's plan of care, revised on 08/12/24, documented that staff were to help with transfers before and after meals and at bedtime. R11 ' s plan of care dated 09/01/23 documented, signs would be added to R11's room and bathroom to remind him to call for assistance. R11 ' s plan of care documented a fall on 03/05/25, the intervention was to place nonskid strips on the threshold of the bathroom entrance. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R11 ' s EMR under Event Note Fall dated 01/29/25 documented the nurse was informed by staff that R11 was on the floor in his room. The nurse arrived at R11's room and observed R11 on the floor sitting upright, with his back against the right side of his bed, and his wheelchair was facing him towards his left side. R11 was alert, and R11 was wearing shoes; no new injuries were noted. R11 was assisted back into his wheelchair. R11 stated he lost his balance and fell . R11 ' s plan of care lacked an intervention for his fall. R11 ' s EMR under Event Note Fall dated 02/02/25 documented the nurse was notified by a CNA that R11 had fallen. Upon entering R11 ' s room, R11 was observed sitting at the end of his bed on his floor with his legs stretched out in front of him. The CNAs applied a gait belt and performed range of motion to all extremities without difficulty. R11 was unable to explain how he ended up on the floor. R11 had his shoes on, his guardian was notified. R11 was helped to a resting position in his bed, with his call light placed at his side. R11 ' s plan of care lacked an intervention for his fall. R11 ' s EMR under Event Note Fall dated 03/02/25 documented nurse was called to R11 ' s room by a Certified Medication Aide (CMA). Upon entering the room, R11 was observed on the floor near the end of his bed with his back to the door. CNAs were getting him fitted with a gait belt to assist him to a standing position. Range of Motion performed. R11 denied hitting his head; his guardian, director of nursing, and physician were notified. The intervention was to place nonskid strips in the entrance threshold of the bathroom. R11 ' s EMR under Event Note Fall dated 05/02/25 documented nurse was notified R11 had fallen and was found on the floor. The director of nursing and the administrator were in R11 ' s room, and a Certified Nurse ' s Aide (CNA). R11 ' s head was resting on the wall, resident admitted to hitting his head on the wall. R11 was helped into his bed without complication. R11 stated he was sitting in his chair. R11 denies passing out. R11 did not remember how he had hit his head. When the nurse asked how he ended up on the floor, he just repeated he was in his chair and then hit his head. This nurse called the resident's guardian and notified her that the resident fell , and the facility was planning to send him to the Emergency Department (ED) for evaluation, due to him admitting to hitting his head. The resident spoke with his guardian, and she agreed to send R11 to the hospital. The resident was then transported to the hospital. R11 ' s care plan lacked an intervention for the fall. On 05/05/25 at 07:05 AM, R11 laid on his back in bed, with his right leg hanging off the bed. On 05/06/25 at 08:51 AM, R11 was sitting on the side of his bed. On 05/07/25 at 10:24 AM, Licensed Nurse (LN) I stated all nurses were to put interventions in the care plan for each fall. She stated the intervention was communicated to all staff during staff huddles. On 05/07/25 at 10:53 AM, Certified Nurse ' s Aide (CNA) M stated she did not have access to the care plan. She stated she would ask her nurse, or her nurse would let her know if there were special instructions for each resident she was to care for. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/07/25 at 11:02 AM, Administrative Nurse D stated administrative staff meet each week, and if there has been a fall, the team discusses interventions. He stated the intervention for the fall was put into the care plan during the meeting. The facility ' s Comprehensive Care Plan policy, dated 03/25, documented an individualized, comprehensive person-centered care plan that included measurable objectives and time frames to meet the resident's medical, nursing, mental, cultural, and psychological needs was developed for each resident. The care plan should describe the resident's nursing, medical physician and mental and psychosocial preferences, the care plan should have specific measurable objectives and time frames with a goal.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 37 residents. The sample includes 12 residents. Based on observation, record review, and interviews, the facility failed to provide consistent weekend activities. This deficient practice placed the affected residents at risk for decreased psychosocial well-being. Findings included: - A review of the facility's Activity Calendar for March, April, and May 2025 was completed. The review revealed in March 2025 the following weekend activities were scheduled: Activities in March revealed on Saturday's hydration cart, daily chronicles, activity cart, and movie matinee. On Saturday, 05/08/25, Karaoke with [NAME], and Bingo with Sannie. On Sundays in March, TV worship hour, an activity cart, and a Tubi movie. On 03/16/25, Victory Hill Church Singers. The review revealed in April 2025, the following weekend activities were scheduled: Activities for April Saturdays: hydration cart, daily chronicles activity cart on 04/05/25, bingo with [NAME], and 04/12/25 rise and shine roaming East, bingo, [NAME] store, jewelry making, and making and eating pinwheels. On 04/19, bingo. On Sundays in April, TV worship, activity cart, and Tubi movie, on 04/13/25, an Easter egg hunt, and on 04/27/25, Victory Hill Church singers. The review revealed in May 2025, the following weekend activities were scheduled: Activities for May on Saturdays: a hydration cart, daily chronicles, an activity cart, and a movie matinee. On 05/10/25, activities with [NAME], on 05/17/25, a garden meet, and on 05/24/25, activities with [NAME]. On Sunday's TV worship, activity cart, and a Tubi movie, on 05/25/25, Victory Hill Church singers. On 05/06/25 at 10:05 AM, Resident Council members reported that activities rarely occurred on weekends, and never a variety of activities on weekdays. The council reported that they watched TV or read. The council reported they would like activities on the weekends, such as interactive groups, and they stated they would like to have staff lead the activities. On 05/07/25 at 10:44 AM, Activities Staff Z stated she lets residents do their own thing on the weekends. Activities Staff Z stated she does leave the activities cart on for the residents on the weekends. She stated that staff could put a movie in for the residents, and residents do very well leading their own activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/07/25 at 10:53 AM, Certified Nurse's Aide (CNA) M stated she did not do activities on the weekends she had worked. The facility's Activities and Social Events policy, dated 10/24, documented the residents have the right to choose the types of activities and social events in which they wish to participate. The facility would provide activities on lost days, including weekends and holidays, as well as scheduled religious and social activities. Residents are free to decide whether to attend any activity or other scheduled events.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 37 residents. The sample included 12 residents, with two residents reviewed for positioning and mobility. Based on observation, record review, and interviews, the facility failed to assess or provide a restorative range of motion for Resident (R) 16. This deficient practice placed the resident at risk for discomfort, stiffness, and the possibility of forming contracture (abnormal permanent fixation of a joint or muscle). Findings included: - R16's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of seizure (violent involuntary series of contractions of a group of muscles), hemiparesis/hemiplegia (weakness and paralysis on one side of the body) following cerebral infarction (stroke - the 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) effecting left nondominant side, attention and concentration deficit, hypertension (high blood pressure), metabolic encephalopathy (a condition in which brain function is disturbed either temporarily or permanently due to different diseases or toxins in the body), hyperlipidemia (condition of elevated blood lipid levels), and major depressive disorder (major mood disorder that causes persistent feelings of sadness). The Quarterly Minimum Data Set (MDS) dated [DATE] documented R16 had a Brief Interview of Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. The MDS documented R16 had impairment on one side of her body, both upper and lower limbs. The MDS documented R16 required set up and clean up for eating, was dependent on staff for toileting, and needed partial to maximum assistance from staff for dressing and bathing. The MDS documented R16 did not receive any therapies during the observation period. R16's The Functional Abilities (Self-Care Mobility) Care Area Assessment (CAA) dated 11/03/24 documented R16 had functional limitations related to medical conditions as well as physical deconditioning. R16 had a stroke, resulting in hemiparesis. R16's Care Plan dated 11/13/24 documented R16 had limited physical mobility related to hemiplegia following a stroke. R16's plan of care documented R16 would maintain or improve her current level of mobility through the review date. R16's plan of care documented she would remain free of complications related to immobility, including contractures, thrombus (blood clot) formation, skin breakdown, and fall-related injuries. The plan of care for R16 stated physical therapy and occupational therapy as ordered, and as needed (PRN). On 05/05/25 at 08:35 AM, R16 laid on her bed, R16's flaccid left hand laid on her lap. On 05/06/25 at 08:30 AM, R16 laid on her bed watching TV. R16's left arm laid on her abdomen. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/06/25 at 08:30 AM, R16 stated she had never had range of motion for her hand; she stated she had never had any therapy since coming to the facility. R16 stated she would like to have some kind of therapy. She stated that right now her hand had no contractures, and she would like to have exercises on her hand to ensure she doesn't get contractures. On 05/07/25 at 10:24 AM, Licensed Nurse (LN) I stated the Certified Nurse's Aides (CNAs) were doing exercises with the residents. LN I stated that the orders or education to the CNAs came from the therapy department. She stated that right now, the facility did not have anyone specific for restorative therapy. On 05/07/25 at 10:53 AM, CNA M stated she does not do any range of motion or exercises with the residents. She stated exercises would come from the therapy department. On 05/07/25 at 11:02 AM, Administrative Nurse D stated that at this time the facility did not have a restorative aide and did not have a restorative therapy program. On 05/07/25 at 11:05 AM, Consultant Nurse GG stated that at this time the facility did not have a restorative aide, and the facility was looking into the restorative program. The facility's Range of Motion Exercises policy dated 10/24 documented residents with limited range of motion would receive appropriate treatment and services to increase range of motion and or prevent further decrease in range of motion. Residents with a limited ability of mobility would receive appropriate services, equipment, and assistance to maintain and improve mobility with the maximum practicable independence unless a reduction in mobility was demonstrably unavoidable.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41713 The facility identified a census of 37 residents. The sample included 12 residents, with five residents reviewed for accidents. Based on observation, record review, and interview, the facility failed to ensure a safe environment free from accident hazards for Resident (R) 32 when staff transferred R32 with the assistance of one staff instead of two, and failed to use a gait belt (belt used to help transfer or stabilize during activity). This deficient practice resulted in a fall that caused a fracture (broken bone). The facility also failed to implement new fall interventions for R11. This placed R32 and R11 at risk for preventable falls and related injuries. Findings included: - R32's Electronic Medical Record (EMR) documented diagnoses of hemiplegia and hemiparesis (weakness and paralysis on one side of the body) following a cerebral vascular incident (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), insomnia (inability to sleep), delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), major depressive disorder (major mood disorder that causes persistent feelings of sadness), displaced closed fracture (traumatic bone break where two ends of the bone separate out of their normal positions without a break in the skin), and a history of falling. R32's Annual Minimum Data Set (MDS) dated [DATE] documented she had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. R32 had impairment of both the upper and lower extremities on one side. The MDS recorded R32 required substantial assistance to total dependence on staff for her functional abilities and activities of daily living (ADL). The MDS recorded R32 had no history of falls since the previous assessment. R32 had a recent surgery that required skilled nursing care. R32's Falls Care Area Assessment (CAA) dated 01/03/25 documented R32 had a fall with a major injury (hip fracture) because she attempted to transfer without waiting for adequate staff assistance. R32 had hemiparesis following a CVA. R32's Care Plan revised on 10/23/24 directed staff that she had a fall on 10/19/24 and staff were to use a gait belt with two-person assistance for transfers. The plan of care directed staff to provide care in pairs (two staff present). The plan of care directed staff to check R32's range of motion after a fall. and continue interventions on the at-risk plan. The plan of care directed staff if the resident had a fall with no apparent acute injuries, staff were to determine and address causative factors of the fall. R32's plan of care lacked any new intervention related to the fall on 12/20/24. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R32's Progress Notes tab of the EMR documented an Event Note: Fall Related by Licensed Nurse (LN) J, dated 12/20/24. The note stated the Certified Nurse Aide (CNA) came to the nurse stating R32 fell on to the floor. On entering R32's room, LN J observed R32 on the floor; the resident's legs were towards the bed. The note documented R32 hit her head as she fell to the floor while transferring from her bed to her wheelchair. The note documented R32 grabbed the armrest of the wheelchair and stood up; R32 then lost her balance attempting to pivot around into the wheelchair. The note documented that after the fall, R32 complained of a headache. Staff notified the provider, director of nursing (DON), and family representative. An Event Note: Fall Related in R32's EMR dated 12/20/24 at 07:44 PM documented a late entry addendum to the previous note on 12/20/24. The note reported the CNA told the nurse the CNA was transferring R32 from the bed to her wheelchair when R32 lost her balance and fell . The note documented the CNA lowered R32 to the floor. The note documented R32's head was facing the bed, and her legs were under the end side of her bed. R32 told staff her foot hurt, though assessment revealed there was no shortening of either leg or rotation of either foot. The note documented two CNAs transferred R32 back into bed using the Hoyer (total body mechanical lift) lift. An Event Note: Fall Related in R32's EMR dated 12/21/24 at 02:35 AM documented R32 was on fall follow-up with neurological checks. The note recorded R32 said she had not hit her head when she fell but her left leg really hurt. Later that day R32 complained her whole body hurt. The note recorded R32 said she had hit her head, and she wanted a pain pill but not Tylenol (a pain medication). An Alert Note in R32's EMR dated 12/21/24 at 09:16 AM documented R32 complained of leg pain and called Emergency Medical Services (EMS) on her own. Staff notified the provider, DON, and family representative. The note documented R32 stated her pain stemmed from the fall she had the previous day; she said she was in pain all night, and she needed something stronger than Tylenol. The note documented R32 told the emergency services technicians (EMT) that she wanted something stronger than Tylenol. EMS transported R32 to the hospital. An Alert Note in R32's EMR dated 12/21/24 at 12:15 PM documented LN G spoke with the hospital Emergency Department (ED) who reported R32 admitted for a hip fracture. The note documented the ED reported R32's hip fracture surprised the ED staff because R32 yelled about being in pain, but then fell asleep. Staff notified R32's on-call provider, DON, and family representative. A SPN: Admission Note dated 12/24/24 at 03:33 PM in R32's EMR documented R32 arrived at the facility at 02:45 PM via facility transportation. The note documented R32 came back to the facility in a bad mood and refused to go to her room to be assessed; R32 refused three times and stated she wanted to stay up in her wheelchair for dinner. The note recorded R32 stated the hospital staff was mean and rude to her which was why she was in a bad mood. The note documented the staff told R32 if she laid down, facility staff would get her back up for dinner, but the resident refused to lay down for the admission assessment. An After Visit Summary in the Misc. tab of R32's EMR dated 12/24/24 documented a hospital stay from 12/21/24 to 12/24/24 for a hip fracture. The summary noted a left hip percutaneous pinning (a surgical procedure where pins or screws are inserted through small incisions in the skin to hold the broken bone fragments together) surgery was performed on 12/22/24. The discharge instructions included directions for activity as tolerated, instructed by physical therapy. The discharge instructions directed R32 to follow up with the orthopedic surgeon (surgeon specializing in bones) in two weeks. (continued on next page)

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	175219	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kaw River Care and Rehab	750 Blake Street Edwardsville, KS 66111

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An Event Note: Fall Related dated 12/26/24 at 01:18 PM in R32's EMR documented the Interdisciplinary Team (IDT) met to discuss R32's fall on 12/20/24. The note documented CNA N, who was new, had transferred R32 with just one staff because R32 had insisted. The note documented CNA N lowered R32 to the floor. CNA N stated R32 did not hit her head but R32 stated she had. The note recorded staff determined that R32 needed two-person assistance with transfers using a gait belt as the root cause for the fall. The IDT reviewed R32's Care Plan and noted staff were directed to provide care in pairs. The note documented R32 had been sent to the hospital for a hip fracture. A typed Fall Incident Statement given on 05/07/25 by CNA N documented that on 12/20/24, the shift was very busy. CNA N noticed R32 had her call light on, so she knocked and entered R32's room to ask what she needed. R32 told CNA N she wanted to get up and get dressed. CNA N helped her get dressed, and when it was time to transfer R32 from the bed to the wheelchair, CNA N expressed to R32 that she was not confident transferring R32 alone. R32 urgently and strongly insisted that she be assisted immediately. CNA N stated she felt pressured by R32 because she was not confident in transferring R32 alone but R32 insisted, so CNA N proceeded to try to help R32. During the transfer R32 became unsteady. CNA N attempted to prevent the fall by guiding R32 safely to the floor to minimize the impact and ensure R32 did not hit her head or any nearby objects. CNA N immediately looked for the nurse and called for help. The nurse assessed R32, and all the appropriate protocols were followed. Later, two other CNAs along with CNA N assisted R32 into her wheelchair. CNA N then took R32 to the dining room. CNA N stated it was her fault for not thinking the situation through and failing to assert herself when she should have told R32, not yet or waited and called for another CNA. CNA N said it was a very busy time and she could not find anyone else to help, so CNA N simply followed what R32 instructed her to do because CNA N felt pressured. CNA N stated she had learned her lesson and would make it a priority to follow all transfer protocols in the future to ensure the safety of the residents. On 05/07/25 at 08:48 AM, R32 lay in her bed. She stated on the day of the accident only one staff member assisted her while she was transferred. R32 stated CNA N did not use a gait belt while she assisted R32 with the transfer from the bed to the wheelchair. On 05/07/25 at 08:50 AM, Administrative Staff A stated R32's fall on 12/20/24 was not called into the State Agency as the resident was able to tell staff exactly what happened, and the situation which caused the fall. Administrative Staff A stated when the incident happened there was no concern over any injuries because R32's only reported mild pain. Administrative Staff A stated it was not until the day after the incident that R32 notified staff of her severe pain and was sent to the hospital for evaluation. The facility's Accident and Incidents-Investigating and Reporting policy dated 10/24 documented that all accidents or incidents involving residents, employees, and vendors, occurring on the facility's premises shall be investigated and reported to the Administrator. The Nurse Supervisor shall promptly initiate and document an investigation of the accident or incident. The facility would strive in compliance with current rules and regulations governing accidents and incidents involving a medical device. 49634 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	- R11's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of Overactive bladder, Psychotic disorder (a severe mental illness characterized by a significant impairment in an individual's ability to distinguish between reality and fantasy), substance dependence, delusional disorders (a mental illness where individuals experience one or more non-bizarre delusions for at least a month, without other signs of psychosis like hallucinations or disorganized thinking), major depressive disorder (major mood disorder that causes persistent feelings of sadness), epilepsy (brain disorder characterized by repeated seizures), mood effective disorder (characterized by significant disturbances in mood, encompassing a range of conditions from depression to mania), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), hypertension (high blood pressure), lack of coordination, muscle weakness, repeated falls, cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), reduced mobility need for assistance with personal care, flaccid (weak and flabby) hemiplegia (paralysis of one side of the body) effecting left nondominant side, pain, and vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain). The Quarterly Minimum Data Set (MDS) for R11 dated 03/31/25 recorded a Brief Interview for Mental Status (BIMS) score of seven, which indicated severely impaired cognition. The MDS documented R11 required staff to set up and clean up when eating and needed substantial to maximum assistance from staff with dressing and toileting. The MDS documented R11 was frequently incontinent and had one fall with injury. R11's Falls Care Area Assessment (CAA) dated 07/08/24 documented R11 had a fall with a skin tear to his left calf of his leg. R11's Care Plan, revised on 08/05/24, documented staff would offer bathroom assistance to R11 when doing rounds when he was awake. R11's plan of care, revised on 08/12/24, documented that staff were to help with transfers before and after meals and at bedtime. R11's plan of care, dated 09/01/23, documented signs would be added to R11's room and bathroom to remind him to call for assistance.R11's plan of care documented a fall on 03/05/25; the intervention was to place nonskid strips on the threshold of the bathroom entrance. On 05/05/25 at 07:05 AM, R11 laid on his back in bed, with his right leg hanging off the bed. R11's bathroom did not have nonskid strips placed. On 05/06/25 at 08:51 AM, R11 was sitting on the side of his bed. R11's bathroom did not have nonskid strips placed. On 05/07/25 at 10:24 AM, Licensed Nurse (LN) I stated that interventions that were put in place should be followed through. LN I stated she was unsure how the communication was related to staff on what interventions for falls had been put in place. On 05/07/25 at 10:42 AM, Certified Nurse's Aide (CNA)M stated that if a new intervention had been put in place for a fall, she would know this information by asking her nurse. She stated the nurse on duty would inform her of any falls that had happened and the interventions put in place. She stated she does not have access to the care plan. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 05/07/25 at 11:02 AM, Administrative Nurse D stated all staff have access to the communication board, and that was where interventions that had recently been put in place would be found. He stated that staff are asked to read the communications from the last day the staff member had worked to the current day. The facility's Accidents and Incidents policy, dated 10/24, documented all accidents or incidents involving residents, employees, visitors, vendors, occurring in the facility, the nurse supervisor would promptly initiate and document an investigation of the accident or incident. Premises shall be investigated and reported to the Administrator.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 41713 The facility identified a census of 37 residents. The sample included 12 residents, four Certified Nurse Aides (CNAs), and one Certified Medication Aide (CMA) who were sampled for performance reviews. Based on record review and interview, the facility failed to complete the required nurse aide performance review at least once every 12 months. This placed the residents at risk for inadequate care. Findings included: - A review of the facility's staffing list revealed the following CNAs and a CMA were employed with the facility for more than 12 months, lacked evidence that a performance review had been completed: CMA R with a hire date of 01/18/17. The facility lacked evidence that a performance review was completed in the last 12 calendar months upon request. CNA Q with a hire date of 04/01/21. The facility lacked evidence that a performance review was completed in the last 12 calendar months upon request. CNA O with a hire date of 03/07/22. The facility lacked evidence that a performance review was completed in the last 12 calendar months upon request. CNA P with a hired date of 03/22/22. The facility lacked evidence that a performance review was completed in the last 12 calendar months upon request. CNA MM with a hire date of 09/01/22. The facility lacked evidence that a performance review was completed in the last 12 calendar months upon request. On 05/07/25 at 11:08 AM, Administrative Nurse D stated he had not been able to find where prior management staff completed nurse aide performance reviews as required. Administrative Nurse D stated that he would be completing performance reviews on the nurse aide staff and would have them scheduled annually going forward. The facility lacked a policy for nurse aide performance evaluations.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 41713 The facility identified a census of 37 residents. The sample included 12 residents. Based on record review and interview, the facility failed to ensure that the daily posted nurse staffing data included the facility census. Findings included: - On 05/06/25 at 01:20 PM, the daily posted staffing sheets were requested for the past 18 months. The daily posted staffing sheets reviewed from 01/01/24 to 03/31/25 lacked the daily facility census number. On 05/07/25 at 11:00 AM, Administrative Nurse D stated the staffing coordinator was responsible for ensuring that the daily posted staffing sheet was posted. Administrative Nurse D stated that he had been made aware recently that the daily posted staffing sheets had not included the census number and has since corrected the issue. The facility's Posting Direct Care Daily Staffing Numbers dated 10/24 documented the facility would post on a daily basis for each shift, the number of personnel responsible for providing direct care to residents.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 26768 The facility had a census of 37 residents. Based on observation, interview, and record review, the facility failed to date three insulin pens when opened, ensure medications were secure when unattended, and failed to remove expired medication from use. This deficient practice placed residents who may have received those medications at risk for ineffective medication. Findings included: - On 05/05/25 at 07:08 AM, the facility's east hall nurse medication and treatment cart held three opened, undated insulin pens for three different residents. Licensed Nurse (LN) H verified the lack of dates. On 05/05/25 at 02:10 PM, the west hall nurse treatment cart was unlocked and unattended by licensed staff. At that time, Administrative Nurse D and Administrative Staff A verified that it should not be unlocked when out of sight of the licensed staff and started looking for the staff responsible for the cart. LN G came out of a closed resident's room near the cart. On 05/06/25 at 07:16 AM, the facility's medication room refrigerator held two vials of Prevnar 23 (pneumococcal vaccine that protects against 23 types of pneumococcal bacteria), single syringes that expired in October 2024, and three vials of Moderna COVID-19 vaccine that expired on 03/10/25. The medication refrigerator temperature logs lacked documentation for May 2025. On 05/07/2025 at 1100 AM, Administrative Nurse D verified that staff were to date insulin pens when opened and dispose of them 28 days after opening. He verified that licensed staff should remove expired medications from potential use. The facility's Storage Recommendations for Injectable Diabetes Medications guidelines, dated 2024, stated that if insulin pens were opened, they were approved for use for 28 days. The facility's Storage of Medications policy, dated 03/2025, stated the facility would store all drugs and biologicals in a safe, secure, and orderly manner. The facility should not use discontinued, outdated, or deteriorated drugs or biologicals. Compartments containing drugs and biologicals should be locked when not in use, and carts used to transport such items should not be left unattended if open or otherwise potentially available to others.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 37 residents. The sample included 12 residents, who were reviewed for hospice services. Based on observation, record review, and interviews, the facility failed to ensure a communication process was implemented, which included how the communication would be documented between the facility and the hospice provider. This deficient practice created a risk for missed or delayed services and impaired care for Resident (R) 30 and R25. Findings Included: - R30's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of 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), respiratory failure with hypoxia (occurs when the lungs cannot adequately transfer oxygen into the blood, leading to a low level of oxygen in the blood and tissues), congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid), pain, unsteadiness on feet, lack of coordination, weakness, diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), hypertension (high blood pressure), muscle weakness, and major depressive disorder (major mood disorder that causes persistent feelings of sadness). The Quarterly Minimum Data Set (MDS) for R30 dated 03/21/25 recorded a Brief Interview for Mental Status (BIMS) score of seven, which indicated severely impaired cognition. The MDS documented R30 was independent with eating, required partial to moderate assistance from staff for toileting, and was dependent on staff with bathing. The MDS documented R30 received hospice services during the observation period. The Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 11/25/24 documented R30 had occasional incontinence and required some assistance with toilet transfers. R30's Care Plan dated 02/05/2025 documented R30 was admitted to hospice and requires palliative care due to end-of-life processes. The plan of care documented the relative amounts and types of curative, restorative, and palliative care appropriate for R30 would be dependent on the individual goals of care and informed choices. R30's plan of care documented activity as tolerated, and staff would administer medications for comfort before activity and or care (Pain medications/respiratory treatments) as ordered. The plan of care for R30 documented staff would assist with supporting activities of daily living (ADL) function of ambulation and mobility to the extent needed. R30's plan of care lacked collaboration of care with the facility and the hospice provider. A review of the hospice-provided communication binder revealed R30 was admitted to hospice services on 02/04/25. On 05/05/25 at 09:42 AM, R30 laid in her bed with her head covered with a blanket. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/07/25 at 10:24 AM, Licensed Nurse (LN) I stated she knew each resident who required hospice services had a binder, and she was sure the information was in the binder. LN I stated that the hospice aides communicated with staff, and the staff left the facility knowing what equipment was provided and if bathing was done. LN I stated she was not sure about supplies, as normally the aide would just leave supplies in the resident's rooms. On 05/07/25 at 10:53 AM, Certified Nursing Aide (CNA) M stated she did know where the resident's hospice binders were kept but was unsure what was in the binder. CNA M stated that if she did not know where to find something for a resident, she would go to her nurse. CNA M stated she did not have access to the resident's care plans but could see the care plan if she asked a nurse. On 05/07/25 at 11:02 AM, Administrated Nurse D stated that the care plan for hospice and the care plan for the facility should match. Administrative Nurse D stated hospice and the facility should collaborate on care, and the information should be accessible to staff. The facility's Hospice Program policy, reviewed on 10/24, documented the community may contract for hospice services for residents who wish to participate in such programs, including services that will be provided and the coordination of services. The community may limit the hospice providers in relation to the coordination and communication of care within the community. 41713 - R25 ' s Electronic Medical Record (EMR) documented diagnoses of congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid), chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and hypertension (HTN - elevated blood pressure). R25 ' s Significant Change Minimum Data Set (MDS) dated [DATE] documented he had a Brief Interview for Mental Status (BIMS) score of nine, which indicated moderately impaired cognition. R25 had impairment on his lower extremity on one side. R25 was independent to needing partial to moderate staff assistance for his functional abilities. The MDS lacked an indication that R25 was on hospice services. R25 ' s Functional Abilities Care Area Assessment (CAA) dated 05/01/25 documented he required the assistance of one staff for many activities of daily living (ADL). (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R25 ' s Hospice Care Plan dated 04/21/25 directed staff to adjust the provision of ADLs to compensate for R25 ' s changing abilities. The plan of care directed staff to encourage his participation to the extent the resident wishes to participate, assess his coping strategies, and respect his wishes. The plan of care directed to consult with the physician and Social Services to have hospice care for the resident in the facility. The plan of care directed staff to encourage him to express his feelings and listen with non-judgmental acceptance and compassion. The plan of care directed staff to encourage a support system of family and friends, keep the environment quiet and calm, and keep linens clean, dry, and wrinkle-free. Keep lighting low and familiar objects within reach. The plan of care directed staff to observe R25 closely for signs of pain and administer pain medications as ordered, and notify the physician immediately if there was breakthrough pain. The plan of care directed staff to review R25 ' s living will and ensure it was followed, and involve the family in discussions. The hospice care plan was available for review in the media/copy room closet. The plan of care directed staff to work cooperatively with the hospice team to ensure the R25's spiritual, emotional, intellectual, physical, and social needs are met and work with the nursing staff to provide maximum comfort for the resident. R25 ' s care plan lacked the hospice contact information, how often hospice staff would visit R25, the supplies provided by hospice, the list of medications provided by hospice, and any durable medical equipment (DME) items provided. R25's Orders tab of the EMR documented a physician ' s order dated 04/21/25 for hospice services. R25 ' s Misc. tab of the EMR contained his hospice order and plan of care. On 05/06/25 at 11:15 AM, R25 wheeled himself in his wheelchair about the facility. On 05/07/25 at 10:24 AM, Licensed Nurse (LN) I stated she knew each resident who required hospice services had a binder, and she was sure the information was in the binder. LN I stated that hospice aides communicated with staff, the staff let the facility know what equipment was provided, and if bathing was done. LN I stated she was not sure about supplies, as normally the aide would just leave supplies in the resident ' s rooms. On 05/07/25 at 10:53 AM, Certified Nursing Aide (CNA) M stated she did know where the resident ' s hospice binders were kept but was unsure what was in the binder. CNA M stated that if she did not know where to find something for a resident, she would go to her nurse. CNA M stated she did not have access to the resident ' s care plans but could see the care plan if she asked a nurse. On 05/07/25 at 11:02 AM, Administrated Nurse D stated that the care plan for hospice and the care plan for the facility should match. Administrative Nurse D stated that hospice and the facility should have a collaboration of care, and the information should be accessible to staff. The facility ' s Hospice Program policy, reviewed 10/24, documented the community may contract for hospice services for residents who wish to participate in such programs, including services that would be provided and the coordination of services. The community may limit the hospice providers in relation to the coordination and communication of care within the community.