STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175397	A. Building B. Wing	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rossville Healthcare & Rehab Center	600 Perry Rossville, KS 66533

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42966 The facility identified a census of 70 residents. The sample included three residents. Based on record review and interviews, the facility failed to ensure the required information was provided on an involuntary notification of discharge to Resident (R) 1 and/or his representative. This deficient practice placed R1 at risk for an inappropriate discharge and impaired resident rights. Findings included: - R1 admitted to the facility on [DATE] and discharged from the facility on 06/02/24. R1's Electronic Medical Record (EMR) documented a diagnosis of dementia (a progressive mental disorder characterized by failing memory, and confusion) with other behavioral disturbances. The Admission Minimum Data Set (MDS) dated [DATE], documented R1 had a Brief Interview for Mental Status (BIMS) score of three which indicated severe cognitive impairment. R1 experienced delusions (untrue persistent beliefs or perceptions held by a person although evidence shows it was untrue) during the assessment period. The Quarterly MDS dated [DATE], documented R1 had a BIMS score of three which indicated severe cognitive impairment. R1 experienced delusions during the assessment period. R1 had physical and verbal behaviors directed towards others and wandering behavior one to three days in the assessment period, and other behavioral symptoms not directed towards others four to six days in the assessment period. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 03/01/24, documented R1 was admitted to the facility due to a progressive decline in cognition related to dementia. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Care Plan, dated 05/20/24, documented R1 had a behavior problem related to confusion, agitation, and delirium (sudden severe confusion, disorientation, and restlessness) and directed one-to-one observation was no longer needed because it increased R1's agitation, a sign that R1 was upset was when he went to his room and shut his door, staff were not to leave R1 unattended at any time, R1 liked to go outside with staff, staff attempted to call R1's representative if they saw any signs of R1 becoming agitated or aggressive, and if R1 was upset and redirection was not working then staff contacted R1's representative to see if he was available to come visit which calmed R1 down in the past. The Care Plan documented interventions, dated 05/21/24, that R1 enjoyed listening to jazz and rock and roll music, and staff avoided eye contact with R1 as it agitated him. The Orders tab of R1's EMR documented an order with a start date of 06/02/24 for emergency discharge due to violence against staff and arrest to protect other residents and staff who were afraid of R1. R1's EMR revealed the following: A General Note on 06/02/24 at 10:35 AM, documented that R1 hit an employee with his fist around 08:30 AM and continued to be agitated. R1 walked around, spit on people, and cursed. The police department was called and they arrived at 09:00 AM to take statements then they left. At 10:00 AM, R1 continued to be aggressive and hit a staff member who had not interacted with him. The police were called and they came to talk to R1. Police asked R1 to come with them to the next room to talk to them and he started cursing. R1 slammed a door into a wall. The police officer cuffed R1 and took him to jail. The nurse tried to call R1's representative but had to leave a message. A General Note on 06/02/24 at 10:45 AM, documented that R1 was out of the facility and was arrested for a warrant. A call was placed to the provider and an order was obtained for emergency discharge due to violence against staff and arrest to protect other residents who were fearful of R1. Upon request, the facility provided a three-page Notice of Transfer or Discharge for R1. The Notice of Transfer or Discharge documented R1 was transferred or discharged because the safety of individuals in the facility was endangered due to the clinical or behavioral status of the resident on 06/02/24. The notice did not provide the appropriate agency for R1 or his representative to contact for an appeal on the transfer or discharge. The notice documented R1 and R1's representative were notified in writing on 06/03/24. On 06/11/24, R1's representative provided the email he received from Administrative Staff B on 06/03/24 at 05:39 PM with the Notice of Transfer or Discharge. The Notice of Transfer or Discharge he received was two pages, with the second page blank. The notice did not include a statement of R1/his representative's appeal rights including the entity that receives those requests, the information for the Long-Term Care Ombudsman (LTCO), the agency responsible for the protection and advocacy of individuals with developmental disorders, and the agency responsible for the protection and advocacy of individuals with a mental disorder. On 06/11/24 at 01:25 PM, Administrative Staff B stated that R1's Notice of Transfer or Discharge was the first notice she had sent. She stated R1 was arrested on 06/02/24 and on 06/03/24, Administrative Staff A gave her the discharge notice to send to the jail and R1's representative. She stated the discharge notice had the initial discharge information and another page behind it. Administrative Staff B stated she did not pull up her email to check that the full notice was sent. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/11/24 at 01:36 PM, Administrative Staff A stated on 06/02/24, R1 escalated and hit staff so the police were called. She stated R1 was arrested for open warrants. Administrative Staff A stated she was instructed to use the appropriate transfer/discharge notice form for discharge for the safety of other residents. She stated the location where he was taken after the arrest was put on the notice. Administrative Staff A stated the transfer/discharge notice form was a corporate form that had the contact information for the State Agency (SA) and LTCO. She stated she hoped those were the correct agencies since the form came from corporate. Administrative Staff A stated on 06/03/24, she handed Administrative Staff B the three-page transfer/discharge notice for R1 but she was not sure if she was copied on the email. The facility's Transfer and Discharge (including Against Medical Advice [AMA]) policy, last revised 01/09/24, directed in an emergency transfer or discharge initiated by the facility for medical reasons or for the immediate safety and welfare of a resident, the facility provided a transfer notice as soon as practicable to the resident and representative and in case of discharge, notice requirements and procedures for facility-initiated discharges were followed. The facility failed to ensure the required information was provided on an involuntary notification of discharge to R1 and/or his representative. This deficient practice placed R1 at risk for an inappropriate discharge and impaired resident rights.