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	08/14/2024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42966 The facility identified a census of 71 residents. The sample included three residents. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 1 remained free from staff to resident verbal abuse. This deficient practice placed R1 at risk for further abuse and a decline in her psychosocial well-being. Findings included: - R1's Electronic Medical Record (EMR) documented diagnoses of schizoaffective disorder (a mental disorder in which a person experiences a combination of symptoms of schizophrenia [psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought]) and borderline personality disorder (a disorder characterized by disturbed and unstable interpersonal relationships and self-image along with impulsive, reckless, and often self-destructive behavior). The Annual Minimum Data Set (MDS) dated [DATE], documented R1's short-term and long-term memory were okay, and she made decisions regarding daily life independently. R1 had verbal behaviors directed toward others one to three days in the assessment period. The Cognitive Loss/Dementia (progressive mental disorder characterized by failing memory, confusion) Care Area Assessment (CAA) dated 06/07/24, documented R1 refused to answer any questions related to Brief Interview for Mental Status (BIMS) testing. R1 knew staff and resident names, her location, the time of day, and her way around the facility. R1 frequently rejected care and only allowed certain people to give her medications. The Behavioral Symptoms CAA dated 06/07/24, documented R1 frequently rejected care and only allowed certain people to give her medications. R1 would dislike someone suddenly and call them derogatory names and yell at them, which was not uncommon for her. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Care Plan, dated 06/16/20, documented R1 had a behavior problem of rejection of evaluations during assessments related to borderline personality disorder and directed staff to intervene as necessary to protect the rights and safety of others. Staff should approach and speak to R1 in a calm manner, divert R1's attention, remove R1 from the situation, and take her to an alternate location as needed. The care plan documented an intervention, revised on 10/06/21, that directed staff received education to have two staff members present when providing R1 with care and services. The care plan documented an intervention, dated 06/23/23, that directed R1 often yelled and had outbursts at other residents and staff; staff attempted to redirect R1 and allowed her time to calm down. Licensed Nurse (LN) G's Witness Statement, dated 08/13/24, documented on 08/12/24, early in the shift, she heard R1 and CNA M talking in R1's room. CNA M asked R1 how she was doing and if she needed anything. R1 responded by telling CNA M to just leave, she was making a fool out of herself. CNA M left R1's room without incident. LN G stated R1 had her light on later so she answered it and R1 requested a cup of ice. When CNA M brought R1 a cup of ice, LN G stated she heard yelling coming from R1 and CNA M. She stated R1 appeared noticeably upset after CNA M exited her room and stated CNA M threw a cup of ice. LN G observed water and ice on the floor, side table, and bed. LN G stated CNA M was upset, and stated R1 called her racial slurs. R1 and CNA M continued to call each other inappropriate names and make comments towards each other. LN G notified Administrative Nurse D and local law enforcement. The facility asked CNA M to leave the building. LN H's Witness Statement, dated 08/13/24, documented on 08/12/24 at 08:30 PM, CNA M stated that R1 referred to her in a derogatory manner. CNA M appeared very distraught as did R1. R1 stated CNA M yelled at her. LN H stated staff visualized ice cubs on R1's floor, table, and bed. LN H stated he spoke with CNA M again and she reiterated that R1 used racial slurs. CNA M went to the conference room and filled out a witness statement. LN H stated when CNA M exited the conference room, she engaged with R1 again, referred to R1 as a cracker, and raised her voice to R1. He stated R1 became extremely agitated and began yelling at CNA M and other staff. LN H stated staff asked CNA M to exit the facility to which she complied but made statements that were antagonistic and audible to R1 before finally leaving at 08:52 PM. The facility's Entity Reports and Complaint Data Collection, not dated, documented on 08/12/24 at approximately 08:00 PM, LN G heard CNA M talking to R1 in her room. CNA M asked R1 how she was doing and if she needed anything. R1 responded by telling CNA M to just leave, she was making a fool out of herself. CNA M left R1's room without any incidents. Later, R1 had her call light on and LN G answered it. R1 requested a cup of ice. When CNA M returned to R1's room with the ice, LN G heard yelling in R1's room from R1 and CNA M. LN G entered R1's room and R1 appeared noticeably upset after CNA M exited her room. R1 stated that CNA M threw the cup of ice. LN G observed water and ice on the floor, side table, and bed. Upset, CNA M stated R1 used racial slurs towards her. R1 and CNA M continued to use inappropriate names and make inappropriate comments towards each other. LN G removed CNA M from the area immediately and placed her on suspension before she left the premises. The facility notified local law enforcement who obtained a statement from R1 and took CNA M's contact information. R1's skin assessment revealed no skin conditions. CNA M resigned effective immediately. On 08/14/24 at 01:23 PM, R1 lay in her bed and watched television. She refused to discuss the incident. On 08/14/24 at 01:49 PM, CNA M was unavailable for an interview. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/14/24 at 02:00 PM, CNA N stated she prevented verbal abuse by de-escalating a situation. She stated it could be difficult sometimes and if she could not de-escalate a situation then she got a second person to help or witness. CNA N stated R1 did call staff names and if R1 became rude towards her, CNA N stated she remained kind to R1. On 08/14/24 at 02:09 PM, LN I stated she prevented verbal abuse with redirection of the resident or staff; if a resident or staff did not get along then she moved the staff to another hall; and she called family and administration staff to address the issue. She stated that R1 had a history of being very vocal with name-calling, throwing things, yelling, slamming her door, and refusing care. LN I stated if she heard a verbal exchange between staff and a resident, she removed the staff member and kept the resident safe. She stated she called administration immediately and a staff member stayed with the resident. On 08/14/24 at 02:19 PM, Administrative Nurse D stated on 08/12/24, she received a call from LN G who reported there had been an incident between CNA M and R1. She stated she did not receive a lot of details that night, only that words had been exchanged. Administrative Nurse D stated she advised LN G that CNA M needed to be suspended pending an investigation. She stated staff told her CNA M filled out a witness statement and left it in the conference room, but the law enforcement officer took it with him. Administrative Nurse D stated CNA M had not answered any phone calls to provide a statement to her. She stated she expected staff to disengage in tough situations and ask another staff member to trade. If staff felt a situation began escalating, they needed to ask for assistance. Administrative Nurse D stated she expected staff in the area to remove the involved staff member and protect the resident then report it to her and law enforcement. She stated staff told her CNA M and R1 called each other names and LN H reported he heard CNA M call R1 a name after R1 made comments to her. On 08/14/24 at 02:36 PM, Administrative Staff A stated she expected if staff had a challenging resident, they told the resident they needed to step away and asked if the resident needed anything. She stated she expected staff to leave a situation and not escalate it. On 08/15/24 at 12:47 PM, LN H was unavailable for an interview. On 08/15/24 at 12:48 PM, LN G was unavailable for an interview. On 08/15/24 at 01:27 PM, CNA M was unavailable for an interview. The facility's Abuse, Neglect, and Exploitation policy, not dated, directed the facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibited and prevented abuse, neglect, exploitation, and misappropriation of resident property. The policy defined verbal abuse as the use of oral, written, or gestured communication or sounds that willfully included disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability. The facility failed to ensure R1 remained free from verbal abuse. This deficient practice placed R1 at risk for further abuse and a decline in her psychosocial well-being.

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. 42966 The facility identified a census of 71 residents. Based on record review and interviews, the facility failed to ensure Certified Nurse Aide (CNA) M received the required effective communication education. This deficient practice placed residents at risk for impaired care. Findings included: - The facility's Entity Reports and Complaint Data Collection, not dated, documented on 08/12/24 at approximately 08:00 PM, LN G heard CNA M talking to Resident (R) 1 in her room. CNA M asked R1 how she was doing and if she needed anything. R1 responded by telling CNA M to just leave, she was making a fool out of herself. CNA M left R1's room without any incidents. Later, R1 had her call light on and LN G answered it. R1 requested a cup of ice. When CNA M returned to R1's room with the ice, LN G heard yelling in R1's room from R1 and CNA M. LN G entered R1's room and R1 appeared noticeably upset after CNA M exited her room. R1 stated that CNA M threw the cup of ice. LN G observed water and ice on the floor, side table, and bed. Upset, CNA M stated R1 used racial slurs towards her. R1 and CNA M continued to use inappropriate names and make inappropriate comments towards each other. LN G removed CNA M from the area immediately and placed her on suspension before she left the premises. The facility notified local law enforcement who obtained a statement from R1 and took CNA M's contact information. R1's skin assessment revealed no skin conditions. CNA M resigned effective immediately. Upon request, the facility was unable to provide documentation that CNA M completed education on effective communication from the facility as required. On 08/14/24 at 02:36 PM, Administrative Staff A stated that the required onboarding training included abuse, neglect, exploitation; any facility-specific items; skills checkoffs for nursing staff; resident rights; and effective communication. She stated she could not answer if the facility completed effective communication onboarding training. The facility did not provide a policy on required education including effective communication training. The facility failed to ensure CNA M received the required effective communication education. This deficient practice placed residents at risk for impaired care.