STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175497	A. Building B. Wing	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverview Estates	202 S Washington Street Marquette, KS 67464

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 - 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** The facility identified a census of 27 residents, with three residents reviewed for abuse, neglect, and exploitation. Based on record review, observation, and interview, the facility failed to ensure Resident (R) 2 and R1 remained free from verbal and mental abuse. This placed R2 and R1 at risk for continued abuse, embarrassment, humiliation, and decreased quality of life due to impaired psychosocial well-being. Findings included: - R2 ' s Electronic Medical Record (EMR) documented R2 had diagnoses of multiple sclerosis (MS-progressive disease of the nerve fibers of the brain and spinal cord), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and pain. R2's Quarterly Minimum Data Set, (MDS) dated [DATE], documented R2 had a Brief Interview for Mental Status score of 15, which indicated intact cognition. The MDS documented R2 had an indwelling urinary catheter (a tube inserted into the bladder to drain the urine into a collection bag) and was always incontinent of bowel. The MDS documented R2 as dependent on staff for all his activities of daily living (ADL) except for eating. The ADL Functional/Rehabilitation Potential Care Area Assessment, (CAA) dated 12/23/24, documented R2 as at risk for continued functional decline due to his diagnosis of MS and chronic pain. R2 was dependent on staff assistance for ADLs, including transfers and hygiene needs. R2 could feed himself finger foods but usually required staff assistance with his meals. R2 had severe contractures (abnormal fixation of the joints or muscles) of his hands and legs due to MS. R2 ' s Care Plan interventions dated 10/06/23 directed staff to know R2 was incontinent of bowel and staff were to check and change R2 every two to three hours. The plan directed staff to not rush R2, allow extra time to complete ADLs, and have a consistent approach among caregivers. The plan directed staff to allow R2 to have control over situations, establish a trusting relationship with R2, and encourage R2 to become involved in social interactions. (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 - Actual harm Residents Affected - Few	The Facility Incident Report, dated 05/28/25, documented on 05/26/25, R2 was scheduled to have a bath. Certified Nurse Aide (CNA) O had two orientees, CNA P and CNA Q, go with her to R2 ' s room to train them on how to transfer and bathe R2. The report documented CNA P reported while they assisted R2 in his bed, R2 was incontinent of stool, which was normal for him. The report documented CNA O stated to R2, You are going to clean my shoes, you are going to buy me new shoes, you need to stop pooping so we can get you in the shower chair, and Oh, that ' s great. You ' re still pooping. The report documented R2 apologized repeatedly. The report noted after R2 ' s shower, the CNAs transferred R2 back to his room in the shower chair, CNA O stopped at the nurse ' s desk and told the staff present R2 pooped in the bathhouse, and it needed to be cleaned up. The report recorded R2 was interviewed and stated he felt embarrassed by what CNA O said to him. The report documented after questioning, CNA O admitted she said some of the things reported, but she was joking, and said she felt R2 knew she was joking. The report documented the facility terminated CNA O from employment. CNA P ' s Witness Statement, notarized on 05/27/25, documented at 03:00 PM, CNA O, CNA P, and CNA Q were getting R2 up for his shower. The statement noted when staff placed R2 in the lift sling, R2 began having bowel movements. CNA P stated CNA O started making remarks to R2 stating, You are going to clean my shoes, and You are going to buy me new shoes. CNA P stated CNA O kept repeating the comments and R2 kept saying, I ' m so sorry girls. CNA P documented CNA O glared at R2 whenever he looked at her. CNA P documented that CNA O then said, You need to stop pooping so we can get you in the shower, and Oh that ' s great. You are still pooping. CNA P noted the three CNA staff got R2 cleaned up and into the shower, R2 started to have incontinent stools again, and CNA O stated, You need to stop pooping. It ' s going all over the place,. CNA O kept giving R2 dirty looks. CNA P wrote when CNA O finished with R2 ' s shower, CNA O pushed R2 back to his room and then stopped at the nurse ' s desk and announced in front of everyone that R2 pooped again after the shower, and it needed to be cleaned up. CNA O ' s Witness Statement, notarized on 05/27/25, documented on 05/26/25 she assisted R2 to the shower. CNA O wrote she showed the other CNAs how to get R2 into the shower chair, R2 was incontinent of bowel movement at that time and asked if it got on their shoes. CNA O noted she jokingly replied, Yes, but they are washable and everyone laughed. CNA O documented that R2 kept apologizing, and CNA O reassured R2 that it was okay because her shoes and clothes were washable. On 06/02/25 at 11:30 AM, R2 sat up in bed with a neck pillow behind his neck and watched a program on his iPad. R2 had contractures to his bilateral hands but was able to use a stylus to run the iPad. R2 stated he had no control over his bowels and when staff assisted him up in the lift for transfers, he was always incontinent of stool. R2 confirmed the things CNA O said to him, and he stated she made him feel bad and humiliated in the shower room that day. R2 said everyone else at the facility treated him very well. On 06/02/25 at 11:45 AM, CNA P stated that R2 was such a sweet man, and he had no control over his bowels due to his diagnosis of MS. CNA P stated that making R2 feel bad for something he had no control over was wrong. CNA P stated she recently received education on ANE and reporting suspected abuse or neglect immediately. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 06/02/25 at 11:55 AM, Administrative Nurse D stated there were several times CNA O would say things to other staff, would have to be redirected not to say things like that, then she would say she was just joking. Administrative Nurse D stated at first, CNA O would not admit what she said to R2, but then CNA O did finally admit what she said after she already filled out her Witness Statement. Administrative Nurse D stated this kind of behavior of staff degrading residents would not be tolerated by any of the staff working at the facility, CNA O was terminated from employment, all staff were assigned ANE education in Relias (a training portal) and received the education verbally before working their next shift. The facility ' s Abuse, Neglect, and Exploitation Policy, revised 04/12/22, documented the facility had developed and implemented this policy and procedure to prohibit abuse, neglect, exploitation, or misappropriation of property by any perpetrator, including but not exclusive to any staff member or volunteer of the facility or any contracted agency staff, vendors, family member or visitors of the elder or other elders, or any other elders. Facility staff will not allow others to use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. - R1 ' s Electronic Medical Record (EMR) documented R1 had diagnoses of Alzheimer ' s disease (progressive mental deterioration characterized by confusion and memory failure), dementia (progressive mental disorder characterized by failing memory, and confusion), major depressive disorder (major mood disorder which causes persistent feelings of sadness), psychosis (any major mental disorder characterized by a gross impairment in reality perception), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), restlessness, and agitation. R1's Significant Change Minimum Data Set (MDS) dated [DATE] documented R1 had a Brief Interview for Mental Status (BIMS) score of three, which indicated severely impaired cognition. The MDS documented R1 had physical behaviors directed toward others during the observation period. The MDS documented R1 required the use of a wheelchair pushed by staff for locomotion and required maximum staff assistance for all her activities of daily living (ADL). The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 03/24/25 documented R1 had a diagnosis of Alzheimer ' s disease and was alert and oriented to herself only. The CAA noted R1 was placed on hospice care due to Alzheimer ' s disease and was at risk for impaired cognition related to end-of-life care. The CAA documented R1 could become agitated with staff when she was in pain, she required substantial assistance due to total dependence with ADL care and was non-ambulatory. The Psychosocial Well-Being CAA, dated 03/24/25, documented R1 did not do well with groups of people or loud noises and would become agitated. The CAA documented R1 was offered one-on-one activities from staff as she would allow. The Communication CAA, dated 03/24/25, documented R1 ' s diagnoses of Alzheimer ' s disease and major depressive disorder increased R1 ' s risk for impaired communication. The CAA documented R1 was not always able to communicate her needs to staff. The CAA documented R1 typically showed agitation when she needed something. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	R1 ' s Care Plan documented R1 could have behaviors of cussing and hitting, which typically occurred during baths and bowel movements. The plan directed staff R1 liked to listen and sing to country music (03/27/25). The plan directed staff to explain to R1 step by step what staff were doing when providing care, as this helped calm R1 down to know what was going to happen (11/13/24). The plan directed staff to provide R1 with a calm environment when she was agitated (12/13/23). The plan directed staff to provide R1 maximum to total assistance for all her cares (12/13/23). The Facility Incident Report, dated 05/05/25, documented on 05/01/25 at approximately 07:00 PM, Certified Nurse Aide (CNA) M and CNA N provided peri-care and bedtime care for R1. The report noted R1 became agitated, and CNA N attempted to calm R1 by assuring her cares were almost done. The report documented that CNA M stated, No [R1], I ' m going to make this take longer just to [expletive] you off. The report documented CNA N reported the occurrence to LN G at 07:15 PM and Licensed Nurse (LN) G reported the incident to Administrative Nurse D. The facility told CNA M to immediately exit the facility. The report documented CNA M refused to write a statement and was terminated from employment on 05/02/25. CNA N ' s Witness Statement, notarized on 05/05/25, documented while providing care to R1, CNA M told R1 to shut up. CNA N stated she told R1 they were almost done, and CNA M stated, No, R1. I ' m going to make this take longer just to [expletive] you off. CNA N stated she stayed quiet, she and CNA M exited R1 ' s room together, and CNA N reported the incident to LN G. On 06/02/25 at 10:00 AM, R1 sat in a recliner in the day room, watched a western on TV, and fidgeted in the recliner, restless. R1 would not answer questions or communicate. On 06/02/25 at 10:30 AM, CNA N stated that R1 was easy to take care of and was very sweet. CNA N stated that R1 did not like to be exposed for long periods of time when cares were provided, but if R1 started to get agitated, she was easily redirected. CNA N stated the facility provided education regarding ANE and knew if she saw or heard something, she would report it immediately. On 06/02/25 at 10:45 AM, LN H stated that R1 was easy to care for and easily redirectable. LN H stated she was educated regarding ANE and knew to report any possible instances of abuse immediately to administrative staff and to keep residents safe. On 06/02/25 at 11:30 AM, Administrative Nurse D stated the incident of verbal abuse by CNA M was unacceptable. Administrative Nurse D said CNA M refused to provide a witness statement regarding the incident and refused to talk to administrative personnel about the incident. Administrative Nurse D stated the facility assigned ANE training to all staff in Relias (a training portal), and the facility verbally educated staff on all shifts until all staff were trained. The facility ' s Abuse, Neglect, and Exploitation Policy, revised 04/12/22, documented the facility had developed and implemented this policy and procedure to prohibit abuse, neglect, exploitation, or misappropriation of property by any perpetrator, including but not exclusive to any staff member or volunteer of the facility or any contracted agency staff, vendors, family member or visitors of the elder or other elders, or any other elders. Facility staff will not allow others to use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The facility identified the above deficient practices and implemented immediate corrective actions, which were all completed on 05/31/25 and included: All nursing staff re-educated on recognizing and reporting abuse, neglect, and exploitation, and the CNA perpetrators were terminated from employment. Due to the corrective action completed before the onsite survey, the citation was deemed past noncompliance at a G scope and severity to represent R2's actual psychosocial harm evidenced by embarrassment and humiliation.