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	03/20/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26768 The facility had a census of 23 residents. The sample size included 12 residents. Based on record review and interview, the facility failed to notify Resident (R) 26's physician or family when staff noted an abnormal bulge in R26's right abdomen on 01/03/25. The facility nursing staff also failed to notify the physician on 01/06/25 when R26 had a further deterioration in condition with shallow, labored respirations. R26's skin was pale and moist to the touch, and she had coarse lung sounds throughout. R26 did not respond when staff called her name, nor did she communicate with staff. LN H failed to call the physician or send R26 to the ER at that time. This deficient practice placed R26 at risk for serious health consequences. Findings included: - R26's Electronic Medical Record (EMR) documented diagnoses of sepsis, ulcer of the esophagus (the tube that carries food and liquids from the mouth to the stomach) with bleeding, fracture (broken bone) of shaft of the right humerus (upper arm bone), and age-related osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk). R26's Care Plan, dated 11/22/24, directed staff to assist with activities of daily living (ADL) as needed and staff was to notify the resident's physician of any changes in condition. The care plan directed staff to monitor and report signs of respiratory distress. The Progress Note, dated 01/03/25 at 09:25 PM, documented that during care for R26 the nurse noted a bulge in her right mid-lower abdomen. The area was soft to the touch but had a ridge in the circumference of the bulge measuring 10 centimeters (cm) in diameter. R26 denied any pain with it or when gently touched. No further assessment of this concern was documented. The Progress Note, dated 01/04/25 at 05:25 AM, documented blood pressures today of 107/52 millimeters of mercury (mmHg) and 90/53 mmHg (normal for a person over [AGE] years old would be 140/80 mmHg), pulses of 58 and 103 beats per minute (normal range 60-100 bpm). R26 was very lethargic and took only two bites of the noon meal. R26 refused to come out of her room for supper. LN H notified the physician who stated her vital signs (blood pressure and pulse) were within normal limits. The physician-directed staff to notify her primary physician of her condition by fax. The Progress Note, dated 01/05/25 at 12:24 AM, documented R26 complained of increased pain and the scheduled Percocet (narcotic pain relief drug) was not effective in pain management this evening. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175497	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2025
NAME OF PROVIDER OR SUPPLIER: Riverview Estates		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Progress Note, dated 01/05/25 at 06:58 PM, documented R26 was hypotensive (low blood pressure) with tachycardia (rapid heartbeat greater than 100 beats per minute - bpm). R26 was struggling to talk and drink liquids. The note stated LN H contacted the physician and informed him R26 acted similarly the last time she was septic. The physician ordered R26 to have one gram of Rocephin every 24 hours for 7 days and if R26 did not show any improvement, or her condition worsened send her to the emergency room (ER). On 01/06/25 at 01:50 AM, vital sign documentation revealed R26's blood pressure was 94/46 mmHg, pulse 131 bpm, and respiration were 18 breaths per minute. On 01/06/25 at 02:52 AM, vital sign documentation revealed R26's blood pressure was 95/55 mmHg, pulse 77 bpm, and respirations were 22 breaths per minute. The Progress Note, dated 01/06/25 at 02:55 AM, documented R26 required oxygen supplementation at two liters per minute due to her respirations were shallow and labored. R26's skin was pale and moist to the touch. R26 refused fluids and pursed her lips tight when oral care was offered. The note documented LN H elevated the head of her bed due to respirations with lung sounds, which were coarse throughout. R26 did not respond to staff when they called her name, but she repeatedly shook her head no. On 01/06/25 there was no further assessment of R26 documented until 05:10 AM. The Progress Note, dated 01/06/25 at 05:10 AM, documented a CNA (certified nurse aide) M called LN H to R26's room. R26 had no pulse and no respiration. On 03/19/25 at 11:16 AM, Administrative Nurse D stated she was unaware of the bulge the nurse noted in the resident's abdomen on 01/03/25. Administrative Nurse D verified there was no further follow-up of that issue and she would expect nursing to follow up with further assessment. Administrative Nurse D verified on 01/06/25 at 02:55 AM, that staff should have called Emergency Medical Services (EMS) or the physician when R26 worsened per the physician's order eight hours earlier. The facility's Standards of Care policy, dated 09/18/21, stated the Lippincott Manual for Nursing Procedures (7th edition) would serve as the basis for standard nursing practice. The policy stated it would not replace the responsibilities of professional nursing education and policies, protocols or guidelines may be developed by the facility to specifically address the long-term care environment. Nurses were to refer to the [NAME] for standards of care, utilize, and revise as needed under the guidance of the director of nursing and the infection preventionist. The facility's Admission Assessment and Follow Up policy, dated September 2012, directed nursing staff to notify the supervisor and attending physician of immediate needs the resident may have and report any other information in accordance with facility policy and professional standards of practice. (continued on next page)

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	03/20/2025

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

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to notify R26's physician or family when staff noted an abnormal bulge in R26's right abdomen on 01/03/25. The facility nursing staff also failed to notify the physician on 01/06/25 when R26 had a further deterioration in condition with shallow, labored respirations. R26's skin was pale and moist to the touch, and she had coarse lung sounds throughout. R26 did not respond when staff called her name, nor did she communicate with staff. LN H failed to call the physician or send R26 to the ER at that time. This deficient practice placed R26 at risk for serious health consequences.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175497	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2025
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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 0600 Level of Harm - Immediate jeopardy to resident health or safety 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** 26768 The facility had a census of 23 residents. The sample size included 12 residents, with 12 residents reviewed for neglect. Based on record review and interview, the facility failed to prevent the neglect of Resident (R) 26, when staff failed to timely and competently assess and provide care for R26, who had a known history of sepsis (a life-threatening systemic reaction that developed due to infections which cause inflammation throughout the entire body). On 01/05/25 at 06:58 PM, R26 struggled to talk and drink liquids. Licensed Nurse (LN) H contacted the on-call physician and reported R26 acted similar to the last time R26 was septic. Based on this information, the physician ordered one gram of Rocephin (an antibiotic) every 24 hours for seven days and stated if R26 did not show any signs of improvement, or her condition worsened, then LN H was to send R26 to the emergency room . On 01/06/25 at 02:55 AM, R26 had oxygen on at two liters per minute, with shallow, labored respirations. R26's skin was pale and moist to the touch. R26 had the head of her bed elevated to 30 degrees due to respirations with coarse lung sounds throughout. R26 did not respond when staff called her name, nor did she communicate with staff and LN H failed to call the physician or send R26 to the ER. Just over 2 hours later, at 05:10 AM, Certified Nurse Aide (CNA) M called LN H to R26's room and R26 had no pulse and no respirations. These failures ultimately resulted in R26's expiration at the facility on 01/06/25 sometime between 02:55 AM and 05:10 AM and placed R26 in immediate jeopardy. Findings included: - R26's Electronic Medical Record (EMR) documented diagnoses of sepsis, ulcer of the esophagus (the tube that carries food and liquids from the mouth to the stomach) with bleeding, fracture (broken bone) of shaft of the right humerus (upper arm bone), and age-related osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk). R26's Care Plan, dated 11/22/24, directed staff to assist with activities of daily living (ADL) as needed and staff was to notify the resident's physician of any changes in condition. The care plan directed staff to monitor and report signs of respiratory distress. The Progress Note, dated 01/03/25 at 09:25 PM, documented during care for R26 the nurse noted a bulge in her right mid-lower abdomen. The area was soft to the touch but had a ridge in the circumference of the bulge measuring 10 centimeters (cm) in diameter. R26 denied any pain with it or when gently touched. No further assessment of this concern was documented. The Progress Note, dated 01/04/25 at 05:25 AM, documented blood pressures today of 107/52 millimeters of mercury (mmHg) and 90/53 mmHg (normal for a person over [AGE] years old would be 140/80 mmHg), pulses of 58 and 103 beats per minute (normal range 60-100 bpm). R26 was very lethargic and took only two bites of the noon meal. R26 refused to come out of her room for supper. LN H notified the physician who stated her vital signs (blood pressure and pulse) were within normal limits. The physician-directed staff to notify her primary physician of her condition by fax. The Progress Note, dated 01/05/25 at 12:24 AM, documented R26 complained of increased pain and the scheduled Percocet (narcotic pain relief drug) was not effective in pain management this evening. (continued on next page)

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

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Progress Note, dated 01/05/25 at 06:58 PM, documented R26 was hypotensive (low blood pressure) with tachycardia (rapid heartbeat greater than 100 beats per minute - bpm). R26 was struggling to talk and drink liquids. The note stated LN H contacted the physician and informed him R26 acted similarly the last time she was septic. The physician ordered R26 to have one gram of Rocephin every 24 hours for 7 days and if R26 did not show any improvement, or her condition worsened send her to the emergency room (ER). On 01/06/25 at 01:50 AM, vital sign documentation revealed R26's blood pressure was 94/46 mmHg, pulse 131 bpm, and respirations were 18 breaths per minute. On 01/06/25 at 02:52 AM, vital sign documentation revealed R26's blood pressure was 95/55 mmHg, pulse 77 bpm, and respirations were 22 breaths per minute. The Progress Note, dated 01/06/25 at 02:55 AM, documented R26 required oxygen supplementation at two liters per minute due to her respirations were shallow and labored. R26's skin was pale and moist to the touch. R26 refused fluids and pursed her lips tight when oral care was offered. The note documented LN H elevated the head of her bed due to respirations with lung sounds, which were course throughout. R26 did not respond to staff when they called her name, but she repeatedly shook her head no. On 01/06/25 there was no further assessment of R26 documented until 05:10 AM. The Progress Note, dated 01/06/25 at 05:10 AM, documented a CNA (certified nurse aide) M called LN H to R26's room. R26 had no pulse and no respiration. On 03/19/25 at 11:16 AM, Administrative Nurse D stated she was unaware of the bulge the nurse noted in the resident's abdomen on 01/03/25. Administrative Nurse D verified there was no further follow-up of that issue. Administrative Nurse D verified on 01/06/25 at 02:55 AM, that staff should have called Emergency Medical Services (EMS) or the physician when R26 worsened per the physician's order eight hours earlier. The facility's Standards of Care policy, dated 09/18/21, stated the Lippincott Manual for Nursing Procedures (7th edition) would serve as the basis for standard nursing practice. The policy stated it would not replace the responsibilities of professional nursing education and policies, protocols or guidelines may be developed by the facility to specifically address the long-term care environment. Nurses were to refer to the [NAME] for standards of care, utilize, and revise as needed under the guidance of the director of nursing and the infection preventionist. The facility's Admission Assessment and Follow Up policy, dated September 2012, directed nursing staff to notify the supervisor and attending physician of immediate needs the resident may have and report any other information in accordance with facility policy and professional standards of practice. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's Abuse and Neglect- Clinical Protocol, dated March 2018, stated the nurse would assess the resident and document related findings. The physician, staff, and management would identify situations that could be construed as neglect. The physician would provide adequate documentation regarding significant negative outcomes that have resulted from a resident's underlying medical illness or conditions, despite appropriate care. The medical director would advise staff and management on ways to ensure that basic medical, functional, and psychosocial needs were being met and that potentially preventable or treatable conditions affecting function and quality of life were addressed appropriately. The facility failed to prevent the neglect of R26, when staff failed to timely and competently assess and provide care for R26, who had a known history of sepsis. On 01/05/25 at 06:58 PM, R26 struggled to talk and drink liquids. LN H contacted the on-call physician and reported R26 acted similar to the last time R26 was septic. Based on this information, the physician ordered one gram of antibiotic every 24 hours for seven days and stated if R26 did not show any signs of improvement, or her condition worsened, then LN H was to send R26 to the emergency room . On 01/06/25 at 02:55 AM, R26 had oxygen on at two liters per minute, with shallow, labored respirations. R26's skin was pale and moist to the touch. R26 had the head of her bed elevated to 30 degrees due to respirations with coarse lung sounds throughout. R26 did not respond when staff called her name, nor did she communicate with staff and LN H failed to call the physician or send R26 to the ER. Just over 2 hours later, at 05:10 AM, CNA M called LN H to R26's room and R26 had no pulse and no respirations. These failures ultimately resulted in R26's expiration at the facility on 01/06/25 sometime between 02:55 AM and 05:10 AM and placed R26 in immediate jeopardy. The following citations represent the findings of a partial extended annual survey. On 03/19/25 at 05:41 PM Administrative Staff A received a copy of the Immediate Jeopardy Template and was informed of the immediate jeopardy for Resident (R) 26. The facility completed the following corrective actions to remove the immediacy for R26: Immediate education regarding F600 began 03/19/25 and was completed 03/20/25 at 12:30 PM. Nursing staff were not allowed to work until they were educated on the policy and clinical protocols for assessing residents and notification to the physician upon changes in condition. On 03/20/25, an onsite verified the completion of the corrective actions to remove the immediacy. After the immediacy was removed the deficient practice remained at a scope and severity of G to represent the actual harm to R26.

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 26768 The facility had a census of 23 residents. Based on observation, interview, and record review, the facility failed to perform background checks as required for four employees. The employees were allowed access to residents without knowing if they had been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law. This deficient practice placed the 23 residents of the facility at risk for potential abuse, neglect, or exploitation. Findings included: - On 03/18/25 a review of staffing for background checks for facility staff was completed. Upon request and review the facility was unable to provide evidence a criminal background check had been completed before four employees began working around and with residents. The facility records revealed the following staff started employment at the facility before the background checks returned: Certified Nurse Aide (CNA) N started on 07/09/22 and the background check was not verified until 02/04/24. CNA O started on 01/24/24 and the background check was not verified until 02/12/24. Housekeeping Staff U started on 11/05/21 and the background check was not verified until 12/03/24. Maintenance Staff V started on 02/20/24 and the background check was not verified until 02/22/24. On 03/18/25 at 01:39 PM, Administrative Staff A verified the facility had not received the background checks for four staff prior to those staff working in the facility. The facility's Monitoring Background Checks policy, dated 09/06/2021, stated following each background check on each newly hired employee, human resource personnel would routinely check the state website for the results of the checks. The date of the background check, the result, and the date the result was recorded would be tracked. The facility failed to perform background checks as required for four employees who were allowed access to residents without knowing if they had been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26768 The facility had a census of 23 residents. The sample included 12 residents with one reviewed for urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag). Based on observation, interview, and record review, the facility failed to provide Resident (R) 11 a device to secure the catheter tubing to keep it from pulling and causing discomfort. This deficient practice placed R11 at risk for pain or injury related to the catheter use and R11 developed two open sores related to the catheter rubbing. Findings included: - R11's Electronic Medical Record (EMR) documented diagnoses of an open wound of the penis (male organ with urethra tube which carries urine to outside the body), pain, and Urinary Tract Infection (UTI - an infection in any part of the urinary system). The Quarterly Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The MDS documented R11 required maximum staff assistance for toileting, had a urinary catheter, and occasional moderate pain. The MDS documented R11 had no skin issues. R11's Care Plan for urinary catheter, dated 01/03/25, directed staff to provide a 16Fr. (French) 30 cubic centimeters (cc) catheter, and change the catheter per physician's order. The staff were directed to not allow tubing or any part of the drainage system to touch the floor and provide catheter care daily and as needed. The staff were to change the catheter bag weekly, assess the drainage, and record the amount, type, color, and odor. The staff were to observe for leakage and irrigate the catheter only if an obstruction was suspected. The staff were to keep the catheter system a closed system as much as possible, manipulate tubing as little as possible during care, and measure and record the urine output. The staff was to position the catheter collection bag below the level of the bladder and store the collection bag inside a protective dignity pouch. The staff was to use a catheter strap as needed and ensure enough slack was left in the catheter tubing between the meatus (opening on the penis which leads into the body) and the strap. The Physician Order, dated 10/17/24, directed staff to ensure a 16Fr.30 cc catheter was in place. The Progress Note, dated 03/12/2025 at 09:06 AM documented R11's catheter change was completed. When changing the catheter, R11's penis was found to have two sores. The sores were approximately 0.5 centimeters (cm) in diameter. R11's catheter rubbed against the sores. The physician was faxed and the family was notified regarding the issue. The Progress Note, dated 03/17/2025 at 11:43 AM documented R11 denied abuse or neglect and nursing staff reported that catheter tubing was rubbing against the penis area. The note stated licensed nurses were to apply protective barrier cream to the area until healed and after healed to prevent skin impairments. The care plan was reviewed and updated to ensure the catheter tubing was not pressing or rubbing against his perineal area or penis which could cause skin impairments. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/19/25 at 12:00 PM, Licensed Nurse (LN) H donned personal protective equipment (PPE) and took gauze, Calmoseptine, and wound cleanser into R11's room. R11 was in bed and LN H performed wound care to the two penis wounds as ordered. R11 had no catheter secure device or strap-on. On 03/19/25 at 12:00 PM, LN H stated that R11 did not leave the device on due to the adhesive. LN H thought he had signed a risk agreement to not wear the securing device. On 03/19/25 at 12:10 PM, Administrative Nurse D verified staff should have placed a secure device for the resident's catheter tubing to prevent pulling on it as care planned and he had no risk agreement to not wear a secure device or strap. The facility's Urinary Catheter Care policy, dated August 2022, directed staff to ensure the catheter remained secured with a securement device to reduce friction and movement at the insertion site. The policy stated staff should record any problems noted at the insertion site such as redness, bleeding, irritation, or pain. The facility failed to provide R 11 a device to secure the catheter tubing to keep it from pulling and causing discomfort. This deficient practice placed R11 at risk for pain or injury related to the catheter use and R11 developed two open sores related to the catheter rubbing.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 26768 The facility had a census of 23 residents. The sample included 12 residents. Based on observation, interview, and record review, the facility failed to properly date opened bags of food with the open date and the expiration date. This practice placed the 23 residents at risk for foodborne illness and poor-quality food. Findings included: - On 03/13/25 at 08:20 AM, an inspection of the facility kitchen cold storage revealed the #4 upright freezer had seven opened, undated bags of frozen vegetables and potato items. The #5 freezer contained an opened box of hamburger patties with the plastic bag open to the air and undated. On 03/13/25 at 08:20 AM, Dietary Staff BB verified the bags were undated or the date was not readable. She stated the marker staff used for frozen foods was not appropriate as the ink rubbed off. The facility's Food Receiving and Storage policy, dated October 2017, stated foods would be received and stored in a manner that complied with safe food handling practices. The policy stated all foods stored in the refrigerator or freezer would be covered, labeled, and dated with a use-by date. The freezer must keep frozen foods solid, and wrappers of frozen food must stay intact until thawing, opened containers must be dated and sealed or covered during storage. The facility failed to properly date opened bags of food with the open date and the expiration date. This deficient practice placed the 23 residents at risk for foodborne illness and poor-quality food.

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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** 27168 The facility had a census of 23 residents. The sample included 12 residents with one reviewed for hospice (a type of health care that focuses on the terminally ill patient's pain and symptoms and attending to their emotional and spiritual needs at the end of life) services. Based on observation, record review, and interview, the facility failed to ensure coordinated care and services provided by the facility with the care and services provided by hospice for Resident (R) 13. This placed the residents at risk for inadequate end-of-life care. Findings included: - R13's Electronic Health Record (EHR) revealed diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion) with behavioral disturbance, arteriosclerotic heart disease (ASHD - is a condition where the arteries that supply blood to the heart become narrowed and hardened due to buildup of plaque, a sticky substance), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R13's Significant Change Minimum Data Set (MDS), dated [DATE], recorded R13 had severe cognitive impairment. The MDS recorded she required extensive staff assistance with transfers and activities of daily living (ADLs). The MDS documented the resident received hospice services. R13's facility Care Plan, dated 03/04/25, recorded R13 required extensive staff assistance with most ADL care. R13's Care Plan documented the resident had a diagnosis of dementia and required hospice services. The care plan directed the staff to provide comfort and encourage family and friends' support system. The care plan directed staff to observe closely for signs of pain and administer medications as ordered. The facility care plan lacked instruction on the services provided by hospice including the frequency and type of support visits, supplies and medical equipment provided by hospice, medications covered by hospice, and the hospice contact information. Review of R13's clinical record revealed the resident was admitted to hospice care on 03/04/25. The facility had a plan of care provided by hospice in the electronic health record. On 03/13/25 at 12:45 PM, R13 was dressed in street clothes in a recliner in her room. R13 was talking about house insulation coming down and the house was very cold, continued to talk but had word salad. On 03/19/25 at 10:30 AM, Administrative Nurse D verified the facility lacked specific information on the facility care plan that coordinated with the hospice care plan. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175497	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2025
NAME OF PROVIDER OR SUPPLIER Riverview Estates		STREET ADDRESS, CITY, STATE, ZIP CODE 202 S Washington Street Marquette, KS 67464	

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Hospice Program policy, dated July 2021, documented hospice services are available to residents at the end of life. The facility has an agreement in place with at least one Medicare-certified hospice to ensure that residents who wish to participate in a hospice program may do so. When a resident has been diagnosed as terminally ill, the Director of Nursing Services would contact the hospice agency and request that a visit/interview with the resident/family be conducted to determine the resident's wishes relative to participate in the hospice program. It is the responsibility of the hospice to manage the resident's care as it relates to the terminal illness and related conditions, including: Determining the appropriate hospice plan of care. Change the level of services provided when it is deemed appropriate. Provide medical direction, nursing, and clinical management of the terminal illness. Provide spiritual, bereavement, and/or psychosocial counseling and social services as needed; and Providing medical supplies, durable medical supplies, durable medical equipment, and medications necessary for the palliation of pain and symptoms. In general, it is the responsibility of the facility to meet the resident's personal care and nursing needs in coordination with hospice representatives and ensure the level of care provided is appropriately based on the individual resident's needs. Coordinated care plans for the resident's hospice services would include the most recent hospice plan of care as well as the care and services provided by the facility including the responsible provided and discipline assigned to specific tasks, in order to maintain the resident's highest practicable physical, mental and psychosocial well-being. The coordinated care plan would reflect the resident's goals and wishes, as stated in his/her advanced directive and during ongoing communications with the resident's representative, including: a. Palliative goals and objectives. b. Palliative interventions. c. medical treatment and diagnostic tests. The coordinated care plan would be revised and updated as necessary to reflect the resident's current status. The facility failed to coordinate care between the facility and the hospice provider for R13, who received hospice services. This deficient practice placed her at risk for inadequate end-of-life care.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 27168 The facility had a census of 23 residents. The sample size included 12 residents. Based on observation, record review, and interview, the facility failed to adhere to infection control for enhanced barrier precautions (EBP - an infection control intervention designated to reduce transmission of resistant organisms that employs targeted gown and glove used during high contact resident care activities), for Resident (R) 13 who had Influenza A (a contagious viral infection of the nose, throat and lungs that is spread from person to person through respiratory droplets). This placed the residents at increased risk for infection. Findings included: - On 03/13/25 at 09:30 AM, observation revealed License Nurse (LN) I entered the room of R13, who was on Droplet Precautions EBP. Observation revealed a sign posted on the resident's door of the resident's room giving instruction on personal protection equipment (PPE - gown and gloves). The PPE equipment and supplies were located in an over-the-door hanging container in the resident's room. Continued observation revealed LN I entered the resident's room and donned only gloves. LN I sat down beside the resident while she was in bed and began to talk to her about how she was feeling and conversing back and forth. LN I was in the room for approximately eight minutes when LN J observed LN I in the resident room and explained to LN I the resident required staff and visitors to don a gown due to R13 being on contact and droplet precautions. LN I stood up and went to the PPE that was stored on the resident's door and donned a gown then sat down next to the resident in her bed and started talking to her again. On 03/19/25 at 09:45 AM, Administrative Nurse D verified R13's room door had a Contact Isolation sign posted on the door and instructions for wearing appropriate PPE. Administrative Nurse D verified the resident's door had a sign that stated, Contact Precautions and anyone entering the room should wash their hands, don gloves, and a mask. The sign did not indicate to wear a gown. Administrative Nurse D stated she would discuss the Isolation precautions with Administrative Nurse E, the Infection Preventionist, and verify the Isolation Precautions the resident should be on due to the resident had been diagnosed with Influenza A. Administrative Nurse D stated she would wear a gown if the resident had droplet precautions. On 03/19/25 at 01:00 PM, Administrative Nurse E verified after reviewing the infection control protocol Droplet Precautions and Contact Precautions that the staff should wear PPE when providing care for R13 which would include washing hands, donned gloves, mask, and gown. Administrative Nurse E stated she obtained the signs and the guidelines from the CDC website. Administrative Nurse E said the facility would do some education with the staff regarding EBP and wearing PPE for resident care. The facility's Enhanced Barrier Precautions policy, dated March 2024, documented EBP's are utilized to reduce the transmission of multi-drug resistant organisms (MDROs) to residents. EBP was used as an infection prevention and control intervention to reduce the transmission of multi-drug resistant organisms (MDROs) to residents. EBPs employ targeted gown and gloves used in addition to standard precautions during high-contact resident care activities when contact precautions do not otherwise apply. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Gloves and gown are applied prior to performing the high-contact resident care activities (as opposed to before entering the room) PPE is changed before caring for another resident. Face protection may be used if there is also a risk of splash or spray. Examples of high-contact residents are activities requiring the use of gowns and gloves for EBP's including: Dressing Bathing/showering Transferring Providing hygiene Changing linens Changing briefs or assisting with toileting Device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator.); and Wound care (any skin opening requiring a dressing). The facility's Isolation-Categories of Transmission-Based Precautions, policy, dated September 2020, documented that Transmission-Based Precautions were initiated when a resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of an infection; or has a laboratory-confirmed infection, and is at risk of transmitting the infection to other residents. Standard precautions are used when caring for residents at all times regardless of their suspected or confirmed infection status. Transmission-based precautions are additional measures that protect staff, visitors, and other residents from becoming infected. These measures are determined by the specific pathogen and how it is spread from person to person. The three types of transmission-based precautions are contact, droplet, and airborne. The Centers for Disease Control and Prevention (CDC) maintains a list of diseases, modes of transmission, and recommended precautions. When a resident is placed on transmission-based precautions, appropriate notification is placed on the room entrance door and on the front of the chart so that personnel and visitors are aware of the need for any type of precautions. a. The signage informs the staff of the type of CDC precautions, instructions for the use of PPE, and/or instructions to see a nurse before entering the room. (continued on next page)

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	175497	A. Building B. Wing	03/20/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	b. Signs and notifications comply with the resident's right to confidentiality or privacy. When transmission-based precautions are in effect, non-critical resident-care equipment items such as a stethoscope, and digital thermometer would be dedicated to a single resident when possible. If re-use of items is necessary, then the items would be cleaned and disinfected according to current guidelines before use with another resident. Droplet Precautions are implemented for an individual documented or suspected to be infected with microorganisms transmitted by droplets (large particles that can be generated by the individual coughing, sneezing, talking, or by performance of procedures such as suctioning). Residents on droplet precautions are placed in private room if possible. Mask are worn when entering the room. Gloves, gown, and goggles are worn if there is a risk of spraying respiratory secretions. The facility failed to ensure staff applied the appropriate PPE required for EBP for R13. This placed the resident at increased risk for infection.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27168 The facility had a census of 23 residents. The sample includes 12 residents, with seven residents reviewed for immunizations, Resident (R) 5, R10, R11, R13, R16, R21, and R22, to include pneumococcal (a disease that refers to a range of illnesses that affect various parts of the body and are caused by infection) vaccinations. Based on record review and interviews, the facility failed to offer, or obtain an informed declination or a physician-documented contraindication for the pneumococcal PCV20 vaccination per the latest guidance from the Centers for Disease Control and Prevention (CDC). This placed the residents at risk for pneumococcal infection and related complications. Findings included: - Review of R10, R11, R13, R16, and R21 clinical medical records lacked evidence the facility or the resident representative received or signed a consent to receive or informed declination for the pneumococcal vaccine PCV20. Review of R5's electronic health record revealed the resident was admitted to the facility on [DATE]. R5 had not been offered or received a pneumococcal vaccine since admission. Review of R22's electronic health record revealed the resident was admitted to the facility on [DATE]. R22 had not been offered or received a pneumococcal vaccine since admission. On 03/19/25 at 02:00 PM, Administrative Nurse E stated residents are offered the pneumonia vaccines on admission and as indicated. Administrative Nurse E said the facility would sign a consent or deny receiving the vaccine. Administrative Nurse E verified that every resident in the building had not been reviewed to determine if they were eligible to receive the PVC20 vaccine or not. Administrative Nurse E verified they did not have a definitive system in place to determine who was eligible, if they were eligible if they had been offered or declined the vaccinations, and it was something they had recently been working on. On 02/13/25 at 2:35 PM, Administrative Nurse D verified the facility lacked a system in place to identify which residents were eligible for which pneumococcal vaccination. Administrative Nurse D stated they did not have a system in place to identify which pneumococcal vaccine the residents were eligible for or if they were eligible and if so for which one. (continued on next page)

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	175497	A. Building B. Wing	03/20/2025

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Pneumococcal Vaccine policy dated; October 2019 documented all residents were offered pneumococcal vaccines to aid in the prevention of pneumonia/pneumococcal infections. Prior to or upon admission, residents are assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, are offered the vaccine series within thirty days of admission to the facility unless medically contraindicated or the resident has completed the current recommended vaccine series. Assessment of pneumococcal vaccination status was conducted within five working days of the resident's admission if not conducted prior to admission. Before receiving a pneumococcal vaccine, the resident or legal representative receives information and education regarding the benefits and potential side effects of the pneumococcal vaccine. Provision of such education is documented in the resident's medical record. Pneumococcal vaccines are administered to residents per the facilities physician approved pneumococcal vaccination protocol. Residents/representatives have the right to refuse vaccinations. If refused, appropriate information is documented in the resident's medical record indicating the date of refusal of the pneumococcal vaccine. Administration of the pneumococcal vaccines was made in accordance with the current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination. The facility failed to offer the PCV20 pneumococcal vaccination for R5, R10, R11, R13, R16, R21 and R22. This deficient practice placed the residents at risk of acquiring, spreading, and experiencing complications from pneumonia.