

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/07/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E531</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/07/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>KEARNY COUNTY HOSPITAL LTCU</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>607 COURT PL</b> <b>LAKIN, KS 67860</b>		
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F 000	INITIAL COMMENTS	F 000			
F 225 SS=D	<p>The following citations represent the findings of a partial extended survey for investigation of complaints #KS00101571 and #KS00102282.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4)</p> <p>INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and</p>	F 225			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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F 225	<p>Continued From page 1</p> <p>certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: The facility had a census of 40 residents. Based on observation, interview and record review, the facility failed to immediately report two allegations of mental abuse/exploitation of residents (two residents photographed/videoed by an employee with a cell phone and the images then sent to unknown recipients )to the State Survey and Certification agency, failed to thoroughly investigate the allegations, and then failed to submit the results of the investigations to the State Survey and Certification agency within 5 working days. (Residents #5 and #6)</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- The facility provided evidence of an investigation into an allegation of mental abuse/exploitation of at least two facility residents. According to the documents, on 5/25/16 an anonymous person called Administrative Nurse B and reported Direct Care Staff C sent out videos of residents via "Snap Chat", a social media program which allowed users to send pictures and/or videos to chosen recipients and those pictures/videos then disappeared within a certain length of time. Administrative Nurse B reported the anonymous phone call to the Human Resources department, and they attempted to call the anonymous caller back. When the anonymous caller did not answer, Administrative Nurse B called Direct</li> </ul>	F 225			

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F 225	<p>Continued From page 2</p> <p>Care Staff C and discussed the allegation made by the anonymous caller and reminded Staff C of the facility's cell phone use policy. Documents provided by the facility revealed no evidence of completion of a thorough investigation into the incident following the 5/25/16 allegation. Then, on 6/6/16, 11 days after the original allegation, Risk Management Staff D received an anonymous video which contained images of residents #5 and #6 as well as Direct Care Staff C and Direct Care Staff E. On the video and in the presence of the residents, Direct Care Staff C called the residents derogatory names, used foul language and made fun of the residents. According to the investigation documents, Direct Care Staff E denied knowledge Direct Care Staff C took videos of residents, but confirmed Staff C used his/her cell phone during the shift. Direct Care Staff C denied the allegations. The facility reported the two allegations of resident mental abuse/exploitation to the State Survey and Certification agency on 6/22/16, 29 days after the 5/25/16 allegation and 16 days after the 6/6/16 allegation.</p> <p>Review of the facility's investigation of the incident revealed, as of 6/29/16, the investigation lacked notarized witness statements from any staff members, including Direct Care Staff C and Direct Care Staff E who were both involved in the incident. The investigation also lacked evidence of interviews with other staff who may have witnessed similar incidents, and no interviews with alert and oriented residents to determine if they experienced similar mental abuse/exploitation.</p> <p>During observations on 6/29/16 and 6/30/16, residents #5 and #6 resided on the facility's</p>	F 225			

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F 225	<p>Continued From page 3</p> <p>"Special Care Unit." Both residents had obvious cognitive impairment.</p> <p>During an interview on 6/29/16 at 11:00 a.m., Administrative Nurse B denied knowledge of the need to report all allegations of abuse, neglect or exploitation to the State Survey and Certification agency within 24 hours of the incident, and the need to investigate each allegation thoroughly and submit the investigation to the State agency within 5 working days.</p> <p>According to the facility's 11/2011 "Abuse, Neglect &amp; Exploitation" policy with a most recent review date of 1/16, "Exploitation means misappropriation of an adult's property or intentionally taking unfair advantage of an adult's physical or financial resources for another individual's personal or financial advantage by the use of undue influence, coercion, harassment, duress, deception, false representation or false harm or illness. ...All incidents of suspected and/or reported abuse within the facility will be investigated by the Administrator, Risk Manager, Director of Nursing Services or Director of Nursing using the appropriate investigational tools provided." The facility also defined "mental abuse" as humiliation, harassment, threats of punishment or deprivation directed toward residents. The facility policy did not include specific requirements as related to the timing of reporting allegations to the State agency and submission of investigations.</p> <p>The facility failed to immediately report two allegations of mental abuse/exploitation of residents (two residents photographed/videoed by an employee with a cell phone and the images then sent to unknown recipients) to the State</p>	F 225			

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F 225	Continued From page 4	F 225			
F 226 SS=F	<p>Survey and Certification agency, failed to thoroughly investigate the allegations, and then failed to submit the results of the investigations to the State Survey and Certification agency within 5 working days. (Residents #5 and #6)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: The facility had a census of 40 residents. Based on interview and record review, the facility failed to update their 11/2011 Abuse, Neglect and Exploitation policy with information from the CMS (Center for Medicare and Medicaid Services) S &amp; C (Survey and Certification) letter 11-30 regarding "Reporting Reasonable Suspicion of a Crime in a Long-Term Care Facility" dated 8/12/11. The facility also failed to develop and implement ANE (abuse, neglect and exploitation) policies which included specific requirements related to the time limitations to report allegations of ANE to the State Survey and Certification agency, time limits to conduct investigations of each allegation, and then time limitations for submission of the investigations to the State Survey and Certification agency. The facility failure to develop/implement the ANE policy which included all the required information placed all facility residents at risk.</p>	F 226			

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F 226	<p>Continued From page 5</p> <p>Findings included:</p> <p>-As requested, the facility provided the 11/2011 ANE (abuse, neglect and exploitation) policy with a most recent review date of January 2016. Review of the policy revealed no information related to information from the CMS (Center for Medicare and Medicaid Services) S &amp; C (Survey and Certification) letter 11-30 regarding "Reporting Reasonable Suspicion of a Crime in a Long-Term Care Facility" dated 8/12/11. The policy also lacked specific requirements related to the time limitations to report allegations of ANE to the State Survey and Certification agency, time limits to conduct investigations of each allegation, and time limitations for submission of the investigations to the State Survey and Certification agency.</p> <p>During an interview on 6/29/16 at 11:00 a.m., Administrative Nurse B denied knowledge of the need to report all allegations of abuse, neglect or exploitation to the State Survey and Certification agency within 24 hours of the incident, and the need to investigate each allegation thoroughly and submit the investigation to the State agency within 5 working days. Administrative Nurse B confirmed the policy did not include the specific time requirements to report, investigate and submit investigations to the State agency.</p> <p>During an interview on 6/29/16 at 2:00 p.m., Administrative Nurse A confirmed the facility ANE policy lacked information related to reporting reasonable suspicion of a crime in a long term care facility as outlined in S&amp;C letter 11-30. Nurse A provided evidence administrative staff reviewed the requirements related to reporting reasonable suspicion of a crime in 2013, and provided some</p>	F 226			

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F 226	Continued From page 6 staff education at that time. The facility failed to then include the information in the ANE policy.  The facility failed to update their 11/2011 Abuse, Neglect and Exploitation policy with information from the CMS S & C letter 11-30 regarding "Reporting Reasonable Suspicion of a Crime in a Long-Term Care Facility" dated 8/12/11. The facility also failed to develop and implement ANE ( abuse, neglect and exploitation) policies which included specific requirements related to the time limitations to report allegations of ANE to the State Survey and Certification agency, time limits to conduct investigations of each allegation, and then time limitations for submission of the investigations to the State Survey and Certification agency. The facility failure to develop/implement the ANE policy which included all the required information placed all facility residents at risk.	F 226			