| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175332 | A. BUILDING _____ B. WING _____ | C 08/16/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ROCK CREEK OF OTTAWA | 1100 W 15TH STREET OTTAWA, KS 66067 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 000 | INITIAL COMMENTS<br><br>The following citations represent the findings of complaint investigation #164743.<br><br>This 2567 was electronically sent to the facility on 08/17/21. | F 000 | | |
| F 609 SS=D | Reporting of Alleged Violations<br>CFR(s): 483.12(c)(1)(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>This REQUIREMENT is not met as evidenced | F 609 | | |

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 609 | Continued From page 1 | F 609 | | |

by:
The facility reported a census of 62 residents. Based on record review and interviews, the facility failed to report an allegation of abuse for one sampled resident, Resident (R) 1, to the state agency within five days of the occurrences, as required.

Findings included:

- Resident (R) 1 diagnoses included displaced intertrochanteric fracture of the left femur (upper leg bone), history of subsequent encounter for closed fracture with routine healing, muscle weakness (feel weak and tired or your muscles may be sore), acute (sudden) pain (physical suffering or discomfort caused by illness or injury) due to trauma (physical injury), unsteadiness of feet (loss of balance), osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), cognitive communication deficit (impairment in organization/thought organization, sequencing, attention, memory).

The five day "Minimum Data Set" (MDS), dated 07/26/21, revealed the residents' Brief Interview Mental Status (BIMS) score of 11, indicating moderately impaired intact cognition. The resident did not have mood disorder or negative behaviors. The resident required two-person extensive assistance with bed mobility, transfer, and toileting. The resident received as needed pain regimen for frequent pain rated 7/10.

The care plan guided staff to assist resident with transfer, bed mobility and toileting.

Review of the electronic records, on 07/30/21

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| F 609 | Continued From page 2 | F 609 | | |

revealed the resident thought she had "popped out" a stitch on her left hip. Upon assessment, the resident had an approximately a quarter size amount of blood from the resident's left hip dressing.

On 08/16/21 at 08:16 AM, Administrative Staff A, reported on 08/03/21, the resident's family reported to the facility that the resident had an allegation of abuse that involved an unidentified staff member who pulled the resident up in the her bed with her sheets and threw the resident back onto her bed. The resident fell onto the television remote that was on her bed, that opened the surgical wound on the resident's left hip. The allegation occurred on 07/30/21 at 04:30 PM. Administrative Staff A advised the family member that the facility would "Look into" the allegation of abuse.

However, on 08/16/21 at 04:02 PM, Administrative Staff A advised that she had not reported the alleged allegation of abuse for R (1) to the hotline, to the state agency.

On 08/16/21 at 08:20 AM, Administrative Nurse D advised that the alleged allegation of staff to R (1) abuse was not reported to state agency, as required.

On 08/16/21 at 12:22 PM, a family member reported a staff member entered the resident's room, pulled the resident up with her sheets, and "Threw" the resident back on her bed. When she was thrown on the bed, the remote was in the resident's bed, and the resident landed on the remote. The resident's incision broke open because of the staff member. He reported the abuse to the facility.

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| F 609 | Continued From page 3<br><br>The facility policy, revised 01/2021, "Abuse Reporting, Resident, Staff, and Family" documented reports of resident abuse shall be reported to state agencies and the findings of the abuse investigations will also be reported.<br><br>The facility failed to report to the state agency as required, when this resident had an alleged of staff to resident abuse. | F 609 | | |
| F 610 SS=D | Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.<br><br>§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>This REQUIREMENT is not met as evidenced by:<br>The facility reported a census of 62 residents, with one resident sampled for investigation of abuse. Based on interview and record review, the facility failed to thoroughly investigate allegation of staff to resident abuse for Resident (R)1. | F 610 | | |

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| F 610 | Continued From page 4 | F 610 | | |

Findings included:

- Resident (R) 1 diagnoses included displaced intertrochanteric fracture of the left femur (upper leg bone), history of subsequent encounter for closed fracture with routine healing, muscle weakness (feel weak and tired or your muscles may be sore), acute (sudden) pain (physical suffering or discomfort caused by illness or injury) due to trauma (physical injury), unsteadiness of feet (loss of balance), osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), cognitive communication deficit (impairment in organization/thought organization, sequencing, attention, memory).

The five day "Minimum Data Set" (MDS), dated 07/26/21, revealed the residents' Brief Interview Mental Status (BIMS) score of 11, indicating moderately impaired intact cognition. The resident did not have mood disorder or negative behaviors. The resident required two-person extensive assistance with bed mobility, transfer, and toileting. The resident received as needed pain regimen for frequent pain rated 7/10.

The care plan guided staff to assist resident with transfer, bed mobility and toileting.

Review of the electronic records, on 07/30/21 revealed the resident thought she had "popped out" a stitch on her left hip. Upon assessment, the resident had an approximately a quarter size amount of blood from the resident's left hip dressing.

On 08/16/21 at 08:16 AM, Administrative Staff A,

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| F 610 | Continued From page 5 | F 610 | | |

reported on 08/03/21, the resident's family reported to the facility that the resident had an allegation of abuse that involved an unidentified staff member who pulled the resident up in the her bed with her sheets and threw the resident back onto her bed. The resident fell onto the television remote that was on her bed, that opened the surgical wound on the resident's left hip. The allegation occurred on 07/30/21 at 04:30 PM. Administrative Staff A advised the family member that the facility would "Look into" the allegation of abuse. However, Administrative staff A reported she never completed a thorough investigation related to the allegation of abuse.

On 08/16/21 at 08:20 AM, Administrative Nurse D advised that the alleged allegation of staff to R (1) abuse was not investigated as required.

On 08/16/21 at 12:22 PM, a family member reported a staff member entered the resident's room, pulled the resident up with her sheets, and "Threw" the resident back on her bed. When she was thrown on the bed, the remote was in the resident's bed, and the resident landed on the remote. The resident's incision broke open because of the staff member. He reported the abuse to the facility.

The facility policy, revised 01/2021, "Reporting and Investigating Alleged Violations of Abuse, Neglect, Exploitation or Mistreatment" documented the facility would conduct a prompt, thorough and complete investigation in response to reportable allegations of abuse, neglect, mistreatment ....

The facility failed to thoroughly investigate allegation of staff to resident abuse for Resident

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| F 610 | Continued From page 6<br>(R)1, as required. | F 610 | | |