STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089066	A. BUILDING: _____ B. WING _____	05/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES SOUTH	14005 214TH ROAD HOLTON, KS 66436

(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) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations are the result of a survey for re-licensure conducted on 5/11/21, 5/12/21, 5/13/21 and 5/17/21 at the above named home plus facility in Holton, KS.	S 000		
S5085 SS=D	26-42-201 (c) Functional Capacity Screen Reassessment (c) Designated staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: K.A.R. 26-42-201 (c)(2) The census equaled 11 residents. The sample included 3 residents. Based on record review, observation and interview for one sampled resident, (#511), the operator failed to ensure designated staff conducted a screening to determine each resident's functional capacity following any significant change in condition as defined in K.A.R. 26-39-100. Findings included: - Record review for resident #511 recorded an admission date of 12/31/18 with diagnoses of chronic bronchitis, heart disease, hypertension, chest pain, atrial fibrillation and cardiac pacemaker.	S5085		

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089066	A. BUILDING: _____ B. WING _____	05/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES SOUTH	14005 214TH ROAD HOLTON, KS 66436

(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) COMPLETE DATE
S5085	Continued From page 1 Functional Capacity Screen dated 5/4/20 recorded resident required physical assistance with bathing, supervision with dressing, transfers, walk/mobility and independent with toileting and eating, continent of bladder and unable to perform management of medications and treatments. Observation on 5/11/21 at 3:05pm revealed resident in bed with head of bed elevated and Oxygen via nasal cannula. Nursing notes dated 5/6/21 at 4:00pm recorded resident " ... Incontinent of bowl and bladder, increased complaint of pain, Hospice notified. Resident cleaned up and asked to lay in bed. Redness to coccyx medium from stool incontinence. Rotating side to side, will wait for new orders from Hospice." Signed by licensed nurse #B Interview on 5/12/21 at 12:30pm with licensed nurse #B confirmed resident coccyx was irritated and resident has been incontinent for 2 weeks. She confirmed resident wears briefs, has not gotten up to the toilet for the past week, cannot bathe self, dress self, toilet self, transfer self, she does not walk and does not eat, only drinking fluids. She confirmed the FCS was not updated to reflect this change in resident condition. She confirmed the annual FCS was due on 5/4/21 and had not been completed. For resident #511, the operator failed to ensure designated staff conducted a screening to determine each resident's functional capacity following any significant change in condition as defined in K.A.R. 26-39-100.	S5085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089066	A. BUILDING: _____ B. WING _____	05/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES SOUTH	14005 214TH ROAD HOLTON, KS 66436

(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) COMPLETE DATE
S5105	Continued From page 2	S5105		
S5105 SS=E	26-42-202 (a) Negotiated Service Agreement a) The administrator or operator of each home plus shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-42-202 (a) The census equaled 11 the sample included 3 residents. Based on reviews of facility records for residents (#511, 513), the operator failed to ensure the Negotiated Service Agreement (NSA) completed for residents who required health care services, contained a description of the services the resident will receive, identification of the provider of each service and identification of each party responsible for payment if outside resources provide a service. Findings included:	S5105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089066	A. BUILDING: _____ B. WING _____	05/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES SOUTH	14005 214TH ROAD HOLTON, KS 66436

(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) COMPLETE DATE
S5105	Continued From page 3 - Record review for resident #511 recorded an admission date of 12/31/18 with diagnoses of chronic bronchitis, heart disease, hypertension, chest pain, atrial fibrillation and cardiac pacemaker. Functional Capacity Screen dated 5/4/20 recorded resident required physical assistance with bathing, supervision with dressing, transfers, walk/mobility and independent with toileting and eating, continent of bladder and unable to perform management of medications and treatments. Negotiated service agreement (NSA) dated 5/4/20 recorded staff to assist resident with bathing and management of medications and treatments. Nursing notes dated 3/30/21 at 6pm recorded: "Resident back from [hospital] swing-bed. Resident admitted to hospice." Signed by licensed nurse #B NSA lacked an entry for the outside provider for Hospice services. Interview on 5/12/21 at 12:30pm with licensed nurse #B confirmed resident NSA lacked entry for resident use of the outside provider services for Hospice. Confirmed an addendum was not completed when resident began hospice services on 4/6/21. - Record review for resident #513 recorded an admission date of 5/9/21 with diagnoses of hypertension, congestive heart failure, falls and chronic kidney disease. Functional Capacity screen dated 5/7/21	S5105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089066	A. BUILDING: _____ B. WING _____	05/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES SOUTH	14005 214TH ROAD HOLTON, KS 66436

(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) COMPLETE DATE
S5105	Continued From page 4 recorded resident required physical assistance with bathing and dressing and unable to perform management of medications and treatments. Negotiated service agreement/ health care service plan (NSA/HCSP) dated 5/7/21 recorded staff to assist resident with bathing, dressing and management of medications and treatments. Outside resources: [home health agency name] Nursing notes dated 5/7/21 at 6pm recorded: "Resident to start on home health with PT and OT. (physical therapy and occupational therapy) NSA lacked the services provided by the home health agency and party responsible for payment of those services. Interview on 5/12/21 at 11:50am with licensed nurse #B confirmed resident received outside provider services for PT/OT and skilled nursing for hypertension monitoring and the NSA lacked the services and party responsible for payment of those services. For residents #511 and 513, the operator failed to ensure the Negotiated Service Agreement (NSA) completed for residents who required health care services, contained a description of the services the resident will receive, identification of the provider of each service and identification of each party responsible for payment if outside resources provide a service.	S5105		
S5116 SS=D	26-42-202 (d) NSA revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the	S5116		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089066	A. BUILDING: _____ B. WING _____	05/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES SOUTH	14005 214TH ROAD HOLTON, KS 66436

(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) COMPLETE DATE
S5116	Continued From page 5 following requirements: (1) At least once every 365 days;(2) following any significant change in condition, as defined in K.A.R. 26-39-100; (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant; and (4) if requested by the resident or the resident ' s legal representative, staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. This REQUIREMENT is not met as evidenced by: K.A.R 26-42-202 (d)(2) Findings included: The facility reported a census of 11 residents. The sample included 3 residents. Based on record review and interview for 1 resident (#511) the operator failed to ensure the review and if necessary, revision of each negotiated service agreement following any significant change in condition, as defined in K.A.R. 26-39-100. Findings included: - Record review for resident #511 recorded an admission date of 12/31/18 with diagnoses of chronic bronchitis, heart disease, hypertension, chest pain, atrial fibrillation and cardiac pacemaker. Functional Capacity Screen dated 5/4/20 recorded resident required physical assistance with bathing, supervision with dressing, transfers,	S5116		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089066	A. BUILDING: _____ B. WING _____	05/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES SOUTH	14005 214TH ROAD HOLTON, KS 66436

(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) COMPLETE DATE
S5116	Continued From page 6 walk/mobility and independent with toileting and eating, continent of bladder and unable to perform management of medications and treatments. Negotiated service agreement (NSA) dated 5/4/20 recorded staff to assist resident with bathing and management of medications and treatments. Observation on 5/11/21 at 3:05pm revealed resident in bed with head of bed elevated and Oxygen via nasal cannula. Nursing notes dated 5/6/21 at 4:00pm recorded resident " ... Incontinent of bowl and bladder, increased complaint of pain, Hospice notified. Resident cleaned up and asked to lay in bed. Redness to coccyx medium from stool incontinence. Rotating side to side, will wait for new orders from Hospice." Signed by licensed nurse #B Interview on 5/12/21 at 12:30pm with licensed nurse #B confirmed resident coccyx was irritated and resident has been incontinent for 2 weeks. She confirmed resident wears briefs, has not gotten up to the toilet for the past week, cannot bathe self, dress self, toilet self, transfer self, she does not walk and does not eat, only drinking fluids. She confirmed the NSA was not updated to reflect this change in resident condition. She confirmed the annual NSA was due on 5/4/21 and had not been completed. For resident #511 the operator failed to ensure the review and if necessary, revision of each negotiated service agreement following any significant change in condition, as defined in K.A.R. 26-39-100.	S5116		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089066	A. BUILDING: _____ B. WING _____	05/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES SOUTH	14005 214TH ROAD HOLTON, KS 66436

(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) COMPLETE DATE
S5155 SS=E	26-42-204 (a) Health Care Services (a) The administrator or operator in each home plus shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(a) The facility reported a census of11 residents. The sample included 3 residents. For all residents, based on record review and interview for 2 sampled residents (#511, 512), the operator failed to ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. Findings included: - Record review for resident #511 recorded an admission date of 12/31/18 with diagnoses of chronic bronchitis, heart disease, hypertension, chest pain, atrial fibrillation and cardiac pacemaker. Functional Capacity Screen dated 5/4/20 recorded resident required physical assistance	S5155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089066	A. BUILDING: _____ B. WING _____	05/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES SOUTH	14005 214TH ROAD HOLTON, KS 66436

(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) COMPLETE DATE
S5155	Continued From page 8	S5155		

with bathing, supervision with dressing, transfers, walk/mobility and independent with toileting and eating. Resident unable to perform management of medications and treatments.

Negotiated service agreement/ health care service plan dated 5/4/20 recorded Staff to assist resident with bathing and management of medications and treatments.

Observation on 5/11/21 at 3:05pm revealed resident in bed with head of bed elevated and Oxygen via nasal cannula.

Nursing notes dated 5/6/21 at 4:00pm recorded resident " ... Incontinent of bowl and bladder, increased complaint of pain, Hospice notified. Resident cleaned up and asked to lay in bed. Redness to coccyx medium from stool incontinence. Rotating side to side, will wait for new orders from Hospice." Signed by licensed nurse #B

Interview on 5/12/21 at 12:30pm with licensed nurse #B confirmed resident coccyx irritated and has been incontinent for 2 weeks. Resident previously always slept in her chair and only recently moved to the bed. Resident wears briefs and does not get up to the toilet for the past week. Staff are to turn resident side to side every 2 hours. She confirmed care plan lacked entries for resident sleeping in the chair and now bed, for staff repositioning for pressure relief and staff to check and change resident instead of toileting. She confirmed resident is unable to get out of bed on her own and could not evacuate on her own and HCSP lacked entry for evacuation assistance.

- Record review for resident #512 recorded

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089066	A. BUILDING: _____ B. WING _____	05/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES SOUTH	14005 214TH ROAD HOLTON, KS 66436

(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) COMPLETE DATE
S5155	Continued From page 9	S5155		

admission date of 12/31/2020 with diagnoses of dementia, cellulitis of lower left extremity, Peripheral vascular disease, pressure ulcer bilateral feet and osteomyelitis.
Functional capacity screen dated 12/31/20 recorded resident required physical assistance with bathing, dressing, toileting, transfer, walk/mobility and eating and unable to perform management of medications and treatments. Resident incontinent of bladder and has a history of falls/unsteadiness.

Negotiated service agreement/ health care service plan (NSA/HCSP) dated 12/31/21 recorded staff to provide physical assistance with bathing, dressing, toileting, transfer, walk/mobility and eating and unable to perform management of medications and treatments. Resident to use a personal alarm and fall mat for fall prevention.

Observation on 5/11/21 at 10:48am revealed resident in his room in a recliner with a pressure reduction cushion under him, a hospital bed with 4 side rails is in the room. Bed had a regular mattress and resident left leg is amputated below the knee.

Nursing notes dated 1/18/21 at 2:00pm recorded "resident discharged from [hospital] back to the [facility]after above the knee amputation with ace wrap applied and intact."

HCSP lacked entries for resident use of a hospital bed with 4 side rails, pressure reduction cushion and recent left leg amputation requiring changes in transfer/mobility assistance.

Interview on 5/12/21 at 12:50pm with licensed nurse #B confirmed HCSP lacked entries for resident use of a hospital bed with 4 side rails,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089066	A. BUILDING: _____ B. WING _____	05/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES SOUTH	14005 214TH ROAD HOLTON, KS 66436

(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) COMPLETE DATE
S5155	Continued From page 10 pressure reduction cushion and recent left leg amputation requiring changes in transfer/mobility assistance. She confirmed resident is unable to exit the facility unassisted and HCSP lacked entry for resident evacuation assistance. She confirmed resident required pressure reduction assistance including a boot to right foot while in bed and required to be checked and changed by staff every 2 hours for incontinence and HCSP lacked entries for these resident needs. She stated they do not do assessments for safety and ability to use side rails. For residents #511 and 512 the operator failed to ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement.	S5155		
S5161 SS=E	26-42-204 (d) Health Care Services (d) The negotiated service agreement shall contain a description of the health care services to be provided and the name of the licensed nurse responsible for the implementation and supervision of the plan. This REQUIREMENT is not met as evidenced by: KAR 2-6-42-204(d) The facility reported a census of 11 residents. The sample included 3 residents. Based on record review and interview for 2 sampled residents (#512, 513), the operator failed to ensure the negotiated service agreement	S5161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089066	A. BUILDING: _____ B. WING _____	05/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES SOUTH	14005 214TH ROAD HOLTON, KS 66436

(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) COMPLETE DATE
S5161	Continued From page 11 contained the name of the licensed nurse responsible for the implementation and supervision of the health care service plan. Findings included: - Record review for resident #512 recorded admission date of 12/31/2020 with diagnoses of dementia, cellulitis of lower left extremity, Peripheral vascular disease, pressure ulcer bilateral feet and osteomyelitis. Functional capacity screen dated 12/31/20 recorded resident required physical assistance with bathing, dressing, toileting, transfer, walk/mobility and eating and unable to perform management of medications and treatments. Negotiated service agreement/ health care service plan (NSA/HCSP) dated 12/31/21 recorded staff to provide physical assistance with bathing, dressing, toileting, transfer, walk/mobility and eating and unable to perform management of medications and treatments. NSA lacked the name of the licensed nurse responsible for the implementation and supervision of the health care service plan. - Record review for resident #513 recorded an admission date of 5/9/21 with diagnoses of hypertension, congestive heart failure, falls and chronic kidney disease. Functional Capacity screen dated 5/7/21 recorded resident required physical assistance with bathing and dressing and unable to perform management of medications and treatments. Negotiated service agreement/ health care	S5161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089066	A. BUILDING: _____ B. WING _____	05/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES SOUTH	14005 214TH ROAD HOLTON, KS 66436

(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) COMPLETE DATE
S5161	Continued From page 12 service plan (NSA/HCSP) dated 5/7/21 recorded staff to assist resident with bathing, dressing and management of medications and treatments. NSA lacked the name of the licensed nurse responsible for the implementation and supervision of the health care service plan. For residents #512 and 513 the operator failed to ensure the negotiated service agreement contained the name of the licensed nurse responsible for the implementation and supervision of the health care service plan.	S5161		
S5185 SS=D	26-42-206 (a) (b) (c) Dietary Services (a) The administrator or operator of each home plus shall ensure the provision or coordination of dietary services to residents as identified in each resident ' s negotiated service agreement. (b) The supervisory responsibility for dietetic services shall be assigned to one employee. (c) If a resident ' s negotiated service agreement includes the provision of a therapeutic diet, mechanically altered diet, or thickened consistency of liquids, a medical care provider ' s order shall be on file in the resident ' s clinical record, and the diet or liquids, or both, shall be prepared according to instructions from a medical care provider or licensed dietitian. This REQUIREMENT is not met as evidenced by: KAR 26-42-206(a)(c)	S5185		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089066	A. BUILDING: _____ B. WING _____	05/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES SOUTH	14005 214TH ROAD HOLTON, KS 66436

(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) COMPLETE DATE
S5185	Continued From page 13	S5185		

The facility reported a census of 11 home plus residents. The sample included 3 residents. Based on record review and interview for 1 sampled resident (#512) receiving mechanically altered diet and/or thickened liquids, the operator failed to ensure provision or coordination of dietary service to the residents as identified in each resident's negotiated service agreement and a medical care provider's order shall be on file in the resident's clinical record and the diet or liquids, or both, shall be prepared according to instructions from a medical care provider or licensed dietitian.

Findings included:

- Record review for resident #512 recorded admission date of 12/31/2020 with diagnoses of: dementia, cellulitis left lower extremity, peripheral vascular disease, pressure ulcer bilateral feet and osteomyelitis.

Functional Capacity Screen dated 12/31/2020 recorded resident required physical assistance with eating.

Negotiated service agreement/health care service plan (NSA/HCSP) dated 12/31/2020 recorded: staff will prepare and serve 3 meals per day and provide assistance with eating as needed.

Signed physician's orders dated 4/30/21 recorded Diet: mechanical soft with nectar thick fluids.

Interview on 5/12/21 at 10:58am with certified staff #H confirmed she was preparing the food for lunch. She stated resident #512 is to receive nectar thick liquids and pureed food. She

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089066	A. BUILDING: _____ B. WING _____	05/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES SOUTH	14005 214TH ROAD HOLTON, KS 66436

(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) COMPLETE DATE
S5185	Continued From page 14 confirmed she does not have written instructions for preparation of mechanically altered diets stating "I've done it for so many years I just do it." Facility policy titled: Diet Protocol, recorded: "If the resident is in need of a therapeutic diet, the diet served shall be based on written instructions from a physician or licensed dietician. Staff will ensure that diets are followed according to the diet order and to the NSA." Staff not instructed on proper diet orders for resident, facility lacked signed diet instructions for proper preparation of resident diet as per doctor's orders and NSA/HCSP lacked entry for the mechanically altered diet for resident. For resident #512, who was to receive a mechanically altered diet and/or thickened liquids, the operator failed to ensure provision or coordination of dietary service to the residents as identified in each resident's negotiated service agreement and the medical care provider's order on file in the resident's clinical record and the diet or liquids, or both, shall be prepared according to instructions from a medical care provider or licensed dietitian.	S5185		
S5215 SS=F	26-42-104 (d) Disaster and Emergency Preparedness Education (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the home ' s emergency management plan; (2) education of each resident upon admission to the home regarding emergency	S5215		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089066	A. BUILDING: _____ B. WING _____	05/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES SOUTH	14005 214TH ROAD HOLTON, KS 66436

(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) COMPLETE DATE
S5215	Continued From page 15 procedures; (3) quarterly review of the home ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-42-104 (d) (3) The census equaled11 residents. Based on interviews and review of records, for all residents, the operator failed to ensure disaster and emergency preparedness when the operator failed to ensure quarterly reviews of the facility's emergency management plan with staff and residents. Findings included: Review of the facility's disaster and emergency management plan on 5/11/21 at 4:20pm with operator #A recorded the following: Reviews with staff were conducted on 1/16/19, 9/11/19 and 3/11/2020. Records lacked reviews of the emergency management plan with employees for the 2nd and 4th quarters of 2019 and 2nd, 3rd and 4th quarters of 2020 and first quarter of 2021. Records lacked any reviews of the emergency management plan with residents for 2019, 2020 and 2021. The last conducted evacuation drill of the facility was conducted on 1/4/19. Records lacked evacuations for 2020 or 2021.	S5215		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089066	A. BUILDING: _____ B. WING _____	05/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES SOUTH	14005 214TH ROAD HOLTON, KS 66436

(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) COMPLETE DATE
S5215	Continued From page 16 Interview on 5/11/21 at 4:20pm with operator #A confirmed records lacked reviews of the emergency management plan quarterly with staff and residents and an evacuation had not been conducted since 1/4/19. For all residents, the operator failed to ensure disaster and emergency preparedness when the operator failed to ensure quarterly reviews of the facility's emergency management plan with staff and residents.	S5215		
S5230 SS=F	26-42-207 (b)(5)(6) (c) Infection Control Policies (b)(5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; (c) Each administrator or operator shall ensure the home ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. This REQUIREMENT is not met as evidenced by: K.A.R 26-42-207 (c) The facility reported a census of 11 residents. The sample included 3 residents. Based on	S5230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089066	A. BUILDING: _____ B. WING _____	05/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES SOUTH	14005 214TH ROAD HOLTON, KS 66436

(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) COMPLETE DATE
S5230	Continued From page 17 record review, and interview, for all residents, the operator failed to ensure compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. Findings included: - On 5/11/21 at 4:10pm, during personnel review with operator #A, facility records lacked documentation for tuberculosis (TB) skin tests according to guidelines for the following recent staff hired: Certified staff #C, hire date 1/13/21, record lacked evidence of a two- step TB test by the facility. Record lacked documentation of a TB symptom screen. Certified staff #D, hire date 10/8/19, record lacked evidence of a two- step TB test by the facility. Record lacked documentation of a TB symptom screen. Certified staff #E, hire date 8/2/20, record lacked evidence of a two- step TB test by the facility. Record lacked documentation of a TB symptom screen. Certified staff #F, hire date 4/20/21, record lacked evidence of a two- step TB test by the facility. Record lacked documentation of a TB symptom screen. Certified staff #G, hire date 3/15/21, record lacked evidence of a two- step TB test by the facility. Record lacked documentation of a TB symptom screen.	S5230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089066	A. BUILDING: _____ B. WING _____	05/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES SOUTH	14005 214TH ROAD HOLTON, KS 66436

(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) COMPLETE DATE
S5230	Continued From page 18 Interview on 5/11/21 at 4:10pm with operator #A confirmed staff records lacked evidence of TB testing according to guidelines. Interview on 5/12/21 at 12:50pm with licensed nurse #B confirmed resident #512 records lacked evidence of a two step TB test. For all residents of the facility the operator failed to ensure compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105.	S5230		
S5258 SS=F	26-42-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff records shall contain the following information: (1) Evidence of licensure, registration, certification, or a certificate of successful completion of a training course for each employee performing a function that requires specialized education or training; (2) supporting documentation for criminal background checks of facility staff and contract staff, excluding any staff licensed or registered by a state agency, pursuant to K.S.A. 39-970 and amendments thereto; (3) supporting documentation from the Kansas nurse aide registry that the individual does not have a finding of having abused, neglected, or exploited a resident in an adult carehome; and (4) supporting documentation that the individual does not have a finding of having abused, neglected, or exploited any resident in an adult care home, from the nurse aide registry in each state in which the individual has been known to work as a certified nurse aide.	S5258		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089066	A. BUILDING: _____ B. WING _____	05/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES SOUTH	14005 214TH ROAD HOLTON, KS 66436

(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) COMPLETE DATE
S5258	Continued From page 19 This REQUIREMENT is not met as evidenced by: KAR 26-42-102 (d)(1)(2) The facility reported a census of 11 home plus residents. Based on record review and interview for 5 of 5 recently hired staff (#C, D, E, F, G), the operator failed to provide supporting documentation for criminal background checks(KBI) at the time of hire, and for 4 of 5 certified staff (#C, D, F, G) the operator failed to obtain supporting documentation for evidence of certification at the time of hire. Findings included: - On 5/11/21 at 4:10pm personnel record review for recently hired staff revealed the following: Certified medication aide #C, hire date 1/13/21, record lacked evidence of KBI check upon hire. Registry check for certification dated 1/18/21 (5 days after hire). Certified medication aide #D, hire date 10/8/19, KBI check produced 10/17/19 (9 days after hire). Registry check for certification dated 1/18/21 (5 days after hire). Certified medication aide #E, hire date 8/2/20, KBI check produced 12/16/20 (4 1/2 months after hire). Certified medication aide #F, hire date 4/20/21, record lacked evidence of KBI check upon hire. Registry check for certification lacked date of	S5258		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089066	A. BUILDING: _____ B. WING _____	05/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES SOUTH	14005 214TH ROAD HOLTON, KS 66436

(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) COMPLETE DATE
S5258	Continued From page 20 certification check. Certified medication aide #G, hire date 3/15/21, record lacked evidence of KBI check upon hire. Registry check for certification lacked date of certification check. For all residents of the facility the operator failed to provide supporting documentation for criminal background checks for new hired staff at the time of hire, and failed to obtain supporting documentation for evidence of certification at the time of hire.	S5258		
S5300 SS=D	26-42-205 (d) (1-2) Facility Administration of Medications (d) Home administration of resident ' s medications. If a home is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the home has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(d)	S5300		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089066	A. BUILDING: _____ B. WING _____	05/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES SOUTH	14005 214TH ROAD HOLTON, KS 66436

(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) COMPLETE DATE
S5300	Continued From page 21	S5300		

The facility reported a census of 11 residents. The sample included 3 residents. Based on record review, and interview for 1 resident (#511), the operator failed to ensure all medications and treatments were administered in accordance with a medical care provider's written order and professional standards of practice.

Findings included:

- Record review for resident #511 recorded admission date of 12/31/18 with diagnoses of chronic bronchitis, heart disease, hypertension, chest pain, atrial fibrillation and a cardiac pacemaker.

Functional Capacity Screen (FCS) dated 5/4/20 recorded resident unable to perform management of medications and treatments.

Negotiated Service Agreement/ Health Care Service Plan (NSA/HCSP) dated 5/4/20 recorded staff to provide management of medications and treatments.

May 2021 medication administration record (MAR) recorded the following as needed (PRN) pain medications administered by certified medication aides (CMAs) 10 times between 5/1/21 and 5/11/21.

Roxanol (liquid narcotic for pain) 20mg/ml (milligrams/mililiter) 0.25ml every 1 hour PRN pain or shortness of air (SOA), administered 5 times by CMAs.

Lorazepam (anxiety) 2mg/ml 0.25ml every 4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089066	A. BUILDING: _____ B. WING _____	05/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES SOUTH	14005 214TH ROAD HOLTON, KS 66436

(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) COMPLETE DATE
S5300	Continued From page 22 hours PRN anxiety/ SOA, administered 1 time by a CMA. Roxanol 20mg/ml, 0.5 ml every hour PRN for severe pain. Administered 5 times by CMAs. Medication binder contained blank forms for nurse notification for PRN medications. Record lacked documentation of consultation with a licensed nurse prior to administration of PRN medications to the resident for this delegated nursing task, lacked PRN record for reason PRN medications were given, and lacked follow-up documentation for effectiveness of the PRN medications. Resident record lacked signed physician's orders for administration of Roxanol and Lorazepam. May 2021 MAR recorded 16 administration times, for 9 different medications, circled as not administered from 5/1/21 to 5/11/21. Record lacked reasons medications were not administered. Interview on 5/12/21 at 12:15pm with licensed nurse #B confirmed resident record lacked documentation of nurse consultation prior to administration of PRN medications, lacked PRN record for reason given and lacked follow-up documentation for effectiveness of the PRN medications. She confirmed record lacked physician's orders for the narcotic medications Roxanol and Lorazepam. She confirmed medications were circled on the MAR because resident had been refusing her medications for a couple weeks and record lacked documentation of notification of the physician of resident's refusal of the medications.	S5300		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089066	A. BUILDING: _____ B. WING _____	05/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES SOUTH	14005 214TH ROAD HOLTON, KS 66436

(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) COMPLETE DATE
S5300	Continued From page 23 For resident #511 the operator failed to ensure all medications and treatments were administered in accordance with a medical care provider's written order and professional standards of practice.	S5300		
S5315 SS=E	26-42-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the home in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the home in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the home. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of	S5315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089066	A. BUILDING: _____ B. WING _____	05/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES SOUTH	14005 214TH ROAD HOLTON, KS 66436

(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) COMPLETE DATE
S5315	Continued From page 24 expiration. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(h) The facility reported a census of 11 residents. The sample included 3 residents and 1 focus review resident. Based on observation and interview for 3 residents (#511, 512 and 514), the licensed nurses and medication aides failed to ensure all medications and biologicals were securely and properly stored in accordance with each manufacturer's recommendations or those of the pharmacy provider and with federal and state laws and regulations. Findings included: - On 5/11/21 at 11:50 am observed on a shelf in the locked medication room, with operator/CMA #A, a large padlocked tool box contained the following narcotic medications: For resident #511: Lorazepam Concentrate (narcotic for pain) 2mg/ml (milligrams/milliliter), fill date of 5/6/21, bottle opened. For resident #512: Lorazepam Concentrate (narcotic for pain) 2mg/ml (milligrams/milliliter), fill date of 3/31/21, bottle opened. For resident #514: Lorazepam Concentrate (narcotic for pain) 2mg/ml (milligrams/milliliter), fill date of 9/16/20, bottle opened. Box for the medications labeled as follows: "Store at cold temperature, refrigerate 36 degrees to 46	S5315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089066	A. BUILDING: _____ B. WING _____	05/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES SOUTH	14005 214TH ROAD HOLTON, KS 66436

(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) COMPLETE DATE
S5315	Continued From page 25 degrees. Medications were not stored under refrigeration as per manufacturer's recommendations. Interview on 5/11/21 at 11:50am with operator/CMA #A confirmed medications were not stored in the refrigerator. For residents #511, 512 and 514, the licensed nurses and medication aides failed to ensure all medications and biologicals were securely and properly stored in accordance with each manufacturer's recommendations or those of the pharmacy provider and with federal and state laws and regulations.	S5315		
S5316 SS=E	26-42-205 (i) Disposition of Medication (i) Accountability and disposition of medications. Licensed nurses and medication aides shall maintain records of the receipt and disposition of all medications managed by the home in sufficient detail for an accurate reconciliation. (1) Records shall be maintained documenting the destruction of any deteriorated, outdated, or discontinued controlled medications and biologicals according to acceptable standards of practice by one of the following combinations: (A) Two licensed nurses; or (B) a licensed nurse and a licensed pharmacist. (2) Records shall be maintained documenting the destruction of any deteriorated, outdated, or discontinued non-controlled medications and biologicals according to acceptable standards of practice by any of the following combinations: (A) Two licensed nurses; (B) a licensed nurse and a medication aide; (C) a licensed nurse and a licensed pharmacist; or	S5316		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089066	A. BUILDING: _____ B. WING _____	05/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES SOUTH	14005 214TH ROAD HOLTON, KS 66436

(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) COMPLETE DATE
S5316	Continued From page 26 (D) a medication aide and a licensed pharmacist. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(i) The facility reported a census of 3 residents. The sample included 3 residents and 3 focus review residents. Based on observation, record review, and interview for 3 sampled (511, 512, 513) and 3 (514, 515, 516) focus review residents, the operator failed to ensure certified medication aides and the licensed nurse failed maintain records of the disposition of medications in sufficient detail for an accurate reconciliation. Findings included: - On 5/11/21 at 11:50 am observed on a shelf in the locked medication room, with operator/CMA #A, a large padlocked tool box contained the following narcotic medications missing medications according to reconciliation (count sheet) or lacking a count sheet on record: For resident #511: Codeine Sulfate (pain) 30mg (milligrams), fill date 4/28/21 for 30 tablets, 28 on card, no count sheet. (2 tablets unaccounted for). For resident #512: Clonazepam (anxiety) 0.5mg, fill date 12/31/20, 6 tablets on card, count sheet recorded 9 tablets. (3 tablets unaccounted for).	S5316		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089066	A. BUILDING: _____ B. WING _____	05/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES SOUTH	14005 214TH ROAD HOLTON, KS 66436

(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) COMPLETE DATE
S5316	Continued From page 27 Hydrocodone/APAP (pain) 5/325mg, fill date 3/11/21, 30 tablets on card, no count sheet. Morphine sulfate liquid (pain) 20mg/ml (milliliter), fill date 3/31/21; no count sheet. Lorazepam concentrated liquid (anxiety), fill date 3/31/21, administer 0.5ml every 6 hours as needed. Bottle open, no count sheet. For resident #513: Tramadol HCL (hydrochloride) (pain) 50mg, fill date 5/7/21, 172 tablets on 3 cards, count sheet recorded 174 tablets. (2 tablets unaccounted for). APAP (acetaminophen)/ codeine (pain) solution 120mg/12mg/5ml, fill date 5/7/21, no count sheet. For resident #514: Morphine sulfate liquid(pain) 20mg/ml, fill date 9/16/20, administer 0.25ml to 0.5ml every 2 hours as needed; bottle contained 25 ml, count sheet recorded 25 ml. (3 ml unaccounted for). For resident #515: Alprazolam 0.25mg (anxiety) tablets, fill date 12/1/20, 19 tablets on card, count sheet recorded 20 tablets. (1 tablet unaccounted for). For resident #516: Clonazepam 0.5mg (anxiety), Fill date 4/6/20, 13 tablets on card, count sheet recorded 14 tablets. (1 tablet unaccounted for). Resident roster recorded all residents received medication administration assistance. Facility policy on Narcotics recorded: "The med room contains a storage box that is locked. All narcotics must be kept in the storage box and counted at each shift change."	S5316		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089066	A. BUILDING: _____ B. WING _____	05/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES SOUTH	14005 214TH ROAD HOLTON, KS 66436

(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) COMPLETE DATE
S5316	Continued From page 28 Interview on 5/11/21 at 11:50am with operator/CMA #A confirmed resident narcotic reconciliation count sheets lacked accurate reconciliation of the narcotic medications. For residents #511, 512, 513, 514, 515, 516, the operator failed to ensure certified medication aides and the licensed nurse failed maintain records of the disposition of medications in sufficient detail for an accurate reconciliation.	S5316		
S5380 SS=F	28-39-437 Plumbing and Piping Systems (i) Plumbing and piping systems. (1) Backflow prevention devices or vacuum breakers shall be installed on fixtures to which hoses or tubing can be attached. (2) Water distribution systems shall be arranged to provide hot water at hot water outlets at all times. The temperature of hot water shall range between 98° F and 120° F at showers, tubs, and lavatories accessible to residents. This REQUIREMENT is not met as evidenced by: KAR 28-39-437(i)(2) The facility reported a census of 11 residents. The sample included 3 residents. Based on observation, record review and interview for all residents, the operator failed to ensure the facility water distribution system maintained a safe hot water temperature between 98 and 120 degrees Fahrenheit (F) at the sinks in resident use areas. Findings included:	S5380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089066	A. BUILDING: _____ B. WING _____	05/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES SOUTH	14005 214TH ROAD HOLTON, KS 66436

(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) COMPLETE DATE
S5380	Continued From page 29 - During facility tour on 5/11/21 revealed elevated hot water temperatures at the following locations in the older part of the facility. (facility has a new addition and an older part (front)) At 11:35am at the sink in the open concept kitchen: 130.8F At 11:41am at the sink in the front resident bathroom/shower room: 127.9F. At 1:07pm hot water was retested with licensed nurse #B and revealed the following hot water temperatures: Kitchen sink: department thermometer: 129.5F; facility thermometer: 128.9F Bathroom sink: department thermometer: 124.1; facility thermometer: 124.5F Residents were observed actively ambulating/ using wheelchairs in the main areas of the facility including the dining room and kitchen repeatedly on 5/11/21 and 5/12/21. Interview on 5/11/21 at 1:10pm with facility operator #A and licensed nurse #B stated the hot water heater for the older portion of the facility is located in the attic and licensed nurse #B stated she will turn the temperature down. Recheck of facility hot water temperatures in the older part of the facility on 5/12/21 revealed the following: At 11:40am at the sink in the open concept kitchen: 131.0F	S5380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089066	A. BUILDING: _____ B. WING _____	05/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES SOUTH	14005 214TH ROAD HOLTON, KS 66436

(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) COMPLETE DATE
S5380	Continued From page 30 At 11:42am at the sink in the front resident bathroom/shower room: 126.2F. May 2021 Water temp log for the facility recorded entries for May 1-11th for the kitchen sink ranging from 117.6F to 119.6F and for the front bathroom ranging from 118.2F to 119.6F. Interview on 5/12/21 at 10:10am with operator #A stated "I had a hot water policy, I can't find it." For all residents, the operator failed to ensure the facility water distribution system maintained a safe hot water temperature between 98 and 120 degrees Fahrenheit (F) at the sinks in resident use areas.	S5380		