| 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 _____ | 05/15/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| 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 |
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| S 000 | INITIAL COMMENTS<br><br>The following citations are the result of an abbreviated survey conducted on 5/14/19 and 5/15/19 at the above named home plus facility in Holton, KS. | S 000 | | |
| S5028 SS=J | 26-42-101 (f) (3) Staff Treatment of Residents Reporting<br><br>(f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the home as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met:<br>(A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation.<br>(B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress.<br>(C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator.<br>(D) Appropriate corrective action shall be taken if the alleged violation is verified.<br>(E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report.<br>(F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation.<br><br>This REQUIREMENT is not met as evidenced by: | S5028 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| S5028 | Continued From page 1<br>KAR 26-42-101 (f) (3)<br><br>The facility reported a census of 5 residents. The sample included 3 residents and one closed review resident. Based on record review and interview for 1(#02) sampled resident, the operator failed to ensure that allegation of abuse and neglect was reported to the department within 24 hours, an investigation was started when the operator was notified of an alleged violation, each allegation was thoroughly investigated, appropriate corrective action taken, and the department's complaint investigation report was completed and submitted to the department within five working days of the initial report. This failure placed the resident in immediate jeopardy for harm, injury or death.<br><br>Findings included:<br><br>- Record review for resident #02 recorded admission date of 8/2/18 with diagnoses of: cerebrovascular accident (CVA), dementia, depression and diabetes mellitus type 2.<br><br>Functional Capacity Screen (FCS) dated 3/15/19 recorded resident required physical assistance with bathing, dressing, toileting and transfer. Resident recorded as unable to perform walk/mobility and management of medications and treatments. Resident is occasionally incontinent (2) and has problems with short term memory, long term memory, memory/recall and decision making. Resident has a history of falls/unsteadiness and impaired hearing.<br><br>Negotiated service agreement (NSA) and Health care service agreement (HCSP) recorded staff is to provide physical assistance with: bathing, | S5028 | | |

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| S5028 | Continued From page 2 | S5028 | | |

dressing, transfers, walk/mobility (resident is unable to ambulate, is able to self-propel wheelchair), medications (resident self-injects insulin) and treatments and peri-care (incontinence care). Cognition: "resident with history of CVA and dementia. [resident's child] will be contacted for all decision making".

On 5/14/19 at 9:00am, observed resident #02 in his/her room in a wheelchair. Resident was wearing a long sleeve shirt and trousers, had one shoe off and one shoe on. Resident's thumb on the right hand was swollen. When asked what happened to make his/her thumb be swollen, resident stated: "Oh they beat me up" When asked who beat him/her up, resident stated "Those ones at night, they don't like me." When asked what they did, resident replied, "I don't like to talk about it." Resident further stated, "They've done it twice now." Also observed a large approximately 3-inch purple area on the top of resident's left hand.

Observation on 5/14/19 at 11:20am with certified staff #E and #F in resident room: staff toileted resident, directed him/her to stand to transfer to toilet, resident followed directions, used the grab bar, stood and pivoted as directed, was not combative or argumentative. Resident smiled and joked with staff repeatedly. Observation of resident's skin revealed: a small approximate ½ inch by 1/8 inch light purple bruise on left middle back, a blood soaked band aide covering a ½ inch round abrasion on the left knee with a second healed area approximately ½ inch long below it, twelve purple round areas all along top of right forearm 1/2 to 1 inch (approximate) in size, large 3 inch purple area top of left hand and 3 purple areas top of left forearm each approximately 1 inch round. Noted on middle

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| S5028 | Continued From page 3 | S5028 | | |

abdominal area 2 spots purple/green in color, each approximately 1- inch round.

Interview on 5/14/19 at 11:30 with resident observed he/she was able to recall his/her former occupation and converse about details, name of child, where he/she grew up and was able to identify spouse by name from a photo.

Last nurse's note on record recorded the following: 3/12/19 at 2:00pm: "Resident's [child] took resident to podiatrist appointment. No new orders. Will continue to follow closely." Signed by licensed nurse #B.

Interview on 5/14/19 at 12:10pm with licensed nurse #B and operator #A (regarding resident's swollen thumb) the following questions were asked:

What do you know about resident's swollen thumb? Licensed nurse #: "I noticed it a week or so ago"

Was it bruised? "It was a little bruised and swollen, but range of motion was normal."

Did it hurt? "He/she said it was a little tender."

What happened? Operator #A: "I don't think he/she said." Licensed nurse #B: "He/she self-propels his/her wheelchair, in frames of doors he/she will put his/her hands down there."

Did you report it to the doctor? Licensed nurse #B: "No"

What about the large bruise on his/her left hand? Operator #A: "It is not uncommon for him/her to have those on his/her hands. He/she had them

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| S5028 | Continued From page 4<br>when he/she came in."<br><br>Do you have any documentation at all (for the bruise and swollen thumb)? Licensed nurse #B: "No"<br><br>Review of resident's "admission nursing assessment" dated 8/2/18 at 1:00pm recorded: general skin condition: dry and warm, skin condition "WNL" (within normal limits) (no bruises or skin issues were recorded). Signed by licensed nurse #B. Licensed nurse #B confirmed no bruises or skin issues were recorded on the document.<br><br>Interview with resident on 5/14/19 at 12:50 with licensed nurse #B and operator #A, when asked what happened, resident stated: "I got beat up by those night girls, it's better off I just forget it." "I don't know what their names are, I wish I'd never showed it." When licensed nurse #B asked resident, "Who was it?" Resident responded: "It was one of those people that work here at night, all that came from them, at night you don't know what they got in their head, it would be a bad deal if I got the wrong person. Why don't we just start out with some new staff? It was that woman at night the 2 of them, maybe 3, you know what a black person looks like?" Licensed nurse #B then asked: "Were they black?" Resident stated, "I don't know, it was at night. It was at night both times, they carry a lot of weight, I'm not sure they were black, it was night."<br><br>On 5/14/19 at 1:50pm received notarized statement from licensed nurse #B, recorded: "4/12/19- report received from day shift staff that resident thumb was swollen. During assessment thumb was swollen, resident able to move back and forth and use during normal activity. | S5028 | | |

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Resident was asked what happened to his/her thumb and resident state that he/she did not know. No other complaints stated from resident. Report from night shift was read and it stated that he/she was disgruntled about being woke up to be checked and changed. When those staff asked about the incident they stated that resident does not like to be awoke in the middle of the night and can be aggressive with staff ...."

On 5/14/19 at 1:50pm received notarized statement from operator #A, recorded: "4/12/19- When I arrived at the facility in the morning, day shift reports that [#02] thumb is swollen. I informed them that [licensed nurse #B] would be in soon and could take a look at it then. When [licensed nurse #B] arrived at the facility he/she examined [#02] hand and asked him/her what happened. He/she said he/she did not know. We reviewed the shift report from the previous night and it stated that he/she was grumpy and combative while being checked and changed. We reached out to the previous shift to gather information about why he/she was grumpy and if they had any idea of why his thumb was swollen. Both employees explained that he/she does not like to be woken up in the middle of the night and they struggle to get him/her changed ...."

Interview on 5/14/19 at 2:00pm, licensed nurse #B and operator #A confirmed facility did not have a written investigation, did not report the allegation of abuse to the department, did not interview staff on day shift and did not document about the swollen thumb or bruises.

Notarized statement from certified staff #E received 5/14/19 at 11:50am recorded: "On April 12 (approximately), I and (certified staff #J) got [#02] out of bed to find his/her right thumb

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swollen and bruised. I asked him/her what happened, and he/she said, 'The big one tried to break my thumb, I don't know what he/she was so mad about.' I reported what I saw immediately to the operators and they came to assess the situation. They told me that things would be handled and there was protocol they had to follow. They also needed to do their own investigation and talk to the employees involved (certified staff #G, #H) I didn't fill out and incident report or a report with the state because I thought they would resolve the situation. About a month later (May 7th?) I came back to work after a 4-day weekend and noticed a large bruise on his/her left hand and fingerprint-like bruises on his/her right arm. I reported it to [operator #A] and [licensed nurse #B]. On multiple occasions [certified staff #G, #H] reported [#02] as combative, although no other shifts have that problem. When it is a night shift with one of them and another employee, they do not report having issues with [#02]."

Notarized statement from certified staff #F, received 5/14/19 at 12:00pm recorded: "On the first of April on a Friday when certified staff #E and #J was getting [#02] up in the morning. They noticed that [#02] hand was bruised, and his/her thumb was swollen. Certified staff #E came and got me so that I could look at it. In the meantime (certified staff #E) was calling [operator #A and licensed nurse #B]. When I went in to [#02] room to take a look. He she was very upset saying that the girls at night were being mean and throwing him/her around. [#02] said that the big one grabbed his thumb and pulled it backwards and said that he/she was going to break his/her thumb if he/she didn't behave. He/she also had a scrape on his/her knee from hitting it on the wall. Also, on the first part of May (I think a Wednesday) when Certified staff #E and I got

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| S5028 | Continued From page 7<br>[#02] up. We noticed that the hand with the sore thumb, the top of the hand was all bruised and sore and on the other arm there was bruises all up and down his/her arm and hand there was finer-tip bruises. He/she said that was very sore."<br><br>Several observations in resident's room on 5/14/19 revealed resident has a twin bed with a bed cane on the outside head of the bed. The bed is pushed against the wall with the pillow at the top right.<br><br>Notarized statement from Certified staff #H received 5/14/19 at 5:30pm recorded: "I was not aware of swollen thumb or bruising on resident's hand until notified and told by operator #A and licensed nurse #B. Resident is known and has been witnessed to punch wall in his/her room. Resident is and has been combative with overnight staff ..."<br><br>Interview on 5/14/19 at 5:25pm, operator #A and licensed nurse #B stated staff has never told them resident #02 hits the wall with his/her fist, confirmed facility has never completed a staff in-service on abuse, neglect and exploitation.<br><br>Notarized statement from Certified staff #G received 5/14/19 at 6:25pm recorded: "I noticed that [#02] has bruising on his/her right hand and up on his/her arm. I did not notice that his/her thumb was swollen ..... On several occasions while trying to turn him/her, he/she holds onto his/her rail and going against us .... He/she also cusses and hits at us ..."<br><br>Interview on 5/14/19 at 5:00pm with certified staff #H confirmed facility administration did not request a written statement from him/her. He/she stated, "I write everything on the shift report, so | S5028 | | |

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| S5028 | Continued From page 8<br>they know what's going on."<br><br>Interview on 5/14/19 at 5:15pm with certified staff #D stated he/she never has trouble with resident #02 being combative. He/she stated "He/she does get flirtatious sometimes .... He/she has complained about the people that come in when it is dark, says they are rough, or they cuss at him/her. We really only have 2 people who work nights here, [Certified staff #G and #H]."<br><br>Interview on 5/14/19 at 5:17pm with certified staff #C stated resident #02 is never combative with him/her. Confirmed [#02] can be flirtatious but will stop if told to. He/she confirmed resident has complained of other staff, "he/she calls them the black ladies, we figure he/she means nights, in the dark, he/she sometimes says, 'the big fat lady.' He/she will say they were upset with him/her, or he/she was loud and worked up last night. They sit right up by his/her room.<br><br>Shift report form dated 4/11/19 for shift 10-6 recorded for [#02]: "checked at 10pm, hitting staff in face"<br><br>Shift report form dated 4/12/19 for 6-2 shift: "right thumb and hand is sore. Otherwise no concerns."<br><br>Shift report form dated 5/8/19 for shift 2-10pm: "Bad mood. Bruises all up and down his/her arms. Bed at 8.'"<br><br>Shift report forms for night shifts on 5/2/19, 5/6/19, 5/7/19, 5/12/19, and 5/13/19 recorded resident as combative or abusive.<br><br>Time card records confirmed: | S5028 | | |

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| S5028 | Continued From page 9<br><br>Certified staff #G worked every night shift (10pm to 6am approximately); from 4/10/19 to 4/15/19, and10pm to 6am every night from 5/3/19 until 5/13/19.<br><br>Certified staff #H worked every night shift from 4/10/19 to 4/18/19 and 10pm to 6am 5/1/19, 5/2/19 and every night from 5/4/19 to 5/7/19.<br><br>Certified staff #E worked day shift (6am to 2pm approximately) from 4/10/19 to 4/13/19, did not work day shift 5/3/19 to 5/6/19 and worked day shift daily from 5/7/19 to 5/9/19.<br><br>Certified staff #F worked day shift every day from 4/10/19 to 4/19/19 and every day shift 5/6/19 to 5/11/19.<br><br>Facility policy on Abuse, Neglect and exploitation recorded:<br><br>"The care home strictly prohibits staff from any action that is abusive, neglectful or exploits resident in their care ....signs of abuse may include but are not limited to bruising, welts, abrasions, puncture wounds ... ..."<br><br>Reporting procedure: "any staff member who discovers or suspects neglect, abuse, or exploitation will immediately report the occurrence to the operator ..... The operator will ensure that each allegation is reported to the department on aging within 24 hours of the allegation. Immediate measures shall be taken to prevent further potential abuse, neglect or exploitation while the investigation is in progress ... The operator will maintain a written record of the reports and all reports will be held in the strictest confidence ...." | S5028 | | |

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| S5028 | Continued From page 10<br><br>Interview/request for any recent reports to the department on 5/14/19 at 10:40am with operator #A stated, "We've made no reports to the state."<br><br>On 5/14/19 at 5:25pm operator #A and licensed nurse #B were notified facility was found to be in potential immediate jeopardy for lack of investigation regarding a reported potential abuse of a resident. A written plan was requested to keep residents safe starting tonight and each night going forward.<br>.<br><br>The jeopardy was removed on 5/14/19 at 5:40pm when the operator provided the following plan: "Certified staff #G and #H will be suspended pending investigation of operator and RN (registered nurse). We will be interviewing all staff and residents within 24 hours. Alternate staff or management will be working 3rd shift or other scheduled shifts in their place until investigation is completed. When the investigation is complete, we will make a decision regarding their employment based upon the safety of our residents. We will be completing an in-service regarding abuse, neglect and exploitation Wednesday May 15, 2019." signed by operator #A and licensed nurse #B. | S5028 | | |
| S5251 SS=E | 26-42-105 (f) (11) Resident Records Documentation of Incidents<br><br>(f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action. | S5251 | | |

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| S5251 | Continued From page 11<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-42-105(f)(11)<br><br>The facility reported a census of 5 residents. The sample included 3 residents and 1 closed review resident. Based on observation, record review and interview for 1 sampled resident (#02) and 1 closed review resident (#04) , the operator failed to ensure documentation on residents in accordance with accepted professional standards and practices including all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken and results of the action.<br><br>Findings included:<br><br>- Record review for resident #02 recorded admission date of 8/2/18 with diagnoses of: cerebrovascular accident (CVA), dementia, depression and diabetes mellitus type 2.<br><br>Functional Capacity Screen (FCS) dated 3/15/19 recorded resident required physical assistance with bathing, dressing, toileting and transfer. Resident recorded as unable to perform walk/mobility and management of medications and treatments.<br><br>Negotiated service agreement (NSA) and Health care service agreement (HCSP) recorded staff is to provide physical assistance with: bathing, dressing, transfers, walk/mobility, medications and treatments. | S5251 | | |

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|---|---|---|---|
| | B089066 | A. BUILDING: _____ B. WING _____ | 05/15/2019 |

| 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 |
|---|---|---|---|---|
| S5251 | Continued From page 12<br><br>Shift report dated 5/11/19 2pm to 10pm, "resident was found on floor of his/her room, alarm sounding ..... [operator #A] notified"<br><br>Incident/accident report for Falls recorded 5/11/19 at 8:00pm "operator notified of resident found on floor ... RN (registered nurse) will be in Sunday morning to check on resident ..."<br><br>Fax to physician dated 5/12/19 recorded "resident fell last night out of wheelchair, no injuries, vital signs stable (VSS) will continue to follow. Signed by licensed nurse #B.<br><br>Last nurse's note on record recorded the following: 3/12/19 at 2:00pm: "Resident's [child] took resident to podiatrist appointment. No new orders. Will continue to follow closely." Signed by licensed nurse #B.<br><br>Interview on 5/14/19 at 11:55am with licensed nurse #B stated he/she assessed the resident on Sunday (5/12/19) at about 1:00pm, he/she confirmed record lacked documentation in the nurses notes of the fall and assessment.<br><br>On 5/14/19 at 9:00am, observed resident #02 in his/her room in a wheelchair. Resident's thumb on the right hand was swollen and observed a large approximately 3-inch purple area on the top of resident's left hand.<br><br>Interview on 5/14/19 at 12:10pm with licensed nurse #B and operator #A were asked:<br><br>What do you know about resident's swollen thumb? Licensed nurse #B: "I noticed it a week or so ago"<br><br>Do you have any documentation at all (for the | S5251 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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|---|---|---|---|---|
| S5251 | Continued From page 13 | S5251 | | |

bruise and swollen thumb)? Licensed nurse #B: "No"

On 5/14/19 at 1:50pm received notarized statement from licensed nurse #B, recorded: "4/12/19- report received from day shift staff that resident thumb was swollen. During assessment thumb was swollen, resident able to move back and forth and use during normal activity ....."

Resident record lacked documentation of a swollen thumb and bruises on 4/12/19, and fall on 5/12/19, including notification of family, nursing assessment of injury/incident at time of occurrence, notification of physician of injuries and follow up of resident condition following the injuries/ incidents.

Record review for resident #04 recorded admission date of 10/14/11 with diagnoses of: Alzheimer's, chronic obstructive pulmonary disease and stress incontinence.

FCS dated 3/15/19 recorded resident required physical assistance with bathing and is unable to perform management of medications and treatments.

NSA/HCSP dated 3/15/19 recorded staff to assist resident with bathing and management of medications and treatments.

Nurses notes recorded entries on 4/2/19 at 8:00pm: "resident toenails trimmed ...." And last nurses note: on 5/7/19 at 1:30pm: "resident DCd (discharged) to [another facility] ...."

Fax to physician dated 4/8/19 recorded: "[resident] has a skin tear that has been closed and open times 2 .... Today site is more red on

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|---|---|---|---|---|
| S5251 | Continued From page 14<br><br>RFA (right forearm) ...." Orders written for Ceftin (antibiotic) 250mg (milligrams) BID (twice a day) for 10 (days).. signed by licensed nurse #B.<br><br>April 2019 MAR (medication administration record) recorded the antibiotic was administered twice a day for 10 days by staff.<br><br>Shift report dated 5/2/19 2pm to 10pm recorded resident "came out for supper, wanted arm wrapped, [licensed nurse #B put TAO (triple antibiotic ointment) on it."<br><br>Nurses notes lacked entries for assessment and treatment of the skin tear including notification of the physician, description of the injury, notification of family and follow-up of condition after antibiotic therapy.<br><br>For residents #02 and #04, the operator failed to ensure documentation on residents in accordance with accepted professional standards and practices including all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken and results of the action. | S5251 | | |