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	175525	A. BUILDING _____ B. WING _____	C 01/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

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F 000	INITIAL COMMENTS The following citations are the result of a complaint investigation for KS00176758 and KS00176707. The 2567 was sent electronically on 01/24/23.	F 000		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for	F 604		

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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restraints.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 41 residents with three residents reviewed for abuse and neglect. Based on record review and interview, the facility failed to protect Resident (R) 1 from abuse of physical restraint when Certified Nurse's Aide (CNA) M restrained R1 by placing her forearm across R1's upper thighs to keep R1 from moving which caused bruises to R1's upper right thigh measuring 13 centimeters (cm) by 6.5 cm that were blue/green to purple in color and in an oblong shape and bruises to her upper left thigh measuring 6.5 cm by 4.5 cm blue/green to purple in color and oval in shape. This deficient practice of manually restraining R1 to keep her from moving placed R1 at risk for injury and impaired psychosocial well-being.

Findings included:

- R1's Electronic Medical Record documented diagnoses of vascular dementia (progressive mental disorder characterized by failing memory, confusion), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

The "Quarterly Minimum Data Set (MDS)," dated 10/21/22, documented R1 had a Brief Interview for Mental Status (BIMS) score of seven which indicated severe cognitive impairment. The MDS further documented R1 was totally dependent on two staff for transfers, required extensive assistance of two staff for bed mobility, dressing,

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and toilet use, and required extensive assistance of one staff for locomotion, personal hygiene, and eating.

The "Activity of Daily Living (ADL) Care Plan," dated 10/21/22, documented R1 required assistance with ADLs. The care plan instructed staff R1 required assistance of one staff for bed mobility, incontinence care, eating, personal hygiene, and bathing. The care plan instructed staff R1 required two staff assistance using a total lift for transfers.

The "Dementia/Anxiety Care Plan," dated 10/21/22, documented R1 often exhibited repetitive movements and restlessness. The care plan instructed staff to give R1 clear explanations of any care given, provide R1 opportunities for choice during cares, and to provide R1 consistency with cares to promote comfort with ADL's.

The "Facility Incident Report," dated 12/13/22, documented on the night shift of 12/08/22 to 12/09/22 on the 10:00 PM to 06:00 AM shift, R1 was restless in bed. CNA M entered R1's room at 11:10 PM with R1's wheelchair and remained in R1's room until 11:13 PM. During CNA M's time in R1's room, CNA M claimed R1 had thrown her pillow onto the floor, so CNA M picked the pillow up and returned it to R1 and CNA M resumed stocking R1's room. R1 continued to be restless and threw her pillow again. CNA M stated she tried to reposition R1 and the bed was unlocked and made a banging noise against the wall and R1 had hit the wall with her hand a couple of times. Licensed Nurse (LN) G, LN H, and CNA N were at the nurse's station and heard the banging coming from R1's room. LN G hollered out,

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"What's going on in there?" CNA M reported to the other staff the bed was not locked and R1 had hit her hand against the wall a couple of times. LN G, LN H, and CNA N did not go into R1's room at this time as they were in close enough proximity at the nurse's station to hear CNA M's answer. CNA M went into R1's room again on 12/09/22 at 12:03 to 12:05 AM and reported R1 was continuing to be restless and was repeatedly kicking her blankets off and was causing her motion sensor to alarm. CNA M went back into R1's room at 12:12 AM to 12:17 AM and then again at 02:03 to 02:08 AM. At 02:34 AM, CNA M and CNA N went into R1's room to provide R1 with cares and get her up to her chair due to R1 continuing to be restless. At this time, CNA N noticed the bruises to the top of R1's thighs. CNA N reported she heard CNA M say "watch they will try to pin that on me." CNA N reported the bruises to LN G and she assessed R1's bruises and then asked LN H to come to the unit to assist her. LN G and LN H sent CNA M on break outside of the facility and called Administrative Nurse D regarding possible abuse at 03:04 AM. Administrative Nurse D arrived to the facility at 03:15 AM. CNA M returned to the facility and the Administrative Nurse D instructed CNA M to leave and discontinue her duties as an aide. R1 was assesed to have a blue-green to purple colored bruise to her right upper thigh consistent with a ecchymosis (bruising) that measured 13 cm by 6.5 cm, was oblong in shape, and had varying degrees of firmness with palpation consistent with a hematoma (collection of blood trapped in the tissues of the skin or in an organ, resulting from trauma). R1's left upper thigh had sustained a bruise that was blue-green to purple in color, was oval in shape, and had the same varying degrees of firmness with palpation that measured 6.5 cm

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by 4.5 cm. Administrative Nurse D asked R1 if someone had placed their hands on her and R1 said yes and pointed to her legs. Law enforcement was called, and the law enforcement officer asked CNA M to come to the police station to make a statement.

The "Witness Statement," dated 12/09/22, documented CNA N stated R1was setting off her floor alarm by moving her feet. CNA N went into R1's room to ask R1 why she was trying to get out of bed. R1 stated she wanted to get up. CNA N asked R1 if she wanted to get up to her chair and eat a snack and R1 replied, "Yes." CNA N raised the bed up and pulled back R1's covers and saw the bruises on R1's legs. CNA N stepped out of the room and asked LN G if any bruising had been reported to her. LN G checked her paperwork and then went into R1's room to assess the bruises. LN G left R1's room to go and get LN H. CNA N brought R1 out to the sitting room and put on a movie for her to watch and fed her a pudding and gave her something to drink. R1 was content.

The "Witness Statement," dated 12/09/22, documented LN G stated on 12/08/22 at 11:30 PM she and CNA N had been sitting in the nurse's station when she heard banging on the wall coming from R1's room. LN G stated there was two to three banging noises with one of the banging noises being R1's bed hitting the wall and the other two banging noises were unfamiliar to LN G. LN G stated she yelled, "What is going on in there?" LN G stated CNA M replied, "She [R1] keeps getting out of bed." LN G stated R1 had been restless. Later in the night at approximately 02:30 AM, CNA M and CNA N went to get R1 up to her chair per R1's request as

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R1 was restless again. CNA N yelled for LN G to come see R1's legs. LN G stated when she arrived at R1's room she saw bruising to R1's legs. The right leg bruise measured 6 cm by 10 cm and the left leg bruise measured 4 cm by 3 cm and 3 cm by 1 cm. LN G stated all three bruises were fresh with dark blue centers fading to light blue around the edges and were slightly raised. R1 stated the areas hurt after LN G assessed them. LN G asked CNA M and CNA N where the bruises came from. CNA M stated, "Those are old." LN G then went and got LN H to assist. R1 was up in her chair and was content. LN G stated she and LN H called the Administrative Nurse D to come to the facility.

The "Witness Statement," dated 12/09/22, documented LN H stated LN G had come to her regarding R1's bruising to her legs. LN H went to assess R1 and noted blue bruising to the top of R1's bilateral legs with lumps under the bruising. LN H stated she and LN G tried to piece together plausible scenarios of how the bruises had been sustained without any luck. LN H took CNA M into the break room to talk to her about the bruises to R1. CNA M stated, "She [R1] was restless and I was trying to put a pillow in place. When I rolled her, she was banging on the walls. I noticed the bruises earlier and meant to tell LN G but I forgot."

The "Skin/Wound Note," dated 12/10/22, documented bruises noted to R1's upper thighs bilaterally. The bruises are dark blue in the center fading to light blue around the edges.

The "Skin/Wound Note," dated 12/11/22, documented bruising continues to R1's bilateral upper thighs. The left thigh has two bruises both

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are had and dark blue in the middle fading to light blue around the edges. The right thigh bruise has increased in size and the dark blue area continues to be hard to the touch. R1 reports the areas hurt.

The "Skin/Wound Note," dated 12/12/22, documented R1 continued to have bruising to her bilateral upper thighs. The area on the right thigh continued to be hard. The area has yellow around the edges and the middle continues to be a dark blue. The bruises to the left thigh continued to be dark blue in the center and fade to light blue around the edges. R1 complained of pain to all areas.

The "Skin/Wound Note," dated 12/13/22, documented R1 continued to have bruising to her bilateral upper thighs. The left thigh bruises both had dark blue centers with light blue around the edges. The right thigh bruise had a dark blue center with yellow around the edges and continues to be hard to the touch. R1 complained of pain to all affected areas.

The "Skin/Wound Note," dated 12/20/22, documented R1 continue to have bruising to her bilateral thighs. The left thigh bruise had green/yellow discoloration and the right thigh is purple to yellow in discoloration with a large knot.

The "Skin/Wound Note," dated 12/26/22, documented R1 continued to have bruising to her bilateral upper thighs. Bruising to the left thigh was lightening up in comparison to the right thigh which was still pink/red in color. A lump was still noted to the right thigh. R1 denied pain to the areas.

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The "Skin/Wound Note," dated 12/30/22, documented the bruising to R1's right thigh continued to fade. There continue to be a large, firm, raised hematoma like area remained to the site since the first notation on 12/09/22. No redness or warmth were noted. R1 denied pain to the area.

The "Skin/Wound Note," dated 01/02/23, documented the bruising to R1's bilateral thighs had faded. The areas continue to be hard to touch and slightly raised. R1 denied pain.

On 01/09/23 at 01:30 PM, the law enforcement officer stated that CNA M had admitted that she had placed her forearm across R1's upper thighs to keep her from moving so she cover her up with a blanket and quickly exit the room.

On 01/09/23 at 01:45 PM, R1's representative stated that R1 was dependent on the facility for all of the care that she needed. R1's representative stated R1 still had bruises to the tops of her thighs and it had been a month since it had happened.

On 01/09/23 at 02:00 PM, Administrative Nurse D stated that CNA M told her that R1 kept kicking off her blankets and that her arms may have come into contact with R1's legs when she was replacing the blanket. Administrative Nurse D stated that routine care does not typically result in injury to a resident. Administrative Nurse D stated under no circumstances were residents to be held down against their will.

The facility's "Abuse, Neglect, and Exploitation," policy, dated February 2017, documented abuse is the willful infliction of injury, unreasonable

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F 604	Continued From page 8 confinement, intimidation, or punishment with resulting harm, pain, or mental anguish. All elders of the facility will be free of physical, emotional, and sexual abuse, neglectful treatment, and misappropriation of funds and resources. The facility failed to protect R1 from abuse when CNA M restrained R1 with her forearm placed across R1's upper thighs to keep R1 from moving which caused bruises to R1's upper bilateral thighs. This deficient practice of restraining R1 to keep her from moving placed R1 at risk for injury and impaired psychosocial well-being.	F 604		