STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175414	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE VILLAGE	86 TWENTY-SECOND AVENUE MOUNDRIDGE, KS 67107

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #145014. The 2567 was electronically sent to the facility on 09/04/19.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation 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)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: The facility had a census of 69 residents. The sample included three residents sampled for abuse. Based on observation, interview, and record review, the facility failed to provide a safe environment and protect residents from abuse, when staff found Resident (R) 1 lying on her bed with no brief on, feet flat on the bed, knees bent up, and her legs spread apart. Certified Nurse Aide (CNA) M, was observed standing in front of R1, between her legs, with his pants unzipped, and down around his hips, placing R1 in immediate jeopardy This deficient practice had the potential to affect the other 68 residents in the facility.	F 600	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 09/04/2019

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F 600	Continued From page 1	F 600		

Findings include:

- R1's quarterly "Minimum Data Set" (MDS), dated 08/10/19, documented she had a Brief Interview for Mental Status (BIMS) score of 8, indicating moderate cognitive impairment. The MDS documented the resident required extensive assistance of one staff for bed mobility, transfers, walking in her room, dressing, toileting, personal hygiene, and bathing. The MDS documented R1 used a walker and wheelchair for mobility.

The care plan, dated 08/10/19, directed staff to provide the resident a whirlpool bath in the mornings, twice a week. The care plan documented the resident preferred to get out of bed between 05:30 AM and 09:00 AM, and after grooming and getting dressed, had breakfast in the dining room. The care plan documented R1 liked female care givers, but she liked and would work with CNA M.

Review of the facility's investigation documented on 08/27/19 at 04:50 AM, Licensed Nurse (LN) G notified Administrative Nurse D of concerns of abuse toward R1 by CNA M. LN G reported CNA N called LN H to R1's room. CNA N reported she entered R1's room and observed CNA M standing and facing R1's bed with his pants unzipped. CNA N reported R1's incontinent brief was on the floor next to her bed and her nightgown was up around her waist. CNA N yelled out "What are you doing?" and CNA M's pants fell to the floor. CNA N called for LN H to come immediately and she told CNA M to get out of the room. LN H sent CNA M to the nurse's desk, away from all residents, and staff stayed with R1 to ensure her safety. Staff assisted R1 to the bathroom at her

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F 600	Continued From page 2	F 600		

request. LN G contacted law enforcement at 05:13 AM and they arrived at the facility at approximately 05:30 AM.

On 08/28/19 at 02:15 PM, observation revealed R1 in her bed, covered with a blanket, and her eyes closed.

On 08/29/19 at 08:40 AM, Administrative Nurse D stated staff notified her on 08/27/19 at approximately 05:12 AM of a potential abuse situation involving R1 and CNA M. Administrative Nurse D stated she instructed LN G to call the police and Administrative Nurse D came to the facility immediately.

On 08/29/19 at 10:36 AM, CNA N stated on 08/27/19 at approximately 04:50 AM, CNA M said he would give R1 a bed bath. CNA N offered to help and told CNA M to turn R1's call light on when he was ready for her to come to R1's room. CNA N said the call light never sounded, so she knocked on the door and entered R1's room. CNA N observed R1 on the lower part of her bed, without a brief on, knees bent, feet flat on the bed, and her legs spread apart. CNA N stated she observed CNA M facing R1, positioned between her legs, with his pants unzipped and holding on to them with one hand. CNA N stated she asked what he was doing, and he fumbled for words and stated, "It's not what it looks like" and his pants fell to the floor. CNA N stated R1's bed had been raised and was even with CNA M's hips.

On 08/29/19 at 12:39 PM, LN H verified she observed CNA N at the door of R1's room, and CNA Aide N screamed at her to come to R1's room. LN H stated she entered the room and

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observed R1 at the bottom of her bed with her legs dangling off the bed, her night gown up to her waist, no incontinent brief on, and her genital area exposed. LN H verified she observed CNA M with his pants unzipped.

On 08/29/19 at 02:54 PM, LN G stated she received a call from LN H and was told she needed help with a situation. LN G stated she called Administrative Nurse D at 05:12 AM to report the situation, and Administrative Nurse D instructed her to call the police. LN G stated she called the police at 05:13 AM, and they arrived at the facility at approximately 05:30 AM.

The facility's Abuse, Neglect and Exploitation policy, dated 12/11/17, documented the purpose of the policy was to ensure residents were free from verbal, physical, sexual, and mental abuse. The policy documented the definition of sexual abuse as the non-consensual sexual contact of any type with a resident, but is not limited to sexual harassment, sexual coercion, or sexual assault.

The facility failed to ensure residents were protected from abuse, when CNA M abused R1.

On 08/29/19 at 06:20 PM, Administrative Staff A and Administrative Nurse D were provided a copy of the IJ Template and notified that the facility failed to ensure R1 was protected from abuse and this constituted immediate jeopardy at F600. The immediate jeopardy was determined to begin on 08/27/19, when the facility discovered CNA M abused R1.

The facility implemented abuse in-service education for all staff immediately after the

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F 600	Continued From page 4 incident. This deficient practice was identified as past non-compliance and was corrected on 08/27/19. The deficient practice remained at a "G" scope and severity following completion of all staff education.	F 600		