STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175380	A. BUILDING _____ B. WING _____	C 05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CEDARS	1021 CEDARS DRIVE MCPHERSON, KS 67460

(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 are the result of abbreviated survey and complaint investigation KS00178253. The 2567 was sent electronically on 05/30/23.	F 000		
F 600 SS=D	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 identified a census of 37 residents. The sample included three residents. Based on observation, record review and interview the facility failed ensure Resident (R) 1 remained free from staff to resident abuse and neglect when the facility failed to ensure the necessary number of staff as directed by R1's care plan, which directed staff to have two staff assistance for use with the sit to stand lift (a device used to assist a resident to rise from the seated position but does not support the resident's entire body weight) and staff then used their foot to kick R1's foot into	F 600		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 600	Continued From page 1	F 600		

place on the lift. The deficient practice left R1 at risk of injury and psychosocial impairment.

Findings included:

- The electronic medical record (EMR) for R1 documented diagnoses of cerebral infarction (stroke-disruption of blood and oxygen to the brain causing brain cell death), and cerebrovascular disease (a condition that affects the flow of blood to the brain).

The "Significant Change Minimum Data Set" (MDS) dated 01/09/23 documented R1 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R1 required extensive assistance of two staff for bed mobility, transfers, dressing, and toileting activities of daily living (ADLs). R1 had impairment of both upper and lower extremities on one side. R1 required a wheelchair for mobility. R1 was on hospice services.

The "Quarterly MDS" dated 04/10/23 for R1 documented a BIMS score of 15 indicated intact cognition. R1 required extensive assist of two staff for most ADLs and was total dependence on staff of two for transfers. R1 had impairment of both upper and lower extremities on one side. R1 required a wheelchair for mobility. R1 was on hospice services.

The "ADL Care Area Assessment" dated 01/10/23 for R1 documented to proceed to the care plan with the amount of assistance required for resident.

R1's "ADL Care Plan" dated 11/15/22 directed staff R1 required assistance of two staff members

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F 600	Continued From page 2	F 600		

for transfers, bed mobility and toileting. The care plan directed staff to use the sit to stand lift with two staff for transfers. With a start date of 11/15/22 the care plan directed staff that R1 required the assistive device of full lift.

A "Grievance Form" with a date of 01/10/23 by Social Services X, as reported by R1, documented R1 reported a staff member was "rough" with him during transfers. Social Services X notified Administrative Nurse D and facility vice president who completed an investigation and interviewed staff and other residents. The investigation was completed by Administrative Nurse D and Administrative Staff B. Social Services X was notified on 01/13/23 by Administrative Nurse D that she (Administrative Nurse D) had spoken with the involved staff member, Certified Medication Aide (CMA) R, and provided additional training and in-service. Social Services X followed up with R1 on 01/13/23 and he reported the situation had gotten better. Social Services X informed R1 of her follow up and R1 agreed to let Social Services X know if an issue arises again.

A "Witness Statement of Facts" dated 02/10/23 signed by CMA R documented R1 used the sit to stand lift. R1 had issues standing upright to be safe while on the lift. CMA R had prompted R1 repeatedly to stand tall while on the lift and explained that it was unsafe to use the sit to stand lift if R1 cannot bear weight and stand. CMA R used a full sling lift to transfer R1 in a safer manner. R1 reported to other staff he felt like CMA R punished him by using the full lift. R1 also made comments to CMA R about how she should find another job. Thes incidents were reported by CMA R's charge nurse.

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F 600	Continued From page 3	F 600		

A "Witness Statement of Facts" dated 02/10/23 by Consultant GG documented the nurse asked R1 how he was feeling and R1 stated he was cold last night. R1 stated that CMA R turned off his heat. R1 went on to say that CMA R was also rough when he was in the lift, if his foot was in the wrong place CMA R "kicks it" into place. R1 said CMA R had bumped him into the wall while in the lift and when CMA R removed the lift strap, she pulled it roughly and "yanks" it off and caused him pain. R1 further stated CMA R was mean to him and said CMA R abuses him. R1 continued saying it had been getting worse over the last few weeks. Consultant GG then notified Administrative Nurse D.

A "Witness Statement of Facts" dated 02/10/23 by Certified Nurse Aide (CNA) M documented when CNA M was getting R1 up after CMA T and her put on R1's jacket, R1 asked how to get an aide to transfer to another house. R1 then told CMA T and CNA M that CMA R told him yesterday to button up his own shirt and kicked his foot. R1 had also told them that CMA R told R1 to wheel himself to breakfast. CNA M recorded CMA R had not answered any of R1's lights that day, in fact CMA R told CNA M she was avoiding R1.

A "Witness Statement of Facts" dated 02/10/23 by CMA T documented she was assisting R1 up for the day with another aide CNA M. R1 asked if there was any way to get someone moved out of the house. CMA T asked if R1 wanted to move and R1 said no. R1 said he wanted a certain staff out of there (CMA R). CMA T asked what happened and R1 said CMA R told him to button his own shirt. R1 also stated the CMA R kicked

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F 600	Continued From page 4	F 600		

his foot because it was not on the lift correctly.

A typed statement dated 02/10/23 from Administrative Nurse D documented Consultant GG came to her that morning to discuss some concerns brought to her attention by R1. Consultant GG told Administrative Nurse D that R1 stated CMA R had been short with him and rough with cares. Consultant GG stated R1 had used the term abuse. Consultant GG completed a witness statement. Administrative Nurse D went to speak with R1 and asked him what was going on. R1 said every time CMA R walked in, she goes to the thermostat and turns his heat off. R1 states this type of thing had been going on a couple of months and then stated that it has always been bad. R1 stated he thought CMA R and him were friends and he had her as an aide the first time he was at the facility. R1 reported CMA R hits the wall with the lift when she takes him in and out of the bathroom; CMA R "yanks" the sling off to remove it after transfers and it pulls his skin. R1 denied ever having a bruise or skin issue related to cares from CMA R. R1 also reported that CMA R "kicks" him when he was on the lift to get his feet in the right position if they were not in the correct spots. R1 also reported that CMA R made him attempt to button his own shirt and that was something he could not do on his own due to limited dexterity. R1 also reported CMA R put him in the hall after getting him ready for meals and encouraged him to wheel out independently. R1 mentioned twice that he did not want CMA R fired but did not want her in the house. R1 denied any issues with any other staff members. Administrative Nurse D encouraged R1 to let staff know immediately if there were any staff concerns or he felt like he was being treated with respect or dignity in any way. CMA R was

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F 600	Continued From page 5	F 600		

sent home at the beginning of investigation by the administrator pending investigation.

A "Witness Statement of Facts" dated 02/12/23 by Licensed Nurse (LN) H documented CMA R had mentioned to that nurse that R1 was giving her a hard time and was not standing in the lift. CMA R told the nurse that she told R1 that if he did not stand, she was going to use the full lift on him. CMA R told this nurse that when standing R1 in the lift, he would not stand up and would "hang" and not attempt to stand. CMA R said R1 would tell her he was an old man and he had two strokes. CMA R said that a few times while R1 was on the lift, she would use her feet to move R1's feet as they would start to move while standing in the lift. LN H spoke with R1 who said he did not like CMA R because she was always in a bad mood and threatened to use the full lift on him when he could not stand.

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On 05/15/23 at 12:40 PM R1 sat in his wheelchair in his room, with a lift sling under him in the wheelchair. R1 stated on the day of that incident, CMA R thought he should be advancing more in the lift and she used her foot to move his leg onto the lift. R1 stated he has had two strokes and was weak from the most recent one. R1 stated CMA R was the only staff assisting him that day with the sit to stand lift.

On 05/15/23 at 12:46 PM CNA M stated R1 had complained to her and the hospice nurse about CMA R. CNA M told the charge nurse about the incident. CNA M said CMA R was not allowed to do any cares with R1 anymore. CNA M stated she had not heard or had any complaints from other resident about CMA R. CNA M stated R1 was not happy after being switched to the full lift after

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F 600	Continued From page 6	F 600		

physical therapy (PT) re-evaluated the need to use the full lift.

On 05/15/23 at 01:44 PM LN H stated via phone conversation that R1 complained about CMA R being rough at times with his cares and when he was not able to move his foot or leg when CMA R wanted him too she would use her foot/leg the kick his foot into the right place. R1 had told LN H that he felt CMA R was being mean to him. LN H stated CMA R told her about the incident with R1.

On 05/15/23 at 02:50 PM Administrative Nurse D stated usually the sit to stand lift only required one staff assist with its used and the full lift required two staff and she was not aware that R1's care plan directed staff to have two staff with his transfers with the sit to stand lift. Administrative Nurse D stated she did an investigation regarding the incident with R1 and CMA R but did not report the incident to the state because after investigation the facility found there to be no evidence of abuse. Administrative Nurse D stated R1 was upset and felt like he was being degraded when he was changed to having to use the full lift. Administrative Staff D stated that herself and PT staff both further explained in depth the need of the full lift use for his safety and his inability to stand as needed when using the sit to stand lift.

On 05/15/23 at 04:02 PM LN G stated she had worked at the facility since April but had worked at the facility prior to that when R1 first came to the facility. LN G stated R1 had used the sit to stand lift, but a few months ago and ever since she had been back R1 used a full lift with two staff. LN G stated the aides did have access to resident care plans and were available also in a book at the

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F 600	Continued From page 7	F 600		

nurse's station. LN G stated the facility just had a big training about the lifts a couple of months ago.

On 5/15/23 at 04:10 PM CMA S stated R1 was care planned to have two staff with him for the sit to stand lift for a short time, but R1 now has to use the full lift after he was evaluated by PT. CMA S stated R1 did not like the full lift and felt like he was being picked on and he felt staff just didn't want to help him anymore to use the sit to stand lift.

The "Abuse, Neglect, Exploitation and Crime Prevention and Management" Policy last revised 12/16 documented: As soon as it is reported that there was alleged abuse of a resident by an employee, the employee was to be immediately suspended pending the outcome of the investigation and asked to leave the premises until they were called in for review of the findings upon completion of the investigation. Any employee that had knowledge of, was suspicious of, or was witness to an incident of abuse, shall immediately report their concerns to their supervisor, DON, and/or Administrator. The Supervisor will report the incident to the DON and the Administrator immediately. Upon completion of the investigation, administration would discuss the outcome with any involved employees. If the accusation was validated administration would complete disciplinary action and/or termination at that time. The Administrator or designee will report to Kansas Department for Aging and Disability Services (KDADS) injuries of an unknown source immediately and investigate. Evidence of these investigations will be made to KDADS with five working days of the incident. Proof of investigation will be provided on appropriate state forms.

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F 600	Continued From page 8 The facility failed to ensure R1 remained free from staff to resident abuse and neglect. The deficient practice left R1 at risk of injury and psychosocial impairment.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 609		

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F 609	Continued From page 9	F 609		

The facility identified a census of 37 residents. The sample included three residents. Based on observation, record review and interview, the facility failed to identify an allegation as potential abuse and neglect and failed to report to the State Agency (SA) as required when R1 reported that Certified Medication Aide (CMA) R was being rough with cares and kicked R1's leg/foot. This placed R1 at risk for ongoing neglect and abuse.

Findings included:

- The electronic medical record (EMR) for R1 documented diagnoses of cerebral infarction (stroke-disruption of blood and oxygen to the brain causing brain cell death), and cerebrovascular disease (a condition that affects the flow of blood to the brain).

The "Significant Change Minimum Data Set" (MDS) dated 01/09/23 documented R1 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R1 required extensive assistance of two staff for bed mobility, transfers, dressing, and toileting activities of daily living (ADLs). R1 had impairment of both upper and lower extremities on one side. R1 required a wheelchair for mobility. R1 was on hospice services.

The "Quarterly MDS" dated 04/10/23 for R1 documented a BIMS score of 15 indicated intact cognition. R1 required extensive assist of two staff for most ADLs and was total dependence on staff of two for transfers. R1 had impairment of both upper and lower extremities on one side. R1 required a wheelchair for mobility. R1 was on hospice services.

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F 609	Continued From page 10	F 609		

The "ADL Care Area Assessment" dated 01/10/23 for R1 documented to proceed to the care plan with the amount of assistance required for resident.

R1's "ADL Care Plan" dated 11/15/22 directed staff R1 required assistance of two staff members for transfers, bed mobility and toileting. The care plan directed staff to use the sit to stand lift with two staff for transfers. With a start date of 11/15/22 the care plan directed staff that R1 required the assistive device of full lift.

A "Grievance Form" with a date of 01/10/23 by Social Services X, as reported by R1, documented R1 reported a staff member was "rough" with him during transfers. Social Services X notified Administrative Nurse D and facility vice president who completed an investigation and interviewed staff and other residents. The investigation was completed by Administrative Nurse D and Administrative Staff B. Social Services X was notified on 01/13/23 by Administrative Nurse D that she (Administrative Nurse D) had spoken with the involved staff member, Certified Medication Aide (CMA) R, and provided additional training and in-service. Social Services X followed up with R1 on 01/13/23 and he reported the situation had gotten better. Social Services X informed R1 of her follow up and R1 agreed to let Social Services X know if an issue arises again.

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F 609	Continued From page 11	F 609		

stand lift if R1 cannot bear weight and stand. CMA R used a full sling lift to transfer R1 in a safer manner. R1 reported to other staff he felt like CMA R punished him by using the full lift. R1 also made comments to CMA R about how she should find another job. These incidents were reported by CMA R's charge nurse.

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A "Witness Statement of Facts" dated 02/10/23 by CMA T documented she was assisting R1 up

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F 609	Continued From page 12	F 609		

for the day with another aide CNA M. R1 asked if there was any way to get someone moved out of the house. CMA T asked if R1 wanted to move and R1 said no. R1 said he wanted a certain staff out of there (CMA R). CMA T asked what happened and R1 said CMA R tells him to button his own shirt. R1 also said if he does not do it, CMA R will not do it for him. R1 also stated the CMA R kicked his foot because it was not on the lift correctly. R1 said CMA R leaves him in his wheelchair in the hall and refuses to push him to/from his room.

A typed statement dated 02/10/23 from Administrative Nurse D documented that Consultant GG came to her that morning to discuss some concerns brought to her attention by R1. Consultant GG told Administrative Nurse D that R1 stated CMA R had been short with him and rough with cares. Consultant GG stated R1 had used the term abuse. Consultant GG completed a witness statement. Administrative Nurse D went to speak with R1 and asked him what was going on. R1 said every time CMA R walked in, she goes to the thermostat and turns his heat off. R1 states this type of thing had been going on a couple of months and then stated that it has always been bad. R1 stated he thought CMA R and him were friends and he had her as an aide the first time he was at the facility. R1 reported CMA R hits the wall with the lift when she takes him in and out of the bathroom; CMA R "yanks" the sling off to remove it after transfers and it pulls his skin. R1 denied ever having a bruise or skin issue related to cares from CMA R. R1 also reported that CMA R "kicks" him when he was on the lift to get his feet in the right position if they were not in the correct spots. R1 also reported that CMA R made him attempt to button

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175380	A. BUILDING _____ B. WING _____	C 05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CEDARS	1021 CEDARS DRIVE MCPHERSON, KS 67460

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F 609	Continued From page 13	F 609		

his own shirt and that was something he could not do on his own due to limited dexterity. R1 also reported CMA R put him in the hall after getting him ready for meals and encouraged him to wheel out independently. R1 mentioned twice that he did not want CMA R fired but did not want her in the house. R1 denied any issues with any other staff members. Administrative Nurse D encouraged R1 to let staff know immediately if there were any staff concerns or he felt like he was being treated with respect or dignity in any way. CMA R was sent home at the beginning of investigation by the administrator pending investigation.

A "Witness Statement of Facts" dated 02/12/23 by Licensed Nurse (LN) H documented: CMA R had mentioned to that nurse that R1 was giving her a hard time and was not standing in the lift. CMA R told the nurse that she told R1 that if he did not stand, she was going to use the full lift on him. CMA R told this nurse that when standing R1 in the lift, he would not stand up and would "hang" and not attempt to stand. CMA R said R1 would tell her he was an old man and he had two strokes. CMA R said that a few times while R1 was on the lift, she would use her feet to move R1's feet as they would start to move while standing in the lift. LN H spoke with R1 who said he did not like CMA R because she was always in a bad mood and threatened to use the full lift on him when he could not stand.

On 05/15/23 at 12:40 PM R1 sat in his wheelchair in his room, with a lift sling under him in the wheelchair. R1 stated on the day of that incident, CMA R thought he should be advancing more in the lift and she used her foot/leg to move his leg onto the lift. R1 stated he has had two strokes

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F 609	Continued From page 14	F 609		

and was weak from the most recent one. R1 stated CMA R was the only staff assisting him that day with the sit to stand lift.

On 05/15/23 at 02:50 PM Administrative Nurse D stated she did an investigation regarding the incident with R1 and CMA R but did not report the incident to the state because after investigation the facility found there to be no evidence of abuse. Administrative Nurse D stated R1 was upset and felt like he was being degraded when he was changed to having to use the full lift. Administrative Staff D stated that herself and PT staff both further explained in depth the need of the full lift use for his safety and his inability to stand as needed when using the sit to stand lift.

The "Abuse, Neglect, Exploitation and Crime Prevention and Management" Policy last revised 12/16 documented: Residents were to be protected from any physical and mental mistreatment, involuntary seclusion and misappropriation of resident property through the actions of staff, other residents, family members and other visitors. The Abuse coordinator in the facility was the Director of Nursing, Administrator, or facility appointed designee. Report allegations or suspected abuse, neglect or exploitation immediately to the Administrator, other officials in accordance with state law, and state survey and certification agency through established procedures. The Administrator or designee will report to the Kansas Department for Aging and Disability Services (KDADS) injuries of an unknown source immediately and investigate. Evidence of these investigations will be made available to KDADS within five working days of the incident. Proof of investigation will be provided on appropriate state forms.

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F 609	Continued From page 15 The facility failed to report an allegation of abuse and neglect to the state agency as required. This placed R1 at risk for ongoing neglect and abuse.	F 609		