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 06/27/2023

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 KS00180642. The 2567 was sent electronically on 07/06/23.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility identified a census of 38 residents with three residents reviewed for falls. Based on record review, observation, and interview, the facility failed to use safe methods when transferring and ambulating Resident (R) 1, placing her at risk for falling, injury, and pain. On 06/04/23 at 06:45 AM, Certified Medication Aide (CMA) R ambulated R1 from her room to the scale, to weigh R1. CMA R did not place a gait belt on R1. CMA R got R1 close to the scale and then CMA R turned her back to R1 to turn the scale on. During this time, R1 reached for her phone in the basket of her walker and in doing so, lost balance and fell to the floor on her left side. She landed on her left hip/upper thigh. Staff assessed R1 for injury and noted no deformity or bruising. A nurse and CMA R attempted to stand R1, but R1 could not stand so staff sat R1 on the seat of her four-wheeled walker. Staff obtained a	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 07/06/2023

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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wheelchair and pivot transferred R1 to the wheelchair and took R1 to the dining room table for breakfast. Approximately fifteen minutes later, R1 grimaced and held her left leg and stated it hurt a lot. Staff took R1 to her room for further assessment. When moving R1's leg off the wheelchair leg rest, R1 yelled out in pain. The facility transferred R1 to the hospital, where they performed an x-ray showing a mildly displaced intertrochanteric left femoral (a broken left hip) fracture and R1 required a cephalomedullary (surgical treatment for unstable fractures) fixation on 06/04/23.

Findings included:

- R1's Electronic Medical Record (EMR) documented R1 had diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), atrial fibrillation (rapid, irregular heartbeat), and congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid)

The "Quarterly Minimum Data Set (MDS)," dated 05/01/23, documented R1 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderate cognitive impairment. TMDSMDS documented R1 required limited to extensive assistance of one to two staff for bed mobility, transfer, ambulation, locomotion, toileting, personal hygiene, and bathingMDShe MDS documented R1 had two or more non-injury falls during the look back period and was not stable during transitions and walking and required staff for stabilization.

The "Cognitive Loss/Dementia Care Area Assessment (CAA)," dated 02/06/23, directed

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staff to proceed to care plan to support R1's moderate cognitive impairment and best quality of life.

The "Activities of Daily Living CAA," dated 02/06/23, directed staff to proceed to care plan with the amount of assistance needed with activities of daily living and persona cares.

The "Falls CAA," dated 02/06/23, directed staff to proceed to care plan with interventions for prevention of falls.

The "Fall Care Plan," revised 06/04/23, directed staff to assist R1 up after 06:00 AM rounds, keep R1's walker out of sight while she was in bed, and perform frequent visual checks. The plan directed staff to ensure R1 wore shoes when ambulating (no slippers), place a fall mat beside her bed on floor, and to provide a soft touch call light, not to turn away from R1 when walking to the weight scale. New interventions were added to address the 06/04/23 fall which directed staff not to leave R1's cell phone on her walker seat, keep bed in lowest position, and take R1 for a walk when R1 seemed anxious.

The "Fall Assessment," dated 01/30/23, documented a fall risk score of fourteen which indicated R1 was a high fall risk. The Fall Assessment documented R1 was disoriented, R1 had three or more falls in the last three months, R1 had balance problems while standing and walking, and was jerky and unstable when making turns.

The "Facility Incident Report," dated 06/08/23, documented CMA R assisted R1 out of bed to get ready for the day. R1's level of function prior to

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the fall included use of a four-wheeled walker with one staff assist. When CMA R walked R1 out to breakfast, they stopped at the scale due to obtain R1's weight. CMA R turned to activate the scale and R1 reached over to get her cell phone out of her walker basket, to put it on the top of her walker seat. Upon reaching into the basket, R1 lost her balance and fell to the floor landing on her left hip/upper left thigh. The staff notified the nurse on duty. The nurse entered the room and found R1 seated on the floor with CMA R standing behind her, as a backrest. The nurse assessed R1 and R1's vital signs were within normal limits and the left thigh assessment was normal. R1 stated her leg was sore though she had no deformity or pain with palpation. R1 wanted to get off the floor, but could not stand and staff assisted her to a sitting position on her four-wheeled walker seat. Staff obtained a wheelchair and pivot-transferred R1 to the wheelchair. R1 reported again that her leg was just sore. Staff assisted R1 to the dining room table. Approximately fifteen minutes later, R1 was grimacing and holding her left leg. R1 stated her leg hurt a lot. The staff took R1 to her room for further assessment. When the staff moved R1's leg off the wheelchair leg rest, R1 yelled out in pain. With assistance, R1 stood with her weight on her right leg so the left leg could be further assessed. The staff noted no bruising or deformity to the left leg. Due to increased pain in R1's left leg with movement and at rest, the staff notified R1's primary care physician and obtained an order to send R1 to the emergency room. The emergency medical service transferred R1 to the hospital. The facility implemented corrective actions including the staff would ensure they assisted R1 to a seated position on her walker, prior to staff needing to turn away for any reason.

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On 06/27/23 at 10:30 AM, observation revealed R1 laid back in a recliner in the commons area visiting with physical therapy staff. R1's right leg was bent at the knee and she swayed it back and forth.

On 06/27/23 at 10:45 AM, CNA M stated prior to R1's fall and fracture she was very unstable when she stood and walked, and she required one staff assistance with a gait belt for safety.

On 06/27/23 at 11:00 AM, Physical Therapy Assistant GG stated prior to her broken hip, R1 was not stable with standing or ambulation, and staff should always use a gait belt should always.

On 06/27/23 at 11:15 AM, Physical Therapist HH stated R1 had recently come off therapy and therapy recommended R1 required one staff assistance with a gait belt for all transfers and ambulation. Physical Therapist HH stated R1 was unstable and unable to stabilize without assistance with standing and ambulation, prior to her fall with fracture.

On 06/27/23 at 12:00 PM, CMA R stated she did not use a gait belt when she transferred and ambulated R1 the day R1 fell and broke her left hip. CMA R stated there was no gait belt in R1's room and since everyone was busy that morning, she ambulated R1 to the scale without a gait belt. CMA R stated she should have put on R1's call light and waited for someone to come so they could get her a gait belt to use with R1, prior to ambulating R1.

On 06/27/23 at 12:10 PM, Administrative Nurse D stated all the nursing staff should know to use a

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gait belt when transferring and ambulating any of the residents. Administrative Nurse D verified the facilities second day of training covered gait belt use. Administrative Nurse D stated the facilities gait belt policy was vague and needed reviewed.

The facility's "Gait Belt Policy," dated August 2018, documented the rationale for gait belts was to prevent undo injury to the employee or the resident when moving the resident. Staff were directed to obtain a gait belt from the resident's room, explain to the resident what was being done, apply the belt around the resident's waist over their clothing to allow enough room between the belt and the residents clothing to allow a flat hand to be inserted, after procedure remove the belt and return it to its location in residents' room.

The "Fall Management Policy," revised July 2022, documented the facility recognized that falls have the potential of being a devastating event for the residents. Because of this, the facility will systematically assess residents and evaluate fall situations and potential situations with the goal of identifying common fall risks, factors and developing care plan interventions to mitigate potential harm.

The facility failed to use safe methods when transferring and ambulating R1, to include lack of gait belt use and adequate supervision, which resulted in a fall and fractured left hip for R1 and required surgical repair.