STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N059009	A. BUILDING: _____ B. WING _____	02/21/2024

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) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey with attached complaint numbers 185712 and 185989 for the above named facility conducted on 02/19/24, 02/20/24, and 02/21/24.	S 000		
S3081 SS=D	26-41-201 (c) Functional Capacity Screen Reassessment (c) Designated facility staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-201 (c) (1) (2) The facility reported a census of 51 residents. The sample included four "Residents" (R). Based on record review and interview, the Administrator failed to ensure designated facility staff conducted a screening to determine R2's functional capacity at least once every 365 days. The administrator further failed to ensure designated facility staff conducted a screening for R3's functional capacity when she experienced a change of condition.	S3081		

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

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S3081	Continued From page 1 Findings included: - Record review for R2 revealed an admission date of 02/01/23 with diagnoses of Alzheimer's Disease, atrial fibrillation, iron deficiency anemia and anxiety. Review of R2's "Functional Capacity Screen" (FCS) dated 1/30/23 identified R2 was unable to bathe, dress or toilet herself. She required cues for eating, and had impaired short-term memory, impaired long-term memory, impaired memory recall, and impaired decision making. She was incontinent of her bladder and was marked with falls, impaired decision making, wandering and lacked the ability to manage her own medications and treatments. R2's combined "Negotiated Service Agreement / Health Service Plan" (NSA/HSP) dated 01/30/23 directed certified facility staff to physically assist R2 with bathing, dressing and toileting. Certified/Licensed facility staff were instructed to manage R2's medications and treatments. Interview on 02/20/24 at approximately 05:30 PM with Licensed Nurse B and Administrative Nurse C confirmed the FCS was greater than 365 days old. - Record review for R3 revealed an admission date of 05/10/23 with diagnoses of dementia, hypertension, lumbar spinal stenosis and osteoarthritis of the right knee. Review of R3's FCS dated 05/10/23 identified R3 required physical assistance with bathing, dressing, and toileting. F3 required supervision	S3081		

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S3081	Continued From page 2 with transferring and walking. She was unable to manage her own medications and treatments and was occasionally incontinent of her bladder. She was marked with impaired short-term memory, and impaired decision making. She was usually able to make herself understood and she usually understood others. She was marked with falls, impaired decision making, and she used a walker mobility device. Review of R3's combined NSA/HSP dated 08/23/23 directed facility staff to provide physical assistance with bathing, dressing and toileting. Staff were instructed to physically assist R3 with ambulation using a gait belt and her walker. R3 used a walker and wheelchair mobility device. Facility staff to provide health shakes two times daily per R3's medical provider order. The NSA/HSP identified the home health outside provider for physical therapy. Interview on 02/20/24 at approximately 05:30 PM with Licensed Nurse B and Administrative Nurse C confirmed R3's record lacked a screening when she experienced a change of condition and was placed on physical therapy with an outside provider. The Administrator failed to ensure designated facility staff conducted a screening to determine R2's functional capacity at least once every 365 days. The administrator further failed to ensure designated facility staff conducted a screening for R3's functional capacity when she experienced a change of condition.	S3081		
S3092 SS=D	26-41-202 (d) Negotiated Service Agreement Revisions	S3092		

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S3092	Continued From page 3 (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements:(1) At least once every 365 days; (2) following any significant change in condition, as defined in K.A.R. 26-39-100; (3) at least quarterly, if the resident receives assistance with eating from a paid nutrition assistant; and (4) if requested by the resident or the resident ' s legal representative, facility staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-202 (d)(1) The facility reported a census of 51 residents. The sample included four "Residents" (R). Based on record review and interview, the Administrator failed to ensure the review and if necessary, the revision of R2's "Negotiated Service Agreement" (NSA) at least once every 365 days. Findings included: - Record review for R2 revealed an admission date of 02/01/23 with diagnoses of Alzheimer's Disease, atrial fibrillation, iron deficiency anemia and anxiety. Review of R2's "Functional Capacity Screen"	S3092		

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S3092	Continued From page 4 (FCS) dated 01/30/23 identified R2 was unable to bathe, dress or toilet herself. She required cues for eating, and had impaired short-term memory, impaired long-term memory, impaired memory recall, and impaired decision making. She was incontinent of her bladder and was marked with falls, impaired decision making, wandering and lacked the ability to manage her own medications and treatments. R2's combined NSA/"Health Service Plan" (HSP) dated 01/30/23 directed certified facility staff to physically assist R2 with bathing, dressing and toileting. Certified/Licensed facility staff were instructed to manage R2's medications and treatments. Interview on 02/20/24 at approximately 05:30 PM with Licensed Nurse B and Administrative Nurse C confirmed the combined NSA/HSP was greater than 365 days old. The Administrator failed to ensure the review and if necessary, the revision of R2's NSA at least once every 365 days.	S3092		
S3105 SS=D	26-41-202 (j) Negotiated Service Agreement Outside Resource (j) If a resident's negotiated service agreement includes the use of outside resources, the designated facility staff shall perform the following: (1) Provide the resident, the resident's legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family, with a list of providers available to provide needed	S3105		

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S3105	Continued From page 5 services; (2) assist the resident, if requested, in contacting outside resources for services; and (3) monitor the services provided by outside resources and act as an advocate for the resident if services do not meet professional standards of practice This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-202 (j) (3) The facility reported a census of 51 residents. The sample included four "Residents" (R). Based on record review and interview, the Administrator failed to ensure the facility "Licensed Nurse" (LN) monitored the services provided by the outside provider for R3 when R3 developed a wound and chose to use a local home health agency for wound management. Findings included: - Record review for R3 revealed an admission date of 05/10/23 with diagnoses of dementia, hypertension, lumbar spinal stenosis and osteoarthritis of the right knee. Review of R3's FCS dated 05/10/23 identified R3 required physical assistance with bathing, dressing, and toileting. R3 required supervision with transferring and walking. She was unable to manage her own medications and treatments and was occasionally incontinent of bladder. She was marked for impaired short-term memory, and impaired decision making. She was usually able	S3105		

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S3105	Continued From page 6	S3105		

to make herself understood and she usually understood others. She was marked with falls, impaired decision making, and she used a walker mobility device.

Review of R3's combined NSA/HSP dated 08/23/23 directed facility staff to provide physical assistance with bathing, dressing and toileting. Staff were instructed to physically assist R3 with ambulation using a gait belt and her walker. R3 used a walker and wheelchair mobility device. Facility staff to provide health shakes two times daily per R3's medical provider order. The NSA/HSP identified the home health outside provider for physical therapy.

Review of R3's electronic medical record under the "Interdisciplinary Notes" tab revealed the following entries:

On 05/10/23 at 03:06 PM resident admitted to the facility. Resident also noted to have redness to her coccyx. One millimeter slight open area to resident's right cheek by coccyx. Barrier cream applied to area. Primary care provider notified.

Review of R3's signed orders revealed the following signed orders:

07/15/23 Duoderm change every 3 days or as needed if soiled, for a 1 centimeter in length by 0.25 centimeter in width open area to coccyx.

08/15/23 R3 noted to have a one centimeter in length by 0.25 centimeter in width open area to the coccyx that was starting to tunnel. Local home health company to evaluate and treat the wound.

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S3105	Continued From page 7 The record lacked documentation of regular skin assessments performed by the faciity nurse acknowledging the wound on the coccyx. Review of the local home health agency notes revealed the following entries; On 08/17/23 the home health agency received a referral for treatment of R3's stage 2 pressure ulcer. R3 had previously been on same home health services for her wound prior to admission to the facility. R3 had a pressure relief cushion in her recliner and one in her wheelchair. R3 was provided a referral to physical therapy for increased mobility for pressure relief. The order provided at the time of admission to home health were to cleanse the wound with normal saline and gauze or soap and water daily. Apply Zinc cream to the sacrum and buttocks daily and as needed to keep the area covered. On 08/22/23 the home health nurse documented R3 was receiving two protein shakes daily for nutrition and wound healing. On 10/26/23 the home health medical records employee documented that R3's husband was "wondering why patient's wounds were not getting better, he seemed very unhappy". On 10/26/23 the home health agency Registered Nurse documented she spoke to R3's husband and they would continue treatment. The document lacked evidence that she coordinated the concerns to the facility nurse.	S3105		

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S3105	Continued From page 8 On 12/18/23 the home health agency restaged the stage 2 pressure ulcer to a stage 3 pressure ulcer. On 02/19/24 the home health agency Registered Nurse documented "Wound appears to be healing as expected as evidenced by decrease in wound size and drainage amount". Interview on 02/20/23 with Licensed Nurse B confirmed the home health company had been treating the wound, Licensed Nurse B continued to state she had only spoke with the home health company one time, and Licensed Nurse B stated she had not done any documentation on the wound or visualized the wound. Licensed Nurse B stated the home health company did not leave visit notes at the facility, and stated she would call the home health agency to have visit notes provided. Licensed Nurse B confirmed she had not been overseeing the home health agency nurse or the management of the wound. Licensed Nurse B provided the home health agency notes for review by email on 02/21/22 at 09:21 AM. The Administrator failed to ensure the facility LN monitored the services provided by the outside provider for R3 when R3 developed a wound and chose to use a local home health agency for wound management.	S3105		
S3130 SS=D	26-41-203 (d) Special Care Services (d) Special care. Any administrator or operator of an assisted living facility or residential health care facility may choose to serve residents who	S3130		

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S3130	Continued From page 9	S3130		

do not exceed the facility ' s admission and retention criteria and who have special needs in a special care section of the facility or the entire facility, if the administrator or operator ensures that all of the following conditions are met:
(1) Written policies and procedures are developed and are implemented for the operation of the special care section or facility.
(2) Admission and discharge criteria are in effect that identify the diagnosis, behavior, or specific clinical needs of the residents to be served. The medical diagnosis, medical care provider ' s progress notes, or both shall justify admission to the special care section or the facility.
(3) A written order from a medical care provider is obtained for admission.
(4) The functional capacity screening indicates that the resident would benefit from the services and programs offered by the special care section or facility.
(5) Before the resident ' s admission to the special care section or facility, the resident or resident's legal representative is informed, in writing, of the available services and programs that are specific to the needs of the resident.
(6) Direct care staff are present in the special care section or facility at all times.
(7) Before assignment to the special care section or facility, each staff member is provided with a training program related to specific needs of the residents to be served, and evidence of completion of the training is maintained in the employee's personnel records.
(8) Living, dining, activity, and recreational areas are provided within the special care section, except when residents are able to access living, dining, activity, and recreational areas in another

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S3130	Continued From page 10 section of the facility. (9) The control of exits in the special care section is the least restrictive possible for the residents in that section. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-203 (d) (3) The facility reported a census of 51 residents. The sample included four "Residents" (R). Based on record review and interview, the Administrator failed to ensure a written order was obtained from a medical care provider when R3 was admitted to the secured specialty unit. Findings included: - Record review for R3 revealed an admission date of 05/10/23 with diagnoses of dementia, hypertension, lumbar spinal stenosis and osteoarthritis of the right knee. Review of R3's FCS dated 05/10/23 identified R3 required physical assistance with bathing, dressing, and toileting. F3 required supervision with transferring and walking. She was unable to manage her own medications and treatments and was occasionally incontinent of her bladder. She was marked with impaired short-term memory, and impaired decision making. She was usually able to make herself understood and she usually understood others. She was marked with falls, impaired decision making, and she used a walker mobility device.	S3130		

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S3130	Continued From page 11 Review of R3's combined NSA/HSP dated 08/23/23 directed facility staff to provide physical assistance with bathing, dressing and toileting. Staff were instructed to physically assist R3 with ambulation using a gait belt and her walker. R3 used a walker and wheelchair mobility device. Facility staff to provide health shakes two times daily per R3's medical provider order. The NSA/HSP identified the home health outside provider for physical therapy. Review of R3's electronic medical record under the "Orders Tab" revealed the following admission order dated 05/09/23; the medical care provider marked R3 as dependent with functional capacity, she could ambulate with a cane or a walker with assistance only, she could participate in activities, and could leave the facility with family or friends. The resident could have a regular diet. Signed by the medical care provider on 05/09/23. The document lacked identification of the admission being to a locked specialty unit. Observation on 02/19/24 at 10:54 AM during the initial facility tour revealed the door to the entry of the specialty unit is key padded. Interview on 02/20/24 at approximately 05:30 PM with Licensed Nurse B and Administrative Nurse C confirmed R3's record lacked an order from the medical provider for R3's admission to a specialty unit. The Administrator failed to ensure a written order was obtained from a medical care provider when	S3130		

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S3130	Continued From page 12 R3 was admitted to the secured specialty unit.	S3130		
S3155 SS=E	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-204 (a) The facility reported a census of 51 residents. The sample included four "Residents" (R). Based on record review and interview, the Administrator failed to ensure the "Negotiated Service Agreement" (NSA) contained a description of the health care services to be provided for R2 and R3. Findings included: - Record review for R2 revealed an admission date of 02/01/23 with diagnoses of Alzheimer's Disease, atrial fibrillation, iron deficiency anemia and anxiety. Review of R2's "Functional Capacity Screen"	S3155		

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S3155	Continued From page 13 (FCS) dated 01/30/23 identified R2 was unable to bathe, dress or toilet herself. She required cues for eating, and had impaired short-term memory, impaired long-term memory, impaired memory recall, and impaired decision making. She was incontinent of her bladder and was marked with falls, impaired decision making, wandering and lacked the ability to manage her own medications and treatments. R2's combined "Negotiated Service Agreement / Health Service Plan" (NSA/HSP) dated 01/30/23 directed certified facility staff to physically assist R2 with bathing, dressing and toileting. Certified/Licensed facility staff were instructed to manage R2's medications and treatments. Review of R2's "Addendum to Negotiated Service Agreement" dated 01/30/24 stated the following "Fall mat next to bed when resident is laying down in bed. Hospice to bring to facility". Review of the "Physician Order" stated "Consult hospice for an evaluation and admit if appropriate" dated 08/23/23. Review of the facility provided hospice notes revealed and admission to hospice date of 08/25/23. Interview on 02/20/24 at approximately 05:30 PM with LN B confirmed R2's combined NSA/HSP lacked the addition of hospice services. Review of the facility provided investigation revealed on 02/05/24 R2's husband was on the specialty care unit in the common area watching television. R2's husband is a resident on the	S3155		

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S3155	Continued From page 14	S3155		

assisted living unit. When a facility staff member walked by, R2's husband stated he was "raping" his wife. The facility staff member reported the incident to his supervisor. The supervisor then called the specialty unit nurse and the administrator of the building. An investigation was immediately opened, and the interventions put into place immediately were that R2's husband would not be in her room unattended. R2 and her husband's son who is the durable power of attorney was notified and approved the interventions.

Interview on 02/20/24 at approximately 05:30 PM with LN B confirmed R2's combined NSA/HSP lacked the addition of the intervention that R2's husband would not be allowed in R2's room unattended.

- Record review for R3 revealed an admission date of 05/10/23 with diagnoses of dementia, hypertension, lumbar spinal stenosis and osteoarthritis of the right knee.

Review of R3's FCS dated 05/10/23 identified R3 required physical assistance with bathing, dressing, and toileting. R3 required supervision with transferring and walking. She was unable to manage her own medications and treatments and was occasionally incontinent of her bladder. She was marked with impaired short-term memory, and impaired decision making. She was usually able to make herself understood and she usually understood others. She was marked with falls, impaired decision making, and she used a walker mobility device.

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	N059009	A. BUILDING: _____ B. WING _____	02/21/2024

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) COMPLETE DATE
S3155	Continued From page 15 Review of R3's combined NSA/HSP dated 08/23/23 directed facility staff to provide physical assistance with bathing, dressing and toileting. Staff were instructed to physically assist R3 with ambulation using a gait belt and her walker. R3 used a walker and wheelchair mobility device. Facility staff to provide health shakes two times daily per R3's medical provider order. The NSA/HSP identified the home health outside provider for physical therapy. Review of R3's electronic medical record under the "Interdisciplinary Notes" Tab revealed the following entries: On 05/10/23 at 03:06 PM resident admitted to the facility. Resident also noted to have redness to her coccyx. One millimeter slight open area to resident's right cheek by coccyx. Barrier cream applied to area. Primary care provider notified. Review of R3's orders revealed the following signed orders: 07/15/23 Duoderm change every 3 days or as needed if soiled, for a 1 centimeter in length by 0.25 centimeter in width open area to coccyx. 08/15/23 R3 noted to have a 1 centimeter in length by 0.25 centimeter in width open area to the coccyx that was starting to tunnel. Local home health company to evaluate and treat the wound. The record lacked documentation of regular skin assessments performed by the nurse acknowledging the wound on the coccyx.	S3155		

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S3155	Continued From page 16	S3155		

Review of the local home health agency notes revealed the following entries;

On 08/17/23 the home health agency received a referral for treatment of R3's stage 2 pressure ulcer. R3 had previously been on home health services for her wound prior to admission to the facility. R3 had a pressure relief cushion in her recliner and one in her wheelchair. R3 was provided a referral to physical therapy for increased mobility for pressure relief. The order provided at the time of admission to home health were to cleanse the wound with normal saline and gauze or soap and water daily. Apply Zinc cream to the sacrum and buttocks daily and as needed to keep the area covered.

On 08/22/23 the home health nurse documented R3 was receiving two protein shakes daily for nutrition and wound healing.

On 10/26/23 the home health medical records employee documented that R3's husband was "wondering why patients wounds were not getting better, he seemed very unhappy".

On 10/26/23 the home health agency Registered Nurse documented she spoke to R3's husband and they would continue treatment.

The document lacked mention that she coordinated the concerns to the facility nurse.

On 12/18/23 the home health agency restaged the stage 2 pressure ulcer to a stage 3 pressure ulcer.

On 02/19/24 the home health agency Registered

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S3155	Continued From page 17 Nurse documented "Wound appears to be healing as expected as evidenced by decrease in wound size and drainage amount". Interview on 02/20/23 at approximately 05:30 PM with Licensed Nurse B confirmed R3's combined NSA/HSP lacked the health care services to protect the resident from increasing the severity of the pressure wound. She continued to state the home health company had been treating the wound, Licensed Nurse B continued to state she had only spoke the home health company one time, and Licensed Nurse B stated she had not done any documentation on the wound or visualized the wound. Licensed Nurse B stated the home health company did not leave visit notes at the facility, and she confirmed that she would call the home health agency to have visit notes provided. Licensed Nurse B confirmed she had not been overseeing the home health agency nurse and the management of the wound. The Administrator failed to ensure NSA for R2 contained health care services for the addition of hospice services when she experienced a change of condition, and further failed to coordinate health care services after her husband made an inappropriate comment to facility staff in regard to R2. The administrator further failed to ensure the NSA for R3 contained the provision of health care service for protecting her skin and promote the healing of the pressure ulcer on her sacrum.	S3155		
S3171 SS=E	26-41-204 (i) Health Care Services Standards of Practice	S3171		

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S3171	Continued From page 18 (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-204 (i) The facility reported a census of 51 residents. The sample included four "Residents" (R). Based on observation, record review and interview, the Administrator failed to provide healthcare services in accordance with professional standards of practice, when Administrator A failed to ensure an assessment was performed for R1 and R2 on their bed assist devices to ensure the devices posed no risk for entrapment, confirmed the devices were not a restraint, and assessed R1 and R2's ability to safely use the bed assist devices. Administrator A failed to ensure the devices were listed in the comments section of R1 and R2's "Functional Capacity Screening" (FCS) form in the comments sections, and Administrator A further failed to ensure a description of the devices, the purpose of the devices and any special instructions for the devices were listed on R1 and R2's "Negotiated Service Agreements" (NSA)'s. Findings included: - Record review for R1 revealed an admission date of 06/07/23 with diagnoses of Alzheimer's Disease and congestive heart failure .	S3171		

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S3171	Continued From page 19 Review of R1's FCS dated 06/08/23 revealed R1 required physical assistance with bathing, and supervision with dressing, toileting, eating and transferring. She was independent with walking/mobility and eating. R1 was frequently incontinent of her bladder, and had impaired short-term memory, impaired memory recall, and impaired decision making. She was able to make herself understood and she understood others. She was marked with falls, used a walker mobility device and lacked the ability to manage her own medications. The FCS lacked documentation of a bilateral bed assist device in the comment section. R1's combined NSA/ "Health Service Plan" (HSP) dated 06/08/23 directed certified facility staff to assist R1 with showers twice weekly and identified the hospice provider would provide R1 a shower once weekly. Certified facility staff to provide R1 with physical assistance with putting on her compression stockings, physical assistance with toileting hygiene, and to physically assist R1 out of chairs. Certified/Licensed facility staff to manage her medications and treatments. The combined NSA/HSP lacked a description of the bilateral bed assist device, the purpose of the device and R1's ability to use the device and any special instructions for the device. R1's record lacked the documentation of an assessment being performed to confirm the device was not a restraint, R1's ability to safely use the device and documentation of the findings in R1's record.	S3171		

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S3171	Continued From page 20 Observation on 02/20/24 at approximately 06:30 PM of R1's bed revealed there was an inverted "U" shaped device that was narrow at the top and wider at the bottom attached to each side of the top half R1's hospital bed. The devices were attached securely to the frame of the bed and there were no large openings. The devices measured at the top approximately 8 inches in width, the bottom section of the device measured 10 inches in width, and the height of the devices from the bedframe to the top rail measured approximately 20 inches. Interview on 02/19/24 at approximately 01:36 PM with "Licensed Nurse B confirmed she has not done any bed rail assessments, and the facility does not have a policy on the use of bed assist devices. She continued to state the beds in the specialty unit are all the same type of beds and have the bed assist devices on them as a part of the bed. She stated if the resident does not use the attached bed assist devices you can fold them into the down position. She stated not all residents use the bed assist devices and they are left in the down position. - Record review for R2 revealed an admission date of 02/01/23 with diagnoses of Alzheimer's Disease, atrial fibrillation, iron deficiency anemia and anxiety. Review of R2's FCS dated 1/30/23 identified R2 was unable to bathe, dress or toilet herself. She required cues for eating, and had impaired short-term memory, impaired long-term memory, impaired memory recall, and impaired decision making. She was incontinent of her bladder and	S3171		

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was marked with falls, impaired decision making, wandering and lacked the ability to manage her own medications and treatments.

The FCS lacked documentation of a bilateral bed assist device in the comment section.

R2's combined NSA/HSP dated 01/30/23 directed certified facility staff to physical assist R2 with bathing, dressing and toileting. Certified/Licensed facility staff were instructed to manage R2's medications and treatments.

The combined NSA/HSP lacked a description of the bilateral bed assist device, the purpose of the device and R2's ability to use the device and any special instructions for the device.

R2's record lacked the documentation of an assessment being performed to confirm the device was not a restraint, R2's ability to safely use the device and documentation of the findings in R2's record.

Observation on 02/20/24 at approximately 06:30 PM of R2's bed revealed there was an inverted "U" shaped device that was narrow at the top and wider at the bottom attached to each side of the top half R2's hospital bed. The devices were attached securely to the frame of the bed and there were no large openings. The devices measured at the top approximately 8 inches in width, the bottom section of the device measured 10 inches in width, and the height of the devices from the bedframe to the top rail measured approximately 20 inches.

Interview on 02/19/24 at approximately 01:36 PM

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S3171	Continued From page 22	S3171		

with "Licensed Nurse B confirmed she has not done any bed rail assessments, and the facility does not have a policy on the use of bed assist devices. She continued to state the beds in the specialty unit are all the same type of beds and have the bed assist devices on them as a part of the bed. She stated if the resident does not use the attached bed assist devices you can fold them into the down position. She stated not all residents use the bed assist devices and they are left in the down position.

The FDA (food and drug administration) "Bedrails in Assisted Living, Residential Health Care and Home Plus Facilities" recommended the following:

Complete an assessment of the resident to confirm that the device is not a restraint.

Complete an assessment of the resident to determine the purpose of the device and the resident's ability to safely use the device and document the findings in the resident's record.

Complete an assessment of the device using the recommendations in the FDA guidance to ensure the device is securely attached to the bed or bedframe and poses no risk for entrapment and document the findings in the resident record.

If the purpose of the device is to assist the resident with transfers, the FCS should document the resident's functional capacity based on the use of the device and should be listed in the comments section.

Include a description of the device, its purpose

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S3171	Continued From page 23 and special instructions on use and monitoring in the resident's NSA. Document periodic reassessments of the resident's use of the device and their ability to use it safely and reassessment of the safety of the device in the resident's record. The Administrator failed to provide healthcare services in accordance with professional standards of practice, when Administrator A failed to ensure an assessment was performed for R1and R2 on the bed assist devices to ensure the devices posed no risk for entrapment, confirmed the devices were not a restraint, and R1 and R2's ability to safely use the bed assist device. Administrator A failed to ensure the devices were listed in the comments section of R1 and R2's FCS form in the comments sections, and Administrator A further failed to ensure a description of the devices, the purpose of the devices and any special instructions for the devices were listed on R1 and R2's NSA's.	S3171		
S3261 SS=E	26-41-105 (f) (11) Resident Record Documentation of Incidents (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 This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-105 (f) (11)	S3261		

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S3261	Continued From page 24 The facility reported a census of 51 residents. The sample included four "Residents" (R). Based on record review and interview, the Administrator failed to ensure the documentation of all incidents, symptoms and other indications of illness or injury including the date, time of occurrence, action taken and results of the actions for R2 and R3. Findings included: - Record review for R2 revealed an admission date of 02/01/23 with diagnoses of Alzheimer's Disease, atrial fibrillation, iron deficiency anemia and anxiety. Review of R2's "Functional Capacity Screen" (FCS) dated 01/30/23 identified R2 was unable to bathe, dress or toilet herself. She required cues for eating, and had impaired short-term memory, impaired long-term memory, impaired memory recall, and impaired decision making. She was incontinent of her bladder and was marked with falls, impaired decision making, wandering and lacked the ability to manage her own medications and treatments. R2's combined "Negotiated Service Agreement / Health Service Plan" (NSA/HSP) dated 01/30/23 directed certified facility staff to physically assist R2 with bathing, dressing and toileting. Certified/Licensed facility staff were instructed to manage R2's medications and treatments. Review of the facility provided investigation revealed on 02/05/24 R2's husband was on the	S3261		

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specialty care unit in the common area watching television. R2's husband is a resident on the assisted living unit. When a facility staff member walked by, R2's husband stated he was "raping" his wife. The facility staff member reported the incident to his supervisor. The supervisor then called the specialty unit nurse and the administrator of the building. An investigation was immediately opened, and the interventions put into place immediately were that R2's husband would not be in her room unattended. R2 and her husband's son who is the durable power of attorney was notified and approved the interventions.

Review of R2's electronic medical records under the "Interdisciplinary Notes" tab revealed the following entries;

On 11/27/23 at 02:19 PM R2 had been anxious and was refusing to stand and "listen to commands". When staff attempted to "stand resident up to transfer, resident refused and was grabbing on to the wheelchair". Resident was requiring a two person assist.

The document lacked an entry for actions taken and results of actions taken for R2 increased anxiety and resident refusal to stand with one person assist.

R2's medical record lacked documentation of the incident on 02/05/24.

Interview on 02/20/24 at approximately 05:30 PM with Administrator A, Licensed Nurse B and Administrative Nurse C confirmed R2's record lacked the documentation of the incident, actions

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S3261	Continued From page 26 taken, and results of the actions taken. - Record review for R3 revealed an admission date of 05/10/23 with diagnoses of dementia, hypertension, lumbar spinal stenosis and osteoarthritis of the right knee. Review of R3's FCS dated 05/10/23 identified R3 required physical assistance with bathing, dressing, and toileting. F3 required supervision with transferring and walking. She was unable to manage her own medications and treatments and was occasionally incontinent of her bladder. She was marked with impaired short-term memory, and impaired decision making. She was usually able to make herself understood and she usually understood others. She was marked with falls, impaired decision making, and she used a walker mobility device. Review of R3's combined NSA/HSP dated 08/23/23 directed facility staff to provide physical assistance with bathing, dressing and toileting. Staff were instructed to physically assist R3 with ambulation using a gait belt and her walker. R3 used a walker and wheelchair mobility device. Facility staff to provide health shakes two times daily per R3's medical provider order. The NSA/HSP identified the home health outside provider for physical therapy. Review of R3's electronic medical record under the "Interdisciplinary Notes" Tab revealed the following entries: 11/26/23 at 06:05 AM; R3 had exhibited "atypical" behaviors.	S3261		

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S3261	Continued From page 27 The record lacked documentation of actions taken to report the "atypical" behavior or any redirection taken for R3. 12/03/23 at 05:25 AM; R3 only slept two hours. The note indicated R3 stayed up in her chair watching television. R3 "repeatedly screamed for help". Staff assisted her to bed at 03:30 AM and she woke up repetitively asking for help. The record lacked documentation of actions taken for R3 behavior/sleep issues, if the nurse or primary care provider was notified, and further lacked results of the actions taken. 12/13/23 at 09:49 AM; R3 received her shower, and the facility staff documented that R3 had redness in the fold of the groin on the left side. The record lacked documentation of actions taken for the skin issue and further lacked if the facility nurse was notified. 01/09/24 at 05:46 PM; R3 had been hollering out most of the afternoon. R3 could not state why she was hollering. The record lacked documentation of actions take and further lacked if the facility nurse was notified. 06/05/23 at 08:16 PM; R3 had bruises on the "lower back, upper left elbow, and buttocks". The record lacked documentation of how R3 obtained the bruises.	S3261		

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Interview with Administrator A at approximately 01:00 PM confirmed R3 had a fall on 06/04/23.

Review of R3's physician orders revealed the following signed orders:

07/15/23 Duoderm, change every 3 days or as needed if soiled. for a 1 centimeter in length by 0.25 centimeter in width open area to coccyx.

08/15/23 R3 noted to have a 1 centimeter in length by 0.25 centimeter in width open area to the coccyx that was starting to tunnel. Local home health company to evaluate and treat the wound.

The record lacked documentation of regular skin assessments performed by the nurse acknowledging the wound on the coccyx.

Interview on 02/20/23 with Licensed Nurse B confirmed the home health company had been treating the wound, Licensed Nurse B continued to state she had only spoke the home health company one time, and Licensed Nurse B stated she had not done any documentation on the wound or visualized the wound. Licensed Nurse B stated the home health company did not leave visit notes at the facility, and she confirmed that she would call the home health agency to have visit notes provided.

Licensed Nurse B provided the home health agency notes for review by email on 02/21/22 at 09:21 AM.

Interview on 02/21/24 at approximately 02:00 PM with Administrator A, Licensed Nurse B and

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(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
S3261	Continued From page 29 Administrative Nurse C confirmed R3's record lacked the documentation of the incident, actions taken, and results of the actions taken for behaviors, falls and wounds. The Administrator failed to ensure the documentation of all incidents, symptoms and other indications of illness or injury including the date, time of occurrence, action taken and results of the actions for R's 2 and 3.	S3261		
S3310 SS=E	26-41-207 (b) (5-6) (c) Infection Control Policies (b) (5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and (c) Each administrator or operator shall ensure the facility ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-207 (c) The facility reported a census of 51 residents. The sample included four "Residents" (R). Based on record review and interview, the Administrator	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N059009	A. BUILDING: _____ B. WING _____	02/21/2024

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) COMPLETE DATE
S3310	Continued From page 30 failed to ensure the facility's compliance with the department's "Tuberculosis" (TB) guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 for R2 and R4. Findings included: - Record review for R2 revealed an admission date of 02/01/23 with diagnoses of Alzheimer's Disease, atrial fibrillation, iron deficiency anemia and anxiety. Review of R2's "Functional Capacity Screen" (FCS) dated 01/30/23 identified R2 was unable to bathe, dress or toilet herself. She required cues for eating, and had impaired short-term memory, impaired long-term memory, impaired memory recall, and impaired decision making. She was incontinent of her bladder and was marked with falls, impaired decision making, wandering and lacked the ability to manage her own medications and treatments. R2's combined "Negotiated Service Agreement / Health Service Plan" (NSA/HSP) dated 01/30/23 directed certified facility staff to physically assist R2 with bathing, dressing and toileting. Certified/Licensed facility staff were instructed to manage R2's medications and treatments. Review of R2's electronic medical record under the "Forms" tab revealed a document titled "Tuberculosis Questionnaire" and was dated 02/01/23. The electronic medial record lacked a current annual TB screening questionnaire.	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N059009	A. BUILDING: _____ B. WING _____	02/21/2024

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S3310	Continued From page 31 Interview on 02/20/24 at approximately 05:30 PM with Licensed Nurse B and Administrative Nurse C confirmed R2's record lacked a current TB screening questionnaire. - Record review for R4 revealed an admission date of 01/02/24 with diagnoses of malignant neoplasm of unspecified ovary, essential hypertension, sick sinus syndrome, presence of cardiac pacemaker, and other signs and symptoms with cognitive functions and awareness. Review of R4 FCS dated 12/21/23 revealed R4 was independent with bathing, dressing, toileting, transferring, walking, eating, and management of medications. She was continent of her bladder and had impaired short-term memory and impaired decision making. She was able to make herself understood and she usually understood others. She was marked with impaired hearing and used a walker mobility device. Review of R4's electronic medical record under the "TB screening and Immunizations" tab revealed an entry dated 01/03/24 that Tubersol administered. The entry lacked a site administered and further lacked the date the test was read. Interview on 02/20/24 at approximately 05:30 PM with Licensed Nurse B and Administrative Nurse C confirmed R4's electronic medical record lacked documentation of the required first step of the TB test being administered within seven days of admission to the facility. Licensed Nurse B	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N059009	A. BUILDING: _____ B. WING _____	02/21/2024

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S3310	Continued From page 32 further confirmed the required two step TB test had not been administered for R4. The Administrator failed to ensure the facility's compliance with the department's TB guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 for R2 and R4.	S3310		