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 11/12/2024

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) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #KS00191729. The 2567 was sent electronically on 11/19/24.	F 000		
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	F 609		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 11/19/2024

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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by:
The facility had a census of 31 residents. The sample included three residents. Based on observation, record review, and interview, the facility failed to ensure staff identified an allegation of rough care as potential abuse and reported immediately to the Licensed Nursing Home Administrator (LNHA). The facility further failed to report the allegation of abuse to the State Agency (SA) as required. This placed the resident at risk for ongoing abuse and mistreatment.

Findings included:

- R1's Electronic Medical Record (EMR) recorded diagnoses of hypertension (HTN-elevated blood pressure), dementia (a progressive mental disorder characterized by failing memory and confusion), generalized osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), personal history of malignant neoplasm (the tendency of a medical condition, especially tumors, to become progressively worse, most familiar as a characteristic of cancer) of the breast, and major depressive disorder (major mood disorder that causes persistent feelings of sadness).

The "Annual Minimum Data Set" dated 09/01/24, documented R1 had severe cognitive impairment. R1 had verbal behaviors directed toward others and rejected care for one to three days of the observation period. R1 was dependent on staff for oral, personal, and toileting hygiene, and dressing. The MDS further documented R1 was always incontinent of bladder and bowel. The resident received scheduled pain medication, an

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F 609	Continued From page 2	F 609		

antianxiety medication (a class of medications that calm and relax people), and an antidepressant (a class of medications used to treat mood disorders).

The "Behavioral Symptoms Care Area Assessment" (CAA), dated 09/13/24, documented a care plan would be developed related to the resident having verbal behaviors due to dementia, HTN, and depression. The CAA further documented R1 had a risk for increased confusion, falls, agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition), and injury.

R1's "Care Plan" dated 03/11/24, directed one to two staff members to assist R1 with bed mobility, transfers, walking, toileting, grooming, personal hygiene, and bathing. The plan further documented R1 would refuse care, become combative, and yell at staff. The plan directed staff to ensure resident safety, then leave R1 with her call light in reach and try to reapproach and attempt talking again later.

The "Physician Orders" dated 07/27/24, directed staff to administer Ativan (an antianxiety) one milligram (mg) twice weekly before showers and one to two mg every two hours as needed for mild to moderate anxiety or agitation for generalized anxiety disorder.

The "Skin Evaluation" dated 10/22/24 and 10/29/24, documented no issues.

The "Interdisciplinary Note" (ID) dated 10/25/24 at 09:04 PM, documented R1 hollered out with care, however, R1 was fine after lying down in bed.

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F 609	Continued From page 3	F 609		

On 11/12/24 at 12:45 PM, observation revealed CMA S and CMA R wheel R1 back to her room in a wheelchair. CMA S and CMA R explained to R1 that they were going to assist R1 onto the mechanical lift and take her to the bathroom. The staff proceeded to provide incontinent care; R1 yelled "Ouch" and "Stop." CMA S and CMA R reported it was common for R1 to yell out especially when cares involved something wet like wipes and showers.

On 11/12/24 Administrative Nurse D was unavailable for an interview.

On 11/12/24 at 10:44 AM, Administrative Staff A reported she was informed by Certified Medication Aide (CMA) R on 11/05/24 of an occurrence with R1 and CMA T that took place on 10/25/24. Administrative Staff A stated CMA R reported to her that Certified Nurse Aide (CNA) M saw CMA T place her hand on R1's arm while R1 was being assisted for transfer and care prior to supper and reported that CMA T had potentially handled R1 roughly. Administrative Staff A confirmed that CMA T was suspended on 11/07/24 pending an investigation of alleged physical abuse. Administrative Staff A stated Administrative Nurse D was aware of the allegation on 10/25/24 and should have informed her of the 10/25/24 allegation of possible physical abuse to R1.

On 11/12/24 at 01:55 PM, CMA R stated she was told by CNA M she had witnessed CMA T squeezing R1's arm while R1 was yelling out and being assisted with a lift transfer. CMA R further stated when she had inquired about the status of the investigation regarding the 10/25/24 occurrence, Administrative Nurse D stated it had

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F 609	Continued From page 4	F 609		

been taken care of. CMA R further reported that on 11/05/24 she called Administrative Staff A and reported the alleged physical abuse of R1 by CMA T, and Administrative Staff A told CMA R she had no knowledge of the incident. CMA R said that since then, Administrative Staff A has called her several times inquiring about the 10/25/24 situation.

On 11/12/24 at 03:05 PM, CNA M stated on 10/25/24 prior to the evening meal, she heard R1 yelling out and went to see if CMA T needed assistance with R1. CNA M stated when she had entered R1's room, CMA T had her hand on R1's left arm. CNA M then proceeded to assist CMA T in providing incontinent care and transfers for the evening meal. CNA M reported after the meal she had noticed R1's left arm was red. CNA M reported the redness on R1's left arm to Licensed Nurse (LN) G and said that CMA T may have handled R1 roughly prior to the evening meal.

On 11/12/24 at 01:30 PM, Administrative Staff A provided an email sent to Administrative Nurse D on 10/25/24 at 08:31 PM by LN G which stated at about 05:55 PM on 10/25/24 CNA M reported a concern she witnessed prior to the evening meal of CMA T being more rough than necessary and CNA M felt she should bring it to the nurses' attention. The email continued to state when LN H came on duty, both nurses took R1 into her room and examined her. LN G stated R1 had bruising to her arms, typical per her normal and none stood out, R1 was pleasant and cooperative, and there was no new bruising. LN G stated she and LN H had a conversation with CMA T in the email regarding CMA T asking for help when necessary and what to expect when caring for R1.

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F 609	Continued From page 5 The facility's "Abuse, Neglect, Exploitation and Crime Prevention and Management" policy, dated 05/2023, documented the facility must ensure that all allegations of abuse, neglect, injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the facility, the State Survey Agency, to other officials in accordance with state law, and take all necessary corrective actions depending on the results of the investigation. The facility failed to ensure staff identified an allegation of rough care as potential abuse and reported it immediately to the LNHA. The facility further failed to report the allegation of abuse to the SA as required. This placed the resident at risk for ongoing abuse and mistreatment.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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	F 610		

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appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:

The facility had a census of 31 residents. The sample included three residents. Based on observation, record review, and interview, the facility failed to initiate protective measures and fully investigate an allegation of abuse for Resident (R) 1. This placed the resident at risk for ongoing abuse.

Findings included:

- R1's Electronic Medical Record (EMR) recorded diagnoses of hypertension (HTN-elevated blood pressure), dementia (a progressive mental disorder characterized by failing memory and confusion), generalized osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), personal history of malignant neoplasm (the tendency of a medical condition, especially tumors, to become progressively worse, most familiar as a characteristic of cancer) of the breast, and major depressive disorder (major mood disorder that causes persistent feelings of sadness).

The "Annual Minimum Data Set" dated 09/01/24, documented R1 had severe cognitive impairment. R1 had verbal behaviors directed toward others and rejected care for one to three days of the observation period. R1 was dependent on staff for oral, personal, and toileting hygiene, and dressing. The MDS further documented R1 was always incontinent of bladder and bowel. The resident received scheduled pain medication, an antianxiety medication (a class of medications that calm and relax people), and an

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F 610	Continued From page 7	F 610		

antidepressant (a class of medications used to treat mood disorders).

The "Behavioral Symptoms Care Area Assessment" (CAA), dated 09/13/24, documented a care plan would be developed related to the resident having verbal behaviors due to dementia, HTN, and depression. The CAA further documented R1 had a risk for increased confusion, falls, agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition), and injury.

R1's "Care Plan" dated 03/11/24, directed one to two staff members to assist R1 with bed mobility, transfers, walking, toileting, grooming, personal hygiene, and bathing. The plan further documented R1 would refuse care, become combative, and yell at staff. The plan directed staff to ensure resident safety, then leave R1 with her call light in reach and try to reapproach and attempt talking again later.

The "Physician Orders" dated 07/27/24, directed staff to administer Ativan (an antianxiety) one milligram (mg) twice weekly before showers and one to two mg every two hours as needed for mild to moderate anxiety or agitation for generalized anxiety disorder.

The "Skin Evaluation" dated 10/22/24 and 10/29/24, documented no issues.

The "Interdisciplinary Note" (ID) dated 10/25/24 at 09:04 PM, documented R1 hollered out with care, however, R1 was fine after lying down in bed.

On 11/12/24 at 12:45 PM, observation revealed CMA S and CMA R wheel R1 back to her room in

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a wheelchair. CMA S and CMA R explained to R1 that they were going to assist R1 onto the mechanical lift and take her to the bathroom. The staff proceeded to provide incontinent care; R1 yelled "Ouch" and "Stop." CMA S and CMA R reported it was common for R1 to yell out especially when cares involved something wet like wipes and showers.

On 11/12/24 Administrative Nurse D was unavailable for an interview.

On 11/12/24 at 10:44 AM, Administrative Staff A reported she was informed by Certified Medication Aide (CMA) R on 11/05/24 of an occurrence with R1 and CMA T that took place on 10/25/24. Administrative Staff A stated CMA R reported to her that Certified Nurse Aide (CNA) M saw CMA T place her hand on R1's arm while R1 was being assisted for transfer and care prior to supper and reported that CMA T had potentially handled R1 roughly. Administrative Staff A confirmed that CMA T was suspended on 11/07/24 pending an investigation of alleged physical abuse. Administrative Staff A stated Administrative Nurse D was aware of the allegation on 10/25/24 and should have informed her of the 10/25/24 allegation of possible physical abuse to R1.

On 11/12/24 at 01:55 PM, CMA R stated she was told by CNA M she had witnessed CMA T squeezing R1's arm while R1 was yelling out and being assisted with a lift transfer. CMA R further stated when she had inquired about the status of the investigation regarding the 10/25/24 occurrence, Administrative Nurse D stated it had been taken care of. CMA R further reported that on 11/05/24 she called Administrative Staff A and

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reported the alleged physical abuse of R1 by CMA T, and Administrative Staff A told CMA R she had no knowledge of the incident. CMA R said that since then, Administrative Staff A has called her several times inquiring about the 10/25/24 situation.

On 11/12/24 at 03:05 PM, CNA M stated on 10/25/24 prior to the evening meal, she heard R1 yelling out and went to see if CMA T needed assistance with R1. CNA M stated when she had entered R1's room, CMA T had her hand on R1's left arm. CNA M then proceeded to assist CMA T in providing incontinent care and transfers for the evening meal. CNA M reported after the meal she had noticed R1's left arm was red. CNA M reported the redness on R1's left arm to Licensed Nurse (LN) G and said that CMA T may have handled R1 roughly prior to the evening meal.

On 11/12/24 at 01:30 PM, Administrative Staff A provided an email sent to Administrative Nurse D on 10/25/24 at 08:31 PM by LN G which stated at about 05:55 PM on 10/25/24 CNA M reported a concern she witnessed prior to the evening meal of CMA T being more rough than necessary and CNA M felt she should bring it to the nurses' attention. The email continued to state when LN H came on duty, both nurses took R1 into her room and examined her. LN G stated R1 had bruising to her arms, typical per her normal and none stood out, R1 was pleasant and cooperative, and there was no new bruising. LN G stated she and LN H had a conversation with CMA T in the email regarding CMA T asking for help when necessary and what to expect when caring for R1.

The facility's "Abuse, Neglect, Exploitation and

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F 610	Continued From page 10	F 610		

Crime Prevention and Management" policy, dated 05/2023, documented the facility must ensure that all allegations of abuse, neglect, injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the facility, the State Survey Agency, to other officials in accordance with state law, and take all necessary corrective actions depending on the results of the investigation.

The facility ' s "Abuse, Neglect, Exploitation and Crime Prevention and Management" policy, dated 05/2023, documented the facility must ensure that all allegations of abuse, neglect, injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the facility, the State Survey Agency, to other officials in accordance with state law, and take all necessary corrective actions depending on the results of the investigation. For protection, as soon as it is reported that there was alleged abuse of a resident by an employee, the employee is to be immediately suspended pending the outcome of the investigation and asked to leave the premises until they are called in for review of the findings upon completion of the investigation.

The facility failed to fully investigate and initiate protective measures for R1 after an allegation of abuse. This placed the resident at risk for continued abuse.