STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175130	A. Building B. Wing	11/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowbrook Rehabilitation Hospital	427 W Main Street Gardner, KS 66030

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42966 The facility identified a census of 102 residents. The sample included three residents. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 1, a cognitively impaired resident, remained free from staff-to-resident abuse. On 10/31/24, Certified Nurse Aide (CNA) M and CNA N got R1 ready for a shower. R1 started yelling and swatted at CNA M. CNA M swatted at R1 in return. After CNA M and CNA N got R1 up with the Hoyer lift (full body mechanical lift) and into the shower chair. R1 yelled loudly, and CNA M put her hand on R1's mouth and told R1 to hush. This deficient practice resulted in impaired psychosocial well-being for R1 and placed R1 at risk for continued abuse. Findings included: - R1's Electronic Medical Record (EMR) documented diagnoses of hemiplegia (paralysis of one side of the body) and hemiparesis (muscular weakness of one half of the body) following cerebrovascular disease (CVA-stroke- the sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) affecting the right dominant side, cognitive communication deficit, speech and language deficits following cerebrovascular disease, and generalized anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). The Annual Minimum Data Set (MDS) dated [DATE], documented R1 had a Brief Interview for Mental Status (BIMS) score of 99 which indicated R1 was unable to complete the interview. R1 had no behaviors. R1 had impairment on one side of both upper and lower extremities. R1 was dependent on staff for transfers. The Quarterly MDS dated [DATE], documented R1 had a BIMS score of five which indicated severe cognitive impairment. R1 had no behaviors. R1 had impairment on one side of both upper and lower extremities. R1 was dependent on staff for transfers. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 03/26/24, documented R1 had impaired cognition. The Functional Abilities/Rehabilitation Potential CAA dated 03/26/24, documented R1 required assistance with activities of daily living (ADL). (continued on next page)

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	R1's Care Plan dated 07/06/22, documented R1 had impaired cognitive function or impaired thought processes related to short-term memory loss and directed staff to approach R1 in a gentle, friendly, and unhurried manner. R1's Care Plan dated 02/06/23, documented R1 required moderate to extensive dependence on staff for ADLs and directed two staff to transfer R1 with a Hoyer lift using a medium or large lift sling. R1's Care Plan dated 07/27/23, documented R1 resisted care related to anxiety and directed staff to allow her to make decisions about her treatment regime, encouraged R1 to participate as much as possible during care activities, give R1 a clear explanation of all care activities as they occurred with each contact, and praised R1 for appropriate behaviors. The facility's Investigation dated 11/07/24, documented on 10/31/24 at around 04:35 PM, Administrative Nurse D notified Administrative Staff A that CNA N witnessed CNA M put her hand over R1's mouth to keep her from screaming and that CNA M swatted at R1's hand and told her to be quiet. CNA O also witnessed CNA M tell R2 she could not have any more soda and R2 was being annoying. The facility suspended CNA M immediately pending an investigation. Administrative Nurse E assessed R1 without any findings of redness or bruising. The facility notified R1's representative, R1's provider, and law enforcement. The facility investigation substantiated that CNA M was abusive to R1 and R2 and terminated her on 11/07/24 . In CNA N's Witness Statement dated 10/31/24, CNA N stated she and CNA M were getting R1 up for a shower on 10/31/24 and R1 started yelling and screaming. She stated CNA M yelled at R1 and said she was not doing that [expletive] and told R1 to quit her [expletive] too. CNA N stated as she and CNA M got R1 into the wheelchair, R1 started hitting CNA M in the head. CNA N stated CNA M swatted at R1 and told her to be quiet. CNA M also put her hand over R1's mouth as well and taunted R1, making R1 more upset. CNA N stated she felt uncomfortable being in the room with CNA M and she felt bad for R1 as she did not deserve to be treated that way. In CNA M's Witness Statement dated 10/31/24, CNA M stated that on 10/31/24, she did not swat at R1, but she moved R1's hand into the sling so it would not get hurt. CNA M stated she did not put her hand on R1's mouth or touch her in any way that would have hurt R1. In Administrative Nurse E's Witness Statement dated 10/31/24, Administrative Nurse E stated after staff informed her of the incident between CNA M and R1, she went to R1's room to perform a skin assessment. She stated R1 had no obvious skin issues, however, R1 kept using her left arm and motioned towards Administrative Nurse E's arm then R1 grabbed Administrative Nurse E's forearm tightly then let go. Administrative Nurse E stated R1 stated no, then took her hand and covered her mouth with it. Administrative Nurse E asked R1 if CNA M covered her mouth and R1 yelled yes as she nodded her head up and down. Administrative Nurse E informed R1 that the facility took care of the situation and R1 thanked her. On 11/12/24 at 01:09 PM, R1 sat in her wheelchair in her bedroom and watched television. She did not remember staff putting their hands on her mouth on 10/31/24. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	On 11/12/24 at 12:44 PM, CNA N revealed that on 10/31/24, she and CNA M were getting R1 up for a shower between 10:00 AM and 11:00 AM and R1 started yelling. She said she could tell CNA M was getting agitated as R1 was refusing the shower. CNA N said that while they got R1 up, R1 started yelling more and swatting at CNA M. She stated that CNA M swatted back at R1 and taunted her instead of walking away. CNA N said once they had R1 up with the lift and into the shower chair, R1 yelled very loudly, and CNA M put her gloved hand over R1's mouth and told her to hush. She said CNA M said she was not dealing with that [expletive] and told R1 she did not have to deal with R1's [expletive]. CNA N stated she took R1 out of the room and showered her. She said after R1's shower, she took a 15-minute break because she needed a breather and needed to figure out how to handle the situation. CNA N stated she came back in and went to help CNA O with R2. CNA N stated after CNA M told R2 she could not have any more soda, she and CNA O reported to Administrative Nurse D what happened with CNA M and R2 and what happened earlier with CNA M and R1. On 11/12/24 at 12:57 PM, CNA M said she helped CNA N get R1 up for a shower and R1 became agitated and screamed a lot. She said she helped move R1 into her bed after her shower and she moved R1's arm over into the sling and tried to calm her down. CNA M said R1 became agitated before the shower and had become aggressive and hit CNA M a couple of times. CNA M stated she did not put her hand over R1's mouth and never hit her. On 11/12/24 at 01:27 PM, Administrative Nurse E said she had CNA M in her office for being rude to another resident when there was a knock at the door and Administrative Nurse D stepped out. She said that CNA N told Administrative Nurse D what happened with R1, and Administrative Nurse D told Administrative Nurse E they had a bigger issue and Administrative Nurse E went into the hallway. She stated she told CNA M to stay in the office then she and Administrative Nurse D went into Administrative Staff A's office to report what happened with CNA M. Administrative Nurse E said she talked to R1, who was unable to make out sentences, but when asked if she was okay, R1 grabbed Administrative Nurse E's arm and made a smacking motion then made a motion over her mouth. Administrative Nurse E stated she asked R1 if CNA M put her hand over R1's mouth and she stated yes. She stated she had not been notified that CNA M had swatted at R1's arm so when she came out of her room, she asked CNA N if CNA M had smacked R1. Administrative Nurse E said CNA N stated that CNA M swatted at R1's hand because R1 smacked CNA M. Administrative Nurse E stated CNA M talked to the police, filled out a witness statement, clocked out, and left the faciity on suspension. On 11/12/24 at 01:36 PM, Administrative Nurse D stated somebody had written up a grievance about CNA M so she talked to CNA M on 10/31/24 about customer service. She stated while CNA M was in the office, CNA N knocked on the door so Administrative Nurse D stepped out into the hallway. Administrative Nurse D stated CNA N reported that CNA M put her hand over R1's mouth and swatted at the resident. She stated she told CNA M to stay in the office then she reported the incident to Administrative Staff A. Administrative Nurse D stated she had CNA M fill out a witness statement then CNA M talked to law enforcement and the facility suspended her pending an investigation. Administrative Nurse D stated Administrative Nurse E talked to R1 and R1 motioned that her mouth was covered and she was smacked. She stated CNA M denied touching R1. She stated if staff got frustrated during care, she expected staff to make sure the resident was safe and then reapproach them later or find someone else who could help them. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	On 11/12/24 at 03:10 PM, Administrative Staff A stated that on 10/31/24, she was in an interview with law enforcement when Administrative Nurse D and Administrative Nurse E knocked on her door to report that CNA M put her hand on R1's face and slapped her arm. She stated she immediately called CNA M into the office with law enforcement, and CNA M gave her a statement and then wrote a witness statement. Administrative Staff A stated she informed CNA M of her suspension pending the active investigation. During the investigation, Administrative Nurse E assessed R1 and R1 gestured slapping her arm and covering her mouth. Administrative Staff A stated she terminated CNA M after that. She stated she expected staff to report abuse concerns immediately after an incident. Administrative Staff A stated if staff became frustrated during care, she expected them to step out and take a break or let someone else take care of their load until the frustration passed. The facility's Abuse, Neglect, and Exploitation policy, dated 2024, directed the facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, and exploitation and misappropriation of resident property. The facility failed to prevent staff-to-resident abuse for R1 on 10/31/24. This deficient practice resulted in impaired psychosocial well-being for R1 and placed R1 at risk for continued abuse. The facility put the following corrections into place before the onsite visit: The facility suspended CNA M immediately on 10/31/24. Administrative Nurse E assessed R1 with no injuries found on 10/31/24. The facility notified R1's representative, R1's provider, and law enforcement on 10/31/24. The facility obtained witness statements on 10/31/24. The facility conducted abuse, neglect, and exploitation training on 10/31/24. The facility interviewed residents with high BIMS on 11/01/24 regarding abuse. Social Services followed up with R1 on 11/06/24. The facility updated R1's care plan on 11/07/24. The facility terminated CNA M on 11/07/24. Because the facility implemented and completed the corrections before the onsite survey, this deficient practice was cited as past noncompliance. The scope and severity remain a G based on the reasonable person concept due to the circumstances of R1's cognitive impairment and inability to fully express her feelings.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42966 The facility identified a census of 102 residents. The sample included three residents. Based on observation, record review, and interviews, the facility failed to ensure staff immediately reported staff-to-resident abuse for R1 on 10/31/24. This deficient practice placed R1 at risk for further abuse. Findings included: - R1's Electronic Medical Record (EMR) documented diagnoses of hemiplegia (paralysis of one side of the body) and hemiparesis (muscular weakness of one half of the body) following cerebrovascular disease (CVA-stroke- the sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) affecting the right dominant side, cognitive communication deficit, speech and language deficits following cerebrovascular disease and generalized anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). The Annual Minimum Data Set (MDS) dated [DATE], documented R1 had a Brief Interview for Mental Status (BIMS) score of 99 which indicated R1 was unable to complete the interview. R1 had no behaviors. R1 had impairment on one side of both upper and lower extremities. R1 was dependent on staff for transfers. The Quarterly MDS dated [DATE], documented R1 had a BIMS score of five which indicated severe cognitive impairment. R1 had no behaviors. R1 had impairment on one side both upper and lower extremities. R1 was dependent on staff for transfers. The Cognitive Loss/Dementia (progressive mental disorder characterized by failing memory, confusion) Care Area Assessment (CAA) dated 03/26/24, documented R1 had impaired cognition. The Functional Abilities CAA dated 03/26/24, documented R1 required assistance with activities of daily living (ADLs). R1's Care Plan dated 07/06/22, documented R1 had impaired cognitive function or impaired thought processes related to short-term memory loss and directed staff to approach R1 in a gentle, friendly, and unhurried manner. R1's Care Plan dated 02/06/23, documented R1 required moderate to extensive dependence on staff for ADLs and directed two staff transfer R1 with a Hoyer lift using a medium or large lift sling. R1's Care Plan dated 07/27/23, documented R1 resisted care related to anxiety and directed staff to allow her to make decisions about her treatment regime, encouraged R1 to participate as much as possible during care activities, gave R1 a clear explanation of all care activities as they occurred with each contact, and praised R1 for appropriate behaviors. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Investigation, dated 11/07/24, documented on 10/31/24 at around 04:35 PM, Administrative Nurse D notified Administrative Staff A that CNA N witnessed CNA M put her hand over R1's mouth to keep her from screaming and that CNA M swatted at R1's hand and told her to be quiet. CNA O also witnessed CNA M tell R2 she could not have any more soda and R2 was being annoying. The facility suspended CNA M immediately pending an investigation. Administrative Nurse E assessed R1 without any findings of redness or bruising. The facility notified R1's representative, R1's provider, and law enforcement. The facility investigation substantiated that CNA M was abusive to R1 and R2 and terminated her on 11/07/24. In CNA N's Witness Statement dated 10/31/24, CNA N stated she and CNA M were getting R1 up for a shower on 10/31/24 and R1 started yelling and screaming. She stated CNA M yelled at R1 and said she was not doing that [expletive] and told R1 to quit her [expletive] too. CNA N stated as she and CNA M got R1 into the wheelchair, R1 started hitting CNA M in the head. CNA N stated CNA M swatted at R1 and told her to be quiet. CNA M also put her hand over R1's mouth as well and taunted R1, making R1 more upset. CNA N stated she felt uncomfortable being in the room with CNA M and she felt bad for R1 as she did not deserve to be treated that way. On 11/12/24 at 01:09 PM, R1 sat in her wheelchair in her bedroom and watched television. She did not remember staff putting their hands on her mouth on 10/31/24. On 11/12/24 at 12:44 PM, CNA N revealed that on 10/31/24, she and CNA M were getting R1 up for a shower between 10:00 AM and 11:00 AM and R1 started yelling. She said she could tell CNA M was getting agitated as R1 was refusing the shower. CNA N said that while they got R1 up, R1 started yelling more and swatting at CNA M. She stated that CNA M swatted back at R1 and taunted her instead of walking away. CNA N said once they had R1 up with the lift and into the shower chair, R1 yelled very loudly, and CNA M put her gloved hand over R1's mouth and told her to hush. She said CNA M said she was not dealing with that [expletive] and told R1 she did not have to deal with R1's [expletive]. CNA N stated she took R1 out of the room and showered her. She said after R1's shower, she took a 15-minute break because she needed a breather and needed to figure out how to handle the situation. CNA N stated she came back in and went to help CNA O with R2. CNA N stated after CNA M told R2 she could not have any more soda, she and CNA O reported to Administrative Nurse D what happened with CNA M and R2 and what happened earlier with CNA M and R1. On 11/12/24 at 02:45 PM, Certified Medication Aide (CMA) R stated if she witnessed abuse, she stopped the abuse, removed the abuser from the room, and notified the nurse immediately. She stated she reported any abuse concerns immediately and used the abuse calling chain which included calling the numbers on the chain until she spoke with someone personally. On 11/12/24 at 02:56 PM, Licensed Nurse (LN) G stated if she witnessed abuse, she separated the abuser from the victim and reported it immediately. She stated the facility had an abuse calling tree that included Administrative Staff A, Administrative Nurse D, Administrative Nurse E, and social services. LN G stated she reported any concerns of abuse immediately, she did not take a break then report her concerns. On 11/12/24 at 02:30 PM, Administrative Nurse D stated she assumed CNA N reported the incident between CNA M and R1 immediately. She stated she did not know CNA N took a break before reporting the incident. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/12/24 at 03:10 PM, Administrative Staff A stated that she expected staff to report abuse concerns immediately after an incident. On 11/14/24 at 01:34 PM, CNA N stated she remembered that 10/31/24 was half a shift so she did not come in until noon. She stated she was confused regarding the time of the event on 10/31/24. She stated on 10/31/24, she started work at 12:00 PM, and about 30 minutes to an hour later, she helped CNA M get R1 up for a shower. CNA N stated that R1 had bowel movement all over her and CNA M decided she needed a shower. She stated R1 screamed and swatted at CNA M then CNA M swatted back at R1 and taunted R1. CNA N stated once they lifted R1 up in the Hoyer lift to put her in the shower chair, R1 yelled loudly, and CNA M used her gloved hand to cover her mouth once they put her in the shower chair. She stated she took R1 out of the room and gave her a shower. CNA N stated when she was done with the shower, CNA M helped her lay R1 down in bed. She stated she needed a breather for her mental health after the incident and went outside. CNA M stated when she came back in, CNA O needed help getting R2 up so she did that and then she reported what she had witnessed earlier to Administrative Nurse D. She stated she thought she had 24 hours to report abuse which she did and did not know she needed to report abuse immediately. The facility's Abuse, Neglect, and Exploitation policy, dated 2024, directed the facility provided protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, and exploitation and misappropriation of resident property. The policy directed staff to report all alleged violations to the administrator immediately but not later than two hours after the allegation is made if the events that caused the allegation involved abuse or resulted in serious bodily harm. The facility failed to ensure staff reported staff-to-resident abuse for R1 immediately. This deficient practice placed R1 at risk for further abuse.