STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175567	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Logan County Senior Living Inc	615 Price Ave Oakley, KS 67748

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. The facility identified a census of 27 residents, with three residents reviewed for abuse, neglect, and exploitation. Based on record review, observation, and interview, the facility failed to prevent staff from physically forcing Resident (R) 1 to take her medications when she refused to take her medications. On 12/15/24 at approximately 07:20 AM, Licensed Nurse (LN) G attempted to administer medications to R1. R1 swatted LN G's hand away indicating R1 did not want to take the medications. LN G pushed R1's hands away into her lap, removed R1's coffee cup asR1 attempted to grab it and replaced it with a cup of water. LN G then held R1's shoulders and attempted to spoon the medications into R1's mouth. R1 spit out the medications and LN G placed the medications that were spit out back on the spoon and attempted to administer the medications again. LN G grabbed the back of R1's head, pushed her head forward, lifted the water cup up to R1's mouth, and poured water into R1's mouth. R1 attempted to spit the medications back out. Certified Nurse's Aide (CNA) M intervened, sat beside R1, and encouraged R1 to take her medications. R1 accepted direction from CNA M and swallowed her medications. Based on the reasonable person concept, this deficient practice resulted in feelings of fear for R1 and placed R1 at risk for further psychosocial harm, intimidation, and neglect. Findings included: - R1's Electronic Medical Record (EMR) documented R1 had diagnoses of Alzheimer's Disease (progressive mental deterioration characterized by confusion and memory failure), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), major depressive disorder (major mood disorder which causes persistent feelings of sadness), and need for assistance with personal care. The Quarterly Minimum Data Set (MDS), dated 12/31/24, documented R1 had a Brief Interview for Mental Status (BIMS) score of three, which indicated severely impaired cognition. The MDS documented R1 required supervision or touch assistance for oral hygiene, toileting hygiene, dressing, and personal hygiene The MDS documented R1 was independent with ambulation, bed mobility, and transfers. The MDS documented R1 had a mood severity score of 15, which indicated moderately severe depression. The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 09/10/24, documented R1 previously lived with her son, had a BIMS score of 6, which indicated severely impaired cognition, and only sometimes understood others. The Functional Abilities CAA, dated 09/10/24, documented R1 was unsteady on her feet, was incontinent of urine, and required some assistance with her activities of daily living (ADL). R1's Care Plan documented R1 had a communication problem with the potential for unmet needs due to (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175567	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/17/2025
NAME OF PROVIDER OR SUPPLIER: Logan County Senior Living Inc		STREET ADDRESS, CITY, STATE, ZIP CODE: 615 Price Ave Oakley, KS 67748	

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F 0600 Level of Harm - Actual harm Residents Affected - Few	miscommunication and confusion. The care plan directed staff to anticipate and meet R1's needs, allow R1 adequate time to respond, not rush R1, and use simple, brief, consistent cues, and words (09/18/24). The care plan documented R1 had the potential for sadness, a sense of hopelessness, and directed staff to allow R1 time to answer questions, verbalize feelings and fears, and encourage participation from R1, who depended on others to make her own decisions (09/18/24). CNA N's Notarized Witness Statement, dated 12/19/24, documented CNA N was in the dining room assisting another resident. LN G was trying to get R1 to take her pills. CNA M stood beside R1. R1 did not want to take her pills. LN G got the pills in R1's mouth and put her hand behind her head and poured water in her mouth so R1 would take her pills. CNA M told LN G she would sit with R1 and make sure R1 got her pills down. LN G walked away. CNA M and CNA N looked at each other and CNA N reported the incident to Administrative Nurse D at 7:38 AM over the phone. Administrative Nurse D's Notarized Witness Statement, dated 12/19/24, documented LN G told Administrative Nurse D R1 usually takes her meds for me. I was just trying to get her to take them. Administrative Nurse D documented LN G stated this after LN G was told she was suspended pending investigation due to a report from other employees who were in the dining room area and witnessed LN G grab R1's neck when LN G tried to administer medications to R1; even after R1 swatted the meds away. CNA M's Notarized Witness Statement, dated 12/20/24, documented CNA M entered the dining room and witnessed LN G trying to force pills into R1's mouth. LN G tipped R1's head back and tried to pour water into R1's mouth. CNA M stated she sat down next to R1 and offered to help. Once R1 swallowed her pills, CNA M and LN G walked away. CNA M and CNA N talked about the incident and CNA N stated she would call and report the incident to Administrative Nurse D. The Facility Incident Report, dated 12/20/24, documented on 12/15/24 at 07:38 AM, Administrative Nurse D received a phone call from CNA N who stated she was in the dining room and LN G was giving medications. LN G went to R1 to give her meds and LN G put her hand on the back of R1's head and tipped her head back to get her to take them around 07:24 AM. Administrative Nurse D notified Administrative Staff A. Administrative Staff A and Administrative Nurse D came to the facility and reviewed the camera footage. Upon review, R1 sat in a dining room chair at the dining room table eating her breakfast meal. LN G approached R1 to administer R1's medications. R1 swatted or pushed R1's hands away which indicated R1 did not want to take the medications. LN G responded by pushing R1's hands down to her lap and removed the coffee cup R1 attempted to grab and replaced it with a cup of water. LN G then used her left arm to hold R1's shoulder and placed the medications into R1's mouth with a spoon. R1 attempted to spit the medications out. LN G took the medications R1 spit out, placed them back on the spoon, and administered them again. LN G grabbed the back of R1's head, pushed her head forward, lifted the water cup to R1's mouth, and poured water into R1's mouth. R1 again attempted to spit out the medications. CNA M approached and sat next to R1 and encouraged R1 to take a drink of water. R1 complied, drank the water, and swallowed her medications. LN G stepped back, monitored R1 for signs of swallowing, and observed LN G resume eating. LN G was placed on immediate suspension pending investigation. LN G's behavior demonstrated frustration and a failure to respect R1's verbal and physical refusal to take medications. LN G violated appropriate care protocols and failed to adhere to resident rights by using physical force to administer medications. On 02/17/25 at 10:00 AM, R1 laid in bed watching television. R1 was unable to have a conversation or answer questions. On 02/17/25 at 11:30 AM, R1 wandered into the activity room and said, I need to go to bed. R1 (continued on next page)

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F 0600

Level of Harm - Actual harm

Residents Affected - Few

pulled out a chair, sat down, And was unable to make conversation. R1 stated again, I need to go to bed, got up from the table, and left the room.

On 02/17/25 at 10:15 AM, CNA N stated R1 did not want to take her medications so LN G forced them into R1's mouth and poured water into R1's mouth. CNA N stated it was unusual for R1 to react like that, as she normally did not react to much of anything.

On 02/17/25 at 12:00 PM, Administrative Nurse D stated she expected facility staff not to force residents to do anything they did not want to. She expected the facility staff to honor resident wishes and resident rights. Administrative Nurse D stated all education was completed with all current staff at the facility by 12/22/24.

The facility's Abuse, Neglect, Exploitation and Misappropriation Prevention Policy, revised April 2021, documented residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse and physical and chemical restraint not required to treat the resident's symptoms. The facility-wide commitment and resource allocation to support the following objectives: Protect the residents from abuse, neglect, exploitation and misappropriation of resident property, develop and implement policies and protocols to prevent and identify abuse or mistreatment of residents, neglect of residents, theft, exploitation or misappropriation of resident property, ensure adequate staffing and oversight/support to prevent burnout, stressful work situations, and high turnover rates, conduct employee background checks and not knowingly employ or otherwise engage any individual who has been found guilty of abuse, neglect, exploitation, misappropriation of resident property by a court of law, had a finding entered into the state registry concerning abuse, neglect, exploitation or mistreatment of residents, establish and maintain a culture of compassion and caring for all residents and particularly those with behavioral, cognitive or emotional problems, provide staff orientation and training programs that include topics such as abuse prevention, identification and reporting, stress management, and handling verbally or physically aggressive resident behavior, implement measure to address factors that may lead to abusive situations, identify all possible incidents of abuse and neglect, investigate and report any allegation within timeframes required by federal requirements, protect residents from any further harm during the investigation, establish and implement QAPI review for analysis of reports, allegations or findings of abuse, neglect, and mistreatment of residents, and involve the resident council in monitoring and evaluating the facility's abuse prevention program.

The facility failed to prevent staff from physically forcing R1 to take her medications. Based on the reasonable person concept, this deficient practice resulted in feelings of fear for R1 and placed R1 at risk for further psychosocial harm, intimidation, and neglect.

The facility completed corrective actions to correct the deficit practice, which were completed by 12/22/24. The actions included: immediate steps were taken to ensure R1's safety following the incident; LN G was immediately suspended pending investigation; all notifications were completed to Administrative Staff A, Administrative Nurse D, R1's responsible party, R1's primary care provider, the Ombudsman, and KDADS; Police were notified and a case was opened; a thorough investigation was conducted including staff interviews, resident assessments and a review of incident details; all staff were re-educated on the Abuse, Neglect, and Exploitation policy and procedures emphasizing the importance of immediate reporting and adherence to abuse prevention protocols; staff educations and retraining on abuse prevention, proper redirection techniques and resident rights to reinforce care standards and ensure compliance; twice daily skin assessments were implemented for R1 to monitor for

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F 0600 Level of Harm - Actual harm Residents Affected - Few	potential injuries with no concerns noted throughout the monitoring period; and a report was made to the KSBN regarding the investigation and findings involving LN G. Since all corrective actions were completed before the onsite survey, the deficient practice was deemed past noncompliance and remained at G to represent the psychosocial harm to R1.