STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175350	A. BUILDING _____ B. WING _____	12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

(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 a Health Resurvey and Complaint Investigation KS00182965. The 2567 was sent electronically on 12/19/23.	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

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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F 609	Continued From page 1	F 609		

by:
The facility had a census of 79 residents. The sample included 18 residents with one reviewed for abuse. Based on observation, record review, and interview the facility failed to ensure staff identified and reported allegations of potential abuse to the administrator of the facility immediately. This placed the residents at risk for ongoing abuse and/or mistreatment.

Findings included:

- R69's Electronic Health Record (EHR) revealed diagnosis of dementia (progressive mental disorder characterized by falling memory, confusion,) major depressive disorder (major mood disorder which causes persistent feelings of sadness,) hypertension (elevated blood pressure.)

R69's "Quarterly Minimum Data Set" (MDS), dated 02/17/23, recorded R69 had severely impaired cognition. The MDS recorded she required limited assistance of one staff assistance for transfers and activities of daily living (ADL.) The MDS further documented R69 had no falls and no skin issues.

R69's "Quarterly MDS," dated 10/06/23, recorded R69 had severely impaired cognition. The MDS recorded she required extensive two staff assistance for transfers and ADLs. The MDS further documented R69 had two non- injury and two minor injury falls and lacked any skin issues.

R69's "Care Plan." dated 09/13/23, recorded R69 requires extensive assistance with most ADL cares. The "Care Plan" documented the resident had impaired mobility due to wandering, and staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

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F 609	Continued From page 2	F 609		

would check on the resident every 15 minutes and had a pressure alarm. The care plan recorded would encourage the resident to sit in a recliner across from the nurse's station window so she could be monitored if she would attempt to get up without staff assistance. The care plan recorded staff would anticipate she would fall due to unsteadiness in her feet, anxiousness and dementia.

The "Fall Risk Assessments," dated 02/15/23, 04/12/23 11/15/23, noted R69 at high risk for falls.

The "Nurse's Note," dated 04/12/23 at 01:14 PM, documented staff heard knocking and discovered R69 on the floor, leaned against the door in the bathroom. The note further documented R69 had blood on the right side of her head near the temple area and blood was noted on the floor. The resident stated she did not know what happened. The clinical record lacked documentation a resident centered intervention was put into place to prevent falls and lacked documentation an investigation was completed for the fall.

The "Nurses Notes," dated 04/21/23 at 05:01 AM, documented staff noted resident rubbing her right hand, evaluation noted bruising to the middle and right of middle knuckle on the right hand. Staff noted a small amount of swelling and the resident complained of tenderness to the right middle knuckle with touch, Staff applied ice and would continue to monitor. The area measured 6.0 centimeters (cm) by 7.5 cm.

The EHR lacked any documented skin assessment that included the bruised right hand.

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	175350	A. BUILDING _____ B. WING _____	12/11/2023

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CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

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F 609	Continued From page 3	F 609		

On 12/05/23 at 11:30 AM, observation revealed R69 sat in her wheelchair at the dining room table and staff would cue and assist her as needed to eat.

On 12/07/23 at 01:00 PM, Administrative Staff A and Nurse Consultant GG stated they had not been informed of R69's fall on 04/12/23 or the bruised hand on 04/23/23 and the staff should report to the administration and an investigation would be completed along with witness statements and reported to the state if indicated.

The facility's "Resident Right to Freedom from Abuse, Neglect, and Exploitation" policy, dated November 6, 2017, documented ensure that all alleged violations involving abuse, neglect, and exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported in the proper timeframe pursuant to the policy. And have evidence that all alleged violations are thoroughly investigated. The policy recorded the facility must report the results of all investigations to the administrator or his /her designated representative and to other officials in accordance with State laws, within 5 working days of the incident. If the alleged violation is verified, appropriate corrective action must be taken. Residents would be protected from further abuse, neglect, exploitation or mistreatment while the investigation was in process.

The facility failed to ensure staff identified and reported an allegation of potential abuse to the facility abuse coordinator or administrative staff immediately to investigate. This placed the residents at risk for ongoing abuse and/or mistreatment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175350	A. BUILDING _____ B. WING _____	12/11/2023

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CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

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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 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: The facility had a census of 79 residents. The sample included 18 residents. Based on observation, record review, and interview, the facility failed to investigate Resident (R)69's unwitnessed fall in the bathroom which resulted in swelling and bruising. This deficient practice placed R69 at risk for unidentified and continued abuse, neglect and/or mistreatment. Findings included: - R69's Electronic Health Record (EHR) revealed diagnosis of dementia (progressive mental disorder characterized by falling memory, confusion), major depressive disorder (major mood disorder which causes persistent feelings of sadness) and hypertension (elevated blood	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175350	A. BUILDING _____ B. WING _____	12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

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F 610	Continued From page 5	F 610		

pressure).

R69's "Quarterly Minimum Data Set" (MDS), dated 02/17/23, recorded R69 had severely impaired cognition. The MDS recorded she required limited assistance of one staff assistance for transfers and activities of daily living (ADL.) The MDS further documented R69 had no falls and no skin issues.

R69's "Quarterly MDS," dated 10/06/23, recorded R69 had severely impaired cognition. The MDS recorded she required extensive two staff assistance for transfers and ADLs. The MDS further documented R69 had two non- injury and two minor injury falls; R69did not have any skin issues.

R69's "Care Plan." dated 09/13/23, recorded R69 required extensive assistance with most ADL cares. R69's "Care Plan" documented the resident had impaired mobility due to wandering, and staff would check on the resident every 15 minutes; the resident had a pressure alarm. The care plan directed staff would encourage the resident to sit in a recliner across from the nurse's station window so she could be monitored if she attempted to get up without staff assistance. The care plan recorded staff would anticipate R69 would fall due to unsteadiness in her feet, anxiousness and dementia.

R69's "Fall Risk Assessments," dated 02/15/23, 04/12/23 and 11/15/23 noted R69 was at high risk for falls.

The "Nurse's Note," dated 04/12/23 at 01:14 PM, documented staff heard knocking and discovered R69 on the floor, leaned against the door in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175350	A. BUILDING _____ B. WING _____	12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

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F 610	Continued From page 6	F 610		

bathroom. The note further documented R69 had blood on the right side of her head near the temple area and blood was noted on the floor. The resident stated she did not know what happened.
R69's clinical record lacked documentation a resident centered intervention was put into place to prevent future incidents and lacked documentation an investigation was completed for the incident.

The "Nurses Notes," dated 04/21/23 at 05:01 AM, documented staff noted the resident rubbed her right hand. Staff evaluated and noted bruising to the middle and right of middle knuckle on the right hand. Staff noted a small amount of swelling and the resident complained of tenderness to the right middle knuckle with touch, Staff applied ice and continued to monitor. The area measured 6.0 centimeters (cm) by 7.5 cm.

R69's EHR lacked any documented skin assessment that included the bruised right hand.

On 12/05/23 at 11:30 AM, observation revealed R69 sat in her wheelchair at the dining room table. Staff cued and assisted her as needed to eat.

On 12/07/23 at 01:00 PM, Administrative Staff A and Nurse Consultant GG stated they were not informed of R69's fall on 04/12/23 or the bruised hand on 04/21/23. They verified staff should report to those type of incidents to the administration so an investigation could be completed along with witness statements and reported to the state agency if indicated.

The facility's "Resident Right to Freedom from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175350	A. BUILDING _____ B. WING _____	12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

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F 610	Continued From page 7 Abuse, Neglect, and Exploitation" policy, dated November 6, 2017, documented ensure that all alleged violations involving abuse, neglect, and exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported in the proper timeframe pursuant to the policy. And have evidence that all alleged violations are thoroughly investigated. The policy recorded the facility must report the results of all investigations to the administrator or his /her designated representative and to other officials in accordance with State laws, within 5 working days of the incident. If the alleged violation is verified, appropriate corrective action must be taken. Residents would be protected from further abuse, neglect, exploitation or mistreatment while the investigation was in process. The facility failed to investigate an unwitnessed fall and a bruising of unknown origin for R69. The placed the resident at risk for unidentified and ongoing abuse, neglect, and/or mistreatment.	F 610		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in	F 623		

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	175350	A. BUILDING _____ B. WING _____	12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

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F 623	Continued From page 8	F 623		

accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175350	A. BUILDING _____ B. WING _____	12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

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F 623	Continued From page 9	F 623		

receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175350	A. BUILDING _____ B. WING _____	12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

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F 623	Continued From page 10	F 623		

well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
The facility had a census of 79 residents. The sample included 18 residents with one reviewed for discharge to the hospital. Based on observation, interview, and record review, the facility failed to notify the ombudsman of the facility-initiated discharge of Resident (R) 81, placing R81 at risk for discharges without oversight of the ombudsman office.

Findings included:

- R81's Electronic Medical Record documented he was admitted to the facility 09/27/23 with diagnoses of atrial fibrillation (rapid irregular heartbeat), hypertension (high blood pressure), left femur (thigh bone) fracture, and anxiety disorder (mental disorder characterized by apprehension, uncertainty and irrational fear).

R81's "Care Plan," dated 10/02/23, directed staff to ensure the call light was within reach and encourage R81 to use it for assistance as needed. Engage the resident in active conversation.

The "Progress Note" to the physician, dated 10/03/23 at 04:30 PM, stated R81 said he would have better acceptance of being in the nursing home if he could visit home, sit on the porch, and see the dogs. The note asked if R81 was ok to discharge to home with family for short visits during his skilled stay.

The "Progress Note," dated 10/03/23 at 07:00

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175350	A. BUILDING _____ B. WING _____	12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

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F 623	Continued From page 11 PM, documented R81 stated that he intended on committing suicide "one way or another" and would continue attempts until he was successful. The nurse spent some time providing therapeutic conversation with R81 and he verbalized that he did have a plan in place to commit suicide and intended to follow through with it. One to one staff care was provided to R81 at all times and all items he could harm himself with were removed from his room. His family arrived at the facility to sit with the resident. They agreed that R81 needed to be sent to the hospital for monitoring and the physician gave a verbal order to transfer to the hospital for psychiatric evaluation. The Progress Note," dated 10/05/23 at 02:12 PM, documented R81 was discharged. On 12/07/23 at 10:08 AM, Social Services Staff X verified the facility had not notified the Ombudsman of the discharge. The facility's "Transfer and Discharge" policy, dated 02/01/20, stated the Social Service Designee would provide notice of transfer to the state ombudsman office. The facility failed to notify the state ombudsman office of the facility-initiated discharge of R81 to a hospital. This placed the resident at risk for decreased oversight and assistance with transfers and discharge.	F 623		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans	F 655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

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F 655	Continued From page 12	F 655		

§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-
(i) Be developed within 48 hours of a resident's admission.
(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-
(A) Initial goals based on admission orders.
(B) Physician orders.
(C) Dietary orders.
(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175350	A. BUILDING _____ B. WING _____	12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

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F 655	Continued From page 13	F 655		

of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by:

The facility had a census of 79 residents. The sample included 18 residents with one reviewed for respiratory care. Based on observation, interview, and record review the facility failed to develop and implement a baseline care plan for Resident (R) 25's use of supplemental oxygen. This deficient practice placed R25 at risk for respiratory complications related to uncommunicated care needs.

Findings included:

- R25's Electronic Medical Record documented diagnoses including chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing)), obstructive sleep apnea (disorder in which a person frequently stops breathing during his or her sleep), and congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid).

The "Admission Minimum Data Set" (MDS), dated 11/21/23, documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented R25 was independent with eating, required moderate staff assistance for dressing, transfers, and maximum staff assistance for wheelchair mobility. The MDS documented R25 used oxygen and a non-invasive ventilator (continuous positive airway pressure-CPAP- ventilation device that blows a gentle stream of air into the nose to keep airway open during sleep).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175350	A. BUILDING _____ B. WING _____	12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

(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 655	Continued From page 14	F 655		

The "Functional Abilities Care Area Assessment" (CAA), dated 11/21/23, stated R25 was admitted because she was no longer able to meet her own needs. She was alert, oriented, aware of her needs, and able to make them known. She required staff assistance with completion of activity of daily living (ADL) functions, received supplemental oxygen continuously, and was short of breath with exertion.

R25's "Care Plan" dated 11/20/23 lacked documentation of R25's oxygen needs or use.

R25's Kardex (nursing tool that gives a brief overview of the care needs of each resident), dated 11/17/23, lacked mention of her oxygen needs.

R25's "Care Plan" dated 12/05/23 (19 days after admission), included oxygen per order of "3L/M/NC" (three liter per minute per nasal cannula), "4.5L/M/NC" (four liters per minute per nasal cannula) with activity. The plan directed staff to monitor R25's oxygen saturation and report as indicated. Staff were to provide COPD monitoring every shift for shortness of breath with activity, shortness of breath while lying flat, cyanosis (bluish discoloration of the skin), accessory muscle use, chest wall movement and/or shape abnormalities, presence of cough and/or sputum (mixture of saliva and mucous), peripheral edema (swelling) or a change in level of consciousness. The plan directed staff to check R25's pulse oximetry (measurement of oxygen saturation) with abnormal findings and apply CPAP as per directions on the treatment record.

The "Physician Order," dated 11/17/23, directed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175350	A. BUILDING _____ B. WING _____	12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

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F 655	Continued From page 15 staff to provide supplemental oxygen at 3L/NC to keep saturation level above 90%, and 4.5L with activity. CPAP on at bedtime and off in the morning. On 12/05/23 at 10:48 AM, observation revealed R25 in her recliner with her eyes closed. She received oxygen per nasal cannula at five liters a minute via an oxygen concentrator. On 12/06/23 at 08:42 AM, observation revealed staff brought R25 in a wheelchair from the shower to her room. Certified Nurse Aide (CNA) O and CNA P used gait belt to transfer R25 to her recliner. R25 was short of breath during the transfer. CNA O verified R25 was on five liters of oxygen. On 12/05/23 at 04:31 PM, Administrative Nurse D stated she did not find the baseline care plan and stated it looked as if one had been started then cancelled. Upon request the facility did not provide a baseline care plan policy. The facility failed to develop and implement a baseline care plan for R25's use of supplemental oxygen. This deficient practice placed R25 at risk for respiratory complications related to uncommunicated care needs.	F 655		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175350	A. BUILDING _____ B. WING _____	12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

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F 657	Continued From page 16	F 657		

the comprehensive assessment.
(ii) Prepared by an interdisciplinary team, that includes but is not limited to--
(A) The attending physician.
(B) A registered nurse with responsibility for the resident.
(C) A nurse aide with responsibility for the resident.
(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 79 residents. The sample included 18 residents. Based on observation, record review, and interview, the facility failed to review and revise Resident (R) 284's "Care Plan" with effective interventions for staff to follow when R284 had behaviors. This placed R284 at risk for unmet care needs.

Findings included:

- R284's Electronic Medical Record (EMR) documented R284 had diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure),

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175350	A. BUILDING _____ B. WING _____	12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

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F 657	Continued From page 17	F 657		

major depressive disorder (major mood disorder which causes persistent feelings of sadness), and dementia (progressive mental disorder characterized by failing memory, confusion) with behavioral disturbance.

R284's "Admission Minimum Data Set" (MDS) documented it was in progress.

R284's "Care Plan," revised on 12/06/23, documented R284 had behaviors of yelling out and asking staff to "take a gun and shoot me" or "just kill me" or "take me outside and let me lay there and die." R284's "Care Plan" lacked interventions for staff to follow when R284 had these behaviors.

The "Nurse's Note," dated 12/03/23 at 02:50 PM, documented R284 was calmer that day although she continued to yell out at other residents and staff, as they passed by in the dining room, for someone to shoot her, to throw her in the river, or to throw her away. Attempts to redirect were short lasting. The note documented the resident tended to be calmer when in her room reading or watching television.

On 12/07/23 at 11:58 AM, observation revealed R284 sat at the dining room table in a wheelchair. R284 yelled out that she wished she was dead, and she might as well be, nobody knew her.

On 12/07/23 at 01:45 PM, Certified Nurse Aide (CNA) O stated R284 had behaviors of yelling out to staff to give her a gun so she could shoot herself. CNA O said she replied to R284 "honey, don't talk that way," then R284 would wait ten minutes and repeat the same thing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175350	A. BUILDING _____ B. WING _____	12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

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F 657	Continued From page 18 On 12/11/23 at 09:59 AM, Administrative Nurse D verified R284's "Care Plan" lacked interventions for staff to follow when R284 had behaviors of yelling out asking people to kill her. Administrative Nurse D stated the care plan nurse, charge nurse, and she were responsible for updating care plans. Administrative Nurse D stated R284's "Care Plan" should have interventions for staff to follow when R284 had behaviors. The facility's "Care Plan Revisions Upon Status Change Policy, "revised 02/02/20, documented the comprehensive care plan would be reviewed and revised as necessary, when a resident experienced a status change. The facility failed to update R284's "Care Plan" with interventions for staff to use when R284 had behaviors of yelling asking people to kill or shoot her. This placed R284 at risk for unmet care needs.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: The facility had a census of 79 residents. The sample included 18 residents. Based on observation, record review, and interview, the facility staff failed to provide necessary services for one of four residents reviewed for activities of daily living (ADLs), when Resident (R) 74 requested staff assistance with repositioning and they told her she would have to wait, then did not	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175350	A. BUILDING _____ B. WING _____	12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

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F 677	Continued From page 19	F 677		

return until 41 minutes later to assist her. This placed R74 at risk for impaired mobility and decreased comfort.

Findings included:

- R74's Electronic Medical Record (EMR) documented R74 had diagnoses of Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), carcinoma (cancer) in right breast, anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), major depressive disorder (major mood disorder which causes persistent feelings pf sadness), and chronic pain.

R74's "Admission Minimum Data Set" (MDS), dated 10/19/23, documented R74 had a Brief Interview of Mental Status (BIMS) score of 14, which indicated intake cognition. The MDS documented R74 required total staff dependence with most ADLs.

The "Functional Ability Care Area Assessment" (CAA), dated 10/19/23, documented R74 was a new admit to facility with diagnosis of breast cancer with metastasis (spread) to her lungs. The MDS documented R74 required substantial/maximum/dependent staff assistance with ADLs due to her impaired physical mobility and weakness.

The "Pain CAA," dated 10/19/23, documented the resident utilized a fentanyl (opioid) patch (topical pain medication) and instructed staff to monitor R74 for nonverbal signs or symptoms of pain, and report if she was not relieved by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175350	A. BUILDING _____ B. WING _____	12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

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F 677	Continued From page 20	F 677		

nonpharmacological (management of pain without medications) interventions. The CAA instructed staff to notify the physician if interventions including medications and non-pharmacological were unsuccessful or if R74 complaint of pain was a significant change.

The "ADL CAA," dated 10/19/23, documented R74 was dependent on staff for most ADLs.

R74's "Care Plan" dated 10/13/23 directed staff to assess for pain, restlessness, agitation, constipation, and other symptoms of discomfort. If present, provide nonpharmacological approaches to aide in decreasing discomfort.

On 12/6/23 at 10:30 AM, R74 placed her pendant call light on. Certified Medication Aide (CMA) M entered R74's room and R74 requested to be repositioned in bed, CMA M stated R74 would have to wait until CMA M had help and said she would be back. At 11:01 AM (41 minutes later) CMA M and Certified Nurse Aide (CNA) N entered R74's room and stated they were ready to assist R74 with repositioning. CNA N stated it took so long to get back to assist R74 because staff were busy on the unit, taking care of other residents. She said she had to work with her restorative residents first and had to take her break before she could accommodate R74's request.

On 12/11/23 at 09:56 AM, Administrative Nurse D stated she expected staff to provide care to R74 within 15 minutes after she had placed her call light on.

The facility's "ADLs Policy," revised 08/01/19, documented a resident who is unable to carry out

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175350	A. BUILDING _____ B. WING _____	12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

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F 677	Continued From page 21 ADLs would receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. The facility staff failed to provide necessary services in a timely manner when R74 requested staff assistance with repositioning in bed, and staff returned 41 minutes later. This placed R74 at risk for decreased comfort.	F 677		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: The facility had a census of 79 residents, The sample included 18 residents with one reviewed for range of motion (ROM). Based on observation, interview, and record review, the facility failed to provide neck stretching exercises for Resident (R) 15 to prevent further decline in	F 688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175350	A. BUILDING _____ B. WING _____	12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

(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 688	Continued From page 22	F 688		

her neck range of motion as discussed during her quarterly care plan meeting. This placed the resident at risk for decreased or impaired comfort.

Findings included:

- R15's Electronic Medical Record documented diagnoses of contracture (abnormal permanent fixation of a joint or muscle) of left shoulder muscle, acquired deformity of neck, contracture of left forearm muscle, osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, shuffling gait, muscle rigidity and weakness).

The "Quarterly Minimum Data Set" (MDS), dated 11/06/23, documented a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS documented R15 was independent with eating, required maximal staff assistance with upper body dressing, hygiene, mobility, and was dependent on staff for lower body dressing and toileting. The MDS documented R15 had no ROM issues, had frequent moderate pain, and no therapy in the past five days. The MDS documented the resident received restorative active range of motion exercises three days during the lookback period.

R15's "Care Plan," dated 11/06/23, stated R15 was receiving restorative care: Bilateral upper extremity (BUE) strengthening in all planes. Pull

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175350	A. BUILDING _____ B. WING _____	12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

(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 688	Continued From page 23	F 688		

to stand using grab bar sitting and reaching with left and right upper extremities in all planes. Perform restorative care per order- do not force or rush. Evaluate progress every month.

The "Progress Note," dated 11/22/23, documented a quarterly care conference was held. The resident received Part B Physical Therapy (PT), Occupational Therapy (OT), and restorative neck stretches/flexes three to five times weekly.

R15's EMR documented active ROM and did not specify the neck stretching exercises.

On 12/05/23 at 04:27 PM, R15 was in her room in a wheelchair with her head tilted far to the right. A neck pillow sat on her bed. R15 stated she had Parkinson's and that was why her neck was contracted. She stated she used to love to sing but could no longer do that.

On 12/06/23 at 08:03 AM, observation revealed R15 ate her breakfast of eggs and raisin bran cereal and though her head was contracted to the right, she was able to eat independently.

On 12/07/23 at 09:23 AM, Therapy Staff HH stated therapy did quite a bit of stretching exercises for R15's neck. She stated the therapy staff looked into getting a neck brace, but the resident did not want that. Therapy Staff HH stated R15 had restorative currently with neck stretches.

On 12/07/23 at 09:26 AM, Certified Nurse Aide (CNA) M stated, "we don't have a scheduled restorative aide [RA]." She stated the regular RA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175350	A. BUILDING _____ B. WING _____	12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

(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 688	Continued From page 24	F 688		

quit several months ago. She stated the RA showed her where the items for restorative were kept and gave a couple of hours of training. CNA M stated usually the CNAs do their work between 06:00 AM and 10:00 AM, then some restorative if they had time in between cares.

On 12/07/23 at 09:55 AM, CNA O stated she received no restorative training.

On 12/07/23 at 10:32 AM, Licensed Nurse (LN) G stated therapy gave the recommendations for activities or exercises for restorative She stated the facility had no trained restorative aides and she was scheduled to provide restorative on Wednesdays. LN G stated she also worked as a nurse in direct care on Wednesdays. She stated she had never performed neck exercises with R15, just upper body and walking exercises.

On 12/11/23 at 10:08 AM, Administrative Nurse D stated the facility had a designated RA every day. She stated the prior RA quit and the facility worked on training staff for restorative services. Administrative Nurse D stated the direct care staff were supposed to provide partial restorative in between their regular work and the activity director sometimes provided restorative activities. She stated one staff took a RA class a month ago.

The facility's "Restorative Nursing Programs" policy, dated October 2018, stated this facility would provide maintenance and restorative services designed to maintain or improve a resident's abilities to the highest practicable level. Nursing personnel are trained on basic, or maintenance, restorative nursing care that does not require the use of a qualified therapist or

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	175350	A. BUILDING _____ B. WING _____	12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

(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 688	Continued From page 25 licensed nurse oversight. This training may include maintaining proper positioning and body alignment. All residents will receive maintenance restorative nursing services, as needed, by certified nursing assistants. Residents, as identified during the comprehensive assessment process, will receive services from restorative aides when they are assessed to have a need for such services. The facility failed to provide restorative neck exercises for R15 to prevent further decline in her neck range of motion as discussed during her quarterly care plan meeting. This placed R15 at increased risk for decreased ROM or contractures.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility had a census of 79 residents. The sample included 18 residents. Based on observation, record review, and interview, the facility failed to provide an environment free from accident hazards when Resident (R) 67's bedrail exceeded the acceptable safety dimension to prevent entrapment. This placed the resident at risk for accidents and preventable injury.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175350	A. BUILDING _____ B. WING _____	12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

(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 689	Continued From page 26	F 689		

Findings included:

- R67's diagnoses from the Electronic Medical Record (EMR) included neuropathy (weakness, numbness and pain from nerve damage, usually in the hands and feet), cerebral infarction (stroke - 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), atrial fibrillation (rapid, irregular heart beat), and pulmonary hypertension (a type of high blood pressure that affects arteries in the lungs and in the heart).

R67's "Admission Minimum Data Set" (MDS), dated 10/21/23, recorded the resident had a Brief Interview for Mental Status (BIMS) score of 14, indicating cognitively intact cognition. The MDS documented R67 required extensive assistance of two staff with bed mobility and transfers, had impaired function on one side lower extremity. The MDS further documented R67 used side rails.

R67's"Care Plan" dated 10/21/23 stated R67 required a quarter side rail for transfers and mobility; staff were to monitor the use of the side rail for entrapment and safety.

R67's EMR recorded a "Device/Transfer Evaluation" dated 10/18/23 which documented a quarter rail to be used for mobility and transfers.

On 12/06/23 at 01:15 PM, observation revealed the rail on the right side of R67's bed, with the other side of the bed against the wall. Further observation revealed the rail measured 16 inches wide by 32 inches tall.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175350	A. BUILDING _____ B. WING _____	12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

(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 689	Continued From page 27 On 12/06/23 at 01:45 PM, Administrative Nurse E verified the bed rail on R67's bed had too large of an opening. On 12/06/23 at 02:15 PM, Administrative Staff A verified the bed rail on R67's bed had too large of an opening and it needed to be removed from the bed. The facility's "Accidents and Supervision" policy, dated 02/01/20, stated the resident environment is to remain as free of accident hazards as is possible; and each resident receives adequate supervision and assistive devices to prevent accidents. The facility failed to provide a safe environment free from accident hazards when R67's bedrail exceeded acceptable safety dimensions to prevent entrapment. This placed R67 at risk for accidents and preventable injury.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: The facility had a census of 79 residents, The sample included 18 residents with one reviewed for respiratory care. Based on observation,	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175350	A. BUILDING _____ B. WING _____	12/11/2023

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CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

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F 695	Continued From page 28	F 695		

interview, and record review, the facility failed to provide Resident (R) 25's supplemental oxygen at the physician ordered rate through the nasal canula and with the use of a non-invasive ventilator. This deficient practice placed R25 at risk for complications resulting from the incorrect rate of oxygen administered.

Findings included:

- R25's Electronic Medical Record documented diagnoses including chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing)), obstructive sleep apnea (disorder in which a person frequently stops breathing during his or her sleep), and congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid).

The "Admission Minimum Data Set" (MDS), dated 11/21/23, documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented R25 was independent with eating, required moderate staff assistance for dressing, transfers, and maximum staff assistance for wheelchair mobility. The MDS documented R25 used oxygen and a non-invasive ventilator (continuous positive airway pressure-CPAP- ventilation device that blows a gentle stream of air into the nose to keep airway open during sleep).

The "Functional Abilities Care Area Assessment" (CAA), dated 11/21/23, stated R25 was admitted because she was no longer able to meet her own needs. She was alert, oriented, aware of her needs, and able to make them known. She

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175350	A. BUILDING _____ B. WING _____	12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

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F 695	Continued From page 29	F 695		

required staff assistance with completion of activity of daily living (ADL) functions, received supplemental oxygen continuously, and was short of breath with exertion.

R25's "Care Plan" dated 11/20/23 lacked documentation of R25's oxygen needs or use.

R25's Kardex (nursing tool that gives a brief overview of the care needs of each resident), dated 11/17/23, lacked mention of her oxygen needs.

R25's "Care Plan" dated 12/05/23 (19 days after admission), included oxygen per order of "3L/M/NC" (three liter per minute per nasal canula), "4.5L/M/NC" (four liters per minute per nasal canula) with activity. The plan directed staff to monitorR25's oxygen saturation and report as indicated. Staff were to provide COPD monitoring every shift for shortness of breath with activity, shortness of breath while lying flat, cyanosis (bluish discoloration of the skin), accessory muscle use, chest wall movement and/or shape abnormalities, presence of cough and/or sputum (mixture of saliva and mucous), peripheral edema (swelling) or a change in level of consciousness. The plan directed staff to checkR25's pulse oximetry (measurement of oxygen saturation) with abnormal findings and apply CPAP as per directions on the treatment record.

The "Physician Order," dated 11/17/23, directed staff to provide supplemental oxygen at 3L/NC to keep saturation level above 90%, and 4.5L with activity. CPAP on at bedtime and off in the morning.

The "Note to the Physician," dated 11/30/23 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175350	A. BUILDING _____ B. WING _____	12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

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F 695	Continued From page 30	F 695		

02:14 PM, stated the resident reported she had not been wearing her CPAP machine at night. The durable medical equipment (DME) company planned to come and add a new pad to her mask. The note did not mention oxygen delivery while using the CPAP.

The "Note to the Physician," dated 12/04/23, included the 11/29/23 note which stated the resident wore four liters of oxygen, but the CPAP mask did not have an oxygen line. The note asked if the facility needed to implement oxygen at 4four liters into the CPAP mask. On 12/06/23 the physician responded "yes; the CPAP does need oxygen during use."

The "Progress Note," dated 12/07/23 at 01:13 PM, documented R25 was very concerned about her health and continued to be nauseous and dizzy with any movement: R25 stayed in her recliner all day and chose to sleep there. Oxygen was in place, but she became out of breath with just standing up for a very short time. The note recorded R25 constantly wanted to sleep and was still tired when awake.

The "Physician Oder," dated 12/08/23, stated R25 was to be admitted to the hospital for further evaluation.

On 12/05/23 at 10:48 AM, observation revealed R25 in her recliner with her eyes closed. She received oxygen per nasal canula at five liters a minute via an oxygen concentrator.

On 12/05/23 at 04:20 PM, observation revealed R25 sat in her recliner and talked on a telephone. She wore oxygen per nasal canula at five liters a minute.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

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F 695	Continued From page 31	F 695		

On 12/06/23 at 07:37 AM, observation revealed R25 in her recliner in recliner with her eyes closed. Her oxygen per nasal canula at five liters a minute.

On 12/06/23 at 08:42 AM, observation revealed staff brought R25 in a wheelchair from the shower to her room. Certified Nurse Aide (CNA) O and CNA P used gait belt to transfer R25 to her recliner. R25 was short of breath during the transfer. CNA O verified R25 was on five liters of oxygen.

On 12/07/23 at 07:38 AM, observation revealed R25 sat in her recliner resident asleep. She wore oxygen per nasal canula at five liters a minute.

On 12/05/23 at 04:31 PM, Administrative Nurse D stated she did not find the baseline care plan and stated it looked as if one had been started then cancelled.

On 12/07/23 at 10:32 AM, Licensed Nurse (LN) G verified R25 received oxygen at five liters a minute. LN G verified R25 should be on three liters a minute usually, and 4.5 liters a minute with activity. LN G verified the resident was not active very often and the oxygen should be at three liters a minute.

On 12/11/23 at 10:00 AM, Administrative Nurse D verified staff should have notified the physician of R25's request for oxygen at five liters a minute and obtained an order before increasing the rate. Administrative Nurse D stated the resident preferred to wear her nasal canula under her CPAP mask at night, but staff should ensure R25 received the physician ordered oxygen rate with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175350	A. BUILDING _____ B. WING _____	12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

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F 695	Continued From page 32 her CPAP at night. The facility's "Oxygen Concentrator" policy, dated 10/01/20, stated oxygen was administered under the orders of the physician. The nurse would verify the physician order for the rate and route of administration of the oxygen. The facility failed to provide R25's supplemental oxygen at the physician ordered rate, placing R25 at risk for complications resulting from the incorrect rate of oxygen administered.	F 695		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced	F 700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175350	A. BUILDING _____ B. WING _____	12/11/2023

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CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

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F 700	Continued From page 33	F 700		

by:
The facility had a census of 79 residents. The sample included 18 residents. Based on observation, record review, and interview, the facility failed to assess the actual bedrail prior to use to assure safety for Resident (R) 67. This placed the resident at risk for injury.

Findings included:

- R67's diagnoses from the Electronic Medical Record (EMR) included neuropathy (weakness, numbness and pain from nerve damage, usually in the hands and feet), cerebral infarction (stroke - 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), atrial fibrillation (rapid, irregular heart beat), and pulmonary hypertension (a type of high blood pressure that affects arteries in the lungs and in the heart).

R67's "Admission Minimum Data Set" (MDS), dated 10/21/23, recorded the resident had a Brief Interview for Mental Status (BIMS) score of 14, indicating cognitively intact cognition. The MDS documented R67 required extensive assistance of two staff with bed mobility and transfers, had impaired function on one side lower extremity. The MDS further documented R67 used side rails.

R67's"Care Plan" dated 10/21/23 stated R67 required a quarter side rail for transfers and mobility; staff were to monitor the use of the side rail for entrapment and safety.

R67's EMR recorded a "Device/Transfer Evaluation" dated 10/18/23 which documented a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175350	A. BUILDING _____ B. WING _____	12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

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F 700	Continued From page 34 quarter rail to be used for mobility and transfers. On 12/06/23 at 01:15PM, observation revealed the rail on the right side of R67's bed, with the other side of the bed against the wall. Further observation revealed the rail measured 16 inches wide by 32 inches tall. On 12/06/23 at 01:45PM, Administrative Nurse E verified the bed rail on R67's bed had too large of an opening. On 12/06/23 at 02:15 PM, Administrative Staff A verified the bed rail on R67's bed had too large of an opening and it needed to be removed from the bed. The facility's undated "Proper Use of Bed Rails "policy, documented the facility shall strive to provide a safe sleeping environment for the residents. To try to prevent deaths/injuries from the beds and related equipment (including the frame, mattress, side rails, headboard, footboard, and bed accessories). Inspection by maintenance staff of all beds and related equipment as part of the regular bed safety program to identify risks and problems including potential entrapment risk. Review that gaps within the bed system are within dimensions established by the FDA. Ensure that bed rails are properly installed using the manufacturer's instructions and other pertinent safety guidance to ensure proper fit. The facility failed to assure R67's bed rail/ transfer bar was adequate for use, placing the resident at risk for entrapment or injury.	F 700		
F 745 SS=D	Provision of Medically Related Social Service	F 745		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175350	A. BUILDING _____ B. WING _____	12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

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F 745	Continued From page 35 CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: The facility had a census of 79 residents. The sample included 18 residents. Based on observation, record review, and interview, the facility failed provide adequate medically related social services to meet Resident (R) 284's mental and behavioral health needs. This placed the resident at risk for decreased quality of care and life. Findings included: - R284's Electronic Medical Record (EMR) documented R284 had diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), major depressive disorder (major mood disorder which causes persistent feelings of sadness), and dementia (progressive mental disorder characterized by failing memory, confusion) with behavioral disturbance. R284's "Admission Minimum Data Set" (MDS) documented it was in progress. R284's "Care Plan," revised on 12/06/23, documented R284 had behaviors of yelling out and asking staff to "take a gun and shoot me" or "just kill me" or "take me outside and let me lay there and die." R284's "Care Plan" lacked interventions for staff to follow when R284 had these behaviors.	F 745		

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	175350	A. BUILDING _____ B. WING _____	12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

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F 745	Continued From page 36	F 745		

The "Nurse's Note," dated 12/03/23 at 02:50 PM, documented R284 was calmer that day although she continued to yell out at other residents and staff, as they passed by in the dining room, for someone to shoot her, to throw her in the river, or to her away. Attempts to redirect were short lasting. The note documented the resident tended to be calmer when in her room reading or watching television.

The "Admission Patient Health Questionnaire (PHQ-9) Assessment," dated 12/01/23, documented R284 had a history of trauma (a deeply distressing or disturbing experience)/post-traumatic stress disorder (disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress).

Review of R284's EMR revealed lacked documentation Social Service Designee (SSD) visited with the resident regarding her behaviors of wanting staff to shoot her.

On 12/07/23 at 11:58 AM, observation revealed R284 sat at the dining room table in a wheelchair. R284 yelled out that she wished she was dead, and she might as well be, nobody knew her.

On 12/07/23 at 01:45 PM, Certified Nurse Aide (CNA) O stated R284 had behaviors of yelling out to staff to give her a gun so she could shoot herself. CNA O said she replied to R284 "honey, don't talk that way," then R284 would wait ten minutes and repeat the same thing.

On 12/07/23 at 02:05 PM, SSD X stated she was aware of R284's behaviors of yelling out "just kill

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175350	A. BUILDING _____ B. WING _____	12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

(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 745	Continued From page 37 me" and she talked to a family member last night and would be putting in a note today regarding this behavior. SSD X stated she had visited with R284 when she had these behaviors. On 12/11/23 at 2:30 PM, Administrative Nurse D stated she was aware of R284's yelling out and wanting staff to shoot her, family had been notified and reported to her R284 had done this for about two years prior to be admitted to facility, and they thought it was just part of her dementia disease. Administrative Nurse D stated SSD should be visiting her regarding this behavior. Upon request the facility failed to provide a policy regarding SSD. The facility's failed to provide adequate medically related social services to meet R284's mental and behavioral health needs. This placed the resident at risk for decreased quality of care and life.	F 745		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175350	A. BUILDING _____ B. WING _____	12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

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F 761	Continued From page 38	F 761		

personnel to have access to the keys.

§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 79 residents. The sample included 18 residents. Based on observation, interview, and record review, the facility failed to discard Resident (R)32's outdated insulin (hormone which allows cells throughout the body to uptake glucose) flex pen. This deficient practice placed the affected resident at risk for ineffective medications.

Findings included:

- On 12/05/23 at 10:45AM, observation revealed R32's Lantus (long-acting insulin) flex pen had an open date of 11/05/23 (31 days) and lacked a discard date.

On 12/05/23 at 10:50 AM, Licensed Nurse (LN) H verified the nurses were to date the flex pens when opened and discard the insulin pen when expired.

On 12/07/23 at 01:30 PM, Administrative Nurse E verified the nurses should label and date the flex pens with the resident's name and discard expired and/or outdated pens.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175350	A. BUILDING _____ B. WING _____	12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

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F 761	Continued From page 39 According to www.Medlineplus.gov, Lantus pens can be used within 28 days of opening, but after that time they must be discarded. The facility's "Labeling of Medication and Biologicals" policy, dated January 01, 2020, documented the facility shall ensure all medication and biologicals used in the facility would be labeled in accordance with current state, federal regulations. All opened or accessed vials should be discarded within 28 days unless the manufacture specifies a different (shorter or longer) date for that opened vial. Labels for individual drug containers must include the date the drug was dispensed and the expiration date when applicable. The facility failed to dispose an outdated insulin flex pen for R32 placing the resident at risk for ineffective medication.	F 761		
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified	F 801		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175350	A. BUILDING _____ B. WING _____	12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

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F 801	Continued From page 40	F 801		

nutrition professional is one who-
(i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose.
(ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional.
(iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.
(iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.

§483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services.
(i) The director of food and nutrition services must at a minimum meet one of the following qualifications-
(A) A certified dietary manager; or
(B) A certified food service manager; or
(C) Has similar national certification for food

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175350	A. BUILDING _____ B. WING _____	12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

(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 801	Continued From page 41	F 801		

service management and safety from a national certifying body; or
D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or
(E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and
(ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and
(iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 79 residents. The sample included two kitchens and 18 residents. Based on observation, record review, and interview the facility failed to provide the services of a full time certified dietary manager for the 79 residents who resided in the facility and received their meals from the kitchen.

Findings included:

- On 12/06/23, review of the noon meal consisted of roast beef, buttered noodles, seasoned squash, dinner roll, and assorted deserts.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175350	A. BUILDING _____ B. WING _____	12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

(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 801	Continued From page 42	F 801		

On 12/06 /23 at 10:56 AM, observation revealed Dietary Staff BB in the kitchen overseeing the preparation of the noon meal.

On 08/29/23 at 04:25 PM, Dietary Staff BB verified she was not a certified dietary manager. Dietary Staff BB stated she had completed the course, failed the test and had to wait six months to repeat the class.

On 12/6/23 at 12:30 PM, Administrative Staff A verified Dietary Staff BB had no dietary manager certification.

On 12/07/23 at 12/05/23 at 8:30 AM, observation revealed dietary staff in the kitchen prepared the breakfast meal.

On 12/07/23 at 09:10 AM, Dietary Staff BB verified she worked at the facility for 24 years and was not a certified Dietary Manager. Dietary Staff BB stated they do not have any pureed or mechanical soft diet.

On 12/11/23 at 2:00 PM, Administrative Staff A verified Dietary Staff BB was not certified.

The Facility's "Director of Food and Nutrition Services " dated 2021 documented the director of food and nutrition services is responsible for all aspects of the food and nutrition services department including but not limited to food safety, cost management, and meeting nutritional need of the residents served. The director of food and nutrition services would be qualified according to the position's job description and guidelines put forth by the agency that regulates the facility. A facility that does not have a full-time dietician (registered dietician nutritionist or RDN)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175350	A. BUILDING _____ B. WING _____	12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

(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 801	Continued From page 43 or clinically qualified nutritional professional must designate a person to serve as director of food and nutrition services. The director of food and nutrition services would be a certified dietary manager (CDM) or is a certified food service manager or has similar national certification for food service management and safety from an national certifying body or has an associate's or higher degree in food service management or in hospitality, if the course study includes food services or restraint management from an accredited intuition of higher learning and states that have established standards for food service managers or dietary managers, must meet state requirements for food service managers or dietary managers. The director of food and nutrition services would carry out his/her daily activities according to the job description, work schedule, and list of duties. The facility failed to employ a full time certified dietary manager to evaluate residents' nutritional concerns and oversee the ordering, preparing, and storage of food for the 79 residents and two kitchens in the facility, placing the residents at risk for inadequate nutrition.	F 801		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175350	A. BUILDING _____ B. WING _____	12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

(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 812	Continued From page 44	F 812		

(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.
(iii) This provision does not preclude residents from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 79 residents. The sample included 18 residents. Based on observation, record review, and interview, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety for all the residents who received their meals from the facility's two kitchens. This placed all residents at risk for food borne illness.

Findings included:

- On 12/05/23 at 08:27AM observation in the first of two kitchens revealed the following:
The walk-in refrigerator had a cracked eggshell, an approximately one-half inch(in) by three in. wide piece of plastic wrap on the floor, and numerous different size pieces of paper underneath the bottom shelf.

The white chest freezer had approximately one-quarter in. of ice around all the inside and had numerous different sized, dried brown, liquid stains on the bottom.

The counter ice machine located at the entrance to the kitchen had numerous different size brown

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175350	A. BUILDING _____ B. WING _____	12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

(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 812	Continued From page 45	F 812		

specks of food particle in and around the tray.

On 12/06/23 at 10:22 AM, observation revealed in the kitchen the following:
The wall behind the ovens located below the oven hood had, approximately six in by eight ft long, had numerous different size dried brown stains.

Underneath the three-sink area a five-gallon bucket of concentrated pot and pan detergent had numerous different size food particles with brown dried substance.

The pipes, approximately five feet long, located underneath the three-sink area had numerous different size blackish substance on them.

The floor ice machine vents located in the dishwashing area had, approximately 12 in by 18 in, gray fuzzy substance throughout them.

The four-square ceiling vents, approximately 18 inches in diameter, had gray fuzzy substance around them which flared out approximately 12 in in each corner.

The outside of the two oven doors and bottom foot plates had numerous different size brown dried liquid substance and the handles, and the outside had white powdery substance.

The two-shelf cart located by the oven had numerous different sized white powdery substance and white dried liquid.

The walk-in refrigerator had a cracked egg with the top piece missing, which showed the yellow yoke and clear liquid placed in the pasteurized egg cartons with other eggs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175350	A. BUILDING _____ B. WING _____	12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

(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 812	Continued From page 46	F 812		

The two fluorescent lights located above the prep table where the spices were had burnt out bulbs.

The three fluorescent light frames, located next to the oven hood, had gray fuzzy particles all around them and the third one, located closest to the dishwashing area, had burnt out light bulbs.

The counter toaster located next to stove top had numerous different size crumbs and gray greasy substance on the top and sides of it and the tray the toaster sat in had the same.

The exchange air vent, approximately three feet (ft) by two ft, located by the dietary manager's office, had gray fuzzy particles throughout.

The perimeter of the kitchen floor, approximately four inches wide and the mopboard had numerous different size blackish substance.

The metal sharp knife container, fastened to the two-door white lower cabinet located on the wall across from the steam table, had numerous different size brownish black substance.

The white bottom cabinet doors located on the wall across from the steam table, had numerous different size dried pink and brown liquid.

Four (one gallon) plastic containers full of water, located underneath the steam table had grayish black substance all around the outside of each one.

The wall underneath the dishwasher area approximately six ft long by three ft high had numerous different size blackish substance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175350	A. BUILDING _____ B. WING _____	12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

(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 812	Continued From page 47	F 812		

The shelf and the legs which held up the dishwasher counter, where the dirty dishes were placed were rusted and the bottom shelf, had a hole in the middle approximately eight in long by four in. wide.

The "Daily Cleaning Duty Sheet," listed task for the morning and evening staff to complete daily.

On 12/06/23 at 11:59 AM, Dietary Manager (DM) BB verified all the issues in the kitchen and stated the kitchen staff had a cleaning schedule, but it did not always get done.

- On 12/05/23 at 09:00 AM, during initial tour, observation in the second of two facility kitchens revealed the following:
One 16-inch oscillating table fan located on the cabinet top blowing air on the food preparation table. The metal fan mesh cover had gray fuzzy substance covering the metal and the three fan blades.

Two 4-foot by 3 -foot ceiling mounted heater and air conditioning units, located on each side of the range hood and blowing air directly across the food preparation area. The air vent grills were rusted and covered with a brown greasy/sticky substance and gray fuzzy substance.

On 12/06/23 at 12:30 PM, Dietary Staff (DS) CC verified the dirty fan, and the overhead heater/air units with dirty register/vents.

The facility's "General Sanitation of the Kitchen" policy, dated 2021, documented the food and nutrition staff would maintain the sanitization of the kitchen through compliance with a written,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175350	A. BUILDING _____ B. WING _____	12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

(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 812	Continued From page 48 comprehensive cleaning schedule. Cleaning and sanitization tasks for the kitchen would be outlined in a written cleaning schedule and tasks would be assigned the responsibility of specific positions. The employee would train on how to perform the cleaning task and employees would initial and date tasks when completed. The facility failed to prepare, store, distribute and serve food under sanitary conditions for the 79 residents residing in the facility, who received meals from the facility kitchens.	F 812		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice	F 849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175350	A. BUILDING _____ B. WING _____	12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

(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 849	Continued From page 49	F 849		

that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:
(A) The services the hospice will provide.
(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175350	A. BUILDING _____ B. WING _____	12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

(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 849	Continued From page 50	F 849		

including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175350	A. BUILDING _____ B. WING _____	12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

(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 849	Continued From page 51	F 849		

clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.
(iv) Obtaining the following information from the hospice:
(A) The most recent hospice plan of care specific to each patient.
(B) Hospice election form.
(C) Physician certification and recertification of the terminal illness specific to each patient.
(D) Names and contact information for hospice personnel involved in hospice care of each patient.
(E) Instructions on how to access the hospice's 24-hour on-call system.
(F) Hospice medication information specific to each patient.
(G) Hospice physician and attending physician (if any) orders specific to each patient.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175350	A. BUILDING _____ B. WING _____	12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

(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 849	Continued From page 52	F 849		

(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.

§483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 79 residents. The sample included 18 residents with two reviewed for hospice (a type of health care that focused on the terminally ill patient's pain and symptoms and attending to their emotional and spiritual needs at the end of life) services. Based on observation, record review, and interview, the facility failed to ensure a coordinated plan of care, which coordinated care and services provided by the facility with the care and services provided by hospice, was developed and available for Resident (R)46. This placed R46 at risk for inappropriate end of life cares.

Findings included:

- R46's Electronic Health Record (EHR) revealed diagnosis of chronic obstructive pulmonary disease (COPD - progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), Alzheimer's disease (progressive mental deterioration characterized by confusion and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175350	A. BUILDING _____ B. WING _____	12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

(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 849	Continued From page 53	F 849		

memory failure), rheumatoid arthritis (chronic inflammatory disease that affects joints and other organ systems), and atrial fibrillation (rapid, irregular heartbeat).

R46's "Significant Change Minimum Data Set" (MDS), dated 10/16/23, recorded R46 had severely impaired cognition. The MDS recorded she required extensive two staff assistance with bed mobility and transfers and received hospice services.

R46's "Care Plan," dated 10/16/23, recorded R46 required extensive assistance with most activities of daily living (ADL) cares. R46's "Care Plan" documented the resident was admitted to hospice for a terminal prognosis of COPD and Alzheimer's disease.

Review of R46's "Care Plans" revealed the resident was admitted to hospice care on 10/16/23, with no evidence of coordination of care between hospice and the facility, and the facility had not received the hospice care plan from hospice. The hospice care plan was not available to review in the in the EHR.

On 12/05/23 at 12:10 PM, observation revealed R46 sat in a wheelchair chair at the dining room table with staff assisting the resident to eat her lunch.

On 12/07/23 at 03:00 PM, Administrative Staff A stated she expected the facility to have a hospice care plan for R46 to be able to coordinate care with hospice services. Administrative Nurse D verified the facility lacked a hospice care plan for R46 since her admission to hospice 10/16/23.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175350	A. BUILDING _____ B. WING _____	12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

(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 849	Continued From page 54 The facility's "Providing End of Life Care" policy, dated February 1, 2020, documented the facility is committed to providing the needed care and services to those resident's at or approaching end of life care in accordance with the resident's preferences, goals, and professional standards of practice in order to promote their highest practicable physical, mental, and psychosocial well-being. The policy documented end of life and palliative care choices made by the resident/representative would be upheld by the facility. The resident's choice of care would be honored. The family and resident/family would coordinate a plan of care and will implement interventions in accordance with the comprehensive assessment, and the resident's needs, goals, and preferences. The plan of care would identify the care and services that each discipline would provide. If the resident chooses hospice services, the care plan would specify the cares and services to be provided by the facility/hospice. The facility would maintain communication with the resident, representative, and hospice as it relates to the plan of care and services provided. The attending physician would assume responsibility for the overall care and treatment of the resident's medical condition. Care would be supervised to ensure that interventions are implemented as written. The facility would monitor and evaluate the resident's response to the established care plan, including the hospice care plan. The facility failed to coordinate care between themselves and hospice services for R46, who received hospice services, placing her at risk for inappropriate end of life care.	F 849		
F 851 SS=F	Payroll Based Journal	F 851		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175350	A. BUILDING _____ B. WING _____	12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

(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 851	Continued From page 55 CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including,	F 851		

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F 851	Continued From page 56	F 851		

but not limited to, start date, end date (as applicable), and hours worked for each individual).

§483.70(q)(3) Distinguishing employee from agency and contract staff.
When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency.

§483.70(q)(4) Data format.
The facility must submit direct care staffing information in the uniform format specified by CMS.

§483.70(q)(5) Submission schedule.
The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 79 residents. Based on observation, interview, and record review, the facility failed to submit complete and accurate staffing information through Payroll Based Journaling (PBJ) as required. This deficient practice placed the residents at risk for unidentified and ongoing inadequate nurse staffing.

Findings included:

- The PBJ report provided by the Centers for Medicare & Medicaid Services (CMS) for Fiscal year (FY) 2023 Quarter 1 indicated the facility did not have licensed nurse coverage 24 hours a day, seven days a week on multiple (5) dates.

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F 851	Continued From page 57 Review of the facility licensed nurse payroll data for the dates listed on the PBJ revealed a licensed nurse was on duty for 24 hours a day seven days a week. On 12/06/23 at 08:30AM, observation revealed a registered nurse on duty in the facility. On 12/07/23 at 01:00PM, Administrative Staff (AS) A verified the facility did not send in the correct data to CMS for payroll-based data. The facility's "Reporting Payroll Based Data Journal" policy, dated 12/01/2019, states complete, and accurate direct care staffing information is to be reported electronically and, in the uniform, specified by CMS. The facility failed to submit accurate PBJ data which placed the residents at risk for unidentified and ongoing inadequate staffing.	F 851		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		

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F 880	Continued From page 58 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 59	F 880		

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 79 residents. The sample included 18 residents. Based on observation, interview, and record review the facility failed to provide infection control measures for residents' oxygen tubing when not in use and failed to implement a surveillance plan for water borne pathogens. This deficient practice placed the residents of the facility at risk for infections.

Findings included:

- Upon request, the facility was unable to provide evidence the facility assessed risks and implemented a surveillance plan to identify and prevent Legionella (prevent Legionella disease (Legionella is a bacterium which can cause pneumonia in vulnerable populations) and other opportunistic waterborne pathogens.

On 12/05/23 at 08:45 AM, observation in R32's room revealed her uncovered oxygen tubing coiled up on the oxygen canister with the nasal canula touching the back of the tubing.

On 12/05/23 at 10:48 AM, observation revealed

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CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

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F 880	Continued From page 60	F 880		

R25's oxygen tank on her wheelchair in the hall with the unbagged/uncovered nasal cannula draped on the seat back.

On 12/06/23 at 07:37 AM, observation revealed R25's oxygen tank on her wheelchair in the hall with the unbagged/uncovered nasal cannula draped on the seat back.

On 12/07/23 at 07:38 AM, observation revealed R25's oxygen tank on her wheelchair in the hall with the unbagged/uncovered nasal cannula draped on the seat back.

On 12/07/23 at 12:55 PM, observation in R32's room revealed her uncovered oxygen tubing coiled up on the oxygen canister with the nasal canula touching the back of the tubing.

On 12/07/23 at 01:01 PM, Administrative Nurse D verified the above finding at 12:55 PM and stated she was just in there and had not noticed it being uncovered. Administrative Nurse D stated staff should place R32's oxygen tubing and nasal canula in the bag on the front of the oxygen canister, with the breathing treatment mask. Administrative Nurse D started to place the oxygen tubing into the bag. When asked by the surveyor, Administrative Nurse D stated she probably should get a new one and placed the tubing into the trash can.

On 12/11/23 at 10:00 AM, Administrative Nurse D stated nasal cannulas should be bagged when not in use.
On 12/11/23 at 10:59 AM, Administrative Staff A stated the facility had nothing in place prior to now to prevent Legionella or other water borne illnesses in the water system.

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F 880	Continued From page 61 The "Infection Prevention and Control" policy, dated 08/15/22, stated a water management program had been established and control measures and testing protocols were in place to address potential hazards associated with the facility's water system. The maintenance Director would serve as the leader of the water management program. The policy stated the facility would conduct an annual review of the infection control program including policies and procedures. The facility's "Oxygen Concentrator" policy, dated 10/01/20, stated oxygen was administered under the orders of the physician. The policy stated staff would keep delivery devices covered in plastic bag when not in use. The facility failed to provide infection control measures for residents' oxygen nasal cannulas when not in use and failed to implement a surveillance plan for water borne pathogens. This deficient practice placed the residents of the facility at risk for infections.	F 880		
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: The facility had a census of 79 residents. The sample included 18 residents. Based on observation, record review, and interview the facility failed to ensure one of two kitchens walk-in freezer was in safe operating condition,	F 908		

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F 908	Continued From page 62	F 908		

when the freezer door continued to build up with ice and fail to completely shut. This placed the residents of one of two buildings who received their meals from that kitchen at risk for foodborne illness.

Findings included:

- On 12/05/23 at 8:27AM, observation in the kitchen revealed the walk-in freezer door had ice buildup on the frame of the door and would not stay closed.

On 12/06/23 at 11:59 AM, Dietary Staff (DS) BB verified the walk-in freezer door had ice buildup on it for about six months, she had notified maintenance, but nothing got done.

On 12/6/23 at 12:30PM, Administrative Staff A stated she was aware of the problem with the walk-in freezer door not closing due to ice buildup.

The facility's "Preventative Maintenance Program Policy," revised 10/25/19, documented the maintenance director was responsible for developing and maintain a schedule of maintenance services to ensure that the buildings, grounds, and equipment were maintained in a safe and operable manner.

The facility failed to ensure and maintain one of two kitchens walk-in freezer was in safe operating condition, when the freezer door would build up with ice and would not completely shut. This placed the residents who received their meals from the facility kitchen at risk for foodborne illness.