Kansas Department for Aging and Disability Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N058003	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	**1100 N 16TH , MARYSVILLE, Kansas, 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
S0000	INITIAL COMMENTS The following represents the findings of a resurvey at the above-named residential healthcare facility conducted on 07/23/26 & 07/27/26.	S0000		
S3280 SS = F	Disaster and Emergency Preparedness CFR(s): 26-41-104 (d) (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the facility ' s emergency management plan; (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This LICENSURE REQUIREMENT is NOT MET as evidenced by: KAR 26-41-104(d)(4) The facility reported a census of eight residents. Based on record review and interview, the administrator failed to ensure disaster and emergency preparedness by ensuring the performance of an emergency drill annually with staff and residents to include an evacuation of the residents to a secure location. Findings included: - On 07/23/26 at 01:10 PM annual evacuation drill documentation was requested which the facility failed to provide.	S3280		

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

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S3280 SS = F	Continued from page 1 Interview on 07/23/26 at 01:11 PM with Maintenance Staff C confirmed an annual evacuation was not completed. The administrator failed to ensure disaster and emergency preparedness by the failure to ensure the performance of an emergency drill annually with staff and residents to include an evacuation of the residents to a secure location.	S3280		
S3299 SS = F	Facility Food Storage CFR(s): 26-41-206 (e) (1) (e) Food storage. Facility staff shall store all food under safe and sanitary conditions. (1) Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving. This LICENSURE REQUIREMENT is NOT MET as evidenced by: KAR 26-41-206(e) The facility reported a census of eight residents. The facility had a main kitchen where food was stored and prepared for all residents. Based on observation and policy review the administrator failed to ensure food items were stored under safe conditions. Findings included: - Observation on 07/23/26 at 12:28 PM in the kitchenette area revealed a refrigerator and cabinets that contained food items for the residents. The refrigerator contained the following food items: One five-pound container of cottage cheese labeled 6/17 and best by date of 07/20/26 One gallon container of milk with date opened 7/12/26 and foul odor One unknown size of squeezable container appears to be mustard, but label read vinegar dated 5/20/24 One zippered bag of unsealed yellow sliced cheese darkened and hard on one end with label that read “6/16”	S3299		

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S3299 SS = F	Continued from page 2 One piece of foil wrapped around a white round egg with no label or date prepared The lower cabinet contained the following food items: One five-pound bag of pancake mix unsealed Two 16-ounce bags of classic potato chips unsealed One 12.5-ounce bag of sour cream and onion crunchy chips unsealed One 13.5-ounce bag of cheese puffs unsealed One 14.5 ounce can chicken broth with use by date of 06/24/26 One 12-ounce container of whipped chocolate frosting with use by date of 03/19/26 On 07/23/26 at approximately 12:32 PM Certified Medication Aide D confirmed the foods were not stored properly or were past their use date. On 07/23/26 at 12:58 PM Administrative Staff A stated her expectation was for staff to send uneaten chips back to the dietary department and check foods in the refrigerator once a week for outdates. She confirmed the foods were not stored per expectation. The administrator failed to ensure foods were stored under safe conditions.	S3299		
S3310 SS = F	Infection Control Policies CFR(s): 26-41-207 (b) (5-6) (c) (b) (5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and	S3310		

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S3310 SS = F	Continued from page 3 (c) Each administrator or operator shall ensure the facility ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 This LICENSURE REQUIREMENT is NOT MET as evidenced by: KAR 26-41-207(c) The facility reported a census of eight residents with three residents included in the sample. Based on interview and record review the administrator failed to ensure the facility remained in compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in KAR 26-39-105 for one resident and one staff. Findings included: - Record review for Resident (R) 3 revealed an admission date of 04/27/26 with a diagnosis of Parkinson’s. R3's record lacked documentation of an initial TB symptom screen. On 07/27/26 at 03:55 PM Administrative Staff B confirmed R3's record lacked a TB symptom screen. - Review of Administrative Staff B’s employee record revealed a hire date of 06/12/25 and lacked documentation of an initial TB symptom screen and TB skin testing. The results were requested which the facility failed to provide. On 07/27/26 at 02:20 PM Administrative Staff B confirmed her record lacked documentation of an initial TB symptom screen and a TB completed two-step skin test. The June 2013 department's "Tuberculosis (TB) Guidelines for Adult Care Homes" documented each new employee and each new resident shall receive a two-step TB skin test and symptom screen questionnaire within seven days of employment or admission.	S3310		

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S3310 SS = F	Continued from page 4 The administrator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in KAR 26-39-105.	S3310		
S3171 SS = D	Health Care Services Standards of Practice CFR(s): 26-41-204 (i) (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This LICENSURE REQUIREMENT is NOT MET as evidenced by: KAR 26-41-204(i) The facility reported a census of eight residents with three included in the sample. Based on observation, interview, and record review the administrator failed to ensure a licensed nurse completed an assessment for the purpose to use a bed assist device, ability to use a bed assist safely without risk of entrapment, and to confirm the bed assist device was not a restraint for Resident (R) 3. The administrator further failed to ensure a gap greater than 4.5 inches between the rails of a bed assist device was covered to prevent entrapment. Findings included: - Record review for R3 revealed an admission date of 04/27/26 with diagnoses of Parkinson’s, repeated falls, and dizziness. The 04/24/26 Functional Capacity Screen (FCS) identified R3 was independent with transfers and was at risk for falls. The 04/28/26 Negotiated Service Agreement (NSA) identified R3 was independent with transfers and facility staff provided a clutter free environment, call light education, and a nightlight to prevent falls. The NSA failed to indicate R3 used a bed cane. R3's record lacked evidence of documentation of a bed assist device assessment. Observation on 07/27/26 at 01:21 PM revealed a bed assist device was attached to the right side of R3's bed. There was a gap greater than 4.75 inches	S3171		

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S3171 SS = D	Continued from page 5 between the rails of the bed assist that lacked a cover to prevent entrapment between the rails. On 07/27/26 at approximately 02:33 PM R3 stated she used the bed assist device to help her get and in and out of bed. On 07/27/26 at 03:09 PM Administrative Staff B confirmed R3's record lacked evidence of documentation a bed rail assessment was completed. The administrator failed to ensure a licensed nurse completed an assessment for the purpose to use a bed assist device, ability to use a bed assist safely without risk of entrapment, and to confirm the bed assist device was not a restraint for R3. The administrator further failed to ensure a gap greater than 4.5 inches between the rails of a bed assist device was covered to prevent entrapment.	S3171		