

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175350	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/26/2025
NAME OF PROVIDER OR SUPPLIER Cambridge Place		STREET ADDRESS, CITY, STATE, ZIP CODE 1100 N 16th Marysville, KS 66508	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>The facility had a census of 72 residents. The sample included 18 residents. Based on observation, interview, and record review, the facility failed to promote care in a manner to maintain and enhance dignity and respect when staff used Styrofoam plates and bowls instead of regular dinnerware for meal service. This placed the residents of the facility at risk for impaired dignity. Findings included:- On 08/24/25 at 12:30 PM, observation during the lunch meal service revealed that staff provided Styrofoam plates for meatloaf, mashed potatoes, and carrots, and used Styrofoam bowls for the strawberry cake. On 08/25/25 at 08:45 AM, observation during the breakfast meal service revealed that staff provided Styrofoam plates for scrambled eggs, toast, and either sausage or bacon, and provided Styrofoam bowls for cereal. On 08/24/25 at 12:55 PM, Dietary Staff (DS) BB stated that the facility used the Styrofoam plates and bowls because the kitchen was short-staffed and did not have enough help to clean the dishes. On 08/26/25 at 10:30 AM, Administrative Nurse D verified that staff should not have used Styrofoam plates and bowls for daily meal service. Administrative Nurse D stated she verified with dietary staff that the reason they use them for the two meals was due to a lack of staff. The facility's Dining Room Standards policy, dated 2020, documented staff would ensure that an attractive, cheerful dining room was maintained with comfortable sound, lighting, furnishings, temperature, and adequate space. The policy documented that single-use disposable dining ware was not permitted except for emergencies.</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>The Facility had a census of 77 residents. The sample included 18 residents, with one reviewed for the environment. Based on observation and interview, the facility failed to provide accommodation of needs for one sampled resident, Resident (R) 66, who had a call light on her wall that was unreachable from her bed. This deficient practice placed R66 at risk for preventable accidents and injuries. Findings included:- On 08/24/25 at 10:30 AM, observation revealed R66 sat in a wheelchair in her room. R66's call light hung on the wall. The call light was unreachable by R66 when she was in bed. On 08/24/25 at 03:00 PM, observation revealed R66 sat in a wheelchair in her room. R66's call light hung on the wall and was unreachable to R66 when she was in bed. On 08/25/25 at 03:08 PM, Certified Nurse's Aide (CNA) MM stated the resident liked to propel herself up and down the halls in her wheelchair and sit in the hall and dining room area. On 08/24/25 at 02:00 PM, Licensed Nurse (LN) I stated the resident was mobile in her wheelchair and had recently had a total knee replacement and was getting therapy, but could not safely ambulate independently. LN I stated every resident should have an accessible call light. On 08/24/25 at 03:15 PM, Administrative Nurse E stated R66 had moved from a room down the hall about one month ago. Administrative Nurse E had not known R66 did not have a call light bedside her bed. Administrative Nurse E verified that the resident should have a permanent call light to access from their bed, and R66 did not have access to one. On 08/26/25 at 10:30 AM, Administrative Nurse D verified that a resident's call light should be accessible to the resident in bed and should not be across the room from the bed. The facility's Call lights: Accessibility and Timely Response policy, dated 09/09/20, documented the facility would ensure it was adequately equipped with a call light at each resident's bedside and bathing area to allow residents to call for assistance, and the call lights would directly relay to a staff member or centralized location to ensure appropriate response. Staff would be educated on the proper use of the resident call light system, including how the system works, and ensure residents' access to the call light. The policy documented with each staff interaction in the resident's room or bathroom, the staff would ensure the call light was within reach of the resident and secured.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility identified a census of 77 residents. The sample included 18 residents, with 13 reviewed for accidents. Based on observation, record review, and interview, the facility failed to secure potentially hazardous cleaning chemicals in a safe, locked area and out of reach of nine cognitively impaired, independently mobile residents. The facility additionally failed to provide adequate supervision and ensure Resident (R) 44's fall prevention interventions were followed, resulting in multiple non-injury falls. This placed the affected residents at risk for preventable accidents. Findings Included: - On 08/24/25 at 09:00 AM, an initial walkthrough of the facility was completed. An inspection of the main nurse's station area revealed a storage closet propped open by a cloth sling rope. An inspection of the storage closet revealed ten containers of purple disinfectant wipes on a shelf in the room. The containers contained the warning, Keep out of reach of children, hazardous to humans, can cause eye irritation, harmful if swallowed. An inspection of the kitchenette across from the main dining hall revealed a purple disinfectant wipe container in an unlocked cabinet above the sink. The container contained the warning, Keep out of reach of children, hazardous to humans, can cause eye irritation, harmful if swallowed. On 08/24/25 at 09:00 AM, Certified Medication Aide (CMA) R stated that cleaning chemicals were to be stored in a locked closet or drawer. On 08/26/25 at 11:30 AM, Administrative Nurse D stated that staff were expected to ensure chemical products were locked up after use. The facility's Chemical Storage policy, revised 01/2020, indicated the facility would ensure an environment free from potentially hazardous materials, chemicals, and equipment. - R44's Medical Diagnosis section within the Electronic Medical Record (EMR) noted diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), muscle weakness, unsteadiness on feet, and a history of falls. R44's Significant Change Minimum Data Set (MDS) completed 08/04/25 revealed a Brief Interview for Mental Status (BIMS) score of zero, indicating severe cognitive impairment. The MDS noted no upper or lower extremity impairments. The MDS noted she required assistance from staff for toileting, bathing, personal hygiene, dressing, and transfers. The MDS noted she required partial to moderate assistance from staff while walking. The MDS noted she was at risk for falls and had a history of falls since the last assessment. R44's Falls Care Area Assessment (CAA) completed 08/18/25 indicated she was at risk for a decline in her activities of daily living (ADL) related to her decreased mobility, fatigue, and cognitive impairment. The CAA noted she had a history of falls. The CAA noted that a care plan was implemented to minimize the risks related to her fall history. R44's Care Plan initiated 10/17/20 indicated she was at risk of falls and altered ADLs related to her medical diagnoses. The plan noted she required non-skid footwear (10/17/20). The plan instructed staff to ensure her call light remained within reach (10/17/20). The plan instructed staff to provide appropriate lighting and ensure her room was free from clutter (10/17/20). The plan noted she was dependent on staff assistance for walking, toileting, transfers, bed mobility, personal hygiene, dressing, and bathing (11/15/23). The plan noted she had an unwitnessed fall and instructed staff to place a brightly colored bow on her front wheeled walker (01/30/24). The plan noted R44 had a non-injury fall on the enclosed patio of the secured unit on 09/04/24. The plan noted R44 had a non-injury fall while not wearing the appropriate non-skid footwear on 10/16/24. The plan noted that staff were re-educated on 03/12/25 to use a gait belt after a fall occurred during staff assistance. The plan noted she had a fall on 03/09/25 while wearing regular non-skid black socks. The plan noted that staff were to sign off under R44's medication administration report on each shift to ensure she had non-skid footwear. The plan noted she had a non-injury fall on 03/21/25 while not wearing non-skid socks. The plan noted that a sign was placed above her bed to remind staff to provide her with the appropriate socks. The plan noted R44 had an unwitnessed non-injury fall in front of the nurse's station on 06/03/25. The plan noted that staff were re-educated that R44 required supervision and/or touch assistance while ambulating. R44's EMR under Progress Notes revealed a Communication with Providers note completed on 09/03/24. The note indicated staff were alerted by the secured unit's patio door alarm and found R44 outside on the patio floor of the enclosed patio. The note revealed R44 was assessed by nursing and brought back inside. On 08/26/25 at 07:41 AM, R44 slept in her bed. Her bed was in the lowest position with a fall mat on the floor next to her bed. R44's front-wheeled walker was positioned next to her recliner. R44's walker did not have a bright-colored ribbon tied to it. An inspection of her room revealed the non-skid sock signage was placed above her room's dresser behind a flowerpot. On 08/26/25 at 09:00 AM, Certified Medication Aide (CMA) R stated R44 used both her walker and wheelchair due to her decline in abilities and being placed on hospice care (end-of-life comfort care).</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility had a census of 77 residents. The sample included 18 residents. Based on observation, record review, and interview, the facility failed to ensure a sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections when staff failed to provide enhanced barrier precautions (EBP - infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high contact care) for Resident (R) 13. The facility staff failed to don (put on) gloves when emptying R13's urinary catheter (a tube inserted into the bladder to drain the urine into a collection bag). The facility staff also failed to wear gloves when picking up an uncovered urinary catheter bag from the floor. This deficient practice placed the residents at risk for possible exposure to infection. Findings included:- On 08/24/25 at 09:30 AM, observation revealed no EBP signage outside R13's door, but personal protective equipment (PPE) was on the inside of R13's room door. On 08/24/25 at 02:50 PM, observation revealed R13's room door opened partway; he stood by a recliner with his uncovered urinary catheter bag and tubing on the floor in front of a recliner. Certified Nurse Aide (CNA) P entered the room without donning gloves or a gown and assisted R13 with sitting in a recliner. CNA P left the room with the catheter bag and tubing still on the floor. On 08/24/25 at 03:38 PM, observation revealed R13 sat in a recliner in his room with the door open, and his urinary catheter bag and tubing were on the floor. Licensed Nurse (LN) J entered the room, with an ungloved hand, picked up the catheter bag, placed it on a walker beside the recliner, and left the room. LN J stated she should have placed gloves on before picking up R13's urinary catheter bag. On 08/25/25 at 01:45 PM, observation revealed R13 sat in a recliner in his room with the door open. CNA O entered the room, without a gown, applied gloves, and asked R13 if she could empty his urinary catheter bag, and he replied, Ok. CNA O retrieved a graduated cylinder from R13's bathroom, set it on the floor underneath the uncovered bag on a walker, unhooked the port from the bag, used an alcohol wipe on the port, opened the port, and drained yellow urine into the graduated cylinder. CNA O closed the port, used an alcohol wipe on the port, and placed it back into the holder on the urinary catheter bag. CNA O took the graduated cylinder into the bathroom, poured the urine into the toilet, set the graduated cylinder on top of the toilet, then removed and discarded the gloves and left R13's room. On 08/25/25 at 01:50 PM, when asked how staff could tell if a resident was on EBP, CNA O pointed to the green triangle in the upper corner of R13's entrance door frame and stated there was a green triangle in the corner of the entrance door. When asked if she should have placed a gown on before emptying R13's urinary catheter bag, she stated yes, but had forgotten. On 08/26/25 at 09:00 AM, Administrative Nurse F stated that staff are made aware of a resident being on EBP when they have a green triangle in the corner of the entrance door frame. EBP supplies are hung on the inside of the entrance door. Administrative Nurse F stated that staff could look at tasks on the computer, and the information is available in the care plan. Administrative Nurse F stated staff should keep a resident's urinary catheter bag and tubing off the floor, but if found uncovered on the floor, they should place gloves on to pick it up off the floor. The facility's Catheter Care Policy, revised 10/01/19, documented it was the policy of this facility to provide catheter care to all residents who have an indwelling catheter in an effort to reduce bladder and kidney infections. The facility's Enhanced Barrier Precautions policy, revised 06/11/25, documented it was the policy of this facility to implement EBP precautions for the prevention of transmission of multidrug-resistant organisms (MDRO-common bacteria that have developed resistance to multiple types of antibiotics). Implementation of EBP would be performed with high-contact care activities. The policy documented high-contact resident care as follows: dressing, bathing, and transferring. Providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use with central lines (a long, thin tube inserted into a large vein in the neck, chest, or groin that reaches a major vein near the heart) urinary catheters, feeding tubes (tube for introducing high-calorie fluids into the stomach), tracheostomy (opening through the neck into the trachea through which an indwelling tube may be inserted), ventilator tube (a medical device that connects a person's windpipe to a ventilator machine, delivering air, oxygen, and medications directly into their lungs to help them breathe when they cannot do so effectively on their own), hemodialysis catheters (a procedure where impurities or wastes are removed from the blood), Peripherally Inserted Central Catheter (PICC) line (a long, thin tube inserted into a vein in the upper arm that is guided to a large central vein near the heart), midline (a long, thin, flexible tube inserted into a peripheral (outside, surface, or surrounding area of an organ, other structure, or field of vision) vein in the arm, typically for administering medications or fluids) catheters, and</p>		