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	04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cambridge Place	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)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on record review, observation, and interview, the facility failed to ensure Resident (R) 1 received her pain medication as ordered to help alleviate her pain. This deficient practice placed R1 at risk of pain and emotional distress from being in pain. Findings included:- R1's Electronic Medical Record (EMR) documented R1 had diagnoses of acute fracture of the lumbar fifth vertebrae (broken lower back bone), dementia (a progressive mental disorder characterized by failing memory and confusion), psychotic disturbance (any major mental disorder characterized by a gross impairment in reality perception), mood disturbance (category of mental health problems, feelings of sadness, helplessness, guilt, and wanting to die were more intense and persistent than what may normally be felt from time to time), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The Significant Change Minimum Data Set (MDS), dated 03/11/26, documented R1's Brief Interview for Mental Status (BIMS) interview of zero, which indicated severely impaired cognition. The MDS documented R1 received scheduled and as-needed pain medication for pain. The MDS documented R1 received opioid (a class of controlled drugs used to treat pain) pain medication daily during the lookback period. The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 03/11/26, documented R1's cognition would be addressed in R1's care plan, instructed staff to communicate with R1 using short, simple sentences to allow R1 adequate time to understand and communicate her needs. R1's Care Plan, dated 02/20/26, directed staff to assess R1 for pain each shift and treat reported pain in a timely manner. The care plan directed staff to assess R1 for pain, restlessness, agitation, constipation, and other symptoms of discomfort, medicate as ordered and evaluate for effectiveness. R1's EMR documented an order from her primary care physician on 02/03/26 to apply a Lidocaine 5% patch to R1's lower back in the morning for back pain. R1's EMR documented an order received from her primary care physician on 02/06/26 to apply a fentanyl transdermal patch 25 micrograms (mcg) every 72 hours for moderate to severe pain. The February Order Summary Report, signed by R1's primary care physician on 02/25/26, documented R1 received a Lidocaine 5% pain patch and a fentanyl transdermal 25 mcg pain patch. The March Medication Administration Record (MAR) documented R1 had not received her Lidocaine 5% patch from 03/14/26 through 03/25/26 due to not being available. The March MAR, documented R1 had received a 25 mcg fentanyl transdermal patch on 03/23/26. On 03/25/26, R1's primary care physician discontinued the 25 mcg fentanyl transdermal patch and replaced it with a 12 mcg fentanyl transdermal patch. The previous 25 mcg fentanyl transdermal patch was not removed from R1's left shoulder, and a new 12 mcg fentanyl transdermal patch was not applied until 03/28/26. The March MAR, documented R1 had to be given a 5 milligram (mg) dose of oxycodone for pain rated at a five on 03/27/26. R1's clinical record lacked evidence staff notified R1's physician that the pain medications were not given to R1. On 04/13/26 at 12:30 PM, observation revealed R1 sat in her wheelchair at the assisted living lunch table with her husband. R1 could not carry on a conversation. R1 stared blankly when asked a question. On 03/04/24 at 12:15 PM, Licensed Nurse (LN) G stated she had known the old fentanyl patch was still on R1's left shoulder 03/27/26, but since they did not have the replacement patch, she chose to leave the old patch on. LN G stated she had not called to check on why the new fentanyl patch was not available. LN G stated she did not know anything about R1 not receiving the Lidocaine (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	patch because the Certified Medication Aides (CMAs) administered them. On 03/04/24 at 01:00 PM, Administrative Nurse D acknowledged that R1 had not received her pain medications as ordered. Administrative Nurse stated there was a lack of communication on the new order for fentanyl between the primary care physician, the facility, and the pharmacy, and new processes were being put in place to ensure orders were not missed. Administrative Nurse D stated the Lidocaine patch had been missed for twelve days; the CMAs had not communicated with the charge nurse or pharmacy about not having the medication, but just charted the medication as unavailable. Administrative Nurse D stated all the nurses and CMAs had received education regarding ensuring medication orders were followed. The undated Pain Management Policy documented the facility must ensure pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences