STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175380	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Cedars	1021 Cedars Drive McPherson, KS 67460

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. The facility had a census of 33. The sample included 12 residents. Based on record review, interview, and observation, the facility failed to provide care for Resident (R) 23 who had a Brief Interview for Mental Status (BIMS) score of eleven, which indicated moderately impaired cognition in a manner that protected and promoted their dignity.Findings included: - On 01/21/26 at 07:55 AM, observation revealed R23 sat at the dining room table. Licensed Nurse (LN) G obtained R23's blood sugar reading using a glucometer (an instrument used to calculate blood glucose) from R23's right index finger. LN G stated, Your blood sugar reading is high. We probably need to contact your doctor and see if he wants to start you on insulin. Continued observation revealed five residents seated in the dining room awaiting breakfast to be served, while other staff and a visitor were in the dining room as well.On 01/22/26 at 10:00 AM, Administrative Nurse D stated staff should not check a resident's blood sugar reading in the dining room. Administrative Nurse D stated staff should take the resident to their room or to a private area.The facility's admission Agreement packet contained the Your Rights and Protection as a Nursing Home Resident policy, dated 04/21/25, which documented a nursing home resident had the right to be treated with dignity and respect.

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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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. The facility has a census of 33 residents. The sample included 12 residents, with three reviewed for Beneficiary Notices. Based on interview and record review, the facility failed to provide two sampled residents, Resident R9 and R28 (or their representative), with the completed Notice of Medicare Non-Coverage (NOMNC) Form 10123, Centers for Medicare and Medicaid Services (CMS).Findings include:- The facility lacked the documentation staff provided R9, or his representative, form 10123, which included a detailed explanation of non-coverage and explained the appeal process. The resident's skilled services ended on 11/20/25.The facility lacked the documentation staff provided R28, or his representative, form 10123, which included a detailed explanation of non-coverage and explained the appeal process. The resident's skilled services ended on 01/13/26.On 01/23/26 at 01:40 PM, Administrative Staff A verified that Form 10123 was not provided to the two residents and should have been given to the resident or the representative.The Medicare form 10123 informed the beneficiary that Medicare may not pay for future skilled therapy. The form included detailed explanations of non-coverage and explained the appeal process.Upon request, on 01/23/26, a policy for Beneficiary Notices was not provided by the facility.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 33 residents. The sample included 12 residents, with seven reviewed for unnecessary medications. Based on observations, interviews, and record review, the facility failed to ensure an appropriate indication or a documented physician rationale, which included the unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the continued use of Resident (R) 11's antipsychotic (a medication used to treat any major mental disorder characterized by a gross impairment testing) medication. The facility further failed to ensure R5 and R31's as-needed (PRN) antianxiety (a class of medications that calm and relax people) medication had a 14-day stop date.Findings Included: - R11's Electronic Medical Record (EMR) recorded diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), and encephalopathy (a broad term for any brain disease that alters brain function or structure). R11's admission Minimum Data Set (MDS) dated [DATE] recorded R11 had severely impaired cognition. The MDS recorded R11 required staff assistance with most activities of daily living (ADL). The MDS recorded the resident received antipsychotic medication during the observation period. The Cognitive loss/Dementia Care Area Assessment (CAA) dated 12/30/25 recorded R11 had been admitted to the facility post-hospitalization for encephalopathy and dementia. The CAA documented R11 received antipsychotic medication twice a day and antidepressant medication once daily. The CAA documented R11 would go back and forth between being cooperative and being non-compliant, refusing care, and rejecting care. R11's Care Plan dated 12/29/25 recorded R11 received antipsychotic medication for the diagnosis of dementia, and staff monitored for side effects and effectiveness every shift. The care plan documented staff monitored for adverse reactions to the medication, such as falls, unsteady gait, refusal to eat, difficulty swallowing, depression, and suicidal ideation. The Physician's Order dated 12/23/25 directed staff to administer Seroquel (antipsychotic) 25 milligrams (mg), twice daily for a diagnosis of dementia with agitation. R11's EMR lacked a documented physician rationale, which included unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the continued Seroquel use. On 01/21/26 at 08:25 AM, observation revealed R11 sat at the dining room table drinking coffee and eating breakfast. R11 told staff she was agitated, she had to sit at the table with other residents, and would prefer to eat alone. On 01/21/26 at 07:45 AM, Administrative Nurse D verified the resident received Seroquel, an antipsychotic medication, with a diagnosis of dementia, which was an inappropriate indication for the medication. Administrative Nurse D verified the physician had been informed of the need for another diagnosis, and the consultant pharmacist identified the need for the correct diagnosis. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Antipsychotic Medication Administration policy, dated 08/05/25, documented guidelines for use of antipsychotic medications are based on a comprehensive assessment of each resident, interdisciplinary team would ensure: A resident who has not used antipsychotics are not given an antipsychotic drug unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the resident's clinical record. Any resident who uses an antipsychotic drug receives routine dose reduction and behavioral interventions unless clinically contraindicated, in an effort to discontinue these drugs to ensure the resident does not receive unnecessary medications, and at the lowest possible dose is administered for the shortest amount of time. All physician orders for antipsychotic medications will be clear and accurate and will include a diagnosis, condition, or indication for use: Tourette's (a condition of the nervous system causing uncontrollable repetitive movements or unwanted sounds) Huntington's (a rare, hereditary condition characterized by progressive mental deterioration, a disabling central nervous system movement disorder) Schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought) Affective Disorder (mental health conditions characterized by significant, persistent disturbances in emotional state) Psychotic disorder with delusions and/or hallucinations (a mental health condition characterized by a loss of contact with reality, where individuals experience severe, abnormal perceptions or fixed, false beliefs) Refractory Severe Depression (treatment resistant depression, occurs when a major depressive episode does not improve after at least two different antidepressant trials at adequate doses) Delusional Disorder (untrue persistent belief or perception held by a person although evidence shows it was untrue) Psychosis in the absence of dementia (any major mental disorder characterized by a gross impairment in reality perception) Hallucinations (sensing things while awake that appear to be real, but the mind created) Bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods) Manic episode (mood characterized by an unstable, expansive emotional state, extreme excitement, hyperactivities) (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medical illnesses with psychosis behavior (any major mental disorder characterized by a gross impairment in reality perception) The DON/Designee and the consultant pharmacist would review the appropriateness of all antipsychotic medication orders. - The Electronic Medical Record (EMR) for R5 documented diagnoses of depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), dementia (a progressive mental disorder characterized by falling memory and confusion), and anxiety (a mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R5's Significant Change Minimum Data Set (MDS) dated [DATE] documented R5 had a Brief Interview for Mental Status (BIMS) score of two, which indicated severely impaired cognition. R5 required substantial staff assistance for toileting hygiene, dressing, personal hygiene, mobility, and transfers. The MDS further documented R5 received an antianxiety medication. R5's Care Plan dated 11/05/25 directed staff to administer antianxiety medications as ordered by the physician, educate the resident and family about the risks, benefits, and side effects of antianxiety medication, report as needed any adverse reactions to antianxiety therapy, and watch for targeted behavior symptoms and document per facility protocol. The Physician's Order dated 11/05/25 directed staff to administer alprazolam (antianxiety medication), 0.5 milligrams (mg), by mouth, every eight hours, PRN, for anxiety. The order lacked a stop date. R5's EMR lacked evidence of a specified duration, which included a physician's rationale for the extended use of the PRN alprazolam. On 01/21/26 at 10:00 AM, R5 was in bed and received her medication without issue. R5 was calm and cooperative with the staff. On 01/21/26 at 10:00 AM, Certified Medication Aide (CMA) R stated R5 got anxious and hollered out a lot, and staff sat with her a lot. CMA R further stated that she received PRN medications as well as scheduled medication for her anxiety. On 01/22/26 at 08:31 AM, Licensed Nurse (LN) H verified that the PRN alprazolam did not have a stop date, and the nurse was supposed to ensure there was a 14-day stop date. LN H further stated that the physician should reassess the resident to make sure she still needed the medication. On 01/22/26 at 10:59 AM, Administrative Nurse D stated that the old computer program would automatically put in a 14-day stop date, but with the new program, it did not do that, and there should be a 14-day stop date for the alprazolam medication. The facility's Psychotropic Medication Use policy, dated 04/07/25, documented that all psychotropic medication would be initiated by the facility only after informed consent related to the drug with the resident and/or the responsible party/family has been obtained. For PRN orders, the ordering practitioner would assess the resident's response to the PRN medication and would document a risk-benefit rationale statement for continued use of the medication and indicate the duration of the PRN order. If the assessment indicated continued use of the medication, a specific duration would be (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	included in the reorder of the medication. - The Electronic Medical Record (EMR) documented R31 had diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), anxiety (mental and emotional reaction characterized by apprehension, uncertainty, and irrational fear), and major depressive disorder (a major mood disorder that causes persistent feelings of sadness). The admission Five-Day Medicare Minimum Data Set (MDS) dated [DATE] documented R31 had a Brief Interview for Mental Status (BIMS) score of three, which indicated severely impaired cognition. R31 was dependent on staff assistance for ambulation, toileting hygiene, and lower-body dressing. R31 required substantial staff assistance for mobility and supervision with transfers. R31 received antianxiety and antidepressant medications (a class of medications used to treat mood disorders) daily. R31's Care Plan dated 12/15/25 directed staff to administer medications as ordered by the physician, report as needed adverse reactions to the anti-anxiety therapy, and watch for the occurrence of target behavior symptoms. The Physician's Order dated 12/21/25 directed staff to administer lorazepam (antianxiety medication) 0.5 milligrams (mg), by mouth, PRN every four hours, for the diagnosis of anxiety. The order lacked a stop date. R31's EMR lacked evidence of a specified duration, which included a physician's rationale for the extended use of the PRN lorazepam. On 01/21/26 at 03:00 PM, R31 propelled herself around the dayroom in her wheelchair. As R31 got close to the front door, the wander guard (a bracelet that helps monitor residents who are at risk of wandering) alarm kept going off, and staff would redirect her. On 01/21/26 at 10:00 AM, Certified Medication Aide (CMA) R stated R31 got anxious and did not like to sit in the recliner for very long. CMA R further stated that she received PRN for her anxiety. On 01/22/26 at 08:31 AM, Licensed Nurse (LN) H verified that the PRN lorazepam did not have a stop date, and the nurse was supposed to ensure there was a 14-day stop date. LN H further stated that the physician should reassess the resident to make sure she still needed the medication. On 01/22/26 at 10:59 AM, Administrative Nurse D stated that the old computer program would automatically put in a 14-day stop date, but with the new program, it did not do that, and there should be a 14-day stop date for the lorazepam medication. The facility's Psychotropic Medication Use policy, dated 04/07/25, documented that all psychotropic medication would be initiated by the facility only after an informed consent related to the drug with the resident and/or responsible party/family has been obtained. For PRN orders, the ordering practitioner would assess the resident's response to the PRN medication and would document a risk-benefit rationale statement for continued use of the medication and indicate the duration of the PRN order. If the assessment indicated continued use of the medication, a specific duration would be included in the reorder of the medication.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 33 residents. The sample included 12 residents, with one reviewed for discharge. Based on the interview and record review, the facility failed to complete a recapitulation (a concise summary of the resident's stay and course of treatment in the facility) of Resident (R) 49's stay.Findings included:- The Electronic Medical Record (EMR) for R49 documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), acute blood loss anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to the body tissues), and lower gastrointestinal bleed (bleeding into the stomach and/or digestive tract).The admission 5-Day Medicare Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of nine, which indicated moderately impaired cognition. R49 required partial staff assistance with toileting hygiene, showers, dressing, personal hygiene, and transfers.R49's Care Plan dated 10/14/25 documented R49 was to be discharged from the facility. The care plan directed staff to encourage verbalizations of fears and concerns, and to clarify any misconceptions. The care plan directed staff to provide her and her family with an opportunity to attend care plan conferences, discharge planning, and offer alternative care options.The Nurse's Note dated 10/06/25 at 12:54 PM documented R49 was admitted to the facility with the diagnosis of lower gastrointestinal bleed and anemia.The Nurse's Note dated 11/05/25 at 03:03 PM documented R49 was discharged with her husband to go home.R49's clinical record lacked a completed recapitulation of R49's stay in the facility.On 01/22/26 at 10:59 AM, Administrative Nurse D verified that a recapitulation upon discharge was not completed when R49 discharged from the facility.The facility's Discharge Planning policy, dated 04/25/25, documented that discharge planning was the process of creating an individualized discharge care plan, which was part of the comprehensive care plan. It involved the interdisciplinary teams working with the resident and resident representative to develop interventions to meet the resident's discharge goals and needs to ensure a smooth and safe transition from the facility to the post-discharge setting. All discharge planning activities are documented in the resident's clinical record.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 33 residents. The sample included 12 residents. Based on observation, interview, and record review, the facility failed to implement interventions for diabetes mellitus (DM -when the body cannot use glucose, not enough insulin is made, or he body cannot respond to the insulin) management for one resident, Resident (R) 2, and failed to implement individualized fall interventions for one resident, R31.Findings included:- The Electronic Medical Record (EMR) for R2 documented a diagnosis of diabetes mellitus.The admission Five-Day Medicare Minimum Data Set (MDS) dated [DATE] documented R2 had a Brief Interview for Mental Status score (BIMS) of 13, which indicated intact cognition. R2 was dependent upon staff for toileting hygiene, mobility, transfers, and did not ambulate. The MDS further documented that R2 received insulin (controls blood sugar by moving glucose from the blood into the cells) daily.R2's Care Plan dated 01/09/26 directed staff to provide R2 a protein snack during the night to keep her blood sugars even. The care plan lacked direction for staff related to her diabetes.The Physician Order dated 12/09/25 directed staff to obtain R2's blood sugars before meals and at bedtime for the diagnosis of diabetes mellitus.Review of the medical record lacked documentation of blood sugar parameters for R2.On 01/21/26 at 08:15 AM, R2 sat in her wheelchair in the dayroom next to her husband.On 01/22/26 at 08:31 AM, Licensed Nurse (LN) H verified R2 did not have blood sugar parameters and would use his nursing judgement to notify the physician if he felt R2's blood sugar was too high. LN H further verified that the Certified Medication Aide (CMA) obtained R2's blood sugars, but the nurse administered the insulin.On 01/22/26 at 08:51 AM, CMA R stated she did not know what the parameters should be for R2's blood sugars. CMA R further stated R2 had blood sugar parameters when they had a different computer program, but with the new system, there were none.On 01/22/26 at 10:59 AM, Administrative Nurse D stated R2 should have physician-ordered blood sugar parameters and that the care plan should provide direction to staff on what to be aware of with R2's diabetes mellitus.The facility's Resident Care Plan policy, dated 10/03/23, documented upon admission each resident would be evaluated by the interdisciplinary team and a care pan would be initiated within 48 hours of admission. The baseline care plan would be revised as needed until the comprehensive care plan was developed. Prior to the comprehensive care plan being completed, the baseline care plan would be shared with the resident and/or resident's representative. The care plan must be reviewed, revised, and documented if a resident's needs [NAME]. The MDS Coordinator was responsible for developing the schedule and advising the other disciplines so all residents can be reviewed according to state and federal standards.- The Electronic Medical Record (EMR) documented R31 had diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), anxiety (mental and emotional reaction characterized by apprehension, uncertainty, and irrational fear), and repeated falls.The admission Five-Day Medicare Minimum Data Set (MDS) dated [DATE] documented R31 had a Brief Interview for Mental Status (BIMS) score of three, which indicated severely impaired cognition. R31 was dependent on staff assistance for ambulation, toileting hygiene, and lower-body dressing. R31 required substantial staff assistance for mobility and supervision with transfers. R31 was at risk for falls, did not have any functional impairment, and had two or more falls since admission.R31's 12/15/25 Care Plan directed staff to determine and address causative factors of the fall, provide activities that promoted exercise and strength building where possible. The plan of care documented to obtain a physical therapy consultation for strength, mobility, and requested the pharmacist to evaluate medications and share findings with the primary care physician.The care plan lacked further interventions related to R31's falls.The Fall Assessment (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated 12/02/25 documented R31 was a high risk for falls.The Fall Investigation dated 12/02/25 at 08:16 PM documented R31 was observed on the floor, positioned in front of the room door, as it appeared she had scooted herself on the floor. R31 was very confused at the time and did not have any signs or symptoms of pain. Staff brought R31 out to the day room. The immediate care plan was to get a fall mat.The Fall Investigation dated 12/10/25 at 01:41 AM documented that at 11:15 PM, staff observed R31 on the floor seated by the entry of her room door and scooted herself closer towards her room door. The fall was unwitnessed, and she did not sustain any injury. The immediate intervention was signs placed in the room to remind her to call for help before she tried to transfer herself.The Fall Investigation dated 12/15/25 at 12:29 PM documented that at 07:30 AM, R31 scooted herself on her room floor. R31 indicated to the staff that she needed to go to the bathroom. The investigator documented that the fall was unwitnessed, and she did not sustain any injuries. The immediate intervention was that signs were placed in the room to remind her to call for help before she tried to transfer herself.The Fall Investigation dated 12/19/25 at 08:50 PM documented R31 scooted herself on the floor in her room. Her bed was in the lowest position, her call light was within reach, and her floor mat was next to the bed. R31 stated she did not know what happened.On 01/21/26 at 10:45 AM, R31 was in bed that was lowered to the floor, and a fall mat was beside the bed. Certified Nurse Aide (CNA) M and CNA N put a gait belt around the resident's waist, CNA M swung her legs off the bed, and she sat on the side of the bed. R31 was able to stand up and hold onto the walker. R31 ambulated to the bathroom; her gait was steady.On 01/21/26 at 10:45 AM, CNA M stated that R31 had numerous falls, so they had her in a low bed and a fall mat by the bed. CNA M further stated R31 had a Wander Guard (a bracelet that helps monitor residents who are at risk of wandering) that went off a lot because when R31 was in her wheelchair, she got close to the doors. The staff tried to put her in a recliner in the dayroom so they could keep an eye on her.On 01/22/26 at 08:31 AM, Licensed Nurse (LN) H stated that R31 had to be out in the dayroom because she had a lot of falls in her room. R31 got very anxious at times and would spend one-on-one time with her.On 01/22/26 at 10:59 AM, Administrative Nurse D stated R31 had a lot of falls in her room that staff should have put interventions into place for those falls. All the incidents in her room were considered falls, even though she scooted herself on the floor.The facility's Resident Care Plan policy, dated 10/03/23, documented upon admission, each resident would be evaluated by the interdisciplinary team, and a care plan would be initiated within 48 hours of admission. The baseline care plan would be revised as needed until the comprehensive care plan was developed. Prior to the comprehensive care plan being completed, the baseline care plan would be shared with the resident and/or the resident's representative. The care plan must be reviewed, revised, and documented if a resident's needs change. The MDS Coordinator was responsible for developing the schedule and advising the other disciplines so all residents could be reviewed according to state and federal standards.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a resident census of 33. The sample included 12 residents, of whom seven were reviewed for accidents. Based on observation, interview, and record review, the facility failed to follow the plan of care for one resident, Resident (R) 9, who had falls in his room and a fall with injury because his shoes were too big. The facility failed to provide a safe environment for R43, who had two falls involving the sit-to-stand lift (which helps transfer residents from one seated surface to another) and did not follow the plan of care.Findings included:- The Electronic Medical Record (EMR) documented R9 had diagnoses of Dementia without behavioral disturbance (a progressive mental disorder characterized by failing memory and confusion) and Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness).The Quarterly Minimum Data Set (MDS) dated [DATE] documented R9 had a Brief Interview for Mental Status Score (BIMS) of 14, which indicated intact cognition. R9 required partial staff assistance for toileting hygiene, showers, dressing, personal hygiene, and supervision for transfers and ambulation. R9 was independent with mobility, had no functional impairment, and had two or more non-injury falls since the prior assessment.The Quarterly MDS dated 11/20/25 documented R9 had a BIMS score of 15, which indicated intact cognition. R9 was dependent upon staff assistance for toileting hygiene and substantial staff assistance for mobility, transfers, putting on shoes, dressing, showers, and personal hygiene. R9 required partial staff assistance for ambulation, was at risk for falls, and had two or more non-injury falls since the prior assessment.R9's Fall Risk Assessments dated 10/23/25 and 01/14/26 documented R9 was a high risk for falls.R9's 11/24/25 Care Plan included the following interventions:05/08/25 - Directed staff to place call light within reach, place personal items and frequently used items within reach, and obtain a physical and occupational therapy consultation.06/11/25 - Educate R9 to use the call light for assistance when transferring.07/23/25 - Directed staff to place a winged mattress on the bed.10/19/25 - Directed staff to put slipper socks on at bedtime, put a night light on in the bathroom.10/23/25 - Directed staff to offer R9 a urinal every two hours.10/27/25 - Directed staff to assist R9 to a recliner in the dayroom when restless at night.11/16/25 - Directed staff to offer R9 to sit in the dayroom when the family is not there.11/21/25 - Directed staff to encourage the use of the dayroom when he is restless, and family is not with him.12/22/25 - Documented R9's family was called to bring in shoes that fit correctly.The Fall Investigation dated 11/16/25 at 09:20 AM documented that the nurse heard a crash from R9's room and he was found on the floor next to his recliner. R9 did not obtain any injury, and R9 stated his legs gave out.The Nurse's Note dated 11/20/25 at 02:04 PM documented that the nurse heard a sound from R9's room. R9 was observed to the side of his recliner under the side table. R9 stated he tried to get out of his recliner. Staff took R9 out to the dayroom so that he could be visualized in high traffic area. The EMR lacked documentation of the fall, which was investigated.The Fall Investigation dated 11/21/25 at 06:45 PM documented R9 was in the recliner, and the nurse heard a loud crash. The nurse found R9 on the floor next to his air conditioner heater unit. R9 stated he tried to get his bed ready. R9 did not sustain any injury.The Fall Investigation dated 12/22/25 at 7:33 AM documented that staff had a gait belt on R9 and had his walker. While staff walked with him, he tripped over his feet and fell onto his left side. The investigation stated that he sustained skin tears, lacerations, a hematoma, and a split fingernail. The investigation stated R9's shoes were too big.The Nurse's Note dated 12/22/25 at 07:33 AM documented R9 was sent to the emergency room for evaluation as he sustained the following injuries from his fall. A laceration (cut) to the left side of the (continued on next page)

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	175380	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Cedars	1021 Cedars Drive McPherson, KS 67460

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	eyebrow, which measured 0.2 centimeters (cm) by 1 cm by 0.2 cm. He sustained a hematoma (a collection of blood trapped in the tissues of the skin or in an organ, resulting from trauma) that measured 4 cm by 3 cm. He sustained a skin tear to the left elbow, which measured 3 cm by 3 cm.The Nurse's Note dated 12/22/25 at 10:36 AM documented R9 had a computed tomography (CT scan- a test that uses X-ray technology to make multiple cross-sectional views of organs, bone, soft tissue, and blood vessels), which was negative for abnormalities. The laceration was closed with Dermabond (a sterile, liquid, topical skin adhesive that acts as a surgical glue to hold closed, easily approximated skin edges of wounds from trauma-induced lacerations), and instructions for wound care were given.On 01/22/25 at 07:52 AM, R9 had a gait belt around his waist. Certified Medication Aide (CMA) R assisted him to stand, and he started to walk with the use of his walker. R9's gait was steady, and CMA R gave him verbal cues on where to go.On 01/21/26 at 01:21 PM, Certified Nurse Aide (CNA) M stated R9 was a one staff assistance with ambulation and that he was in the dayroom for staff visualization, and his wife sits beside him.On 01/22/26 at 08:31 AM, Licensed Nurse (LN) H stated R9 had to sit out in the dayroom because he was not to be left alone in his room except to use the bathroom and to sleep at night due to his falls.On 01/22/26 at 10:59 AM, Administrative Nurse D stated that R9's shoes were too big and that contributed to his fall in December. Administrative Nurse D further stated that staff should have followed the intervention in the care plan for falls.The facility's Falls-Accident Reporting Policy & Procedure, dated 10/03/23, documented that fall interventions would be initiated with documentation on the care plan. Following any fall, a Fall Report would be completed by the licensed nurse to be reviewed by the Quality Assurance Coordinator for further investigation.The facility's Resident Fall Checklist policy, dated 11/13/25, directed staff to have a licensed nurse perform a head-to-toe assessment before being assisted off the floor. Notify the durable power of attorney of the incident and document it in the progress note. Notify the physician, determine the most appropriate intervention to prevent further falls, and update the care plan. Obtain witness statements for all falls with injury or possible injury. Immediately notify the Director of Nursing or designee for all falls with injury, and the Risk Manager for all falls with major injury. Licensed staff would document the progress notes every shift for three days and would notify therapy.- The Electronic Medical Record (EMR) documented R43 had diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), macular degeneration (progressive deterioration of the retina), repeated falls, and weakness.The Quarterly Minimum Data Set (MDS) 07/08/25 documented R43 had a Brief Interview for Mental Status (BIMS) score of four, which indicated severely impaired cognition. R43 required substantial staff assistance with transfers, toileting hygiene, and mobility, and R43 did not ambulate. The MDS further documented R43 had lower functional impairment on both sides and did not have any falls.The Annual MDS dated 10/08/25 documented R43 had a BIMS score of four, which indicated severely impaired cognition. R43 required substantial staff assistance with showers, toileting hygiene, transfers, and did not ambulate. The MDS further documented R43 had no functional impairment and had one non-injury fall.The Fall Assessments dated 04/09/25, 07/10/25, and 10/08/25 documented R43 was a high risk for falls.R43's 11/05/25 Care Plan included the following interventions:02/20/25 - Directed staff to place a fall mat beside the bed.08/11/25 - Documented education to staff about proper sling placement.11/05/25 - Directed staff to anticipate R43's needs and know her routine, reinforce the use of her call light if she was able to remember to use it, and keep the call light within easy reach. The care plan further directed staff to put the bed in a low position at night and personal items within reach.11/17/25 - Documented R43 required two staff with the use of a sit-to-stand lift (which helps transfer residents from one seated surface to another) for safety.The Fall (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Investigation dated 08/11/25 at 02:30 PM documented that during a sit-to-stand transfer, R43's knees gave out. She slid out of the sling and slid off the toilet onto the floor. R43 did not have any injury. The immediate care plan was to make sure the sling was on securely and correctly.The Nurses Note dated 08/11/25 at 03:08 PM documented that R43 slid out of the sling and was on the floor. R43 sat on the bathroom floor with her legs extended towards the door, with her back against the toilet. Staff reported that when R43 was being transferred back to her wheelchair using the sit-to-stand lift, R43 slid out of the sling and slid down the toilet and onto the floor.The Fall Investigation dated 11/17/25 at 03:55 PM documented that during a sit-to-stand transfer to the toilet, R43 let go of the lift, slid through the belt on the sling, and went down onto her bottom. R43 did not have any injuries. The immediate plan of care was to make sure the proper sling was in the room.On 01/21/26 at 11:10 AM, Certified Nurse Aide (CNA) M placed a gait belt around R43's waist. CNA M and CNA N transferred R43 from the recliner to the wheelchair. CNA M stated she was unaware of any falls during transfer with the sit-to-stand lift. CNA M further stated R43 was a one-to-two-person transfer but could use the sit-to-stand lift if needed. CNA M stated R43 sat in the dayroom so staff could keep an eye on her, and she liked to watch television.On 01/22/26 at 07:41 AM, CNA M placed a gait belt around R43's waist, and Licensed Nurse (LN) H transferred her from the recliner to the wheelchair.On 01/22/26 at 08:31 AM, LN H stated that staff transferred R43 with two people and tried to keep her in the dayroom so that staff could watch her. LN H further stated that he was unaware of any falls during the use of the sit-to-stand lift with R43.On 01/22/26 at 10:59 AM, Administrative Nurse D stated when R43 slid through the sling, the staff had not put on the sling correctly, and stated that the second fall with the lift, there was only one staff person with the resident, and was unable to catch her before she slid out. Administrative Nurse D further stated that staff use a two-person transfer except while toileting, then they use the sit-to-stand. Administrative Nurse D stated the care plan should have been updated to reflect that.The facility's Falls-Accident Reporting Policy & Procedure, dated 10/03/23, documented that fall interventions would be initiated with documentation on the care plan. Following any/all, a Fall Report would be completed by the licensed nurse for review by the Quality Assurance coordinator for further investigation.The facility's Resident Fall Checklist policy, dated 11/13/25, directed staff to have a licensed nurse perform a head-to-toe assessment before being assisted off the floor. The policy documented to notify the durable power of attorney of the incident and to document it in the progress note. Notify the physician, determine the most appropriate intervention to prevent further falls, and update the care plan. Obtain witness statements for all falls with injury or possible injury. Immediately notify the Director of Nursing or designee for all falls with injury, and the Risk Manager for all falls with major injury. Licensed staff would document the progress notes every shift for three days and would notify therapy.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 33 residents. The sample included 12 residents, with seven reviewed for unnecessary medications. Based on observation, interview, and record review, the facility failed to obtain blood sugar parameters from the physician for one resident, Resident (R) 2, who had her blood sugar taken four times per day.Findings included:- The Electronic Medical Record (EMR) for R2 documented diagnosis of diabetes mellitus (DM -when the boy cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin).The admission 5-Day Medicare Minimum Data Set (MDS) dated [DATE] documented R2 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated intact cognition. R2 is dependent upon staff for toileting hygiene, mobility, transfers, and does not ambulate. The MDS further documented that R2 received insulin (controls blood sugar by moving glucose from the blood into the cells) daily.R2's Care Plan dated 01/09/26 directed staff to provide R2 a protein snack during the night to keep her blood sugars even. The care plan lacked direction for staff related to her diabetes.The Physician Order dated 12/09/25 directed staff to obtain R2's blood sugars before meals and at bedtime for the diagnosis of diabetes mellitus.Review of the medical record lacked documentation of blood sugar parameters for R2.On 01/21/26 at 08:15 AM, R2 sat in her wheelchair in the dayroom next to her husband.On 01/22/26 at 08:31 AM, Licensed Nurse (LN) H verified R2 did not have blood sugar parameters and would use his nursing judgement to notify the physician if he felt R2's blood sugars were too high. LN H further verified that the Certified Medication Aide (CMA) obtained R2's blood sugars, but the nurse administered the insulin.On 01/22/26 at 08:51 AM, CMA R stated she did not know what the parameters should be for R2's blood sugars. CMA R further stated R2 had blood sugar parameters when they had a different computer program, but with the new system, there were none.On 01/22/26 at 10:59 AM, Administrative Nurse D stated R2 should have physician-ordered blood sugar parameters and that the care plan should provide direction to staff on what to be aware of with R2's diabetes mellitus.Upon request, on 01/22/26, a policy for Blood Sugar Management was not provided by the facility.

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F 0801 Level of Harm - Potential for minimal harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. The facility had a census of 33 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to provide the services of a full-time certified dietary manager for the 33 residents who resided in the facility and received their meals from the kitchen. Findings included:- On 01/20/26 at 09:00 AM, observation revealed that dietary staff in the kitchen prepared the lunch meal. On 01/20/26 at 09:30 AM, Dietary Staff BB verified she was not a certified dietary manager, stated she was taking the course to become certified, and would need to take the test to become certified. Dietary Staff BB stated the facility had two residents with a pureed (smooth, moist, pudding-like food that requires no chewing, designed for residents with severe swallowing or chewing difficulties) diet and three with a minced and moist (soft, moist foods that are easy to swallow and require minimal chewing) diet. On 01/22/26 at 01:00 PM, Administrative Staff A verified Dietary Staff BB was not certified.The facility's Personnel policy, dated 03/26/24, documented the food and nutrition services department would be staffed to ensure that sufficient competent, supportive personnel carry out the functions of the department.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 33 residents. The sample included 12 residents, with one reviewed for hospice (a type of health care that focused on the terminally ill patient's pain and symptoms and attends to their emotional and spiritual needs at the end of life) services. Based on observation, record review, and interview, the facility failed to ensure coordinated care and services provided by the facility with the care and services provided by hospice for Resident (R) 23.Findings included:- R23's Electronic Health Record (EHR) revealed diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), metabolic encephalopathy (when the brain has trouble functioning because of a chemical, or metabolic problem in the body), diabetes mellitus (DM -when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), atrial fibrillation (rapid, irregular heartbeat), and chronic pain.R23's Significant Change Minimum Data Set (MDS) dated [DATE] recorded R23 had a Brief Interview for Mental Status (BIMS) score of eleven, which indicated moderately impaired cognition. The MDS recorded she required extensive staff assistance with toilet hygiene and supervision with oral hygiene, personal hygiene, and activities of daily living (ADL). The MDS documented R23 received hospice services.R23's Activities of Daily Living (ADL) Care Plan dated 12/15/25 recorded R23 had declined in her ability to care for herself after a fall in assisted living. R23 care plan documented R23 exhibited increased confusion, sustained several falls, and required increased staff assistance with most ADL care.Review of R23's clinical record revealed the resident was admitted to hospice care on 11/14/25 with a diagnosis of senile degeneration of the brain. Review of R23's care plan lacked information the resident was on hospice services. On 01/21/26 at 07:55 AM, R23 was dressed in street clothes, seated at the dining room table, eating breakfast.On 01/21/26 at 12:35 PM, Administrative Nurse D verified the facility lacked any information on the facility care plan that the resident received hospice services. Administrative Nurse D verified R11 had been on hospice since 11/14/25 and stated the facility should coordinate with the hospice care plan and the facility care plan.The facility's End Of Life policy, dated 06/03/25, documented the facility's goal was to provide comfort care when the, resident and/or family decides is time to move from a treatment mode to addressing symptoms that cause discomfort, at the time the decide, the physician would be consulted regarding offering the option to use their Hospice benefits if they qualify. The goals of care are to assess and treat pain and symptoms that cause the resident discomfort in the final stages of life. All areas are assessed: the physical, emotional/social, and spiritual. Care is given through an interdisciplinary approach. End of life care does not prolong or hasten death; rather, it lets the natural course of events occur while assuring that the resident is as comfortable as possible. Each resident would receive individualized care that respects his or her goals, likes and choices. Consideration for weight loss and associated sequelae shall be included in end-of-life orders and or care plan. A care plan is developed by the interdisciplinary team that addresses actual and potential problems.