

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175437	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/14/2026
NAME OF PROVIDER OR SUPPLIER McPherson Operator, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1601 N Main Street McPherson, KS 67460	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review, and interview, the facility failed to store, prepare, and serve food under sanitary conditions for the residents who resided in the facility and received meals from the facility's kitchen. Findings included:- On 07/13/26 at 11:30 AM, during a follow-up tour of the dietary department/kitchen, observations revealed:The steam table where prepared food was stored leaked water onto the floor, which was not contained beneath the steam table.The steam table had a black, round power cord that hung above the food being served, which had grey fuzzy material on it.The metal shelving next to the steam table, which stored steam table pans and various other dishes, had a sticky material/grease like feel.The water piping, which was below the dishwasher and three-compartment sink, had black, brown buildup of debris.Dietary Staff (DS) DD prepared and served beverages for the residents, by handling the drinking surface of cups and glasses without washing hands between residents or wearing gloves.DS DD wore a hairnet that did not cover/contain hair while in and out of the kitchen while food and drinks were prepared and served.DS CC lacked the use of gloves while obtaining and preparing two peanut butter sandwiches.During plating food, DS CC handled the plates with his thumb touching the surface on which the food was placed.The fluorescent lights throughout the kitchen and dining room had bug debris in them. On 07/13/26 at 12:30 PM, Consultant GG verified concerns with cleanliness and serving concerns and reported the facility had plans to do some upkeep, cleaning, remodeling, and safe serving. The facility's Sanitation policy, dated 10/2025, documented all kitchen areas and dining areas shall be kept clean, free from litter and rubbish, and protected from rodents, roaches, flies, and other insects. The facility's Preventing Foodborne Illness, dated 10/2025, documented food service employees shall follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness. Hairnets and/or chef caps and/or beard restraints must be worn when cooking, preparing, or assembling food to keep hair from contacting exposed food, clean equipment, utensils, and linens. Contact between food and bare (ungloved) hands is prohibited.		

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to maintain a homelike environment free of unsafe flooring. Findings included:- Observations from 07/12/26 through 07/14/206 revealed concerns with the following flooring:rooms [ROOM NUMBER] had black tape holding down the wood-like laminate flooring in various places throughout the rooms.Rooms 12, 26, 35, and 36 had missing wood-like laminate planks in various places throughout the rooms.The therapy room and activity rooms had black tape holding down wood-like laminate planks throughout the entire rooms. On 07/14/26 at 01:00 PM, Administrative Staff A reported that the facility had a contractor coming to the facility on [DATE] to evaluate the flooring for replacement, and the flooring had been a concern. Administrative Staff A stated it was monitored through the Quality Assurance (QA) meetings for several months. The facility's Floor policy, dated 12/2009, documented that the floors shall be maintained in a clean, safe, and sanitary manner.		

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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** Based on observation, interview, and record review, the facility failed to ensure that Resident (R) 6 was free from antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication without an appropriate indication of use or a physician documented rationale, including risks versus benefits and review of nonpharmacological interventions that were attempted and failed. Findings included:- R6's Electronic Medical Record (EMR) included diagnoses of major depressive disorder (major mood disorder that causes persistent feelings of sadness), 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), dementia (a progressive mental disorder characterized by failing memory and confusion) with agitation, chronic pulmonary edema (accumulation of extravascular fluid in the lung tissues), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) with late onset, and dysphagia (swallowing difficulty). The Quarterly Minimum Data Set (MDS), dated [DATE], documented that R6 had intact cognition with inattention and disorganized thinking, which fluctuated. R6 had not exhibited behaviors. R6 required substantial/maximal support for functional abilities and was dependent on mobility. R6 received a scheduled pain medication regimen and had a condition or chronic disease that may have resulted in a life expectancy of less than six months. The MDS further documented that R6 received an antipsychotic, antidepressant, anticoagulant, diuretic (medication used to promote excretion of fluids), and anticonvulsant. R6 received the antipsychotic on a routine basis, had no gradual dose reduction (GDR) attempt, or physician-documented contraindication. R6's Care Plan initiated on 01/15/2026 documented that R6 utilized psychotropic medications; Seroquel (antipsychotic) and Depakote (anticonvulsant) related to behavior management of dementia with agitation and major depressive disorder. The plan directed staff to administer medications as ordered, consult with pharmacy and physician to consider dosage reduction when clinically appropriate, and the ongoing need for the use. The plan also directed staff to monitor and record the occurrence of target behavior, side effects, and adverse effects of psychotropic medications. The Progress Note dated 02/18/2026 at 04:58 PM documented that R6 had been verbally aggressive with staff, cursing and yelling at them. Staff attempted to assist him with care, and he continued to curse the staff. When the staff left the room, R6 began banging on the wall. The Physician Order date 02/20/2026 directed staff to administer Seroquel 25 milligrams (mgs) at bedtime for a mood disorder and discontinue Abilify (an antipsychotic). The Progress Note dated 03/09/2026 documented that R6 appeared to be tolerating medication well and occasionally yelled out after meals if not taken back to his room. The staff reported that R6 had been cooperative during care. The Progress Note dated 03/26/2026 at 10:25 AM documented that while staff was assisting R6 with lying down after breakfast, R6 made inappropriate sexual comments. The staff informed R6 that he was inappropriate, ensured R6 had a call light, and left the room. The Physician Order dated 04/02/2026 directed staff to administer Seroquel 25 mg twice a day for increased agitation. The Progress Note dated 04/16/2026 at 01:27 AM documented that R6 was being monitored due to increased behaviors including verbally abusive to staff. R6 had received as-needed anti-anxiety medications earlier in the night and had not had any more behaviors so far of the shift. The Physician Order dated 04/30/2026 directed staff to administer Seroquel 25 mg in the morning and Seroquel 50 mg in the evening. R6's EMR lacked documentation related to the nonpharmacological interventions that were attempted prior to initiation (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of Seroquel. The record further lacked evidence of a physician documented rationale which included the risks versus benefits for use of the Seroquel. On 07/13/2026 at 09:30 AM, R6 finished breakfast in the dining room. Certified Medication Aide (CMA) S administered R6's medications. CMA S reported that R6 was cooperative for her, but he could be resistive to care provided by the Certified Nurse Aides (CNA), during which he became verbally and physically abusive. On 07/14/2026 at 10:28 AM, CNA N reported R6 had a few behaviors related to hollering out. CNA N stated she tried to figure out what R6 may need, and R6 could usually verbalize needs. CNA N stated that if R6 had behaviors, she would document them in the EMR and notify the nurse. CNA N was unsure what interventions were for R6's behaviors but would check the Care Plan for specifics. On 07/14/2026 at 11:21 AM, Licensed Nurse (LN) G reported that R6's behaviors consisted of calling out when he wanted to lie down. LN G reported that the CNA's could usually figure out what he needed, and R6 was easily redirected. LN G stated the nurses would document in the progress notes about behaviors and interventions used to treat the resident. On 07/14/2026 at 02:08 PM, Administrative Nurse D reported that R6 had been taking Seroquel due to behaviors. Administrative Nurse D reported the nursing staff would document behaviors and interventions in the progress notes. Administrative Nurse D was unaware of the indications for the use of antipsychotics. The facility's Use of Psychotropic Drugs policy, dated 04/2025, documented residents will only receive psychotropic or other approved medications that have an effect on brain activity when necessary to treat specific conditions for which they are indicated and are effective, and will not be used for discipline or convenience of the staff. Adequate indications for use refer to the identified, documented clinical rationale for administering a medication, which is based upon an assessment of the resident's condition and therapeutic goals, after any other treatments have been clinically contraindicated. For psychotropic medications, without documentation in the record explaining that the practitioner has determined that other treatments have been deemed clinically contraindicated, the indication for use is inadequate. Also, adequate indication for use means that the medication administered is consistent with the manufacturer's recommendation and/or clinical practice guidelines, clinical standards of practice, medication references, clinical studies or evidence-based review articles that are published in medical and/or pharmacy journals.		

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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** Based on observation, 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) for one resident, Resident (R) 46, upon the resident's discharge from the facility. Findings included:- R46's Electronic Medical Record (EMR) documented diagnoses of osteomyelitis (local or generalized infection of the bone and bone marrow) of the lower leg, acquired absence of the left leg below the knee (surgical removal of the body part), and diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin) type two.The admission Medicare 5 Day Minimum Data Set (MDS), dated [DATE], documented R46 had intact cognition. R46 required supervision with toileting hygiene, lower body dressing, and setup assistance with eating, upper body dressing, personal hygiene, and mobility. R46 had lower functional impairment on both sides, had a surgical wound, and had a fall with injury.R46's 03/30/2026 Care Plan documented the following interventions for R46:03/26/2026- R46's goal was to be discharged to home upon completion of skilled services and would like home health services. The care plan documented by the facility would make arrangements with required community resources to support independence post discharge.03/30/2026- obtain blood work and blood cultures as ordered, follow facility protocols for treatments of wounds, and administer medications as ordered. The Nurse's Note, dated 04/28/2026, documented R46 stated he was going to go stay with his family member until he went to his upcoming appointment. Staff explained that they required a physician's order to leave the facility. R46 stated he would pack up his stuff and just leave. The staff explained that if he left against medical advice (AMA), the facility would not be able to send any medication with him and that the insurance might not pay for his state, but R46 did not care. R46 signed AMA paperwork, packed his belongings, and sat outside until his family arrived.R46's EMR lacked a complete recapitulation of his stay in the facility.On 07/14/2026 at 01:50 PM, Administrative Nurse D stated R46 had left AMA during the evening shift. Usually, social service and nursing complete the discharge paperwork. Administrative Nurse D verified a completed recapitulation was not done for R46.The facility's Discharge Summary and Plan policy, dated 03/2026, documented the discharge summary would include a recapitulation of the resident's stay at the facility and a final summary of the resident's status at the time of the discharge in accordance with established regulations governing release of resident information and as permitted by the resident. The recapitulation would include, but not limited to: diagnoses, course of illness, treatment or therapy, pertinent lab, audiology, and consultation results, reconciliation of all pre-discharge medications with the resident's post-discharge medications, for prescribed and over the counter, and a final summary paragraph that may be released to any provider with the consent of the resident or representative.		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure staff used alternative communication methods for one resident, Resident (8), who had difficulty speaking. Finding included:- R8's Electronic Medical Record (EMR) documented diagnoses of left submandibular gland mass (a lump or swelling in the salivary gland located just below the jawbone, tongue mass (an unusual lump or growth on the tongue), dysphasia (difficulty swallowing), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), Parkinsons disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness, and severe protein calorie malnutrition (a life threatening condition caused by a prolonged deficit in both protein and energy intake).The Quarterly Minimum Data Set (MDS), dated [DATE], documented R8 had intact cognition. R8 required partial staff assistance with showers, lower body dressing, putting on his shoes, mobility, and transfers. The MDS documented that he had adequate hearing, unclear speech, usually made himself understood, and moved or spoke slowly for 12 to 14 days during the lookback period. The MDS further documented R8 felt bad about himself for two to six days and felt depressed for two to six days of the lookback period.R8's 05/04/2026 Care Plan included the following interventions:02/04/2026- allow R8 time to speak. Ensure the television was turned down, low noise to be able to hear him, anticipate and meet his needs, encourage him to continue stating thoughts even if he was having difficulty, focus on a word or phrase that made sense, or respond to the feelings R8 was trying to express. The care plan further directed staff to monitor for physical, nonverbal indicators of discomfort or distress, wait 30 seconds before providing R8 with words, document R8's ability to express and comprehend language, memory, reasoning ability, problem-solving, and ability to attend. The CP directed staff to monitor the changes in his ability to communicate and the contributing factors for communication problems and validate R8's message by repeating it aloud.On 07/12/2026 at 08:55 AM, R8 sat in his recliner. R8 was unshaven, he had on a t-shirt that had several large areas of dried sputum (a mixture of saliva and mucus that is coughed up from the lower respiratory tract), no socks or shoes, and his hair was uncombed. The pressure-reducing cushion in his chair also had dried sputum and debris on it, and his gastrostomy tube (G-tube: tube surgically placed through an artificial opening into the stomach) was unsecured and lying freely on his lap. R8's tongue protruded (extended or bulged outward) from his mouth, and he had drool coming out of his mouth that hung down to his shirt. His speech was unclear and soft in tone. As he started to speak, he began to cough, and he had a large amount of thick yellow sputum that he coughed into a tissue. He tried to throw it away in the trash can that sat beside the recliner, but he missed, and it went onto the floor. He had a pad of paper and a pen beside his bed that had a lot of writing on it, which looked unclear. On 07/13/2026 at 08:00 AM, R8 sat in his recliner. When asked how he was doing, he leaned over to his pad of paper and started to write. His writing was shaky, misspelled, and parts of the words were illegible, but eventually communicated that he had had a bad night. He had a towel on his lap and a washcloth on the bedside table. R8 attempted to talk, but his speech was unclear. On 07/13/2026 at 10:30 AM, Licensed Nurse (LN) G gowned and gloved and went into R8's room to administer his 10:00 AM enteral feeding (tube feeding of liquid nutrition directly into the gastrointestinal tract). R8 sat in his recliner with his head resting on the bedside table next to his recliner. LN G attempted to ask him questions about his pain and if he was feeling ok, but his speech was unclear. R8 attempted to write on the pad of paper, but LN G was (continued on next page)		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unable to decipher what was on the paper. She continued to ask the same questions and asked if he wanted his 10:00 AM feeding. R8 continued to try to speak, and LN G would ask him different questions, but he did not give answers that we could understand. LN G asked him again if he wanted his feeding, and he shook his head yes. R8 was still leaning to the left, and LN G asked him to sit up better; he complied. LN G finished his feeding and put the g-tube under his shirt. On 07/13/2026 at 10:45 AM, LN G stated she had tried to give R8 a paper with words so he could tell her what he needed, but she was unsure where it was. She stated that at times it was very difficult to understand what he was saying because the mass in his mouth had gotten larger over the last two weeks. LN G stated that sometimes it was like playing charades to understand what he wants or needs. On 07/13/2026 at 02:50 PM, CNA M stated that sometimes R8 would write down words, shake his head yes or no, but sometimes staff did not really know what he wanted. On 07/14/2026 at 10:50 AM, Certified Medication Aide R stated R8 wrote small, so it was sometimes hard to know what he wanted, but could shake his head yes or no. On 07/14/2026 at 10:20 AM, Social Services X stated R8 would type in his phone to tell her what he needed, but she had to guess what he said, and she would continue to try to decipher the words. Social Services X further stated that she would have to find someone to help her understand what he needed. On 07/14/2026 at 01:45 PM, Administrative Nurse D stated that the mass in R8's tongue has increased in size over the last couple of weeks and that he can say yes or no answers but was very soft spoken. She further stated she had not thought about providing him with any alternative communication methods to help with communication. The facility's Quality of Life-Activities of Daily Living policy, dated 03/2026, documented that the community environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving independent functioning, dignity, and well-being. Residents are provided with appropriate care and services, including communication.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide assistance with activities of daily living (ADL) for one resident, Resident (R) 8, who required assistance from staff with dressing, grooming, and shaving. Findings included:- R8's Electronic Medical Record (EMR) documented diagnoses of left submandibular gland mass (a lump or swelling in the salivary gland located just below the jawbone, tongue mass (an unusual lump or growth on the tongue), dysphasia (difficulty swallowing), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), Parkinsons disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness, and severe protein calorie malnutrition (a life threatening condition caused by a prolonged deficit in both protein and energy intake).The Quarterly Minimum Data Set (MDS), dated [DATE], documented R8 had intact cognition. R8 required partial staff assistance with showers, lower body dressing, putting on his shoes, mobility, and transfers. The MDS documented R46 required supervision with upper body dressing, personal hygiene, and ambulation. The MDS further documented R8 felt bad about himself for two to six days and felt depressed for two to six days of the lookback period.R8's 05/04/2026 Care Plan included the following interventions:02/05/2026- provide one person assistance with bathing, personal hygiene. Allow R46 sufficient time for dressing and undressing. He required oral care frequently due to dry mouth. The plan directed staff to report any decline in function.On 07/12/2026 at 08:55 AM, R8 sat in his recliner. R8 was unshaven, he had on a t-shirt that had several large areas of dried sputum (a mixture of saliva and mucus that is coughed up from the lower respiratory tract), no socks or shoes, and his hair was uncombed. The pressure-reducing cushion in his chair also had dried sputum and debris on it, and his gastrostomy tube (G-tube: tube surgically placed through an artificial opening into the stomach) was unsecured and lying freely on his lap. R8's tongue protruded (extended or bulged outward) from his mouth, and he had drool coming out of his mouth that hung down to his shirt. His speech was unclear and soft in tone. As I started to talk to him, he began to cough, and he had a large amount of thick yellow sputum that he coughed into a tissue. He tried to throw it away in the trash can that sat beside the recliner, but he missed, and it went onto the floor.On 07/13/2026 at 08:00 AM, R8 sat in his recliner. He had a towel on his lap and a washcloth on the bedside table.On 07/12/2026 at 12:40 PM, R8 sat in his recliner with no socks or shoes on. His bare feet were on the floor. He leaned over with his chest on his knees and remained there.On 07/13/2026 at 10:40 AM, after his enteral feeding, Licensed Nurse (LN) G said R8 was never shaved by staff. Observation revealed R8 put his hand to his face and LN G asked him if he would like to be shaved, R46 shook his head up and down to indicate yes. LN G stated she would send someone down to sort it all out.On 07/13/2026 at 11:45 AM, R8 walked with his walker from the bathroom. He had drool hanging from his mouth. He was not wearing any socks or shoes and was still unshaven.On 07/14/2026 at 07:30 AM, R8 was in his recliner, feet elevated. He leaned to the left with his head lying on the bedside table.On 07/14/2026 at 08:25 AM, R8 sat in his recliner. His bed pillow was on the floor; he had a soiled washcloth draped over one arm of the walker. He leaned over and took his phone out of the trash can.On 07/13/2026 at 02:50 PM, Certified Nurse Aide (CNA) M stated R8 was a one person assist with transfers and ambulation, and he was not to be up alone in his room. She stated staff got him up for the day early in the morning, changed his clothes if needed, and repositioned him every two hours and as needed.On 07/14/2026 at 01:45 PM, Administrative Nurse D stated R8 was usually up around 06:00 AM; staff got him dressed, made sure he was clean, and had (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	what he needed. Administrative Nurse D further stated staff should make sure R8 had clean clothes and make sure his hair was combed. The facility's Quality of Life-Activities of Daily Living policy, dated 03/2026, documented that the community environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving independent functioning, dignity, and well-being. Residents who are unable to carry out activities of daily living receive the necessary care and services to maintain good nutrition, grooming, and personal oral hygiene.		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one resident, Resident (R) 8, was invited or provided with individualized person-centered activities. Findings included:- R8's Electronic Medical Record (EMR) documented diagnoses of left submandibular gland mass (a lump or swelling in the salivary gland located just below the jawbone, tongue mass (an unusual lump or growth on the tongue), dysphasia (difficulty swallowing), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), Parkinsons disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness, and severe protein calorie malnutrition (a life threatening condition caused by a prolonged deficit in both protein and energy intake).The Admission/5 Day Medicare Minimum Data Set (MDS), dated [DATE], documented R8 had severely impaired cognition. R8 was dependent upon staff assistance for toileting hygiene, lower body dressing, putting on shoes, mobility, and transfers. R8 was depressed seven to eleven days of the lookback period, had inattention, disorganized thinking, and his level of consciousness fluctuated. The MDS further documented R8 felt listening to music, keeping up with news, going outside, doing things in groups, and religious services were somewhat important.The Quarterly MDS, dated 05/05/2026, documented R8 had intact cognition. R8 required partial staff assistance with showers, lower body dressing, putting on his shoes, mobility, and transfers. The MDS documented R8 felt bad about himself for two to six days and felt depressed for two to six days of the lookback period.R8's 05/04/2026 Care Plan included the following interventions:02/05/2026- R8 was dependent upon staff for activities, cognitive stimulation, and social interaction. All staff are to converse with him while providing care, encourage ongoing family involvement, and invite the family to attend special events, activities, and meals. Introduce R8 to residents with similar backgrounds and interests, and encourage/facilitate interaction. Inviting R8 to schedule activities, he needed 1:1 bedside/in-room visits and activities if unable to attend out of room events. R8 required assistance /escorted to activity functions and would require assistance from staff during the activity. The care plan further directs staff to modify his daily schedule to accommodate his activity participation and provide a program of activities that were of interest and empowered him by encouraging/allowing choice, self-expression, and responsibility. Provide him with an activity calendar and notify him of any changes. If he chooses not to participate, turn on the television or music.The Recreation/Activity admission Assessment, dated 02/09/2026, documented R8 enjoyed music, news, doing things in groups of people, religious services, and going outside,The EMR for R8 lacked documentation he was invited to or participated in activities.On 07/14/2026 at 07:30 AM, R8 was in his recliner with his feet elevated. He leaned to the left with his head lying on the bedside table; he had his television on.On 07/13/2026 at 02:50 PM, Certified Nurse Aide M stated R8 did not attend activities, he watches television in his room or family would visit.On 07/14/2026 at 10:00 AM, Activity Z stated that R8 went to some activities but did not participate by observing. Activity Z stated most of the activities involved food and since R8 cannot eat, he does not like to go to the activity. She further stated that she does not document when resident's go to the activities unless they are doing outside of the facility, so she was unable to provide dates and activities that he attended. Activity Z further stated she did give him some magazines, and she will take him his mail but does not have any type of in-room activity for him.On 07/14/2027 at 10:45 AM, Licensed Nurse (LN) G stated, R8 did not attend activities, he stays in his room most of the time except when he had physical therapy.On 07/14/2026 at 01:45 PM, Administrative Nurse D stated that (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175437	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/14/2026
NAME OF PROVIDER OR SUPPLIER McPherson Operator, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1601 N Main Street McPherson, KS 67460	
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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff takes him outside for short periods of time during breakfast meal and that they were planning on implementing a new program for activities. The facility's Activities and Social Events policy, dated 10/2025, documented resident had the right to choose the types of activities and social events in which they wished to participate in. Activities, social events, and schedules are developed in conjunction with the residents' interests, assessment, and plan of care. The staff would evaluate a resident's physical and mental capacity to participate in various levels of activities. They would note in the medical record any restrictions or needs that might be relevant to participation.		

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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** Based on observation, interview, and record review, the facility failed to implement effective person-centered interventions and review the interventions for effectiveness after repeated falls in order to prevent falls for one resident, Resident (R)8, who had multiple falls. Findings included:- R8's Electronic Medical Record (EMR) documented diagnoses of left submandibular gland mass (a lump or swelling in the salivary gland located just below the jawbone, tongue mass (an unusual lump or growth on the tongue), dysphasia (difficulty swallowing), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), Parkinsons disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness, and severe protein calorie malnutrition (a life threatening condition caused by a prolonged deficit in both protein and energy intake).The Admission/5 Day Medicare Minimum Data Set (MDS), dated [DATE], documented R8 had severely impaired cognition. R8 was dependent upon staff assistance for lower body dressing, putting on shoes, mobility, transfers, and dependent upon staff for toileting. R8 had no functional impairment, no falls, was continent of bladder and bowel and did not ambulate.The Quarterly MDS, dated 05/05/2026, documented R8 had intact cognition. R8 required partial staff assistance with showers, lower body dressing, putting on his shoes, mobility, transfers, toileting, and supervision with ambulation. The MDS documented R8 had no functional limitations, was occasionally incontinent of bladder, and had two or more falls with injury.The Fall Risk Assessments, dated 01/30/2026 and 04/30/2026, documented R8 was a high risk for falls. R8's 05/04/2026 Care Plan included the following interventions:03/12/2026-Anticipate and meet his needs, be sure his call light is ready and encourage him to use it when needing assistance, educate him and his family about safety reminders, follow facility fall protocol, offer toileting, encourage him to lay down in bed in the afternoon, and physical therapy to evaluate and treat. The care plan directed staff to review root cause of past falls, educate the resident, and ensure that he wore appropriate footwear when transferring or in a wheelchair.03/13/2026-orange tape placed around the call light as a reminder to use the call light for assistance.04/29/2026-Provide verbal education to R8 to ask staff to assist with moving furniture.05/05/2026- Verbal education on call light use and toileting assistance was provided.07/07/2026-Signage placed in room to remind R8 to use his call light for assistance.The Fall Investigation, dated 02/02/2026 at 06:30 PM, documented staff found R8 on the floor during walking rounds. He stated he was trying to get changed. The investigation documented the root cause was that he had two mattresses on his bed, and they took off the regular mattress and left on the air mattress.The Fall Investigation, dated 03/11/26 at 04:22 PM, documented R8 was in the bathroom seated on his wheelchair pedals. R8 was unable to say what he was doing. The investigation documented that R8 sustained a skin tear (a traumatic wound that occurs when the outer layer of skin separates from the underlying tissue) to his left forearm that measured two centimeters (cm) x 1.5 cm. R8 had decreased safety awareness and gait imbalance. Staff assisted R8 to the bathroom and back to his bed. Orange tape was placed around the call light, and he was educated to call for assistance.The Fall Investigation, dated 03/12/2026 at 0245 PM, documented R8 was found lying on the floor in his bathroom between the toilet and his wheelchair. He was unable to tell staff what he was doing. The brakes were locked on his wheelchair, and he did not have on non-skid socks. R8 had gait imbalance, decreased safety awareness, and strength. He was assisted into bed, and education was provided for staff with the need to encourage or offer to lie down in the afternoon.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 04/29/2026 at 08:39 AM, documented R8 was on his left side with his head propped up by his arm. He was in the middle of the room between the recliner and television stand. R8 sustained a skinny tear to his left elbow. R8 stated that he tried to move a dining chair to a different spot in his room, lost his balance and fell. Three staff assisted R8 up and into his chair. Education was provided to R8 to call for assistance to move furniture. The Fall Investigation, dated 05/05/2026 at 06:21 PM, documented R8 was on the floor but got himself back up before the nurse could assess him. R8 did not sustain any injury and stated he tried to get himself to the bathroom, slipped and fell. R8 had decreased safety awareness and strength, and gait imbalance. Staff reeducated R8 to use his call light and wait for assistance. The Fall Investigation, dated 06/22/2026 at 03:07 AM, documented staff found R8 on all fours on the floor, he had an abrasion (scrape) to the middle of his forehead and a skin tear to his left elbow. R8 was unable to state what he was doing. Staff assisted the resident back into his recliner and educated him to use his call light. The Nurse's Note dated 07/07/2026 at 08:58 PM, documented R8 was lying on his left side in front of his recliner. His call light was in reach but not turned on. Staff placed signage in his room to remind him to use the call light. On 07/12/2026 at 02:15 PM, R8 walked out of the bathroom with the use of his walker. His gastrostomy tube (G-tube: tube surgically placed through an artificial opening into the stomach) was unsecured and hung down between his legs when he walked. On 07/13/2026 at 11:45 AM, R8 walked over to his dresser with the use of his walker. His G-tube was unsecured and hung down between his legs. On 7/13/2026 at 10:30 AM, Licensed Nurse (LN) G stated he has had falls, she put a sign on the wall so that he could be reminded to use his call light when he got up alone. LN G stated R8 was getting physical therapy to help with strength and balance. On 07/13/2026 at 02:50 PM, Certified Nurse Aide (CNA) M stated R8 was a one person assist and has not gotten up on his own. He has had some falls and was reminded to call for assistance. CNA M stated R8 was impulsive and will get up when he wants to. On 07/14/2026 at 01:45 PM, Administrative Nurse D stated R8 was very weak when he came to the facility, he was very underweight, and he was now receiving therapy. Staff put a sign on his wall reminding him to use the call light for assistance. The facility's Falls and Fall Risk, managing policy, dated 06/2025, documented the interdisciplinary team would attempt to identify appropriate interventions to reduce the risk of falls. If a systemic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions. If falling recurs despite initial interventions, staff would implement additional or different interventions or indicate why the current approach remained relevant.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary treatment and services to prevent complications of enteral tube feeding for one resident, Resident (R)8 when staff failed to properly anchor and secure his gastrostomy tube (G-tube: tube surgically placed through an artificial opening into the stomach) on four separate occasions. Findings included:- R8's Electronic Medical Record (EMR) documented diagnoses of left submandibular gland mass (a lump or swelling in the salivary gland located just below the jawbone, tongue mass (an unusual lump or growth on the tongue), dysphasia (difficulty swallowing), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), Parkinsons disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness, and severe protein calorie malnutrition (a life threatening condition caused by a prolonged deficit in both protein and energy intake).The Admission/5 Day Medicare Minimum Data Set (MDS), dated [DATE], documented R8 had severely impaired cognition. R8 was dependent upon staff assistance for lower body dressing, putting on shoes, mobility, transfers, and dependent upon staff for toileting. The MDS further documented that R8 received 51% or more of his calories via g-tube and did not eat.The Quarterly MDS, dated 05/05/2026, documented R8 had intact cognition. R8 required partial staff assistance with showers, lower body dressing, putting on his shoes, mobility, transfers, toileting, and supervision with ambulation. The MDS further documented R8 received 51% or more of his calories via g-tube and did not eat.R8's 05/04/2026 Care Plan included the following interventions:02/04/2026- Administer medication as ordered, monitor for effectiveness and adverse effects, check residual prior to feeding or administer medications. If there were more than 100 milliliters (ml) of stomach content, withhold the feeding or medications and notify the physician. Discuss with R8 any concerns about tube feedings, the advantages, disadvantages and potential complications. Elevate the head of the bed at least 30-45 degrees (semi or high Fowler's position) if tolerated by the residents physical or medical condition during and for one hour after feeding or medication. R8 was to have nothing by mouth (NPO), obtain and monitor diagnostic work as ordered.The Physician's Order, dated 05/15/2026, directed staff to provide R8 with Two Cal HN (a concentrated, high-calorie and high-protein medical nutritional supplement), five times per day, via g-tube, total volume of 325 ml with each feeding.The Physician's Order, dated 05/15/2026, directed staff to flush the g-tube five times a day with water, 30 ml before and after each feeding, 30ml before and after each medication administration, and 5 to 10ml between each medication. On 07/12/2026 at 08:55 AM, R8 sat in his recliner. His G-tube was unsecured and lying freely on his lap. On 07/12/2026 at 02:15 PM, R8 walked out of the bathroom with the use of his walker. His G-tube was unsecured and hung down between his legs when he walked. On 07/13/2026 at 10:30 AM, Licensed Nurse (LN) G gowned and gloved and went into R8's room to administer his 10:00 AM enteral feeding (tube feeding of liquid nutrition directly into the gastrointestinal tract). LN G 8 asked him again if he wanted his feeding, and he shook his head yes. R8 was still leaning to the left, and LN G asked him to sit up better; he complied. LN G checked for residual, flushed his g-tube with 30 ml of water, she then provided him with 325 ml of his Two Cal, then flushed his g-tube again with 30 ml of water, without any concerns. After she was finished with his feeding she put the G-tube under R8's shirt but did not secure it.On 07/13/2026 at 11:45 AM, R8 walked over to his dresser with the use of his walker. His G-tube was unsecured and hung down between his legs.On 07/14/2026 at 10:45 AM, LN G verified (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that she does not secure the G-tube; she just puts it under his shirt. On 07/14/2026 at 01:45 PM, Administrative Nurse D stated, R8 had come to the facility with a binder but he did not like it, so the family took it home. She stated that they had not tried anything different to see if he could tolerate having the tube secured. The facility's Enteral Nutrition policy, dated 02/2026, documented residents who can eat enough alone or with assistance would not be fed by enteral methods unless the residents clinical condition demonstrated that the enteral feeding was clinically indicated and consented to by the resident and representative. Central supply or Food Service Manager would be responsible for ordering all tube feeding supplies.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported to the Director of Nursing and the Medical Director for Resident (R) 6's use of an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) without an appropriate indication or a physician documented rationale including risks versus benefits and a record of nonpharmacological attempts that were unsuccessful. Findings included: - R6's Electronic Medical Record (EMR) included diagnoses of major depressive disorder (major mood disorder that causes persistent feelings of sadness), 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), dementia (a progressive mental disorder characterized by failing memory and confusion) with agitation, chronic pulmonary edema (accumulation of extravascular fluid in the lung tissues), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) with late onset, and dysphagia (swallowing difficulty). The Quarterly Minimum Data Set (MDS), dated [DATE], documented that R6 had intact cognition with inattention and disorganized thinking, which fluctuated. R6 had not exhibited behaviors. R6 required substantial/maximal support for functional abilities and was dependent on mobility. R6 received a scheduled pain medication regimen and had a condition or chronic disease that may have resulted in a life expectancy of less than six months. The MDS further documented that R6 received an antipsychotic, antidepressant, anticoagulant, diuretic (medication used to promote excretion of fluids), and anticonvulsant. R6 received the antipsychotic on a routine basis, had no gradual dose reduction (GDR) attempt, or physician-documented contraindication. R6's Care Plan initiated on 01/15/2026 documented that R6 utilized psychotropic medications; Seroquel (antipsychotic) and Depakote (anticonvulsant) related to behavior management of dementia with agitation and major depressive disorder. The plan directed staff to administer medications as ordered, consult with pharmacy and physician to consider dosage reduction when clinically appropriate, and the ongoing need for the use. The plan also directed staff to monitor and record the occurrence of target behavior, side effects, and adverse effects of psychotropic medications. The Physician Order date 02/20/2026 directed staff to administer Seroquel 25 milligrams (mgs) at bedtime for a mood disorder and discontinue Abilify (an antipsychotic). The Physician Order dated 04/02/2026 directed staff to administer Seroquel 25 mg twice a day for increased agitation. The Physician Order dated 04/30/2026 directed staff to administer Seroquel 25 mg in the morning and Seroquel 50 mg in the evening. R6's EMR lacked documentation related to the nonpharmacological interventions that were attempted prior to initiation of Seroquel. The record further lacked evidence of a physician documented rationale which included the risks versus benefits for use of the Seroquel. The Pharmacist Medication Regimen Review dated 01/08/2026, 02/06/2026, 03/06/2026, 04/07/2026, 05/20/2026, 06/09/2026 and 07/09/2026, lacked mention of the appropriate indication of use for antipsychotic medication for R6. On 07/14/2026 at 10:28 AM, CNA N reported R6 had a few behaviors related to hollering out. CNA N stated she tried to figure out what R6 may need, and R6 could usually verbalize needs. CNA N stated that if R6 had behaviors, she would document them in the EMR and notify the nurse. CNA N was unsure what interventions were for R6's behaviors but would check the Care Plan for specifics. On 07/14/2026 at 11:21 AM, Licensed Nurse (LN) G reported that R6's behaviors consisted of calling out when he wanted to lie down. LN G reported that the CNA's could usually figure out what he needed, (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and R6 was easily redirected. LN G stated the nurses would document in the progress notes about behaviors and interventions used to treat the resident. On 07/14/2026 at 02:08 PM, Administrative Nurse D reported that R6 had been taking Seroquel due to behaviors. Administrative Nurse D reported the nursing staff would document behaviors and interventions in the progress notes. Administrative Nurse D was unaware of the indications for the use of antipsychotics. The facility's Medication Regimen Reviews, dated -3/2026, documented that the CP shall review the medication regimen per state and federal guidelines. The foci of the CP drug regimen review shall include, at a minimum, psychotropic drugs. A review of new orders for this class of drug to include the documentation of a specific condition as diagnosed and documented in the clinical record. The need for gradual dose reductions, behavioral interventions, unless clinically contraindicated, and review of the resident's psychotropic medications as needed for a documented diagnosis-specific condition.		