

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  175570	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/17/2025
NAME OF PROVIDER OR SUPPLIER  The Shepherd's Center		STREET ADDRESS, CITY, STATE, ZIP CODE  101 Cedar Ridge Drive Cimarron, KS 67835	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> The facility reported a census of 20 residents. The sample included 13 residents with one resident reviewed for discharge. Based on interview and record review, the facility failed to provide Resident (R) 28 a written notification of discharge to the resident and/or his representative as soon as practicable and failed to complete a recapitulation of R28's stay. Findings included:- R28's Electronic Medical Record (EMR) revealed a diagnosis of frequent falls, and 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).R28's 08/04/25 admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) of 15, which indicated intact cognition. The MDS recorded R28 required maximal assistance with bathing, and dressing. The MDS recorded R28 was independent with ambulation. The MDS recorded R28's goal was to discharge back into the community, and she had an active discharge plan.R28's 08/11/25 Functional Abilities Self-Care and Mobility Care Area Assessment (CAA) documented R26 required assistance provided by the staff during the reference period. Staff would continue to provide care with activities of daily living (ADLs) as needed and anticipate the resident's needs.R28's EMR lacked a baseline care plan and comprehensive care plan.R28's Physician Orders documented to discharge R28 from physical therapy on 08/08/25 and may discharge home on [DATE].R28's Progress Note on 08/09/25 at 01:47 PM documented R28 discharged from the facility accompanied by her son and two other family members. R28 left via private vehicle.During an interview on 09/30/25 at 12:51 PM, Licensed Nurse (LN) G reported that Administrative Nurse E would complete the discharge summary and all the paperwork that was required for a discharge. LN G reported she would only complete a final assessment, review medications and write a progress note when a resident discharged .During an interview on 09/30/25 at 12:55 PM, Administrative Nurse E reported that the discharge paperwork would be completed by the charge nurse or Administrative Nurse D. Administrative Nurse E confirmed that the recapitulation of stay, and discharge summary, was not completed in the EMR for R28 and said the facility do not complete a paper discharge for or have the resident/responsible party sign any discharge paperwork.During an interview on 09/30/25 at 05:10 PM Administrative Nurse D stated she expected the nurse to complete a discharge summary that included a summary of their stay at the facility. The facility's policy Admission, Transfer and Discharge dated 08/22/22, documented upon admission, the resident/representative will be informed that if/when the resident is transferred to another health care facility, transferred within this facility, or discharged from this facility, the resident or his/her representative will be informed about the Facility Admission/Transfer/Discharge policies in addition to assurance of comparable care, treatment, and services regardless of the resident's payer source. Documentation or evidence of the resident's/representative's containing details of discharge planning and arrangements for post-discharge careResident's comprehensive care plan will contain resident's goals for admission and desired outcomes.</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 175570
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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> The facility reported a census of 20 residents; the sample included 13 residents. Based on interview and record review, the facility failed to complete a comprehensive Minimum Data Set (MDS) assessment in a timely manner for six residents; Resident (R)1, R2, R5, R14, R18, and R20. Findings included:- R1's Electronic Medical Record (EMR) recorded the Annual MDS, dated [DATE], which was completed on 03/18/25 and submitted on 04/01/25. (46 days later)R2's EMR recorded a comprehensive MDS dated [DATE]. R2's EMR recorded the Significant Change MDS was completed on 08/07/25 and submitted on 08/21/25. (13 days later).R5's EMR recorded a comprehensive MDS dated [DATE]. R5's EMR recorded the Significant Change MDS was completed on 07/29/25 and submitted on 08/21/25. (26 days later).R14's EMR recorded a comprehensive MDS dated [DATE]. R14's EMR recorded the Annual MDS was completed on 09/03/25 and submitted on 09/26/25. (9 days later).R18's EMR recorded a comprehensive MDS dated [DATE]. R18's EMR recorded the Annual MDS was in progress but not completed or submitted as required. (35 days later).R20's EMR recorded a comprehensive MDS dated [DATE]. R20's EMR recorded the Annual MDS was completed on 03/31/25 and submitted on 04/14/25. (52 days later).During an interview on 09/30/25 at 01:04 PM, Administrative Nurse E, the facility's MDS Nurse, confirmed that MDS assessments were in progress or completed late.During an interview on 09/30/25 at 05:10 PM, Administrative Nurse D stated she expected the MDS to be completed and submitted on time.The facility's policy Minimum Data Set (MDS) Accuracy Audits, undated, documented the facility is committed to ensuring the accuracy, timeliness, and completeness of all MDS assessments and refers to the RAI manual.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>The facility had a census of 20 residents. The sample included 13 residents. Based on observation, interview, and record review, the facility failed to accurately complete the Minimum Data Set (MDS) for one resident. Resident (R) 10, related to psychotropic (alters mood or thought) medications. Findings included:- R10's Electronic Medical Record (EMR) revealed diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and insomnia (inability to sleep).R10's 04/09/25 admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) of 13, which indicated intact cognition.The MDS recorded R10 was administered antianxiety (a class of medications that calm and relax people), antidepressant (a class of medications used to treat mood disorders), and diuretic (a medication to promote the formation and excretion of urine) in the lookback period of seven days. The MDS lacked the documentation of antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) and hypnotic (a class of medications used to induce sleep), that R10 received in the lookback period.R10's 04/16/25 Psychotropic Drug Use Care Area Assessment (CAA) documented, triggered related the use of several psychotropic medications being administered to the resident during the reference period. Staff will continue to administer as ordered with monitoring of side effects and observe for changes in mood/behavior. R10's Care Plan dated 04/14/25 documented, R10 received psychotropic medication for the management of depression and anxiety which puts me at risk for adverse side effects. The plan instructed staff to administer vilazodone (an antidepressant) 20 milligrams (mg), by mouth every day. Trazodone (an antidepressant used for insomnia) 50mg, by mouth every day, hydroxyzine (antianxiety medication) 25mg, by mouth every day, and Abilify (antipsychotic medication) 5 mg, by mouth every day. R10's Physician Orders documented Abilify oral tablet, administer 5mg tablet, by mouth one time a day related to depression, date ordered 04/03/25 andHydroxyzine, administer 25mg tablet, by mouth every day related to anxiety, date ordered 04/03/25.During an observation on 09/30/25 at 08:25 AM Certified Medication Aide (CMA) R staff assisted R10 back to her room.During an interview on 09/30/25 at 12:55 PM, Administrative Nurse E, the facility's MDS Nurse, reviewed the 04/09/25 MDS completed for R10 for accuracy of the medications documented in section N and stated she should have documented yes for antipsychotic and hypnotic medications as R10 had been administered the medications in the lookback period.During an interview on 09/30/25 at 05:10 PM, Administrative Nurse D stated she expected the MDS to be completed and submitted on time.The facility's policy Minimum Data Set (MDS) Accuracy Audits undated, documented the facility is committed to ensuring the accuracy, timeliness, and completeness of all MDS assessments and refer to the RAI manual.</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> The facility reported a census of 20 residents; the sample included 13 residents. Based on observations, record review and interviews the facility failed to develop a Baseline Care Plan for Resident (R) 14. Findings included:- R14's Electronic Medical Record (EMR) documented a diagnosis of myocardial infarction (heart attack) and major depression (major mood disorder that causes persistent feelings of sadness). R14's admission Minimum Data Set documented the resident admitted to the facility on [DATE]. R14's EMR record lacked a Baseline Care Plan. On 09/30/25 at 05:20 PM, an interview with Administrative Staff D revealed she expected each resident to have a baseline care plan assessment completed upon admission. The facility policy for Baseline Care Plan, Neighbors Caring For Neighbors, undated, states the facility will develop an initial person-centered care plan within the first forty-eight hours of admission for every resident. The baseline plan will provide instruction for care of the resident. Completion and implementation of the baseline care plan within 48 hours of a resident's admission is intended to promote continuity of care and communication among all facility staff members, increase residents' safety, and safeguard against adverse events that are most likely to occur in the immediate days after admission.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> The facility reported a census of 20 residents; the sample included 13 residents. Based on observations, record review and interviews the facility failed to develop a comprehensive care for Resident (R)14. Findings included:- R14's Electronic Medical Record (EMR) documented a diagnosis of myocardial infarction (heart attack) and major depression (major mood disorder that causes persistent feelings of sadness). R14's admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS noted R14 had behaviors, including rejection of care during the look-back period; R14 was independent with all activities of daily living (ADL). R14's EMR lacked a comprehensive care plan. On 09/30/25 at 05:20 PM, Administrative Staff D said she expected the resident care plans to be completed in a timely manner. The facility's policy Person-Centered, Comprehensive Care Plan, revised 03/31/25, documented it is the policy of this facility to provide an individualized, person-centered interdisciplinary plan of care for all residents that is appropriate to the resident's needs, strengths, limits, and goals based on initial, recurrent, and continual needs of the resident. The comprehensive care plan will meet professional standards of quality. Care, treatment, and services are planned and provided to each resident in an interdisciplinary, comprehensive, collaborative manner to ensure that all interventions are appropriate to the needs of the resident.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>The facility reported a census of 20 residents, The sample included 13 residents. Based on observation, record review and interview the facility failed to revise the care plan for Resident (R) 6 regarding pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) . Findings included:- R6's Electronic Medical Record (EMR) revealed the care plan dated 08/17/23 lacked wound care interventions. The care plan did indicate R6 at risk for cardiac complications and congestive heart failure dated 01/29/2024 with the following interventions check lung sounds and monitor/document labored breathing, monitor labs and vital signs as ordered. Monitor/document report any signs or symptoms of dependent edema of legs and feet, shortness of breath upon exertion, weight gain crackles and wheezes upon auscultation of lungs.R6's Physician's Orders documented to cleanse both buttocks per facility protocol; Pat dry, apply a dressing and change every 72 hours and as needed every day shift every three days for open area on the bilateral buttocks start date 05/05/25On 09/30/25 at 12:35 PM observed resident R6 sitting in her recliner working on her crochet refused to allow observation of wound care.On 09/30/25 at 08:23 AM Licensed Nurse LN G confirmed R6's Care Plan lacked any information regarding R6's wound care.During an interview on 09/30/25 at 05:20 PM with Administrative Staff D revealed she expected the care plans to be completed in a timely manner.The facility's policy Person-Centered, Comprehensive Care Plan revised 03/31/25 It is the policy of this facility to provide an individualized, person-centered interdisciplinary plan of care of all residents that is appropriate to the resident's needs, strength, limits and goals based on initial, recurrent and continual needs of the resident. The comprehensive care plan will meet professional standards of quality. Care, treatment, and services are planned and provided to each resident in an interdisciplinary, comprehensive, collaborative manner to ensure that all interventions are appropriate to needs of the resident.</p>

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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>The facility reported a census of 20 residents. Based on interview and record review, the facility failed to ensure complete the required annual evaluation for two of the five Certified Nursing Aide staff sampled. Findings included:-Review of the staff personnel files revealed the following:1.CNA N, hired on 08/02/23, had a performance evaluation dated 07/25/24 but nothing dated afterwards. 2. CNA O, hired 12/03/20, had a performance evaluation dated 05/06/24 but nothing dated afterwards.On 09/30/25 at 04:25 PM, Administrative Nurse D revealed she is planning on setting up the evaluations on a calendar and said they should be completed in a timely manner.The facility policy Staff Recruitment and Retention Policy, undated, revealed the facility recognizes staff members are the backbone of the organization. Their dedication, skills, and compassion directly impact the quality of care provided to our residents. The facility performs wage comparison and analysis on an annual basis to ensure the facility is offering competitive salaries and benefits to attract and retain qualified staff.</p>		

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>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.</p> <p>The facility reported a census of 20 resident. Based interviews. the facility failed to employ a full-time certified dietary manager for the residents who resided in the facility and received meals from the facility kitchen. Findings included: - Upon request, the facility was unable to provide evidence of adequate training credentials for the Certified Dietary Manager (CDM). On 09/29/25 at 10:35 AM, Dietary Manager BB stated she did not have a certificate or experience with food handling prior to taking the position. She revealed she was currently in classes for her CDM. On 10/1/25 at 03:35 PM, Administrative Staff A revealed she placed Dietary Manager BB in the position and was not aware she needed to have certification, specialized training, or experience. Administrative Staff A said Dietary Manager BB was currently in classes to obtain her CDM. The facility did not provide a policy regarding Certified Dietary Manager.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>The facility reported a census of 20 resident with two satellite kitchens. Based on observation and interview the facility failed to prepare and serve food under sanitary condition to prevent the potential for food borne bacteria. This place the residents at risk for food borne illnesses. Findings included:- On 09/29/25 at 09:40 AM, during the initial tour of the main pantry, observation revealed a dented can of refried beans, one bag of carrots with a lot of frost in the bag covering the carrots. And one sleeve of hash browns with no date. In the south satellite kitchen on the south hall, observation revealed one bag of hot dogs with a date of 07/27/25 with lots of frost, and one bag of carrots with frost covering the bag. In the north satellite kitchen, observation revealed one bag of hot dogs with no date, and one bag of carrots with a large amount of frost in the bag. The mini freezer did not have temperatures recorded from 09/23/25 to 09/29/25. A revisit of both satellite kitchens on 09/30/25 at 01:00 PM revealed the mini freezer temperatures log had not been updated. Neither of the two kitchens had foot-activated trash cans available. On 10/01/25 at 03:35 PM, Administrative Staff A revealed staff were to date any items when opened and they were to make sure the outdated food items were thrown away. Administrative Staff A said temperatures were to be assessed and logged daily. The facility policy Food Preparation and Handling Policy documented the kitchen and equipment will be kept clean, neat, orderly, and well-maintained; the food items will be received, checked, dated with the receiving date and use-by date, and stored properly as delivery is completed. Food from broken packages, swollen or dented cans, or food with abnormal appearance or odor will be immediately discarded. The temperature of foods will be periodically monitored and documented.</p>		

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<p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> The facility identified a census of 20 residents. The sample included 13 residents. Based on observations, interview and record reviews, the facility failed to conduct a thorough facility wide assessment to determine the resources necessary to care for the residents competently during both day-day operations and emergencies. This failure affected all 20 residents residing in the facility. Findings included:- On 09/30/25, the Administrative Nurse D provided a Facility assessment dated [DATE]. A review of the assessment revealed the following. The assessment did not identify the specific staffing levels needed for each unit and the number of Registered Nurses (RN), Licensed Nurses (LPN), Certified Medication Aides (CMA), and Certified Nurse Aides (CNA) needed for each unit, patient acuity, and census. The assessment lacked staffing levels required for each shift to include evenings and weekends. The assessment further lacked information for the contingency staffing plans for events that did not require activation of the facility's emergency plan but had the potential to impact resident care. On 10/1/25 at 01:54 PM, Administrative Staff A stated the percentage of staff had been added on 08/13/25, but the date was not on the assessment. She said she was unaware of the requirement to include the staffing levels, the contingency staffing plan, or the staff recruitment plan in the Facility Assessment. The facility policy Facility assessment dated [DATE] revealed the facility will evaluate the resident population and identify the resources needed to provide necessary care and service the resident requires on an annual basis and at any time of a significant change made to the care or services provided in the facility. Sufficient staff, appropriate competencies, and skills set necessary to care for all residents. Staffing needs for each shift day, evening, night and adjust as necessary based on any changes in the resident population, develop and maintain a plan to maximize recruitment and retention of direct staff, inform contingency planning for events that do not require activation of the facilities emergency but do have the potential to affect resident care including but not limited to availability of direct care nursing staff. The facility will review and update the assessment annually or whenever there is a need or if the facility plans for any change that would require a modification to any part of this assessment.</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>The facility reported a census of 20 residents; the sample included 13 residents. Based on interview and record review, the facility failed to complete a Quality Assurance and Performance Improvement Program (PIP) based on identification, investigation, analysis, and prevention of adverse events in the facility within the past year. Findings included:- Upon request the facility was unable to provide evidence of a PIP completed within the last year. During an interview on 10/01/25 at 03:14 PM, Administrative Staff A stated that she expected Administrative Nurse D to complete all the PIPs for the facility. Administrative Staff A stated she believed the last time a PIP was completed was one and a half years ago. The facility's policy Quality Assurance Performance Improvement Policy, dated 05/16/25, documented the facility had developed, implemented, and maintained an effective, on-going, comprehensive, data driven QAPI program focused on indicators of the outcomes of care and quality of life by addressing the full range of care and services provided by the facility. The facility developed PIPs to examine and improve care or services in areas identified as needing attention. Selection for focused PIPs would focus on incidence, prevalence and severity of problems or potential problems identified per PIP Prioritization Tool.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>The facility reported a census of 20 residents. Based on interview and record review the facility failed to complete a system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility. Additionally, the facility failed to complete a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents. This failure has the potential to affect all 20 residents. Findings included:- Upon request, the facility was unable to provide antibiotic and infection surveillance logs. During an interview on 09/30/25 at 04:04 PM, Administrative Nurse E (Infection Preventionist) stated she had no electronic or paper records to show the collection and analysis of data to track infection rates and identify trends. Administrative Nurse E reported she would read the Electronic Medical Record every day to see if there were any new orders for antibiotics. She reported that she completed a verbal report of the facilities infections, and antibiotic use at the Quality Assurance meetings. The facility's policy Infection Surveillance dated 04/01/25, documented the facility will closely monitor all residents that exhibit signs and symptoms of infection through ongoing surveillance and the facility had a systematic method for collecting, consolidating and analyzing data. The Infection Preventionist will document the data to a monthly infection control log. Continuous surveillance of measure outcomes of system improvements.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  175570	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/17/2025
NAME OF PROVIDER OR SUPPLIER  The Shepherd's Center		STREET ADDRESS, CITY, STATE, ZIP CODE  101 Cedar Ridge Drive Cimarron, KS 67835	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Implement a program that monitors antibiotic use.</p> <p>The facility reported a census of 20 residents; the sample included 13. Based on interview and record review the facility failed to ensure staff adhered to the principles of antibiotic stewardship through monitoring for the appropriate use of antibiotics prescribed to prevent antibiotic resistance and spread of multidrug resistant organisms within the facility. Findings included:- Upon request, the facility was unable to provide antibiotic and infection surveillance logs. During an interview on 09/30/25 at 04:04 PM, Administrative Nurse E (Infection Preventionist) stated she had no electronic or paper records to show the collection and analysis of data to track/monitor antibiotics ordered, and laboratory reports received. Administrative Nurse E reported she would read the Electronic Medical Record every day to see if there were any new orders for antibiotics. She reported that she completed a verbal report of the facility's infections and antibiotic use at the Quality Assurance meetings. The facility's policy Antibiotic Stewardship Program, dated 04/01/25, documented the facility would implement an Antibiotic Stewardship Program, which will promote appropriate use of antibiotics while optimizing the treatment of infections. The Infection Preventionist was responsible to monitor every antibiotic ordered and complete an antibiotic time-out for antibiotics prescribed, summarize antibiotics prescribed, summarize antibiotic resistance based on laboratory data, tracking measures of outcome surveillance related to antibiotic use, and to report the findings.</p>		