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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CEDARS	1021 CEDARS DRIVE , MCPHERSON, Kansas, 67460

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The following citations represent the findings of a Health Recertification Survey. The 2567 was sent electronically on 02/05/26.	F0000		
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.	F0550		

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 reverse for further 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

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

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F0550 SS = D	Continued from page 1 §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: 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.	F0550		
F0582 SS = D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-	F0582		

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F0582 SS = D	Continued from page 2 (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is NOT MET as evidenced by: The facility has a census of 33 residents. The sample included 12 residents, with three reviewed for	F0582		

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F0582 SS = D	Continued from page 3 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.	F0582		
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).	F0605		

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F0605 SS = D	Continued from page 4 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or	F0605		

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F0605 SS = D	Continued from page 5 (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: 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	F0605		

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F0605 SS = D	Continued from page 6 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 12/29/25 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	F0605		

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F0605 SS = D	Continued from page 7 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. 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	F0605		

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F0605 SS = D	Continued from page 8 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) 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 05/21/25 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.	F0605		

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F0605 SS = D	Continued from page 9 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 included in the reorder of the medication.	F0605		

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F0605 SS = D	Continued from page 10 - 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 12/21/25 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.	F0605		

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F0605 SS = D	Continued from page 11 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.	F0605		
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other	F0628		

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THE CEDARS	1021 CEDARS DRIVE , MCPHERSON, Kansas, 67460

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F0628 SS = D	Continued from page 12 documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days.	F0628		

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F0628 SS = D	Continued from page 13 §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is	F0628		

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F0628 SS = D	Continued from page 14 the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to	F0628		

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F0628 SS = D	Continued from page 15 include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: 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 10/10/25 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.	F0628		

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F0628 SS = D	Continued from page 16 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.	F0628		
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	F0657		

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F0657 SS = D	Continued from page 17 This REQUIREMENT is NOT MET as evidenced by: 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 12/15/25 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	F0657		

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F0657 SS = D	Continued from page 18 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 chang. 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 12/21/25 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" dated 12/02/25 documented R31 was a high risk for falls.	F0657		

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F0657 SS = D	Continued from page 19 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.	F0657		

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F0657 SS = D	Continued from page 20 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.	F0657		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: 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:	F0689		

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F0689 SS = D	Continued from page 21 - 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 06/17/25 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	F0689		

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F0689 SS = D	Continued from page 22 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 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.	F0689		

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F0689 SS = D	Continued from page 23 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	F0689		

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F0689 SS = D	Continued from page 24 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 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	F0689		

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F0689 SS = D	Continued from page 25 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	F0689		

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F0689 SS = D	Continued from page 26 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.	F0689		
F0757 SS = D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is NOT MET as evidenced by: 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	F0757		

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F0757 SS = D	Continued from page 27 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 12/15/25 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	F0757		

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F0757 SS = D	Continued from page 28 Management was not provided by the facility.	F0757		
F0801 SS = C	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other	F0801		

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F0801 SS = C	Continued from page 29 clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is NOT MET as evidenced by: 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	F0801		

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F0801 SS = C	Continued from page 30 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.	F0801		
F0849 SS = D	Hospice Services CFR(s): 483.70(n)(1)-(4) §483.70(n) Hospice services. §483.70(n)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(n)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The	F0849		

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F0849 SS = D	Continued from page 31 written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.	F0849		

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F0849 SS = D	Continued from page 32 (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(n)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.	F0849		

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F0849 SS = D	Continued from page 33 (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is NOT MET as evidenced by: 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:	F0849		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CEDARS	1021 CEDARS DRIVE , MCPHERSON, Kansas, 67460

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0849 SS = D	Continued from page 34 - 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 11/27/25 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.	F0849		

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F0849 SS = D	Continued from page 35 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.	F0849		