STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N085014	A. BUILDING: _____ B. WING _____	C 08/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARHURST OF SALINA	2605 S OHIO STREET SALINA, KS 67401

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S 000	INITIAL COMMENTS The following citations represent the findings of an abbreviated survey for complaints #199378, #198840, #198756, #198516, and #198201 at the above named assisted living facility conducted on 07/30/26-08/03/26.	S 000		
S3026 SS=J	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-42-101(f)(1)(A)(B) The facility reported a census of 80 residents. The sample included 5 closed record review residents. Based on record review, observation, and interview, facility failed to provide and/or coordinate services reasonably necessary to ensure Resident (R) 2 and R3's safety and well-being and to avoid harm when the resident, who had a known wander risk, eloped from the secured memory care unit. R2 was on hourly safety checks that were not completed by staff properly. R3 exited through a back exit door and staff cleared the alarm on the door without checking outside to make sure there was not a resident out there. The facility further failed to ensure Certified Medication Aide (CMA) C did not	S3026		

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

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verbally abuse R4. These failures placed the residents in Immediate Jeopardy.

Findings included:

- Review of R2's medical record revealed she admitted to the facility on 11/19/25 with diagnosis of unspecified dementia.

The "Functional Capacity Screen" (FCS) dated 05/02/26 recorded the resident was independent with toileting, transfers, walking/mobility and eating. She required supervision with bathing and dressing and required physical assistance for management of medications and treatments. The FCS recorded R2 had short-term memory impairment and impaired decision making. The FCS further recorded the resident was at risk for wandering and had impaired vision. R2 used no assistive devices for ambulation.

The combined "Negotiated Service Agreement" (NSA)/ "Care Plan" (CP) dated 05/02/26 recorded the resident received reminders for bathing and dressing and assistance in clothing selection. Staff assisted with and administered medications. The NSA/CP recorded staff gave choices, approached the resident in calm manner, encouraged participation in activities, and programs, engaged in small talk to reduce anxiety, provided reminders when forgetful, and provided redirection and visual safety checks every hour.

The resident's "Elopement Risk Assessment" dated 05/02/26 recorded R2 had a diagnosis of dementia, had intermittent confusion, was disoriented to time and place, was highly mobile, and had a history of elopement, wandering, and sundowning. R2 had an elopement risk score of

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S3026	Continued From page 2 59, which indicated a high risk for elopement. The facility provided "Safety Check" document for 05/02/26 revealed Certified Nurse Aide (CNA) D visually observed R2 on 05/02/26 at 03:16 PM. The required safety checks for 04:00 PM and 05:00 PM were not completed. The facility obtained statement dated 05/02/26 from CNA D revealed R2 was last seen on 05/02/26 at approximately 03:45 PM walking in the common area. The facility obtained statement dated 05/02/26 from CNA E revealed R2 was last seen on 05/02/26 at approximately 03:45 PM walking in the common area of the facility. Review of investigation packet provided by facility on 05/02/26 at approximately 05:15 PM staff received a call from another resident's family member who also resided at the facility. R2 was observed around a restaurant that was approximately 1.2 miles away from facility. The family member brought R2 back to the community at approximately 05:25 PM Observation of the area revealed the resident could have traversed along the sidewalk, through facility parking lot, towards main roadway, turning onto the sidewalk that is parallel to main road. Main roadway contains residential and business buildings along it, as well as heavy traffic on roadway at times. The following corrective actions were taken by the facility on 05/02/26 to remove the immediacy: 1. 30-minute safety checks during sundowning hours were implemented, and care plans were	S3026		

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updated.
2. Staff education was completed on the facility missing person's policy and procedure.
3. Door alarm and equipment safety checks were completed and working properly.
4. The facility installed cords on all Memory Care Unit windows, which allowed windows to open, but not tilt past the safety stops.

- Review of R3's medical record revealed she admitted to the facility on 09/05/25 with a diagnosis of dementia.

The FCS dated 04/09/26 recorded the resident was independent with toileting, transfers, walking/ mobility, eating and dressing. R3 required supervision with bathing and required physical assistance for management of medications and treatments. The FCS recorded R3 had short-term memory impairment, memory/recall impairment, and impaired decision making. The FCS further recorded the resident was at risk for wandering and impaired decision making. R3 used no assistive devices for ambulation.

The combined NSA/CP dated 04/09/26 recorded the resident received reminders for bathing and dressing, assistance in clothing selection, and stand by assistance when needed. Staff assisted with and administered medications. The NSA/CP recorded staff provided redirection, hourly safety checks, give choices, spoke in a calm and gentle manner, used positive body language, and encouraged participation in activities and programs. Staff would engage R3 in "small talk" prior to asking R3 to do something to help reduce anxiety and help build rapport.

The resident's "Elopement Risk Assessment" dated 04/09/26 recorded R3 had a diagnosis of

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dementia, intermittent confusion, was disoriented to time and place, was highly mobile and had a history of elopement, wandering, and had sundowning. R3 had an elopement risk assessment score of 59, which indicated the resident was at a high risk for elopement.

The facility provided "Safety Check" dated 04/08/26 R3 was visually observed on 04/08/26 at 07:03 PM by CNA F.

The facility obtained statement from CNA G dated 04/08/26 revealed heard door alarm going off. CNA G noticed another resident standing outside the door that was alarming at the time. CNA G cleared the door alarm without looking out the exit door to make sure another resident was out there.

Review of investigation packet provided by facility on 04/08/26 at approximately 07:25 PM R3 was found by another resident's family member approximately 50 yards from the door she exited and was escorted into the front of the facility by another resident's family member.

Observation of the area revealed the resident could have traversed along the sidewalk to the parking lot or turned right before getting to parking lot, which would lead R3 to the front entrance of the facility.

The following actions were taken by the facility on 04/08/26 to remove the immediacy:

1.30-minute safety checks were implemented during sundowning hours, help with redirection was provided, and care plans were updated.
2.All door alarms and equipment safety check and working properly.

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3. Elopement drill was completed on 04/08/26, 04/09/26, and 04/10/26.
4. Written warning was discussed with CNA G.
5. Staff education was completed on missing person's procedure, elopement policy, external doors, shift change checklist, and use of pagers/walkies.

- Record review for R4 revealed an admission date of 08/29/25 with a diagnosis of senile degeneration of the brain.

The 02/17/26 FCS identified R4 was unable to perform management of medications and treatments. R4 required physical assistance with bathing, dressing, toileting, transferring, and walking/mobility. R4 required supervision with eating, had short-term memory, long-term memory, memory/recall impairment, and decision-making difficulties. The resident was at risk for falls, had impaired vision, and impaired decision making. R4 used a cane/walker/crutch and wheelchair as assistive devices.

The 02/17/26 NSA/CP for R4 documented staff provided physical assistance with bathing, dressing, toileting, and transfers and minimal assistance with eating. The NSA/CP documented for staff to give choices, speak to R4 in a calm and gentle manner, provide redirection, and encourage R4 to explore surroundings safely. The NSA/CP revealed staff were to perform two-hour safety checks on R4.

The notarized "Witness Statement" dated 05/17/26 submitted to the department documented CMA H reported to Administrative Nurse I an incident that occurred 05/17/26 where CMA C stood over R4 and yelled at R4 that she was "being dramatic and difficult". CMA H

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intervened and asked CMA C why she was yelling. CNA C stated that "performing this [expletive] work was not her job". Once Administrative Nurse I was notified, CMA C was immediately sent home.

CNA J's notarized "Witness Statement" dated 05/15/26 revealed other instances with additional residents as well. Comments said by CMA C included the following: she yelled "No! No ma'am! No! Move away!" and further yelled "Oh no old lady, we aren't doing this today!"

CMA C completed Abuse Prohibition and Prevention Agreement on 04/09/26 upon being hired.

The facility's 12/15/2023 "Abuse, Neglect and Exploitation Prevention, Prohibition, and Investigation" policy and procedure, documented verbal, written, facial or body gestures communicated to a Resident in a disparaging or derogatory manner. This includes verbal, written, and facial body gestures to a visitor, staff, or Resident about another resident. Mental abuse includes humiliation, harassment, threats of punishment, or deprivation directed toward the resident.

The following corrective actions were taken by the facility on 05/17/26 to remove the immediacy:

1. CMA C was suspended immediately pending investigation.
2. CMA C was terminated from being employed at facility.
3. ANE education with all staff at next in-service, to include reporting suspected ANE.
4. Staff would monitor memory care residents for signs of fear and distress.

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