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 _____	12/30/2025

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

(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) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey with attached complaints (#196896, #196873, #194369, #191406 and #197627) at the above named facility conducted on 12/23/25 and 12/30/25.	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 26-41-101 (f) (1) (B) The facility reported a census of 68 residents. The sample included 4 record review residents and 2 closed record review residents. Based on record review, observation, and interview, Operator A failed to provide or coordinate services reasonably necessary to ensure Resident (R) 3's safety and well-being and to avoid harm when the resident, who was a known wander risk, eloped from the secured memory care unit through the bistro door without staff knowledge on 12/10/25. R3 ambulated through the facility kitchen and exited the facility through the staff facility door that did not have an alarm.	S3026		

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

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S3026	Continued From page 1 This failure placed the resident in Immediate Jeopardy. Findings included: - Review of the "Resident Roster" obtained on 12/23/25 from Licensed Nurse (LN) B recorded R3 was a wander risk and resided in the memory care unit of the facility. - Review of R3's medical record revealed she admitted to the facility on 11/19/25 with diagnosis of unspecified dementia. The "Functional Capacity Screen" (FCS) dated 11/19/25 recorded the resident was independent with toileting, transfer, walk/ mobility and eating, required supervision with bathing and dressing, and required physical assistance for management of medications and treatments. The FCS recorded R3 had short-term memory impairment and impaired decision making. The FCS further recorded the resident was at risk for wandering and had impaired vision. R3 used no assistive devices for ambulation. The combined "Negotiated Service Agreement" (NSA)/ "Care Plan" (CP) dated 11/19/25 recorded the resident received reminders for bathing and dressing and assistance in clothing selection. Staff assisted 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, redirection and visual checks every two hours.	S3026		

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S3026	Continued From page 2 The resident's "Elopement Risk Assessment" dated 11/19/25 recorded R3 had a diagnosis of dementia, intermittent confusion, was disoriented to time and place, was highly mobile and had a past history of elopement, resulting in a score of 27. The" Elopement Risk Assessment" recorded resident was at a high risk for elopement if score was 16 or higher. Per facility obtained "Safety Check" R3 was visually observed on 12/10/25 at 03:34 PM by CMA E . Per facility obtained statement from Certified Medication Aide (CMA) D, R3 was last seen on 12/10/25 at approximately 03:30 PM walking near the fish tank in the dining room of the facility. Per facility obtained statement from LN C, R3 was last seen on 12/10/25 at approximately 03:35 PM walking near the fish tank in the dining room of the facility. Per facility obtained statement from CMA F, R3 was last seen on 12/10/25 at 03:40 PM. CMA F's statement stated she did not latch the bistro door. Interview on 12/23/25 at 02:18 PM LN B stated she received a call from a citizen of the town on 12/10/25 at approximately 04:31 PM stating someone was walking in the field behind the facility. LN B stated LN C found R3 in the field approximately 200 feet behind the facility at around 04:35 PM. LN B stated R3 was wearing a long sleeve shirt, pants, vest and shoes. LN B	S3026		

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S3026	Continued From page 3	S3026		

stated, per facility video camera footage, R3 walked through the keypad locked memory care unit bistro door at 03:50 PM, which led to the facility kitchen. LN stated per facility video camera footage, R3 walked through the unalarmed facility staff exit door at 03:51 PM. LN B stated the memory care unit bistro door was not securely closed at the time of the incident by staff, which allowed R3 to walk through the facility kitchen and out the unalarmed staff facility door.

"Weather Underground" reported the following temperatures, events, and conditions for 12/10/25 at 03:52 PM; the temperature was 51 degrees F (Fahrenheit), 8 mile per hour wind from the northwest, no precipitation.

Observation of the area revealed the resident could have traversed along the sidewalk to the open field behind the facility or through the parking lot and down the street to the open field behind the facility. The field had tall brush and stubble. The street had no business or residential buildings along it .

Facility's "Elopement Risk Policy and Procedure" dated 06/13/23 recorded, "If a resident is determined to be at risk for elopement, a plan will be developed and implemented and will be reviewed with the care team to include: notification to the care team of elopement risk, interventions to minimize potential for resident elopement, a current resident photograph accessible to the care team."

The Immediate Jeopardy was removed on 12/10/25 at approximately 04:35 PM when the

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S3026	Continued From page 4 resident was found by LN C and brought back into the memory care unit . The following actions were taken by the facility on 12/10/25 to protect the resident: 1. One- hour visual checks implemented and care plan updated, 2. Staff education completed related to monitoring the door is shut between the kitchen and memory care unit bistro and keeping the gate entering the bistro latched at all times, 3. Staff education completed on missing resident and elopement policy, 4. Signs placed on the door between memory care unit bistro, and kitchen to remind staff to keep door closed when not in use, 5. Elopement drill was completed on 12/12/25.	S3026		
S3213 SS=D	26-41-205 (g) (2) Medication Labeling (g) (2) Each prescription medication container shall have a label that was provided by a dispensing pharmacist or affixed to the container by a dispensing pharmacist in accordance with K.A.R. 68-7-14. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (g) (2) The facility reported a census of 68 residents. Based on observation, interview and record review, Operator A failed to ensure prescription medication containers were labeled with a prescription label provided by a dispensing	S3213		

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S3213	Continued From page 5	S3213		

pharmacist or affixed to the container by a dispensing pharmacist in accordance with K.A.R. 68-7-14 for 1 non-sampled Resident (R)8.

Findings included:

- Observation on 12/23/25 at 01:16 PM with Certified Medication Aide (CMA) D of the medication room revealed an insulin injector pen, which was not labeled with resident's name or an open date. CMA D identified the insulin injector pen as belonging to R8. The injector pen had a manufacture label of Lantus Solostar and the injector pen had no other identification or pharmacist labeling.

Review of R8's December 2025 "Medication Administration Record" (MAR) revealed the following, "Lantus Solostar Insulin 10 unit/ milliliter, inject 20 units under the skin daily with breakfast" signed off as administered daily by certified staff from 12/01/25 through 12/23/25.

Signed physician orders dated 12/08/25 recorded, "Lantus Solostar Insulin 100 unit/ milliliter, inject 20 units under the skin with breakfast, initial start: 07/13/25 at 05:15 AM."

Interview on 12/23/25 at 01:16 PM with CMA D confirmed R8's Lantus insulin pen was not labeled with the resident's name or open date.

Operator A failed to ensure prescription medication containers were labeled with a prescription label provided by a dispensing pharmacist or affixed to the container by a dispensing pharmacist in accordance with K.A.R.

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S3213	Continued From page 6 68-7-14 for 1 non-sampled Resident (R)8.	S3213		