STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175154	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lexington Park Nursing & Post Acute Center	1031 SW Fleming Court Topeka, KS 66604

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27168 The facility had a census of 77 residents. The sample included 19 residents. Based on observation, record review, and interview, the facility failed to provide Resident (R)45, R36, and R73 or their representative with written information regarding the facility bed hold policy when they were transferred to the hospital. This placed the resident at risk of not being permitted to return and resume residence in the nursing facility. Findings included: - R45's Electronic Medical Record (EMR) documented R45 had a diagnosis of malignant neoplasm (an abnormal mass of tissue that forms when cells grow and divide more than they should or do not die when they should) of the supraglottic (upper part of the larynx or voice box), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), atherosclerotic heart disease (a type of disease that affects the heart or blood vessels), chronic obstructive pulmonary disease (COPD-progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). R45's Quarterly Minimum Data Set (MDS), dated [DATE], documented R45 had a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented the resident required substantial to maximal staff assistance with toileting and personal hygiene. R45's Care Plan, dated 07/10/24, documented R45 had a feeding tube and would receive feeding and pleasure food; R45 would notify staff when she would like a meal or pleasure food. R45 received tube feeding through the pump as a continuous feeding overnight. R45 had an additional diet order of regular with thin liquids as tolerated. The Progress Note, dated 06/11/24 at 11:49 PM, documented R45 became short of breath and R45 stated she felt like she had something in her throat that was blocking her airway. Staff obtained the resident's oxygen levels and obtained a reading of 71% (normal 95% to 100%) on 3.5 liters of oxygen. Staff administered a breathing treatment and the resident's oxygen levels came up to 78%. Her heart rate was 116 (normal 60-100 beats per minute), and her respirations were 32 (normal 12-16 breaths per minute). The nurse practitioner was contacted, and the resident was sent to the hospital via ambulance. The Progress Note, dated 06/12/24 at 03:09 PM, documented the resident was admitted to hospital. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Progress Notes. dated 06/14/24 at 03:44 PM, documented the resident returned to the facility and was readmitted . R45's clinical record lacked evidence the resident or representative was provided the bed hold policy when she was transferred to the hospital. On 07/16/24 at 08:10 AM, observation revealed R45 sat on the side of her bed with oxygen on per nasal cannula. Continued observation revealed License Nurse (LN) H administered 120 milliliters (ml) of water, crushed Levaquin (antibiotic) 750 milligrams, and Nutra Source Fiber (liquid nutrition) mix and followed with 120 ml of water. On 07/16/24 at 03:30 PM, Social Service X verified she had not provided the resident, or her representative with the bed hold policy when she was transferred to the hospital on 06/12/24. On 07/16/24 at 04:00 PM, Administrative Staff A verified the resident had not been provided the bed hold policy when she was transferred to the hospital on 06/12/24. The facility's Bed-Hold Policy, dated November 28, 2017, documented a written notice, that specifies the duration of the bed-hold policy, would be provided at the time of transfer of a resident for hospitalization or therapeutic leave. A resident whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan would return to the facility to their previous room if available or immediately upon the first availability of a bed. During the admission process, the facility would review the bed-hold policy with the resident and/or representative, The facility failed to provide R45 or her representative with written information regarding the facility bed hold policy when she was transferred to the hospital. This placed the resident at risk of not being permitted to return and resume residence in the nursing facility. 32358 - R36's Electronic Medical Record (EMR) documented R36 had a diagnosis of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), chronic obstructive pulmonary disease (COPD- a chronic inflammatory lung disease that causes obstructed airflow from the lungs) and sepsis (a life-threatening systemic reaction that develops due to infections which cause inflammation throughout the entire body). R36's Quarterly Minimum Data Set (MDS), dated [DATE], documented R36 had a Brief Interview of Mental Status (BIMS) score of six, which indicated severely impaired cognition. The MDS documented the resident required partial to moderate staff assistance with most activities of daily living (ADLs) and received oxygen therapy. R36's Care Plan, revised 07/04/24, instructed staff to monitor R36's body language and facial expressions for signs or symptoms of pain, cough, and shortness of breath. Staff were to listen to her lungs for any sounds of wetness or wheezing and notify the physician if they were heard. The Progress Note, dated 01/04/24 at 05:23 AM, documented R36 was admitted to the hospital. The Progress Note, dated 04/16/24 at 12:55 PM, documented R36 was admitted to the hospital. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R36's clinical record lacked evidence the resident or representative was provided the bed hold policy when she was transferred to the hospital on 01/04/24 or 04/16/24. On 07/16/24 at 08:00 AM, observation revealed R36 self-propelled in a wheelchair down the hall from the dining room to her room. She wore oxygen at two liters, per nasal cannula, with no signs or symptoms of respiratory distress or pain. On 07/16/24 at 12:09 PM Administrative Staff A verified the resident or representative was not provided the facility bed hold policy when she was transferred to the hospital on 01/04/24 and 04/16/24. Administrative Staff A stated the social service designee was responsible for providing the bed hold policy to the resident or representative and it should have been provided. The facility's Bed-Hold Policy, revised 11/28/17, documented a written notice that specifies the duration of the bed-hold policy would be provided to the resident or resident representative upon transfer to hospital or therapeutic leave. The facility failed to provide R36 or her representative with written information regarding the facility bed hold policy when she was transferred to the hospital. This placed the resident at risk of not being permitted to return and resume residence in the nursing facility. - R73's Electronic Medical Record (EMR) documented R73 had a diagnosis of an anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), dementia (a progressive mental disorder characterized by failing memory, confusion), schizoaffective disorder (a mental disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought) and bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods). R73's Annual Minimum Data Set (MDS), dated [DATE], documented R73 had a Brief Interview of Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. The MDS documented the resident required substantial to maximal staff assistance with most activities of daily living (ADLs) and had delusions (untrue persistent beliefs or perceptions held by a person although evidence shows it was untrue). R73's Care Plan, revised 04/11/24, documented R73 had physically and verbally aggressive behavior, had a history of paranoia and accusing others of taking her things, and instructed staff to leave her alone in a safe place if she had these behaviors. The care plan documented if the behaviors persisted despite time alone or redirection to call her representative and let her talk to him. The Progress Note, dated 05/03/24 at 02:12 PM, documented R73 was admitted to the behavioral health hospital. R73's clinical record lacked evidence the resident or representative was provided the bed hold policy when she was transferred to the hospital. On 07/16/24 at 12:09 PM Administrative Staff A verified the resident or representative was not provided the facility bed hold policy when she was transferred to the hospital. Administrative Staff A stated the social service designee was responsible for providing the bed hold policy to the resident or representative and it should have been provided. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Bed-Hold Policy, revised 11/28/17, documented a written notice that specifies the duration of the bed-hold policy would be provided to the resident or resident representative upon transfer to hospital or therapeutic leave. The facility failed to provide R73 or her representative with written information regarding the facility bed hold policy when she was transferred to the hospital. This placed the resident at risk of not being permitted to return and resume residence in the nursing facility.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37450 The facility had a census of 77 residents. The sample included 19 residents with five reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure nonpharmacological symptom management and a specified duration of use for Resident (R) 19 and R18's use of as-needed (PRN) psychotropic (alters mood or thoughts) medication. The facility further failed to ensure an appropriate indication of use or a documented physician rationale and risk versus benefits for the continued use of an antipsychotic (class of medications used to treat a mental disorder characterized by gross impairment in reality testing) and for not attempting a gradual dose reduction (GDR) for R33 and failed to ensure R18's PRN antipsychotic medication had the required 14-day stop date. This placed the residents at risk of receiving unnecessary psychotropic medications. Findings included: - R19's Electronic Medical Record (EMR) documented diagnoses of chronic kidney disease with heart failure, diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), chronic respiratory failure, atrial fibrillation (rapid, irregular heartbeat), dependence on supplemental oxygen, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder, vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), and pseudobulbar affect (a condition which is characterized by an uncontrollable reaction of laughter or crying that is disproportionate to the event). R19's Quarterly Minimum Data Set (MDS), dated [DATE], documented R19 had severe cognitive impairment with no signs or symptoms of delirium (sudden severe confusion, disorientation, and restlessness), psychosis (any major mental disorder characterized by gross impairment in reality perception), or behaviors. R19 required partial/moderate assistance with functional activities such as dressing, and transfers, and substantial/maximum assistance with toileting hygiene, bathing, and bed mobility. R19 was not ambulatory. The MDS further documented R19 had a condition or chronic condition that may result in a life expectance of less than six months and received hospice care (special care to people who are near the end of life). R19 received scheduled and PRN pain medication. R19 took an antianxiety (class of medications that calm and relax people), antidepressant (class of medications used to treat mood disorders), diuretic (medication to promote the formation and excretion of urine), and received oxygen therapy. The Psychotropic Drug Use Care Area Assessment, dated 05/21/24, documented R19 received psychotropic medications and received an antidepressant and antianxiety medication. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R19's Care Plan dated 05/23/24 documented R19 had mood and behavior problems, took Ativan (lorazepam- antianxiety medication) for targeted behavior of racing thoughts; Buspar (antianxiety medication) for a targeted behavior for yelling out; Cymbalta (an antidepressant) for depression and a targeted behavior of self-isolation, and Wellbutrin (antidepressant) with a target behavior of crying. The care plan directed staff to watch for side effects of medications and listed things that made the resident feel down or depressed such as missing family, and friends, and not having their own home. The care plan directed staff to help R19 feel better were calling friends and family on the phone, reading a book, and watching TV. The Physician Order, dated 12/19/23, directed staff to administer lorazepam 0.5 milligrams (mg) by mouth every four hours as needed (PRN) for anxiety related to anxiety disorder. The target behavior listed racing thoughts, and nonpharmacological interventions should be applied before administration. The Consultant Pharmacist (CP) Review, dated 01/08/24 and 06/13/24, documented R19 had an order for PRN Ativan though noted the resident was on hospice services. The CP documented that per Centers for Medicare and Medicaid Services (CMS) regulations, for PRN psychotropic use greater than 14 days, the prescriber must document a clinical rationale in the medical record for the continuance of the PRN agent and indicate the duration that the medication should be continued. The CP recommended re-evaluating the need to continue the PRN order at that time. If continued use is warranted, please provide a clinical rationale as well as the duration below. The physician's response to the CP review on 01/08/24 recorded the rationale for use was the medication was beneficial, and wrote the duration was no stop order or discontinue date. The response lacked a rationale or supporting data as to the benefit and lacked a specified duration. The physician's response to the CP review on 06/13/24 recorded that the rationale for use was hospice and lacked a specified duration of use. R19's April 2024 Electronic Medication Administrative Record (EMAR) revealed the use of PRN lorazepam 14 times that lacked documentation of nonpharmacological interventions used prior to administration. R19's May 2024 EMAR revealed the use of PRN lorazepam 14 times and lacked documentation of nonpharmacological interventions used prior to administration. R19's June 2024 EMAR revealed the use of PRN lorazepam 27 times and recorded the use of nonpharmacological interventions twice. R19's 07/01/24 to 07/15/24 EMAR revealed the use of PRN lorazepam 23 times and recorded nonpharmacological interventions only 11 times. On 07/15/24 at 02:56 PM, observation revealed staff pushed R19 to the dining room in a wheelchair for an activity involving food, drink, and music. On 07/17/24 at 08:00 AM, Certified Nurse Aide (CNA) M reported when R19 was upset, she tried to reassure her calmly, offered to lay her in bed, provided drinks, sat with her, and brought the resident to the nurse's station area. CNA M stated if interventions were not successful, the charge nurse would be notified. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/16/24 at 02:42 PM, Licensed Nurse (LN) H reported R19's mood and anxiety had been up and down. LN H stated the physician frequently saw R19. LN H reported R19's crying episodes had been less with the start of medication for pseudobulbar affect. LN H stated nonpharmacological interventions used for R19 would include turning on audiobooks, activity attendance if not too upset, sitting with the resident, massaging her hands, and doing her nails. LN H also reported the CNAs were good at redirecting conversations and hospice provided music therapy. On 07/17/24 at 08:00 AM, Administrative Nurse D reported the physicians made the decisions related to the use of medications. The pharmacist reviewed the resident's medical record and gave recommendations which were sent to the physician for review. Administrative Nurse D said the nurses and unit directors also reviewed the recommendations for orders. Administrative Nurse D stated nonpharmacological interventions should be attempted and documented before administration of PRN lorazepam. The facility's Unnecessary Medications policy, dated 11/28/17, documented that each resident's drug regimen must be free of unnecessary drugs. An unnecessary drug is any drug when used in excessive doses including duplicate therapy for excessive duration or without adequate monitoring or without adequate indications for this use or in the presence of adverse consequences which indicate the dose should be reduced or discontinued. The facility failed to ensure nonpharmacological symptom management and a specified duration of use for R19's PRN psychotropic antianxiety medication. This placed the resident at risk of receiving unnecessary psychotropic medication and related side effects. R33's Electronic Medical Record (EMR) recorded diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), dementia (progressive mental disorder characterized by failing memory, confusion), major depressive disorder (major mood disorder which causes persistent feelings of sadness), atrial fibrillation (rapid, irregular heartbeat) and acquired absence of left leg below knee. R33's Quarterly Minimum Data Set (MDS), dated [DATE], documented R33 had severe cognitive impairment, had no delirium (sudden severe confusion, disorientation, and restlessness), psychosis (any major mental disorder characterized by a gross impairment in reality perception) or behavioral symptoms. R33 required substantial/maximal assistance with functional abilities and mobility. The MDS further documented R33 received scheduled and PRN pain medication, an antipsychotic, anticoagulant (class of medication to prevent blood clotting), opioid (medication to treat pain), and hypoglycemic (class of medication used to reduce blood sugar). R33 received an antipsychotic on a routine basis, with no gradual dose reduction (GDR) attempt, and a physician documented that a GDR was clinically contraindicated on 03/19/24. R33's Psychotropic Drug Use Care Area Assessment, dated 11/02/23, documented R33 received an antipsychotic and antianxiety (class of medications that calm and relax people) medication. R33's Care Plan, dated 04/25/24, documented a mood and/or behavior problem. R33 received Abilify (antipsychotic) for a targeted behavior of anger and Ativan (an antianxiety medication) for a targeted behavior of pacing. The care plan further directed staff with behavior management. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Physician Order, dated 01/30/24, directed staff to administer Abilify 15 milligrams (mg) in the morning related to major depressive disorder. The Consultant Pharmacist (CP) review, dated 01/09/24, documented R33 was currently receiving Abilify 15 mg daily for depression and had a diagnosis of dementia. The CP noted that while depression was a Food and Drug Administration (FDA) approved indication for this medication (adjunctive treatment for depression), the use of antipsychotics in this patient population was strongly discouraged given the adverse side effects associated with their use. Periodic risk versus benefit assessments were recommended for continued use. The CP recommended considering a trial reduction to Abilify 10 mg at that time to ensure the lowest effective dose was being utilized and minimize the risk for adverse effects. If no changes were warranted, please provide clinical rationale. The physician responded disagree but did not provide a clinical rationale. The CP Review, dated 03/10/24, documented to consider a trial reduction to Abilify 10 mg daily at that time to ensure the lowest effective dose was being utilized and minimize the risk for adverse effects. If no changes were warranted, please provide a clinical rationale below. The physician responded disagree and noted the patient was stable but did not provide a rationale that addressed the benefits of continued use, and at the same dose, despite the risk. On 07/15/24 at 03:13 PM, observation revealed R33 sitting in the dining room enjoying a second root beer float and music-listening activity. On 07/17/24 at 07:57 AM, Administrative Nurse D stated antipsychotic medication was reviewed with the physician and the physician determined the diagnosis. Administrative Nurse D confirmed the CP had recommended a GDR and risk versus benefit documentation for the use of psychotropic medications. The facility's Unnecessary Medications policy, dated 11/28/17, documented that each resident's drug regimen must be free of unnecessary drugs. An unnecessary drug is any drug when used in excessive doses including duplicate therapy for excessive duration or without adequate monitoring or without adequate indications for this use or in the presence of adverse consequences which indicate the dose should be reduced or discontinued. The facility failed to ensure R33 who had dementia and received an antipsychotic medication had a CMS-approved indication for use and an attempted GDR or the required physician documentation. This placed the resident at risk of receiving unnecessary psychotropic medication and related complications. 32358 - R18's Electronic Medical Record (EMR) documented R18 had diagnoses of major depressive disorder (a major mood disorder that causes persistent feelings of sadness) and dementia (a progressive mental disorder characterized by failing memory, and confusion). R18's Quarterly Minimum Data Set (MDS), dated [DATE], documented R18 had a Brief Interview of Mental Status (BIMS) score of 14, which indicated intact cognition. The MDS documented that R18 received an antipsychotic, antianxiety (class of medications that calm and relax people), and antidepressant (class of medications used to treat mood disorders) medication daily during the observation period. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R18's Care Plan, revised 06/20/24, documented that R18 received Ativan (antianxiety medication) and Haldol (antipsychotic medication). The care plan instructed staff to monitor R18 for signs of depression such as having trouble going to sleep or staying asleep, sleeping all the time, decreased appetite and weight loss, crying, or making statements about not wanting to go on or feeling useless. Staff were to notify the nurse and physician if R18 exhibited these behaviors. The Physician Orders, dated 08/21/23 at 02:00 PM, instructed staff to administer R18 Haldol 1 milliliter (ml) of 2 milligrams (mg) per ml liquid every eight hours PRN for nausea. The order lacked a 14-day stop date. The orders instructed staff to administer Ativan tablet, 1 mg, every four hours PRN without a stop date. On 02/27/24 the Consultant Pharmacist (CP) drug regimen reviews documented R18 currently took Haldol 1 ml of every eight hours PRN with a diagnosis of nausea but per Centers of Medicare and Medicaid Services (CMS) guidelines, only the Food and Drug Administration (FDA) approved indications for schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), Tourette's syndrome (condition of the nervous syndrome causing uncontrollable repetitive movements or unwanted sounds) and Huntington's disease (a rare abnormal hereditary condition characterized by progressive mental deterioration, a disabling central nervous system movement disorder) are allowed for the continued use of antipsychotics in residents with dementia. The physician responded only PRN, no change. On 06/15/24 the CP documented that R18 had an order for PRN Ativan and noted that R18 received hospice services. The CP documented that per CMS regulations for PRN psychotropics medication use greater than 14 days, the prescriber must document a clinical rationale in the medical record for the continuance of the PRN agent and indicate the duration that the medication should be continued. The physician's response did not indicate the duration and rationale for the continued use of Ativan. On 07/15/24 at 03:28 PM, observation revealed R18 sat in a recliner in her room, visited with staff in a polite voice, and had no signs or symptoms of pain. On 06/04/24 at 03:20 PM, Administrative Nurse D verified R18's Ativan lacked a stop date and stated it should have one. Administrative Nurse D verified R18's Haldol had a diagnosis of nausea and stated the resident received hospice services and their standing orders had Haldol with a diagnosis of nausea. The facility's Unnecessary Medications Policy, revised 11/28/17, documented that antipsychotic medications are indicated for the treatment of schizophrenia, Tourette's syndrome, and Huntington's disease. The use of antipsychotic medications for any other diagnosis must include physician documentation of the rationale. The facility failed to ensure a 14-day stop date as required for R18's PRN antipsychotic, Haldol. The facility further failed to place a stop date or a physician rationale for extended use with a specified duration on R18's PRN Ativan. This placed the resident at risk for unnecessary psychotropic medications.