STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175184	A. Building B. Wing	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pinnacle Park Nursing & Rehab Center	2936 Georgia Avenue Salina, KS 67401

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and record review, the facility failed to ensure Resident (R) 3 had a physician's order and was assessed for the ability to safely self-administer medications left at the bedside. Findings included: -R3's Electronic Medical Record (EMR) documented diagnoses of major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), hemiplegia (paralysis of one side of the body) and a need for assistance with personal care. R3' s Quarterly Minimum Data Set dated 05/23/26, documented R3 had intact cognition, functional range of motion impairment on one side of the upper and lower extremities, and was dependent on staff for dressing, personal and toileting hygiene, transfers, and bed mobility. R3 was frequently incontinent of urine and bowel. R3's Care Plan dated 06/08/26, documented R3 needed assistance with activities of daily living related to hemiplegia and hemiparesis (weakness and paralysis on one side of the body) following a cerebrovascular disease (any abnormal condition characterized by dysfunction of the heart and blood vessels) affecting the left dominant side. The plan directed staff to transfer R3 using a sit-to-stand lift and two staff members. The Physician Orders directed staff to administer numerous morning medications. On 06/09/26 at 09:30 AM, Licensed Nurse (LN) J prepared R3's morning medication. R3 had been transferred from her electric wheelchair to her recliner. LN J placed the morning medication in a small wooden bowl on the overbed table. LN J reported R3's preference to use a bowl because R3 was able to place the medications into her mouth. R3 took her medications, one pill at a time, followed by a drink of water. On 06/10/26 at 09:28 AM, R3 was sitting in her room in an electric wheelchair. R3 reported she could not reach the bowl of medications placed on the overbed table because the electric wheelchair had lost battery function. R3's wooden bowl had several medications of different sizes and shapes, which were out of reach of the resident, and staff were not present in the room. On 06/10/26 at 09:30 AM, Administrative Nurse D reported LN H was R3's nurse for the shift. LN H stated she thought R3 could reach the medications she left in the bowl but had not stayed in the room while R3 had finished taking the medications. On 06/10/26 at 11:57 AM, Administrative Nurse D stated that LN H should not have left R3's medications in the room. The facility's Resident Self-Administration of Medication policy, dated 2026, documented that a resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely. The results of the interdisciplinary team assessment are recorded on the Medication Self-Administration Assessment Form, which is placed in the resident's medical record. Upon notification of the use of bedside medication by the resident, the medication nurse records the self-administration on the medication administration record.

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

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

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews, the facility failed to ensure Resident (R) 7 had an appropriate indication, or a documented physician rationale which included the multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the continued use of an antipsychotic (class of medications used to treat mental disorder characterized by a gross impairment in reality testing). Findings included:- R7's Medical Diagnosis tab of the Electronic Medical Record (EMR) documented diagnoses of cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), dementia (a progressive mental disorder characterized by failing memory and confusion) with agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition), vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), mood disorder (category of mental health problems, feelings of sadness, helplessness, guilt, and wanting to die were more intense and persistent than what may normally be felt from time to time), and major depressive disorder (major mood disorder that causes persistent feelings of sadness).R7's Significant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) Score of 12, which indicated moderately impaired cognition. R7 received an antipsychotic medication during the look back period. A gradual dose reduction (GDR) was last attempted on 08/25/25. The physician documented a GDR was clinically contraindicated on 01/19/26.R7's Psychotropic Drug Use Care Area Assessment (CAA) dated 03/03/26 documented R7 triggered for psychotropic drug use related to taking an antipsychotic medication for mood disorder and adjunct to depression per review.R7's Care Plan regarding psychotropic medications, initiated on 01/04/24, directed staff to: Administer psychotropic medications as ordered by the physician; behavior monitoring for risperidone (an antipsychotic medication); Consult with the pharmacy and physician to consider dosage reduction when clinically appropriate at least quarterly; discuss with the physician and family about the ongoing need for the use of the medications. Review behaviors and interventions and alternate therapies attempted and their effectiveness as per facility policy; educate me/my family/my caregivers about risks, benefits and the side effects and/or toxic symptoms of psychotropic medication drugs being given; do a gradual dose reduction as ordered; Monitor/document/report as needed (PRN) any adverse reactions of psychotropic medications: unsteady gait, tardive dyskinesia (an abnormal condition characterized by involuntary repetitive movements of the muscles of the face, limbs, and trunk), extrapyramidal symptoms (EPS-movement disorders as a result of taking certain medications) (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia (inability to sleep), loss of appetite, weight loss, muscle cramps nausea, vomiting, or behavior symptoms not usual to the person.R7's Care Plan for psychotropic medications had not been revised with new interventions or any non-pharmacological approaches tried.R7's Orders tab in the EMR documented a physician's order dated 01/29/24 for risperidone (antipsychotic0 0.25 milligrams (mg) by mouth two times daily for mood disorder. This order was discontinued on 08/25/25.R7's Orders tab in the EMR documented a physician's order dated 08/25/25 for risperidone 0.25 mg by mouth two times daily for mood disorder. This order was discontinued 08/26/25.R7's Orders tab in the EMR documented a physician's order dated 08/25/25 for risperidone 0.25 mg by mouth in the morning for agitation and give 0.5 mg by mouth at bedtime for agitation. This order was discontinued 08/26/25.R7's Orders tab in the EMR documented a physician's order dated 08/26/25 for risperidone 0.25 mg by mouth in the morning for mood disorder and give 0.5 mg by mouth at bedtime for mood disorder. This order was discontinued on 02/24/26.R7's Orders tab in the EMR documented a physician's order dated 02/24/26 for risperidone (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	0.25 mg by mouth in the morning and give 0.5.mg at bedtime for adjunct to depression. This order was discontinued on 03/03/26.R7's Orders tab in the EMR documented a physician's order dated 03/03/36 for risperidone 0.25 mg by mouth in the morning and give 0.5.mg at bedtime for adjunct to depression. This order was discontinued on 04/29/26.R7's Orders tab in the EMR documented a physician's order dated 03/29/26 for risperidone 0.25 mg by mouth in the morning for psychosis (any major mental disorder characterized by a gross impairment in reality perception) with delusions and give 0.5 mg by mouth at bedtime for psychosis with delusions.R7's Orders tab in the EMR documented a physician's order dated 03/29/26 for risperidone 0.25 mg via percutaneous endoscopic gastrostomy tube (PEG -a tube surgically placed through an artificial opening into the stomach) in the morning for psychosis with delusions and give 0.5 mg by PEG tube at bedtime for psychosis with delusions. This order was discontinued on 05/21/26.R7's Orders tab in the EMR documented a physician's order dated 03/29/26 for risperidone 0.25 mg by mouth in the morning for psychosis with delusions and give 0.5 mg by mouth at bedtime for psychosis with delusions.R7's Misc tab in the EMR noted a Note to Attending Physician/Provider dated 01/07/26 that documented the resident had an order for risperidone that did not have and FDA-labeled indication. Please review and complete the Risk-Benefit Assessment since the order has a non-FDA -labeled indication. The physician's response dated 01/19/26 indicated the risperidone was given for mood disorder. The order was prescribed for a diagnosed condition and not being used for convenience or discipline. The risperidone was clinically indicated to manage the resident's symptoms or condition where other causes had been ruled out. The residents signs, symptoms, or related causes were persistent or clinically significant enough to warrant the initiation or continuation of medication therapy. The intended or actual benefit was sufficient to justify the potential risk(S) or adverse consequences associated with the medication dose and duration.R7's Misc tab in the EMR noted a Note to Attending Physician/Provider dated 02/10/2026 documented the resident had an order of risperidone 0.25 mg every day and 0.5 mg at bedtime that did not have and FDA-labeled indication. Please assess the resident for a GDR of the risperidone. The physician's response dated 02/16/2026 documented the risperidone's indicated use was for mood disorder. The resident had been assessed, and a GDR was contraindicated because the order had been effective at alleviating the behavioral symptoms that can present a risk of harm to the resident or others, and it was not being prescribed for discipline or staff convenience.On 06/09/2026, R7 sat at a table in the dining room eating his breakfast. R7 received his medications crushed in applesauce by the medication aide. R7 took the medication without rejection or behavior.On 06/10/2026 at 11:54 AM, Administrative Nurse E stated R7 had been on risperidone prior to his admission to the facility. The facility has worked with the physicians and pharmacy to ensure that R7 was not given risperidone for an inappropriate indication for use. Administrative Nurse E stated the most recent diagnosis used had been psychosis, and the physician thought that was an appropriate and approved diagnosis for `. Administrative Nurse E stated that no non-pharamalogical interventions had been tried for R7.On 06/10/2026 at 12:01 PM, Administrative Nurse D stated that the facility held monthly pharmacy consultation meetings with the pharmacist and medical director to go over the psychotropic medications and indications for continued use. The facility had not tried non-pharmacological approaches for R7. Administrative Nurse D stated it had been discussed about the need for the appropriate indication for use of antipsychotics, and the physician indicated that psychosis was an appropriate indication for use. The facility's Use of Psychotropic Medication(s) dated 2025 documented it was the intent of the policy to ensure that residents only receive psychotropic medications when other non-pharmacological interventions were clinically contraindicated. Psychotropic medication was to be used only when a practitioner determined that the medication was appropriate to treat a resident's specific, diagnosed, and documented condition and the medication would be beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medications. Non-pharmacological approaches must be attempted, unless contraindicated, to minimize the need for psychotropic medications, use the lowest dose possible, or (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discontinue the medications. The policy lacked information on an appropriate indication for the use of psychotropic medications.

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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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to prevent injury when a Certified Nurse Aide (CNA) provided footcare to Resident (R) 13, who had a diagnosis of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), and received a cut to her left great toe. Findings included:- The Electronic Medical Record (EMR) documented R13 had a diagnosis of type 2 DM.R13's Quarterly Minimum Data Set (MDS), dated [DATE], documented R13 had intact cognition. She was dependent upon staff for toileting, lower body dressing, putting on her shoes, mobility, and transfers. It was documented R13 received insulin daily.R13's Quarterly MDS, dated 04/29/2026, documented that R13 had intact cognition. She was dependent upon staff assistance for toileting, showers, lower-body dressing, mobility, and did not ambulate. It was documented R13 received insulin daily.R13's 06/09/2026 Care Plan had interventions dated 09/16/2020, that instructed staff to check R13's body for breaks in the skin and to treat them promptly as ordered by the physician. Staff were not to use over-the-counter remedies for foot corns (a small, hardened cone of thickened skin that typically forms on the tops, sides, or between toes due to friction and pressure) and calluses, and they were to refer R13 to a podiatrist (foot doctor) for treatment. Staff were further instructed to educate caregivers that nails were to always be cut straight across, they were never to cut the corners, and were to file the edges with an emery board. Finally, staff were to inspect R13's feet daily for open areas, sores, pressure areas, blisters, edema, or redness. The 03/04/2026 at 08:42 PM Nurse's Note, documented R13 reported that a CNA cut her toenails. The left great toe was bloody on the left side of the nail, and a small piece of skin had been cut off. The note further documented that the area was cleansed with wound cleanser, a band aid was applied, and staff would notify the wound nurse for further treatment orders.The EMR lacked documentation of a wound assessment or that the physician had been notified.On 06/09/2026 at 09:00 AM, R13 sat in her wheelchair in front of the television. She stated she did not have any concerns with her toenails, and the facility made sure a nurse cut her toenails.On 06/09/2026 at 01:00 AM, Licensed Nurse (LN) G stated she was the wound care nurse and was unaware that a CNA had cut R13's skin when providing foot care. LN G further stated that R13 was diabetic, and CNAs were not to have provided any type of foot care to R13.On 06/10/2026 at 10:43 AM, CNA M stated that the Assistant Director of Nursing (ADON) usually provided the foot care for residents and that, as a CNA, she was not to have provided any type of nail care to residents who were diabetic.On 06/10/2026 at 12:03 PM, Administrative Nurse D stated CNAs should not have provided nail care to diabetic residents, and the physician should have been made aware of the injury R13 had received.The facility's Footcare policy, dated 2025, documented that the facility ensured residents received proper treatment and care within professional standards of practice as applicable to maintain mobility and good foot health. As needed, a licensed nurse with adequate training may perform nail care to non-diabetic residents or diabetic residents who are low risk, as determined by a podiatrist or physician. Nursing assistants would inspect skin during baths and would report any concerns to the residents' nurse immediately after the task.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to hold blood pressure medication, per the physician-ordered parameters, for Resident (R) 13. Findings included:- R13's Electronic Medical Record (EMR) documented diagnoses of hypertension (high blood pressure), atrial fibrillation (rapid, irregular heartbeat), and diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin) type 2.The Annual Minimum Data Set (MDS), dated [DATE], documented R13 had intact cognition. R13 was dependent upon staff assistance for toileting, transfers, and lower-body dressing. R13 required substantial staff assistance with showers, personal hygiene, and upper body dressing.The Quarterly MDS, dated 04/29/26, documented that R13 had intact cognition. R13 was dependent upon staff assistance for toileting, showers, lower-body dressing, mobility, and did not ambulate.R13's 06/09/2026 Care Plan included the following interventions for R13:10/05/2020- Give medications as ordered and monitor for side effects such as orthostatic hypotension (blood pressure dropping with change of position), increased heart rate, monitor for and document edema (swelling resulting from an excessive accumulation of fluid in the body tissues), and monitor for abnormalities of urinary output.The Physician's Order, dated 08/28/25, directed staff to administer metoprolol (a high blood pressure medication), 37.5 milligrams (mg), one tablet by mouth twice daily for hypertension. Hold the medication if the systolic blood pressure (SBP-the top number, the force your heart exerts on the walls of your arteries each time it beats) is less than 100 millimeters of mercury (mmHg), and the heart rate (the number of times your heart beats in one minute) is less than 60 beats per minute (bpm).R13's Treatment Administration Record (TAR) for April 2026 documented the following days R13 received the metoprolol when the heart rate was under the ordered parameters:04/01/2026- 57 bpm04/04/2026- 59 bpm04/18/2026- 58 bpmR13's TAR, for May 2026, documented the following days R13 received the metoprolol when the heart rate was under the ordered parameters:05/03/2026- 55 bpm05/10/2026- 54 bpm05/24/2026- 57 bpmOn 06/10/2026 at 10:00 AM, Licensed Nurse (LN) I stated that if the heart rate was below 60 bpm, the staff would hold the medication and document it in the progress notes. LN I verified that there were days R13 received the metoprolol when it should have been held.On 06/10/2026 at 12:03 PM, Administrative Nurse D stated the order should have been clarified as the order was not clear as to whether it should have been held when both the SBP and the heart rate were out of parameters. Administrative Nurse D stated she could understand why the medication was held sometimes when the heart rate was out of parameters and administered at other times. Administrative Nurse D further verified that staff were to follow the physician's orders and hold medication when out of parameters.The facility's Medication Administration policy, revised in 2025, documented that the medications were administered as ordered by the physician and in accordance with professional standards of practice. Staff obtain and record vital signs when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters.