STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175228	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lansing Care and Rehab	210 Plaza Drive Lansing, KS 66043

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 58 residents. The sample included 16 residents, with three reviewed for dignity and respect. Based on observation, record review, and interviews, the facility failed to provide a dignified care environment for Residents (R) 21 and R18. Findings Included:- R21's Electronic Medical Records (EMR) included diagnoses of quadriplegia (inability to move the arms, legs, and trunk of the body below the level of an associated injury to the spinal cord), type two diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and major depressive disorder (major mood disorder). R21's Quarterly Minimum Data Set (MDS) completed 08/19/25 indicated a Brief interview for Mental Status (BIMS) score of 15 (intact cognition). The MDS noted bilateral upper or lower extremity impairments. The MDS noted she used a wheelchair for mobility. The MDS noted she was dependent on staff assistance with toileting, bathing, transfers, bed mobility, personal hygiene, and dressing. The MDS noted no behavioral concerns. R21's Functional Abilities Care Area Assessment (CAA) completed 05/28/25 indicated she required total staff dependence for her activities of daily living (ADL). The CAA noted she was at risk for falls, skin breakdown, impaired nutrition, and pain related to her medical diagnoses. The CAA noted that a care plan was implemented to minimize her risks. R21's Care Plan initiated 06/24/24 indicated she required staff assistance with her ADLs. The plan noted she needed substantial to maximal assistance with bathing, toileting, dressing, personal hygiene, and transfers. The plan indicated she required at least two staff members in her room for any interactions due to the potential for false statements by other staff. The plan noted she had a history of making allegations towards staff (09/27/24). The Facility Incident Report #1090 completed on 09/23/25 indicated Certified Nurse's Aide (CNA) N entered R21's room on 09/18/25. The report indicated R21 asked CNA N why he was in her room. R21 stated in the report, CNA N replied, It's none of your fucking business. The report indicated CNA N was immediately suspended (pending investigation). The report indicated R10 (R21's roommate) witnessed the incident but denied that CNA N used abusive language. The report indicated that CNA N admitted to saying, it's none of your business upon talking to both residents. The report indicated CNA N was provided training related to resident rights, communication, and abuse prevention. (continued on next page)

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/24/25 at 11:36 AM, Certified Medication Aide (CMA) R stated that staff were expected to knock and introduce themselves before entering the resident's rooms. CMA R stated staff should never just enter a room without the resident's permission. She stated that staff were to always speak in a respectful manner. On 09/24/25 at 12:36 PM, Administrative Nurse D stated that staff were expected to always be respectful and provide care that promoted dignity to all residents. She stated that all staff are trained on dementia care, resident rights, and abuse. The facility's Resident Rights policy, revised 10/2022, indicated the facility was to ensure all residents were treated in a dignified manner. The policy indicated the facility was to provide ongoing education and In-service. - R18's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of hypertension (HTN- elevated blood pressure), hyperlipidemia (condition of elevated blood lipid levels), 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), fracture of left pubic ramus fracture (a break or crack in the pelvis bones), diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), dysphagia (swallowing difficulty), and aphasia (condition with disordered or absent language function). The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of zero, which indicated severely impaired cognition. The MDS documented that R18 was rarely or never understood. The MDS documented R18 was dependent on all activities of daily living (ADL) except eating. R18 needed substantial to maximal assistance from staff. R18's Nutritional Status Care Area Assessment (CAA) dated 12/12/24 documented R18 was a long-term guest at the facility. The CAA documented R18 had diagnoses of stroke, DM, aphasia, and HTN. The CAA documented R18 was alert to himself and did not speak much, and would sometimes answer yes or no to the appropriate question. The CAA documented R18 was incontinent of bowel and bladder. The CAA documented R18 was dependent on staff for all ADLs and utilized a staff-propelled Broda chair (specialized wheelchair with the ability to tilt and recline) for locomotion. The CAA documented R18 had contractures (abnormal permanent fixation of a joint or muscle) in his bilateral lower extremities, and does not participate in facility activities, nor does he socialize with anyone. The CAA documented R18 would sleep most of the day, and he had a fall during the lookback period without injury. R18's Care Plan was revised on 09/15/25. R18's plan of care had nutritional risks related to swallowing difficulty and self-feeding difficulty. R18's plan of care documented that the staff were to provide adaptive equipment. R18's plan of care documented staff would utilize a plate guard or divided plate and built-up silverware during mealtimes as needed. The plan of care for R18 documented staff would provide set-up and assistance with meals and snacks. The plan of care for R18 documented R18's abilities would vary regarding his feeding himself; staff were to put food on his spoon, and he would generally feed himself. The plan of care for R18 documented that the staff were to give encouragement to R18, and he would feed himself. On 09/22/25 at 08:33 AM, R18 sat at the breakfast table with his peers. Certified Nurse's Aide (CNA) E stood over R18 and gave him a spoonful of his ground meat. R18's bare abdomen and right side were visible to his peers. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/23/25 at 08:47 PM, R18 sat at the breakfast table with his peers. Administrative Staff F stood over R18, feeding him his breakfast. On 09/24/25 at 11:36 AM, CNA R stated staff should sit by the resident and never tower over a resident when assisting the resident with eating. She stated that residents' skin should be covered when the residents were in the dining area. On 09/24/25 at 11:45 AM, Licensed Nurse G stated staff should sit by the resident, converse with the resident, offer the resident drinks between bites, but never stand to assist a resident with eating. She stated all residents should have their skin covered when in the dining room. On 09/24/25 at 11:55 AM, Administrative Nurse D stated that staff should sit by the resident, never stand while assisting the resident with eating. She stated that a resident's abdomen should be covered while in the dining room. The facility's Respect and Dignity policy, revised 10/2022, documented that residents have the right to be treated with respect and dignity, including the right to retain and use personal possessions, including furnishing and clothing, as space permits, unless to do so would infringe upon the rights and safety of other residents. Residents' possessions, regardless of their apparent value to others, would be treated with respect.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility identified a census of 58 residents. The sample included 16 residents, with two reviewed for abuse and neglect. Based on observation, interview, and record review, the facility failed to prevent staff-to-resident verbal and emotional abuse of Resident (R) 44. Findings Included:- R44's Electronic Medical Records (EMR) included diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), muscle weakness, repeated falls, and the need for assistance with personal care. R44's Quarterly Minimum Data Set (MDS) completed 06/14/25 indicated a Brief interview for Mental Status (BIMS) score of zero (severe cognitive impairment). The MDS noted bilateral upper or lower extremity impairments. The MDS noted she used a wheelchair for mobility. The MDS noted she was dependent on staff assistance for toileting, bathing, transfers, bed mobility, personal hygiene, and dressing. The MDS noted no behavioral concerns. R44's Functional Abilities Care Area Assessment (CAA) completed 12/21/24 indicated she required staff assistance to complete her activities of daily living (ADL). The CAA noted she could verbalize her needs and answer yes and no questions. The CAA noted she displayed behaviors of yelling out and withdrawing from social activities. The CAA noted that a care plan was implemented to minimize risks.R44's Care Plan initiated 09/24/24 indicated she required staff assistance with her ADLs. The plan noted she was dependent on staff assistance with bed mobility, bathing, toileting, dressing, personal hygiene, and transfers. The plan indicated R44 was dependent on staff for activities, cognitive stimulation, and social interactions. The plan instructed staff to provide activities that were compatible with her mental and physical capabilities. The plan instructed staff to provide structured daily routines and familiarity. The plan instructed staff to provide positive feedback and emphasize her positive behavior aspects. The Facility Incident Report #8280 completed on 08/12/25 indicated Certified Nurse's Aide (CNA) O observed CNA P use abusive language towards R44. The report indicated that on 08/12/25, around 05:00 PM, CNA P told R44 Let go of the bear dummy, as she took R44's bear away from R44 against her wishes. The report indicated CNA P then told R44, You ripped it, dummy, after pulling it away from her. The report indicated that CNA O reported the incident, and CNA P was immediately suspended and terminated. The report indicated R44 was immediately assessed with no injury or change in mood. The report indicated R44's bear was her coping mechanism for calming down. On 09/23/25 at 09:45 AM, R44 sat in the day room area. She was clean and well-groomed. On 09/24/25 at 11:36 AM, Certified Medication Aide (CMA) R stated that staff were expected to treat all residents in a kind and respectful manner. She stated that staff were expected to work toward comforting and caring for the residents in their care. She stated the facility provided frequent training related to abuse, resident rights, and communication. On 09/24/25 at 12:36 PM, Administrative Nurse D stated that staff were expected to always be respectful and provide care that promoted dignity to all residents. She stated that all staff are trained on dementia care, resident rights, and abuse.The facility's Abuse, Neglect, and Exploitation policy, revised 08/2024, documented that the resident has a right to be free from verbal, sexual, physical, and mental abuse and involuntary seclusion. The policy indicated it was the responsibility of the facility to treat each resident with respect, kindness, dignity, and care, to keep them free from abuse and neglect, and to take swift action to investigate and adjudicate alleged resident abuse and neglect. Mental abuse includes, but is not limited to, verbal or non-verbal conduct which causes or has the potential to cause humiliation, intimidation, fear, shame, agitation, degradation, harassment, or threats of punishment or deprivation. The policy indicated that all staff were to be educated to identify, prevent, and intervene when potential abuse was identified. The facility identified, implemented, and completed the following corrective actions related to the incident:The facility screened all the affected residents on 08/12/25. The facility assessed R44 for psychosocial trauma from the incident on 08/12/25. CNA P was immediately suspended, terminated, and reported to the investigative agencies on 08/12/25. All staff were educated on Abuse, Neglect, and Exploitation on 08/30/25.The facility will monitor and provide ongoing education through the Quality Assurance and Performance Improvement program (QAPI) team. This deficient practice was deemed past non-compliance when the facility completed the corrective actions on 08/30/25, prior to the surveyor entering the facility.

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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** The facility identified a census of 58 residents. The sample included 16 residents, with six residents reviewed for unnecessary medications. Based on observation, interviews, and record review, the facility failed to ensure 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) for Resident (R) 27, who had a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion). Findings included:- R27's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of dementia, repeated falls, muscle weakness, 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 Significant Change Minimum Data Set (MDS) dated 09/20/24 documented she had severely impaired cognition. The MDS documented R27 had received a diuretic (a medication to promote the formation and excretion of urine) medication, antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication, antidepressant (a class of medications used to treat mood disorders) medication, and antianxiety (a class of medications that calm and relax people) medication during the observation period. The Quarterly MDS dated [DATE] documented she had severely impaired cognition. The MDS documented that R27 received antipsychotic medication and antidepressant medication during the observation period. R27's Psychotropic Drug Use Care Area Assessment (CAA) dated 10/08/25 documented she received antipsychotic medications. The plan of care documented R27's medication was reviewed monthly by the pharmacist, and the physician reviewed any recommendations made by the pharmacist. R27's Care Plan, dated 03/27/21, documented the nursing staff would administer her medications as ordered. R27's EMR under the Orders tab revealed the following physician orders:Haloperidol (antipsychotic) oral tablet 1 milligram (mg), give one tablet by mouth in the afternoon for auditory and visual hallucinations, dated 02/18/25. Seroquel (antipsychotic) oral tablet 50 mg (Quetiapine Fumarate), give 1.5 tablets by mouth two times a day for anxiousness, dated 05/29/25. The facility provided an unsigned Consent for Use of Psychoactive Medication Therapy form, which lacked the physician documentation for the physician's rationale, which included the multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the continued use of an antipsychotic medication for R27, who had a diagnosis of dementia. The facility was unable to provide physician documentation upon request. On 09/23/25 at 11:11 AM, R27 sat in her wheelchair in her room. R27's eyes were closed. On 09/24/25 at 11:55 AM, Administrative Nurse D stated the facility had purchased the preprinted consent forms. Administrative Nurse D stated R27 was on hospice services, and the family wanted her to continue to receive the antipsychotic medication. The facility's Use of Psychotropic Drugs policy, last revised 04/2025, documented residents would only receive psychotropic or other approved medications that have an effect on brain activity when necessary to treat specific conditions for which they are indicated and effective, and would not be used for discipline or the convenience of the staff. Residents and/or their representative have the right to refuse such treatment.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition The facility identified a census of 58 residents. The sample included 16 residents, with three residents reviewed for hospice. Based on observation, interviews, and record review, the facility failed to complete a significant change in the physical condition and complete a comprehensive Significant Change Minimum Data Set (MDS) for Resident (R) 22 with the addition of hospice services. Findings included:- R22's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid), diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), and gastroesophageal reflux (GERD- backflow of stomach contents to the esophagus). The Significant Change MDS initiated on 08/28/25 was not completed for R22's admission on to hospice services. R22 was admitted to hospice services on 08/15/25. R22's Care Area Assessment (CAA) was not completed in the 14 days required after the Significant Change MDS was started on 08/25/25. R22's Care Plan dated 08/28/25 documented the facility would consult with the physician and social services to have hospice care for R22 in the facility. The plan of care documented the hospice provider would provide nurse services two times a week and a certified nurse aide two times a week. R22's EMR lacked an order for admission for hospice services. The facility provided an order printed on the hospice provider's certification form dated 05/15/25. On 09/23/2025 at 02:56 PM, R22 propelled her wheelchair down the hallway from her room to the common area. On 09/24/25 at 09:54 AM, Administrative Nurse F stated she had not completed the Significant Change MDS related to R22's admission on to hospice services. Administrative Nurse F stated she was behind in completed the MDS because she provides care for the residents. On 09/24/25 at 11:55 AM, Administrative Nurse D stated Administrative Staff A and the corporate office staff in charge of MDS's were responsible to ensure the MDS were completed as required by Centers for Medicare & Medicaid Services (CMS). The facility was unable to provide a policy related to the required timing for MDS completion upon request on 09/24/25.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 58 residents. The sample included 16 residents. One resident was sampled for accidents and hazards. Based on observation, interviews, and record review, the facility failed to provide Resident (R) 18's fall interventions as directed by his care plan. Findings included:- R18's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of hypertension (HTN- high blood pressure), hyperlipidemia (condition of elevated blood lipid levels), 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), fracture of left pubic ramus fracture (a break or crack in the pelvis bones), diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), dysphagia (swallowing difficulty), and aphasia (condition with disordered or absent language function). The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of zero, which indicated severely impaired cognition. The MDS documented that R18 was rarely or never understood. The MDS documented R18 was dependent on all activities of daily living (ADL) except eating and needed substantial/maximal assistance from staff. The MDS documented R18 had no falls during the observation period.R18's Falls Care Area Assessment (CAA) dated 12/12/24 documented that R18 was alert to himself and did not speak much, and would sometimes answer yes or no to the appropriate question. The CAA documented R18 was incontinent of bowel and bladder. The CAA documented R18 was dependent on staff for all ADLs and utilized a staff-propelled Broda chair (specialized wheelchair with the ability to tilt and recline) for locomotion. The CAA documented R18 had contracture (abnormal permanent fixation of a joint or muscle) in his bilateral lower extremities, and did not participate in facility activities, nor did he socialize with anyone. The CAA documented R18 would sleep most of the day, and he had a fall during the lookback period without injury. R18's CAA documented he was at risk for further cognitive deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness) decline, decline in ADL function, isolation, depression, falls, fall-related injuries, weight loss/gain, impaired skin integrity, and unmanaged pain. The CAA for R18 documented staff would care plan R18's risks. R18's Care Plan dated 02/23/23 documented R18 was at risk for falls, due to gait/balance problems, incontinence, and unaware of safety needs. R18's plan of care dated 01/31/24 documented a larger bed was provided to provide more comfort and a larger surface area. The plan of care for R18 documented staff were to ensure the floor next to his bed was free from clutter and objects that may cause injury. R18's plan of care dated 04/29/25 documented staff would place additional pillows in R18's room to assist with more comfortable positioning. R18's plan of care dated 10/13/24 documented that the staff were to place R18's bed in the lowest position, and staff were to ensure a fall mat was in place, next to R18's bed. On 09/22/25 at 07:39 AM, R18 laid in bed on his back. R18's pancake call light laid at the bottom of his bed. R18's call light was out of his reach.On 09/23/25 at 09:37 AM, R18 laid in his bed, which was at the lowest position. R18's floor mat was folded up next to his Broda chair. R18's fall mat was not next to his bed. On 09/24/25 at 11:36 AM, Certified Medication Aide (CMA) R stated that call lights were placed within reach of the residents, and mats should be applied to the floor when the residents were laid down after breakfast.On 09/24/25 at 11:45 AM, Licensed Nurse (LN) G stated that call lights should be placed where the resident can reach them. She stated if a resident needed a floor mat, it should be placed beside the bed. On 09/24/25 at 11:55 AM, Administrative Nurse D stated that call lights should be within the reach of the resident, and the fall mats should be placed by the bed as ordered. The facility's Accidents policy, revised 08/22, documented the facility strived to make the environment as free from accident hazards as possible. Resident safety, supervision, and assistance to prevent accidents were facility-wide priorities.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 58 residents. The sample included 16 residents, with six residents reviewed for unnecessary medications. Based on observation, interviews, and record review, the facility failed to ensure the Consultant Pharmacist (CP) had identified and reported irregularities for Resident (R) 22. Findings included:- R22's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid), diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), and gastroesophageal reflux (GERD- backflow of stomach contents to the esophagus). The Annual Minimum Data Set (MDS) dated 12/21/24 documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R22 had received insulin (medication to regulate blood sugar), a diuretic (a medication to promote the formation and excretion of urine), and an antidepressant (a class of medications used to treat mood disorders) during the observation period. The Quarterly MDS dated [DATE] documented a BIMS score of 15, which indicated intact cognition. The MDS documented that R22 had received insulin, diuretic medication, and antidepressant medication during the observation period. R22's Psychotropic Drug Use Care Area Assessment (CAA) dated 01/07/25 documented she had received antidepressant medication for mood management. R22's medication would be followed by the pharmacist monthly, and the recommendations would be reviewed by the physician for further review. R22's Care Plan dated 01/23/24 documented the facility would administer her medication as ordered by the physician. The plan of care documented the facility would monitor R22 for side effects and document the effectiveness. R22's EMR under the Orders tab revealed the following physician orders:Reglan (antiemetic-prevents vomiting) tablet, five milligrams (mg) (Metoclopramide HCl), give one tablet by mouth before meals for nausea, dated 08/15/25. Review of the Monthly Medication Review (MMR) from August 2025 and September 2025 lacked documentation of the recommendations for an Abnormal Involuntary Movement Scale (AIMS) test to monitor for adverse effects from Reglan. The facility was unable to provide an AIMS test upon request. On 09/23/25 at 02:56 PM, R22 propelled her wheelchair down the hallway from her room to the common area. On 09/24/25 at 11:45 AM, Licensed Nurse (LN) G stated the administrative nurse would take care of the MMRs. LN G stated she did complete AIMS testing for the residents. LN G stated a User-Defined Assessment (UDA) would pop up in the resident's EMR when that assessment was due. On 09/24/25 at 11:55 AM, Administrative Nurse D stated the CP would email the MMRs to her and the unit manager monthly. Administrative Nurse D stated the CP should have identified R22's lack of an AIMS test. Administrative Nurse D stated she had notified the CP that R22 should have had an AIMS test completed related to the medication Reglan. Administrative Nurse D stated she had notified their corporate office to initiate a UDA to trigger to be completed as needed. The facility's Consultant Pharmacist Services policy last revised 06/01/24 documented the facility would provide the pharmacy with adequate workspace, access to the residents' complete medical records (including electronic health records, if used), ability to enter documentation/progress notes in the resident's medical record (including electronic health records) when deemed as an expectation by facility, an appropriate environment for resident and family interviews, and important resident information.

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	175228	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lansing Care and Rehab	210 Plaza Drive Lansing, KS 66043

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

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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** The facility identified a census of 58 residents. The sample included 16 residents, with six residents reviewed for unnecessary medications. Based on observation, interviews, and record review, the facility failed to ensure an Abnormal Involuntary Movement Scale (AIMS) test to monitor for adverse effects from the medication Reglan (antiemetic-prevents vomiting) for Resident (R) 22. Findings included:- R22's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid), diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), and gastroesophageal reflux (GERD- backflow of stomach contents to the esophagus). The Annual Minimum Data Set (MDS) dated 12/21/24 documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R22 had received insulin (medication to regulate blood sugar), a diuretic (a medication to promote the formation and excretion of urine), and an antidepressant (a class of medications used to treat mood disorders) during the observation period. The Quarterly MDS dated [DATE] documented a BIMS score of 15, which indicated intact cognition. The MDS documented that R22 had received insulin, diuretic medication, and antidepressant medication during the observation period. R22's Psychotropic Drug Use Care Area Assessment (CAA) dated 01/07/25 documented she had received antidepressant medication for mood management. R22's medication would be followed by the pharmacist monthly, and the recommendations would be reviewed by the physician for further review. R22's Care Plan dated 01/23/24 documented the facility would administer her medication as ordered by the physician. The plan of care documented the facility would monitor R22 for side effects and document the effectiveness. R22's EMR under the Orders tab revealed the following physician orders:Reglan (antiemetic) tablet, five milligrams (mg) (Metoclopramide HCl), give one tablet by mouth before meals for nausea, dated 08/15/25. The facility was unable to provide an AIMS test or any other method of monitoring for side effects upon request. On 09/23/2025 at 02:56 PM, R22 propelled her wheelchair down the hallway from her room to the common area. On 09/24/25 at 11:45 AM, Licensed Nurse (LN) G stated the administrative nurse would take care of the MMRs. LN G stated she did complete AIMS testing for the residents. LN G stated a User-Defined Assessment (UDA) would pop up in the resident's EMR when that assessment was due. On 09/24/25 at 11:55 AM, Administrative Nurse D stated she had notified their corporate office to initiate a UDA to trigger to be completed as needed. Administrative Nurse D stated the AIMS test did not trigger for R22's Reglan because it did not fall under the psychotropic medication class. The facility was unable to provide a policy related to monitoring medication side effects upon request on 09/24/25.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. The facility identified a census of 58 residents. The sample included 16 residents, with one medication room, three medication carts, and two treatment carts. Based on observation, interviews, and record review, the facility failed to appropriately store medications and biologicals when staff failed to ensure the medication carts were always locked when the cart was not within the nurses' line of sight. Findings included:- On 09/22/25 at 07:33 AM, the treatment cart containing residents' treatment supplies, as-needed (PRN) creams, and insulin (hormone medication used to lower blood glucose) pens was unlocked. The cart was in the 200 Hall, and the Administrative Nurse E locked the medication cart. On 09/24/25 at 11:45 AM, Licensed Nurse (LN) G stated that medication carts and treatment carts should be locked if the staff have stepped away and were out of their visual sight. On 09/24/25 at 11:55 AM, Administrative Nurse D stated that medication carts and treatment carts should be locked if the LN or Certified Medication Aide (CMA) could not see the cart.The facility's Storage of Medication policy, revised 10/2024, documented that the facility would store all drugs and biologicals in a safe, secure, and orderly manner.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. The facility identified a census of 58 residents. The sample included 16 residents, with three residents reviewed for hospice services. Based on observation, interviews, and record review, the facility failed to provide a description of the medication and equipment provided to Resident (R) 22 by hospice. Findings included:- R22's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid), diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), and gastroesophageal reflux (GERD- backflow of stomach contents to the esophagus).The Significant Change Minimum Data Set (MDS) initiated on 08/28/25 was not completed for R22's admission into hospice services. R22 was admitted to hospice services on 08/15/25.R22's Care Area Assessment (CAA) was not completed in the 14 days required after the Significant Change MDS was started on 08/25/25. R22's Care Plan dated 08/28/25 documented the facility would consult with the physician and social services to have hospice care for R22 in the facility. The plan of care documented the hospice provider would provide nurse services two times a week and a certified nurse aide two times a week. The plan of care lacked the equipment provided by the hospice services and the medication that would be covered by the hospice services.R22's EMR lacked an order for admission for hospice services. The facility provided an order printed on the hospice provider's certification form dated 05/15/25.On 09/23/25 at 02:56 PM, R22 propelled her wheelchair down the hallway from her room to the common area.On 09/24/25 at 11:37 AM, Certified Medication Aide (CMA) R stated everyone had access to the resident's care plans and their Kardex (nursing tool that gives a brief overview of the care needs of each resident). CMA R stated the staff would refer to the residents' care plan or their Kardex to find out if the resident was on hospice services. CMA R stated the care plan or Kardex should have what the hospice provided for the resident.On 09/24/25 at 11:45 AM, Licensed Nurse (LN) G stated all the staff had access to the resident's care plans and their Kardex. LN G stated hospice information could be found on the care plan and Kardex. LN G stated the resident's care plan should have the hospice information, which included the equipment, medications, and all the services provided by the hospice provider. LN G stated there should be an order from the physician to admit to hospice, which included the terminal diagnosis. On 09/24/25 at 11:55 AM, Administrative Nurse D stated the resident care plan should have the frequency of visits provided by hospice. Administrative Nurse D stated the facility had never obtained a physician order to admit a resident onto hospice after the evaluation from hospice that included the terminal diagnosis. Administrative Nurse D stated the facility had never care planned the equipment, medications, or all the services provided by the hospice provider. The facility's Hospice Program policy, reviewed 10/2024, documented the community would contract for hospice services for residents who wish to participate in such programs, including services that would be provided and the coordination of services. The community may limit the hospice providers as related to the coordination and communication of care within the community. The facility would identify in writing the services that the Hospice would be providing and address in the resident's person-centered care plan. The facility would obtain a physician's order for Hospice services to include diagnosis. Including the physician's orders with the prognosis and the basis for the prognosis.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. The facility identified a census of 58 residents. The facility identified nine residents on Enhanced Barrier Precautions (EBP- infection control interventions designed to reduce transmission of resistant organisms, which employ targeted gown and glove use during high contact care) and one resident on contact precautions (safeguards designed to reduce the risk of transmission of microorganisms by direct or indirect contact). Based on observations, interviews, and record review, the facility failed to ensure Resident (R) 62's continuous positive airway pressure (CPAP- ventilation device that blows a gentle stream of air into the nose to keep the airway open during sleep) mask was stored in a sanitary manner, and further failed to develop, implement, and maintain a water management program to reduce the risk of Legionella (Legionella is a bacterium which can cause pneumonia in vulnerable populations) and other waterborne pathogens. Findings included:- On 09/22/25 at 08:13 AM, R62 sat in her recliner, waiting for breakfast. R62's unbagged CPAP mask rested directly on her bedside table. There was no bag visible for storing the CPAP mask. R62 stated the mask was usually not stored in a bag and normally laid on her bedside table. She stated she did not have a bag for her CPAP mask. On 09/22/25 at 02:10 PM, Administrative Staff A brought a binder with printed directions on monitoring for Legionella. The notebook contained documentation of Legionella testing, the last test completed on 06/2025, and information provided by the Centers for Medicare & Medicaid Services (CMS) on how to track Legionella. The documentation was not specific to the facility. The facility lacked documentation of a risk assessment and evidence of monitoring to identify potential sources of Legionella growth. On 09/24/25 at 11:36 AM, Certified Medication Aide (CMA) R stated that the respiratory mask should be in a dated bag. She stated that the night shift ensured there was a bag in the room, and the day shift ensured the respiratory mask was placed in the bag when not in use.On 09/24/25 at 11:45 AM, Licensed Nurse (LN) G stated that the night shift changes out the bags on Sundays, and any staff member can put the respiratory mask in the bag when they find the mask unbagged. On 09/24/25 at 11:55 AM, Administrative Nurse D stated all respiratory equipment should be placed in a dated bag if the mask was not in use. On 09/24/25 at 12:09 PM, Maintenance U stated he did not have a diagram or text to flow. He stated the rooms are usually full. He stated that housekeeping cleans the rooms even if the resident did not use the restroom. He stated the only control measure he knew of was the testing that was done on 06/2025. The facility's Cleaning, Disinfection, Testing, or Resident Care Items and Equipment policy, revised 11/2024, documents residents' care equipment, including reusable items and durable medical equipment, would be cleaned and disinfected according to Centers for Disease Control and Prevention (CDC) standards.The facility's Water Management, Legionella Testing policy, revised 10/2022, documented that the facility handled and maintained water supply in accordance with recommendations of the Centers for Disease Control and Prevention (CDC), the Healthcare Advisory Committee, and the Food and Drug Administration (FDA). The community would demonstrate measures to minimize their risk of Legionella and other opportunistic pathogens in the building water system through a documented water management program.