STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175253	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rolling Hills Health and Rehab	1319 Seville Street Wichita, KS 67209

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360 The facility had a census of 64 residents. The sample included 17 residents. Based on observation, record review, and interview, the facility failed to revise the care plan for one resident, Resident (R)40, whose hydrochlorothiazide (HCTZ-a diuretic) was discontinued. This placed the resident at risk for inappropriate care due to uncommunicated care needs. Findings included: - The Electronic Medical Record (EMR) for R40 documented diagnoses of bradycardia (low heart rate, less than 60 beats per minute), cerebrovascular accident (CVA-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), chronic kidney disease (longstanding disease of the kidneys leading to renal failure), hypertension (high blood pressure), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), hypotension (low blood pressure), acute kidney failure (a condition in which the kidneys suddenly can't filter waste from the blood), and diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin). The Annual Minimum Data Set (MDS), dated [DATE], documented R40 had moderately impaired cognition and required substantial assistance with all activities of daily living (ADLs). R40 received insulin (a hormone that lowers the level of glucose in the blood), antidepressant (a medication used to treat depression), anticoagulation (a class of medications used to prevent the blood from clotting), and a diuretic (a medication used to promote the formation and excretion of urine) daily. R40's Medicare 5-Day MDS, dated [DATE], documented R40 had severely impaired cognition and was dependent upon staff for toileting, bathing, lower body dressing, and transfers. R40 required substantial assistance for eating, upper body dressing, and mobility. R40 received antidepressant and anticoagulation medication daily. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R40's Care Plan, dated 10/21/24 and initiated on 01/26/22, documented R40 had a history of chronic kidney disease and directed staff to monitor and report changes in mental status, and any weight gain of over two pounds per day. The update, dated 11/19/23, documented R40 had a history of CVA and hypertension, and directed staff to administer hydrochlorothiazide (HCTZ-a diuretic) and lisinopril (a medication used to lower blood pressure) as ordered and monitor for weight changes; notify the physician of any abnormal readings. The update, dated 02/13/24, documented R40 was on HCTZ for diuretic therapy and directed staff to administer medication as ordered, and monitor for any adverse consequences like hypotension and fatigue. Staff were to report pertinent lab results to the physician. R40's Hospital Discharge Summary, dated 10/08/24, documented that R40 was admitted to the hospital on 09/28/24 for bradycardia, acute kidney injury, and to rule out a CVA. The discharge summary directed staff to discontinue R40's HCTZ, 25 milligrams (mg), and lisinopril, 20 mg, per the physician's request. R40's Medication Administration Record, (MAR) dated 10/09/24, documented R40 received both 25 mg HCTZ and 20 mg of lisinopril at the 06:00 AM medication time. On 11/18/24 at 08:15 AM, observation revealed R40 lay in bed with his eyes closed. On 10/20/24 at 01:30 PM, Administrative Nurse D verified the interdisciplinary team worked on the care plans and verified the diuretic therapy care plan for R40's HCTZ should have been taken off the care plan when the medication was discontinued. The facility's Using the Care Plan policy, dated 10/2024, documented care plans should be used in developing the resident's daily care routines and would be available to staff personnel who have the responsibility for providing care or services to the resident. Completed care plans were available to the staff located per facility protocol and utilized to generate resident-specific information. Changes in the resident's condition would be reported to the MDS Assessment Coordinator for applicable review of the care plan, Information contained in the care plan and other documents used by the nursing staff shall be maintained confidentially by established facility policy. The facility failed to revise R40's Care Plan when R40's HCTZ medication was discontinued. This placed the resident at risk for inappropriate care due to uncommunicated care needs.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360 The facility had a census of 64 residents. The sample included 17 residents, with four reviewed for accidents. Based on observation, record review, and interview, the facility failed to ensure a safe environment free from accident hazards for Resident (R) 6 when staff did not use the right type of slide board for R6, who had a previous staff-assisted fall using a slide board. The facility further failed to address the risk after a staff-assisted fall. The facility failed to ensure a safe environment free from accident hazards for R10, who had large openings in the side rails presenting a risk for entrapment. Additionally, the facility failed to ensure a safe environment for R47 who had medications stored on her bookshelf, and for R52 who did not wear a smoke apron as per her plan of care while smoking. These failures placed the affected residents at risk for preventable accidents and related injuries. Findings included: - The Electronic Medical Record (EMR) for R6 documented diagnoses of cerebrovascular accident (CVA-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), hemiparesis/hemiplegia (weakness and paralysis on one side of the body) affecting the left non-dominant side, muscle weakness, diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), hypertension (high blood pressure), and obesity (excessive body fat). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R6 had intact cognition and was dependent on staff for toileting, showers, lower body dressing, and transfers. R6 required substantial assistance from staff for mobility and upper body dressing. R6 had upper and lower functional impairment on one side, had one noninjury fall, and had not received therapy. The Fall Assessments, dated 10/02/24, 07/03/24, 04/03/24, and 01/02/24, documented R6 had a high risk for falls. R6's Care Plan, dated 08/29/24 and initiated on 10/22/15 documented R6 was at risk for falls related to a history of falls, hemiplegia to his left side, and generalized muscle weakness. The update, dated 11/22/23, directed staff to encourage exercise and mobility to maximize and maintain balance, strength, and coordination. Staff were to, answer his call light promptly, use a gait belt when assisting the resident with mobility, and make sure he wore appropriate shoes or nonslip socks when not in bed and during all transfers. The care plan directed staff to monitor for any changes in his mental, emotional, or physical condition. The update dated 05/29/24, directed staff to transfer R6 with two staff and to use the Beasy transfer board (a portable slide board transfer system that has a circular seat that rotates 360 degrees to easily turn to the exact angle, allowing the smallest caregiver ability to transfer someone up to 400 pounds (lbs) using a smooth lateral glide), gait belt, and have his right leg leading. The care plan documented that if the nurse determined R6 was too weak to transfer with the Beasy board, use a Hoyer (full mechanical body lift) and two staff for transfers. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Fall Investigation, dated 10/22/24, documented R6 was on the floor beside his bed, propped up with his right arm. Certified Nurse Aide (CNA) M reported that while in the room, she performed a two-person transfer, using a gait belt and slide board. R6 became weak, so the CNA lowered him to the floor. R6 stated he became weak, his legs went out, and staff slid him down to the floor. R6 did not sustain an injury, had on proper footwear, and denied any pain. The investigation documented the care plan was followed. The investigation documented a statement from CNA M was obtained, and the Director of Nursing (DON) educated the CNA that if R6 experienced weakness, staff were to use the Hoyer lift for transfers. On 11/19/24 at 01:10 PM, observation revealed CNA M and CNA O tried to find a gait belt that fit appropriately around R6's waist. CNA M stated she had used a gait belt around his waist earlier but put it in the laundry so now they had to find one to fit him. CNA M and CNA O both tried three different gait belts on R6 but they were all too short, so CNA O left and found one that was appropriate for R6's size. CNA M lowered R6's bed, placed the wheelchair flush with the side of the bed, and removed the right armrest from the wheelchair. CNA M took the flat, wooden slide board that lacked a circular seat that rotated and attempted to place it under R6's right buttocks (the round fleshy part that forms the lower rear area of a human trunk) but it did not slide under him easily. CNA M grabbed the gait belt to assist R6 in lifting his right buttock and it took CNA O to assist CNA M with lifting. The CNA was then able to quickly slide the wooden transfer board under R6's right side. Continued observation revealed the weight of the resident on the slide board caused it to lift off of the bed on one end, and CNA O stated that staff had to use two hands on it to hold it down so the resident could slide over. CNA O held down the slide board and CNA M assisted R6 to slide over onto the bed. R6's feet were placed on the bed, and he was provided his call light. On 11/19/24 at 01:30 PM, CNA O stated she was the restorative aide who worked all over the building. CNA O said if a resident required the use of a lift or slide board, therapy would train staff on how to do it. CNA O stated she was unaware of any falls related to the slide board for R6. On 11/19/24 at 01:35 PM, CNA M stated staff follow the pocket care plan that tells them how a resident was transferred. When asked if she was aware of any falls for R6, CNA M answered by asking Are you aware of any falls? She then stated she was unaware of any falls with R6 and the slide board. On 11/19/24 at 01:40 PM, Administrative Nurse D stated she would contact therapy to see if R6 needed to be evaluated to make sure the slide board was still appropriate for him. Administrative Nurse D stated R6 was a big man and that the description of the transfer with the slide board did not sound like the transfer was done correctly. On 11/19/24 at 02:00 PM, Licensed Nurse (LN) G stated if R6 was weak, staff were to use the Hoyer lift to transfer him. LN G said there was an occurrence when R6 was weak during a transfer and staff had to lower him to the ground. On 11/19/24 at 02:15 PM, Consultant HH stated R6 was last evaluated in February of 2024 for the use of the slide board and stated staff were trained on how to use it at that time. Consultant HH further stated that any new CNAs would be trained by the other CNAs on how to use the slide board with R6. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/19/24 at 4:40 PM, CNA M stated she was the CNA with R6 when he was lowered to the ground. CNA M stated she had a gait belt around him, and she and another CNA started to transfer him with the slide board but he said he was weak and would not make it, so she lowered him to the ground. CNA M explained that R6 did not stand well, his legs were weak and that he was too far past the wheelchair to be placed back in the chair, so she lowered him to the floor instead. CNA M further stated she couldn't get R6 to the bed or back to the wheelchair before she had to lower him to the floor. CNA M stated she had to watch computer training on transfers and had to demonstrate a transfer to the Director of Nursing, On 10/20/24 at 10:15 AM, CNA N stated when staff transferred R6, there had to be two CNAs and a gait belt because both staff must have their hands on the gait belt to help transfer R6 with the slide board. CNA N stated that R6 was slow-moving and that if he was ever weak, there was time to let him sit for a little bit before they tried to move him. CNA N stated that R6 liked to try to put the slide board under himself, but he did not do it correctly. On 11/20/24 at 01:00 PM, Administrative Nurse D stated she did not watch CNA M transfer R6 with the slide board but had CNA M tell her how R6 was transferred; she watched CNA M do transfers with other residents. Administrative Nurse D stated she did not get a statement from the second CNA nor could she remember who the second CNA was, therefore that second CNA was not provided with reeducation on transfers with slide boards. Administrative Nurse D could not explain what the second CNA was doing while CNA M was trying to transfer R6. The facility's Safe Lifting and Movement of Residents policy, dated 10/24, documented to protect the safety and well-being of staff and residents, and to promote quality, this facility used appropriate techniques and devices to lift and move residents. Staff responsible for direct resident care would be trained in the use of manual (gait/transfer belt, lateral boards) and mechanical lifting devices. Staff would be observed for competency in using mechanical lifts and observed periodically for adherence to policies and procedures regarding the use of equipment and safe lifting techniques. The facility's Falls and Fall Risk, Managing policy, dated 04/24, documented that staff would identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The interdisciplinary team would attempt to identify appropriate interventions to reduce the risk of falls. If a systemic evaluation of a resident's fall risk identified several possible interventions, the staff may choose to prioritize interventions. The facility failed to ensure a safe environment free from accident hazards for R6 when staff did not use the right type of slide board. The facility further failed to address the risk after a staff-assisted fall. This placed R6 at risk for falls and fall-related injuries. - The Electronic Medical Record (EMR) for R10 documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), hypertension (high blood pressure), and chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Quarterly Minimum Data Set (MDS), dated [DATE], documented that R10 had severely impaired cognition and had inattention and disorganized thinking daily. R10 was dependent on staff for toileting, mobility, and transfers. R10 had lower-body impairment on one side. And the MDS documented that R10 used side rails. R10's Side Rail Assessments, dated 09/09/24, 06/06/24, 03/09/24, and 12/09/23, documented no alternative to bed rails was attempted as she used the rails to pull or push for mobility; no alternatives were attempted, and failed; negative physical outcomes were discussed with R10's representative, and the care plan was updated. The assessments noted that R10's family demanded the side rails despite the risks. R10's Care Plan, dated 08/17/24 and initiated on 02/21/24, documented R10 had a hospital bed with quarter-rails up for safety during care and to assist with bed mobility. The plan directed staff to observe for injury or entrapment (being caught in or as in a trap) related to side rail use and reposition as needed to avoid injury. The update, dated 08/19/24, documented R10 used side rails to assist in entering and exiting the bed safely, moving up and down in bed, turning side to side, and pulling herself from a lying position to a sitting position. The care plan documented that side rail precautions were discussed and consent from the family had been obtained. The Physician's Order, dated 06/06/23, ordered a hospital bed with quarter-rails per Durable Power of Attorney (DPOA) preference. The facility's Risk versus Benefits dated 09/07/23, documented the form was for two side rails on R10's bed, and the form documented that if it were signed, the responsible party assumed full responsibility for all possible risks associated with not complying with the recommendations of the skilled professionals of the facility. The form further documented there were other risks from the decision to not comply with the mentioned treatment or recommendations, up to and including death: loss of dignity, pain, serious injury, loss of movement or function, abnormal movements, hospitalization , serious skin problems, falls, broken bones, and possible entrapment of head or body in the side rails. The form indicated that the DPOA signature on the risk versus the non-compliance was clearly explained to them and that they comprehended everything. The form lacked a signature from the resident or responsible party but documented the facility had spoken to the responsible party and the physician via phone. The form was signed by Administrative Nurse D and Administrative Nurse E. On 11/19/24 at 08:00 AM, observation revealed R10's bed with quarter-rails on both sides. Both rails had an opening approximately 18 inches by 15 inches. Continued observation revealed the bed rail was attached to the bed frame. On 11/19/24 at 09:15 AM, Administrative Nurse D stated she was aware the side rail opening was large and R10 was at risk for entrapment but she was unable to change the family's mind so they thought if they assessed and had it on the care plan, that it was ok. Administrative Nurse D stated that R10 originally had the halo transfer bars but the family wanted the quarter rails. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Use of Physical Restraints, Including Bedrails policy, dated 08/24, documented restraints should only be used for the safety and well-being of the resident and only after other alternatives have been tried unsuccessfully. Restraints should only be used to treat the resident's symptoms and never for discipline or staff convenience, or for the prevention of falls. Examples of devices that are/may be considered physical restraints include: using bedrails that keep the resident from voluntarily getting out of bed safely due to their physical or cognitive inability to lower the bed rail independently. Before placing a resident in restraints, there should be a pre-restraint assessment and review to determine the need for restraints, The assessment should be used to determine if there are fewer restricted interventions. Restraints should only be used upon the written order of a physician and after obtaining consent from the resident and/or representative, the order alone was not sufficient to use the restraint. The order shall include the specific reason for the restraint, how the restraint would be used to benefit the resident's medical symptoms, the type of restraint, and the period for the use of the restraint. Restrained residents should be reviewed at least quarterly to determine whether they are candidates for restraint reduction, less restrictive methods of restraints, or total restraint elimination. The care plan should include the measures taken to systematically reduce or eliminate the need for restraint use, and interventions that address not only the immediate medical symptom but the underlying problems that may cause the symptoms. Bed rail use would be based on resident preference and medical symptoms. The facility failed to ensure R10 a safe environment free from entrapment risks related to unsafe openings in R10's quarter-rails used on her bed. This placed R10 at risk for entrapment and related complications. 32358 - R47's Electronic Medical Record (EMR) documented R47 had diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion) and Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure). R47's Quarterly Minimum Data Assessment, (MDS) revised 10/31/24, documented R47 had a Brief Interview of Mental Status (BIMS) score of 12 which indicated moderate cognitive impairment. R47's Care Plan revised 10/31/24, instructed staff to cue and reorientate R47 as needed, discuss with the resident, and administer medications as ordered. On 11/18/24 at 09:48 AM, observation in R47's room revealed the resident had a 32-ounce (oz) bottle of hydrogen peroxide (a liquid chemical used to make hair very pale or to kill bacteria) a two oz bottle of Dermagel psoriasis shampoo (medicated shampoo used to help reduce the itching, scaling, swelling, and skin discoloration) and a two oz bottle of fungiCURE intensive spray (a medication used to treat fungal infection disease caused by a fungus, such as yeast or mold) on a shelf in an open wooden bookshelf, visible from her entrance door. Further observation revealed the bottle of hydrogen peroxide label read may cause fire or explosion, harmful if swallowed, causes severe skin burns and eye damage, and harmful if inhaled. The Dermagel psoriasis shampoo label read for external use only, avoid contact with eyes and keep out of reach of children. The fungiCURE intensive spray box directed it was for external use only and to keep out of reach of children. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/18/24 at 10:26 AM, Administrative Nurse D verified the above finding and stated the items should not be in R47's room they should be locked in the medication cart. Administrative Nurse D took the items to the medication cart and asked the medication aide to lock them up in the cart. Upon request, the facility failed to provide a policy regarding accidents. The facility failed to ensure a safe environment free from accident hazards for R47. This placed the resident at risk for injury and preventable accidents. 27168 - The Electronic Medical Record (EMR) for R52 had diagnoses of chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), major depressive disorder (major mood disorder that causes persistent feelings of sadness), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), muscle weakness and difficulty walking. The Annual Minimum Data Set (MDS), dated [DATE], documented R52 had intact cognition and required partial to moderate assistance from staff for transfers and toileting. The MDS documented the resident required a walker or wheelchair for mobility. The Smoking Evaluation, dated 11/18/24, documented R52 had no cognitive loss, could not light her cigarettes, and required staff supervision. R52's Care Plan, dated 09/19/24, documented R52 was at risk for potential injury related to smoking. The care plan documented the resident required a smoking apron while smoking and could only go outside during supervised smoking breaks. On 11/19/24 at 08:50 AM, observation revealed R52 sat in a wheelchair at the back smoking patio door. She wheeled over to the nurse's cart and received two cigarettes from the staff then wheeled herself outside and sat on the patio and smoked two cigarettes along with eight other residents. Observation revealed the resident did not wear a smoking apron. On 11/20/24 at 10:40 AM, Administrative Nurse E verified R52's Care Plan which documented the resident required a smoking apron and stated the resident would not wear it and would probably refuse. Administrative Nurse E verified the employee who entered the information in the care plan worked for the facility one day a week from home. Administrative Nurse E said R52's plan of care should not have stated the resident required a smoking apron. The facility's Smoking policy, dated October 2024, documented residents are to smoke in designated smoking areas and are not allowed to keep smoking material in their personal possession. The facility is not responsible for providing smoking materials for the residents, including but not limited to lighters. All smoking materials are to be given to facility staff. The resident would receive two cigarettes at a time and would return the lighter to the charge nurse when finished smoking. The policy documented the resident would wear a smoking apron while smoking and would put their cigarette butt in the butt can. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to provide R52 with a smoking apron per her plan of care. This placed the resident at risk for accidents and injuries.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32358 The facility had a census of 64 residents. The sample included 17 residents with one reviewed for dialysis (the process of removing waste products and excess fluid from the body when the kidneys are not able to adequately filter the blood). Based on observation, record review, and interview, the facility failed to ensure ongoing communication with the dialysis provider regarding dialysis treatments and monitoring for Resident (R)54. This placed the resident at risk for complications and health decline. Findings included: - R54's Electronic Health Record (EHR) documented R54 had a diagnosis of stage four chronic kidney disease (CKD- a critical phase when kidneys are severely damaged and can't filter waste from the blood properly). R54 Annual Minimum Data Set (MDS), dated [DATE], recorded R54 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS recorded R54 required setup assistance with eating, upper and lower body dressing, putting on and taking off footwear, personal hygiene, sitting to lying, supervision with oral hygiene, toileting hygiene, showering, rolling left to right, lying to sitting on side of the bed, and sit to stand activity. R54 required supervision with oral hygiene, toileting hygiene, showering, transfers, and ambulation without a mobility device. The MDS recorded the resident received dialysis treatment. R54's Care Plan, dated 09/21/24, documented that R54 received dialysis three times a week on Monday, Wednesday, and Friday. R54's EHR revealed Dialysis Communication Form, from 09/04/24 to 11/18/24 lacked completed information from the dialysis center regarding the resident's treatment, monitoring, or orders. On 11/18/24 at 01:33 PM, observation revealed R54 sat quietly in a recliner in his room. On 11/20/24 at 12:19 PM, Administrative Nurse D stated the facility sent a communication sheet to the dialysis center but verified the facility did not receive the communication sheet information back from the dialysis center. Administrative Nurse D said if there was a change or staff needed to know anything, the dialysis center would call them. The facility's Dialysis Policy, revised 10/24, documented communication between the facility and the dialysis facility shall contain the following: Information if the medication was administered not according to orders or plan of care. New orders and results of labs. Current vital signs and weights. Advanced Directives and code status. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nutritional and fluid management, including residents' compliance with diet, during and /or after dialysis. Response to dialysis and any behaviors that may impede the treatment. Changes or declines in condition unrelated to dialysis and recommendations for monitoring. Concerns for vascular access site; and concerns and risks regarding transport to dialysis. The facility failed to ensure ongoing communication with the dialysis provider regarding R54's dialysis treatments. This placed the resident at risk for complications and health decline.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360 The facility had a census of 64 residents. The sample included 17 residents, with one reviewed for side rails. Based on observation, record review, and interview, the facility failed to obtain written informed consent which included potential risks versus benefits from the resident and/or representative for the use of side rails for Resident (R)10. This placed her at risk for accident or injury due to uninformed choices regarding side rail use. Findings included: - The Electronic Medical Record (EMR) for R10 documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), hypertension (high blood pressure), and chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R10 had severely impaired cognition and had inattention and disorganized thinking daily. R10 was dependent on staff for toileting, mobility, and transfers. R10 had lower-body impairment on one side. The MDS documented that R10 used side rails. R10's Side Rail Assessments, dated 09/09/24, 06/06/24, 03/09/24, and 12/09/23, documented no alternative to bed rails was attempted as she used the rails to pull or push for mobility; no alternatives were attempted, and failed; negative physical outcomes were discussed with R10's representative, and the care plan was updated. The assessments noted that R10's family demanded the side rails despite the risks. R10's Care Plan, dated 08/17/24 and initiated on 02/21/24, documented that R10 had a hospital bed with quarter-rails up for safety during care and to assist with bed mobility. The plan directed staff to observe for injury or entrapment (being caught in or as in a trap) related to side rail use and reposition as needed to avoid injury. The update, dated 08/19/24, documented that R10 used side rails to assist in entering and exiting the bed safely, moving up and down in bed, turning side to side, and pulling herself from a lying position to a sitting position. The care plan documented that side rail precautions were discussed and consent from the family had been obtained. The Physician's Order, dated 06/06/23, ordered a hospital bed with quarter-rails per Durable Power of Attorney (DPOA) preference. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Risk versus Benefits dated 09/07/23, documented the form was for two side rails on R10's bed, and the form documented that if it were signed, the responsible party assumed full responsibility for all possible risks associated with not complying with the recommendations of the skilled professionals of the facility. The form further documented there were other risks from the decision to not comply with the mentioned treatment or recommendations, up to and including death: loss of dignity, pain, serious injury, loss of movement or function, abnormal movements, hospitalization , serious skin problems, falls, broken bones, and possible entrapment of head or body in the side rails. The form indicated that the DPOA signature on the form indicated the non-compliance was clearly explained to them and that they comprehended everything. The form lacked a signature from the resident or responsible party but documented the facility spoke to the responsible party and the physician via phone. The form was signed by Administrative Nurse D and Administrative Nurse E. On 11/19/24 at 08:00 AM, observation revealed R10's bed with quarter-rails on both sides. Both rails had an opening approximately 18 inches by 15 inches. Continued observation revealed the bed rail was attached to the bed frame. On 11/19/24 at 09:15 AM, Administrative Nurse D stated the facility verbally explained the risks of the quarter-rails used on R10's bed to her family, and the family was very insistent that she have them. Administrative Nurse D stated that R10's family was very involved in her care and the bed rails were discussed in her care plan meetings. Administrative Nurse D confirmed the facility had not obtained a signed risk versus benefits from R10 or her responsible party. The facility's Use of Physical Restraints, Including Bedrails policy, dated 08/24, documented restraints should only be used for the safety and well-being of the resident and only after other alternatives have been tried unsuccessfully. Restraints should only be used to treat the resident's symptoms and never for discipline or staff convenience, or for the prevention of falls. Examples of devices that are/may be considered physical restraints include: using bedrails that keep the resident from voluntarily getting out of bed safely due to their physical or cognitive inability to lower the bed rail independently. Before placing a resident in restraints, there should be a pre-restraint assessment and review to determine the need for restraints, The assessment should be used to determine if there are fewer restricted interventions. Restraints should only be used upon the written order of a physician and after obtaining consent from the resident and/or representative, the order alone was not sufficient to use the restraint. The order shall include the specific reason for the restraint, how the restraint would be used to benefit the resident's medical symptoms, the type of restraint, and the period for the use of the restraint. Restrained residents should be reviewed at least quarterly to determine whether they are candidates for restraint reduction, less restrictive methods of restraints, or total restraint elimination. The care plan should include the measures taken to systematically reduce or eliminate the need for restraint use, and interventions that address not only the immediate medical symptom but the underlying problems that may cause the symptoms. Bed rail use would be based on resident preference and medical symptoms. The facility failed to obtain written informed consent from R10 or her representative for using side rails. This placed her at risk for accident or injury due to uninformed choices associated with side rail use.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360 The facility had a census of 64 residents. The sample included 17 residents, with four reviewed for accidents. Based on observation, record review, and interview, the facility failed to ensure Certified Nurse Aide (CNA) staff possessed adequate competency and skill for the use of a slide board for one resident, Resident (R) 6, who was lowered to the ground during a slide board transfer. This placed the resident at risk for injury. Findings included: - The Electronic Medical Record (EMR) for R6 documented diagnoses of cerebrovascular accident (CVA-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), hemiparesis/hemiplegia (weakness and paralysis on one side of the body) affecting the left non-dominant side, muscle weakness, diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), hypertension (high blood pressure), and obesity (excessive body fat). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R6 had intact cognition and was dependent on staff for toileting, showers, lower body dressing, and transfers. R6 required substantial assistance from staff for mobility and upper body dressing. R6 had upper and lower functional impairment on one side, had one noninjury fall, and had not received therapy. The Fall Assessments, dated 10/02/24, 07/03/24, 04/03/24, and 01/02/24, documented R6 had a high risk for falls. R6's Care Plan, dated 08/29/24 and initiated on 10/22/15 documented R6 was at risk for falls related to a history of falls, hemiplegia to his left side, and generalized muscle weakness. The update, dated 11/22/23, directed staff to encourage exercise and mobility to maximize and maintain balance, strength, and coordination. Staff were to, answer his call light promptly, use a gait belt when assisting the resident with mobility, and make sure he wore appropriate shoes or nonslip socks when not in bed and during all transfers. The care plan directed staff to monitor for any changes in his mental, emotional, or physical condition. The update dated 05/29/24, directed staff to transfer R6 with two staff and to use the Beasy transfer board (a portable slide board transfer system that has a circular seat that rotates 360 degrees to easily turn the user to the exact angle, allowing the smallest caregiver ability to transfer someone up to 400 pounds (lbs.) using a smooth lateral glide), gait belt, and have his right leg leading. The care plan documented that if the nurse determined R6 was too weak to transfer with the Beasy board, use a Hoyer (full mechanical body lift) and two staff for transfers. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Fall Investigation, dated 10/22/24, documented R6 was on the floor beside his bed, propped up with his right arm. Certified Nurse Aide (CNA) M reported that while in the room, she performed a two-person transfer, using a gait belt and slide board. R6 became weak, so the CNA lowered him to the floor. R6 stated he became weak, his legs went out, and staff slid him down to the floor. R6 did not sustain an injury, had on proper footwear, and denied any pain. The investigation documented the care plan was followed. The investigation documented a statement from CNA M was obtained, and the Director of Nursing (DON) educated the CNA that if R6 experienced weakness, staff were to use the Hoyer lift for transfers. The Assisting with Transfers To/From a Bed Competency, dated 10/22/24, did not state CNA M was observed for a transfer with a slide board. It documented CNA M was observed for a Hoyer lift transfer with a different resident than the resident she had the fall with. The competencies provided did not include any training or observation for a transfer with the slide board. On 11/19/24 at 01:10 PM, observation revealed CNA M and CNA O tried to find a gait belt that fit appropriately around R6's waist. CNA M stated she had used a gait belt around his waist earlier but put it in the laundry so now they had to find one to fit him. CNA M and CNA O both tried three different gait belts on R6 but they were all too short, so CNA O left and found one that was appropriate for R6's size. CNA M lowered R6's bed, placed the wheelchair flush with the side of the bed, and removed the right armrest from the wheelchair. CNA M took the flat, wooden slide board that lacked a circular seat which rotated and attempted to place it under R6's right buttocks (the round fleshy part that forms the lower rear area of a human trunk) but it did not slide under him easily. CNA M grabbed the gait belt to assist R6 in lifting his right buttock and it took CNA O to assist CNA M with lifting. The CNA was then able to quickly slide the wooden transfer board under R6's right side. Continued observation revealed the weight of the resident on the slide board caused it to lift off of the bed on one end, and CNA O stated that staff had to use two hands on it to hold it down so the resident could slide over. CNA O held down the slide board and CNA M assisted R6 to slide over onto the bed. R6's feet were placed on the bed, and he was provided his call light. On 11/19/24 at 01:30 PM, CNA O stated she was the restorative aide who worked all over the building. CNS O said if a resident required the use of a lift or slide board, therapy would train staff on how to do it. On 11/19/24 at 01:40 PM, Administrative Nurse D stated that R6 was a big man and that the description of the transfer with the slide board did not sound like the transfer was done correctly. On 11/19/24 at 02:15 PM, Consultant HH stated R6 was last evaluated in February of 2024 for the use of the slide board and stated staff were trained on how to use it at that time. Consultant HH further stated that any new CNAs would be trained by the other CNAs on how to use the slide board with R6. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/19/24 at 4:40 PM, CNA M stated she was the CNA with R6 when he was lowered to the ground. CNA M stated she had a gait belt around him, and she and another CNA started to transfer him with the slide board but he said he was weak and would not make it, so she lowered him to the ground. CNA M explained that R6 did not stand well, his legs were weak and that he was too far past the wheelchair to be placed back in the chair, so she lowered him to the floor instead. CNA M further stated she couldn't get R6 to the bed or back to the wheelchair before she had to lower him to the floor. CNA M stated she had to watch computer training on transfers and had to demonstrate a transfer to the Director of Nursing, On 11/20/24 at 01:00 PM, Administrative Nurse D stated she did not watch CNA M transfer R6 with the slide board but had CNA M tell her how R6 was transferred; she watched CNA M do transfers with other residents. Administrative Nurse D stated she did not get a statement from the second CNA nor could she remember who the second CNA was, therefore that second CNA was not provided with reeducation on transfers with slide boards. Administrative Nurse D could not explain what the second CNA was doing while CNA M was trying to transfer R6. The facility's Staff Competency policy, dated 06/24, documented all nurse aide personnel shall participate in regularly scheduled in-service training classes. Nursing staff would demonstrate competency in skills and techniques necessary to care for the resident's needs, as identified through resident assessments and resulting plans of care. The facility failed to ensure CNA staff possessed adequate competency and skill for the use of a slide board for R6, who was lowered to the ground during a staff-assisted slide board transfer. This placed the resident at risk for injury.

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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** 27168 The facility had a census of 64 residents. The sample included 17 residents, with five reviewed for unnecessary medications. Based on observation, interview, and record review, the facility failed to ensure the Consultant Pharmacist identified and reported the lack of an appropriate indication, or the required physician documentation, for Resident (R) 37's use of an antipsychotic (medications used to treat any major mental disorder characterized by gross impairment in reality)and irregularities with R38's blood pressure and pulse monitoring. This placed the resident at risk for unnecessary medications and related side effects. Findings included: - R37's Electronic Medical Record (EMR) recorded diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), and major depressive disorder (MDD-major mood disorder which causes persistent feelings of sadness). R37's Annual Minimum Data Set (MDS), dated [DATE] recorded R37 had a Brief Interview for Mental Status (BIMS) score of six, which indicated severely impaired cognition. The MDS recorded R37 required staff assistance with most activities of daily living (ADLs). The MDS recorded the resident received antipsychotic medication during the observation period. The Psychotropic [alters mood or thought] Drug Use Care Area Assessment (CAA), dated 11/11/24, recorded R37 had a history of decreased appetite, depression, anxiety, and dementia. R37 received Seroquel, (an antipsychotic) clonazepam (an antianxiety medication), Remeron (an antidepressant), and sertraline (an antidepressant). R37's Care Plan, dated 11/07/24 recorded R37 received antipsychotic medication for the diagnosis of dementia, personality disorder, and anxiety. Staff were to monitor for side effects and effectiveness. The plan documented the facility would consult the physician to consider dose reduction when clinically appropriate. The Physician's Order, initial order date 09/09/24, directed the staff to administer Seroquel 25 milligrams (mg), twice daily for a diagnosis of unspecified dementia, moderate with other behavioral disturbances. R37's EMR lacked a documented physician rationale which included the unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the Seroquel use. The Consultant Pharmacist Monthly Medication Review (MMR) dated 12/28/23 R37 received Seroquel with a diagnosis of anxiety and that was an inappropriate diagnosis or indication. The recommendation indicated changed but lacked what the new diagnosis was. The CP MMRs dated 01/30/24, 02/22/24, 03/28/24, 04/24/24, and 05/30/24 documented Seroquel has been associated with metabolic changes including weight gain and dyslipidemia (abnormal cholesterol levels) and recommended the facility should evaluate the continued use of Seroquel. The CP MMR dated 06/20/24, 07/24/24, 08/27/24, 09/27/24, 10/18/24, and 11/13/24 did not make any recommendations related to the continued use of Seroquel. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/18/24 at 04:15 PM, observation revealed the resident sat on the side of her bed. Continued observation revealed Certified Medication Aide (CMA) R administered the resident's medications which included the Seroquel. On 11/20/24 at 08:20 AM, Administrative Nurse D verified that R37 received Seroquel with a diagnosis of dementia with behavioral disturbance which she thought was an appropriate indication for the medication. Administrative Nurse D stated the pharmacist completed monthly reviews and sent them to the facility with concerns and recommendations. Administrative Nurse D said that a few months ago, R37's Seroquel had a diagnosis of anxiety. Administrative Nurse D said that was identified and the diagnosis was changed to dementia with behavioral disturbances. The facility's Pharmacist Services Overview policy, dated October 2024, recorded the facility shall accurately and safely provide or obtain pharmacy services, including the provision of routine and emergency medications and biologicals, and the services of a licensed Pharmacist. The facility would contract with a licensed Pharmacist to help it obtain and maintain timely and appropriate pharmacy services that support residents' needs, are consistent with current standards of practice, and meet state and federal requirements. This includes, but is not limited to, collaborating with the facility, the Medical Director, and the Attending Physician. The facility failed to ensure the CP identified and reported the unapproved indication for the continued use of R37's antipsychotic medication, Seroquel. This placed R37 at risk for unnecessary psychotropic medication and related side effects. 32358 - R38's Electronic Medical Record (EMR) documented that R38 had a diagnosis of atherosclerosis (a buildup of fats, cholesterol, and other substances in and on the artery walls) of the coronary arteries (blood vessels of the heart). R38's Annual Minimum Data Set (MDS), dated [DATE], documented R38 had a Brief Interview of Mental Status (BIMS) score of three which indicated severely impaired cognition. The MDS documented R38 had atherosclerosis. R38's Care Plan, revised 9/20/24, instructed staff to administer medications as the physician ordered. The plan documented that R38 received amiodarone (a medication that prevents and treats an irregular heartbeat) and instructed staff to hold the medication and call the physician if R38's heart rate was less than 60 beats per minute (BPM), or her blood pressure (BP) was less than 90 diastolic (DBP-minimum level of blood pressure measured between contractions of the heart; the bottom number of a blood pressure reading). The Physician Order, dated 09/12/24 at 06:00 AM instructed staff to administer amiodarone HCl, 200 milligrams (mg) tablet, by mouth, one time a day and to notify the physician of R38's heart rate was less than 60 BPM or her DBP less than 90. R38's clinical record revealed R38's DBP was less than 90 and lacked documentation the physician was notified daily from 09/12/24 through 11/13/24. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R38's clinical record revealed R38's pulse was less than 60 BPM and lacked documentation the physician was notified on the following dates: 10/06/24-58 BPM 10/25/24-58 BPM 10/30/24- 57 BPM 11/04/24-57 BPM The Consultant Pharmacist (CP) Regimen Review from 09/27/24 to 11/13/24 lacked documentation the pharmacist identified the above findings regarding R38's blood pressure and pulse monitoring being out of ordered parameters with no physician notification. On 11/18/24 at 04:25 PM, observation revealed R38 sat quietly in a wheelchair in the dining room and visited with other residents in a polite voice at her table. On 11/20/24 at 11:16 AM, Administrative Nurse D verified the CP had not alerted the facility regarding R38's irregularities for blood pressure and pulse monitoring outside of the physician-ordered parameters for the dates listed. The facility's Pharmacist Services Overview policy, dated October 2024, recorded the facility shall accurately and safely provide or obtain pharmacy services, including the provision of routine and emergency medications and biologicals, and the services of a licensed Pharmacist. The facility would contract with a licensed Pharmacist to help it obtain and maintain timely and appropriate pharmacy services that support residents' needs, are consistent with current standards of practice, and meet state and federal requirements. This includes, but is not limited to, collaborating with the facility, the Medical Director, and the Attending Physician. The facility failed to ensure the CP identified and reported to the facility irregularities in R38's blood pressure and pulse monitoring. This placed the resident at risk for unnecessary medication side effects.

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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** 32358 The facility had a census of 64 residents. The sample included 17 residents of which five were reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to notify the physician when Resident (R) 38's blood pressure and pulse were outside the physician-ordered parameters. This placed the residents at risk for ineffective medication regimens and unnecessary medication side effects. Findings included: - R38's Electronic Medical Record (EMR) documented that R38 had a diagnosis of atherosclerosis (a buildup of fats, cholesterol, and other substances in and on the artery walls) of the coronary arteries (blood vessels of the heart). R38's Annual Minimum Data Set (MDS), dated [DATE], documented R38 had a Brief Interview of Mental Status (BIMS) score of three which indicated severely impaired cognition. The MDS documented R38 had atherosclerosis. R38's Care Plan, revised 9/20/24, instructed staff to administer medications as the physician ordered. The plan documented that R38 received amiodarone (a medication that prevents and treats an irregular heartbeat) and instructed staff to hold the medication and call the physician if R38's heart rate was less than 60 beats per minute (BPM), or her blood pressure (BP) was less than 90 diastolic (DBP-minimum level of blood pressure measured between contractions of the heart; the bottom number of a blood pressure reading). The Physician Order, dated 09/12/24 at 06:00 AM instructed staff to administer amiodarone HCl, 200 milligrams (mg) tablet, by mouth, one time a day and to notify the physician of R38's heart rate was less than 60 BPM or her DBP less than 90. R38's clinical record revealed R38's DBP was less than 90 and lacked documentation the physician was notified daily from 09/12/24 through 11/13/24. R38's clinical record revealed R38's pulse was less than 60 BPM and lacked documentation the physician was notified on the following dates: 10/06/24-58 BPM 10/25/24-58 BPM 10/30/24- 57 BPM 11/04/24-57 BPM On 11/18/24 at 04:25 PM, observation revealed R38 sat quietly in a wheelchair in the dining room and visited with other residents in a polite voice at her table. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rolling Hills Health and Rehab	1319 Seville Street Wichita, KS 67209

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/24 at 12:19 PM, Administrative Nurse D verified R38's above findings and stated she put the order in wrong, but staff should have been following the physician's order to call for bp and pulses out of parameters. The facility's Guidelines for Notifying Physicians of Clinical Problems Policy, revised 10/24, documented the charge nurse or supervisor should contact the attending physician at any time if they feel a clinical situation requires immediate discussion and management. The facility failed to ensure R38's drug regimen was free from unnecessary drugs when staff failed to notify the physician when R38 ' s BP and pulses were out of physician-ordered parameters. This placed the residents at risk for ineffective medication regimens and unnecessary medication side effects.

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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** 27168 The facility had a census of 64 residents. The sample included 17 residents, with five reviewed for unnecessary medications. Based on observations, interviews, and record review, the facility failed to ensure an appropriate indication, or a documented physician rationale which included the unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the continued use of Resident (R)37's antipsychotic (a medication used to treat any major mental disorder characterized by a gross impairment testing) medication. This placed R37 at risk for unintended effects related to psychotropic (alters mood or thought) medications. Findings include: - R37's Electronic Medical Record (EMR) recorded diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), and major depressive disorder (MDD-major mood disorder which causes persistent feelings of sadness). R37's Annual Minimum Data Set (MDS), dated [DATE] recorded R37 had a Brief Interview for Mental Status (BIMS) score of six, which indicated severely impaired cognition. The MDS recorded R37 required staff assistance with most activities of daily living (ADLs). The MDS recorded the resident received antipsychotic medication during the observation period. The Psychotropic Drug Use Care Area Assessment (CAA), dated 11/11/24, recorded R37 had a history of decreased appetite, depression, anxiety, and dementia. R37 received Seroquel (an antipsychotic), clonazepam (an antianxiety medication), Remeron (an antidepressant), and sertraline (an antidepressant). R37's Care Plan, dated 11/07/24 recorded R37 received antipsychotic medication for the diagnosis of dementia, personality disorder, and anxiety. Staff were to monitor for side effects and effectiveness. The plan documented the facility would consult the physician to consider dose reduction when clinically appropriate. The Physician's Order, initial order date 09/09/24, directed the staff to administer Seroquel 25 milligrams (mg), twice daily for a diagnosis of unspecified dementia, moderate with other behavioral disturbances. R37's EMR lacked a documented physician rationale which included the unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the Seroquel use. On 11/18/24 at 04:15M, PM observation revealed the resident sat on the side of her bed. Continued observation revealed Certified Medication Aide (CMA) R administered the resident's medications which included the Seroquel. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/19/24 at 08:20 AM, Administrative Nurse D verified the resident received Seroquel, an antipsychotic medication, with a diagnosis of dementia with behavioral disturbances which she thought was an appropriate indication for the medication. Administrative Nurse D verified the physician had been informed of the need for another diagnosis a few months ago when the diagnosis was anxiety, and it was changed at that time to dementia with behavioral disturbance. The facility's Psychotropic Drug Use policy dated April 2024, recorded that residents would receive antipsychotics and psychotropic medications when necessary to treat conditions for which they are indicated and effective and will not be used to discipline or convenience of the staff. Residents and their representatives have the right to refuse such treatment. The facility would review the diagnoses for which the medication classes are being utilized. If they are being utilized for other than their original approved indication, then apply the psychotropic monitoring. The physician's order would include diagnosis, condition, or symptoms for what is being ordered, and monitoring. The facility would complete an evaluation of the resident prior to starting a standing order of a psychotropic. This includes goals of therapy, reason for use (indication, diagnoses); and non-pharmacological interventions attempted, but the resident's quality of life is negatively impacted by the non-use of the medications. During the comprehensive, person-centered care planning process, the resident and/or their representative should be informed of the prescribed treatment. If the resident and/or their representative refuses the treatment, the IDT member (including the physician) should inform the resident about the risks for refusal and discuss appropriate alternatives, such as offering the medication at a different time, in another dosage form, or an alternative medication or non-pharmacological approach if available and document such in the clinical record. Identify and note non-pharmacological approaches as an alternative to or an adjunct to as-needed psychotropic use, and address them in the care plan. The facility would obtain psychotropic consent for new orders, and review and document the resident's target symptoms in the clinical record of anti-depressants, anti-anxiety, and anti-psychotic medications. The nursing anti-psychotic review would be completed at the following schedule: upon admission, if the antipsychotic medication is prescribed; on the addition of any new antipsychotic medication, and at least monthly. Gradual dose reduction would be conducted per CMS guidelines. The facility failed to ensure R37 did not receive antipsychotic medication without an appropriate indication or the required physician documentation for its use. This placed R37 at risk for unintended effects related to psychotropic medications.

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F 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360 The facility had a census of 64 residents. The sample included 17 residents. Based on observation, record review, and interview, the facility failed to prevent significant medication errors for one resident, Resident (R) 40, who received medications in error. Subsequently, R40 required rehospitalization in the intensive care unit (ICU). This also placed R40 at risk for adverse medication effects and other related complications. Findings included: - The Electronic Medical Record (EMR) for R40 documented diagnoses of bradycardia (low heart rate, less than 60 beats per minute), cerebrovascular accident (CVA-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), chronic kidney disease (longstanding disease of the kidneys leading to renal failure), hypertension (high blood pressure), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), hypotension (low blood pressure), acute kidney failure (a condition in which the kidneys suddenly cannot filter waste from the blood), and diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin). The Annual Minimum Data Set (MDS), dated [DATE], documented R40 had moderately impaired cognition and required substantial assistance with all activities of daily living (ADL). R40 received insulin (a hormone that lowers the level of glucose in the blood), antidepressant (a medication used to treat depression), anticoagulant (a class of medications used to prevent the blood from clotting), and a diuretic (a medication used to promote the formation and excretion of urine) medication daily. R40's Medicare 5-Day MDS, dated [DATE], documented R40 had severely impaired cognition and was dependent upon staff for toileting, bathing, lower body dressing, and transfers. R40 required substantial assistance for eating, upper body dressing, and mobility. R40 received antidepressant and anticoagulation medication daily. R40's Care Plan, dated 10/21/24 and initiated on 01/26/22, documented R40 had a history of chronic kidney disease and directed staff to monitor and report changes in mental status, and any weight gain of over two pounds per day. The update, dated 11/19/23, documented R40 had a history of CVA and hypertension, and directed staff to administer hydrochlorothiazide (HCTZ- a diuretic) and lisinopril (a medication used to lower blood pressure) as ordered and monitor for weight changes; notify the physician of any abnormal readings. The update, dated 02/13/24, documented R40 was on HCTZ for diuretic therapy and directed staff to administer medication as ordered, and monitor for any adverse consequences like hypotension and fatigue. Staff were to report pertinent lab results to the physician. R40's Hospital Discharge Summary, dated 10/08/24, documented that R40 admitted to the hospital on 09/28/24 for bradycardia, acute kidney injury, and to rule out a CVA. The discharge summary directed staff to discontinue R40's HCTZ, 25 milligrams (mg), and lisinopril, 20 mg, per the physician's request. R40's Medication Administration Record, (MAR) dated 10/09/24, documented R40 received both 25 mg HCTZ and 20 mg of lisinopril at the 06:00 AM medication time. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	R40's EMR lacked documentation that R40's HCTZ and lisinopril had been discontinued from the MAR as ordered on 10/08/24. The Nurse's Note, dated 10/09/24 at 03:29 PM, documented that R40 was not responding verbally to questions, had minimal eye contact, and was drooling. R40's blood pressure was 68/56 millimeters of mercury (mmHg)(normal blood pressure is 120/80 mmHg). His pulse was thready at 88 beats per minute and his oxygen saturation was 96%. His blood sugar was 215 milliliters (ml) per deciliter (dl). The facility notified the physician and was directed to send R40 to the hospital. The note documented R40 admitted to the hospital to rule out a CVA; and for low heart rate and blood pressure with a second-degree atrioventricular (AV) block (a malfunction in the heart's electrical system that causes a slow heart rate). R40's EMR documented R40 returned to the facility on [DATE]. On 11/18/24 at 08:15 AM, observation revealed R40 laid in bed with his eyes closed. On 11/18/24 at 09:36 AM, Consultant GG stated R40 discharged from the hospital on 10/08/24 and readmitted to the ICU on 10/09/24 with a low heart rate. Consultant GG stated she looked at the facility paperwork that was sent with the resident to see why he was back at the hospital and saw on the MAR that he had received the HCTZ and lisinopril which should have been discontinued upon readmit to the facility. Consultant GG contacted the facility and spoke with Administrative Nurse E who verified that the medications were mistakenly given. On 11/18/24 at 10:30 AM, Administrative Nurse D stated R40 readmitted to the hospital on 10/09/24 due to kidney issues. Administrative Nurse D stated R40 did not receive the HCTZ and lisinopril that were supposed to be discontinued upon readmission to the facility. Administrative Nurse D stated she looked at the MAR and spoke with Certified Medication Aide (CMA) R, who was working the morning of 10/09/24. Administrative Nurse D said CMA R told her the resident did not receive the medications. Administrative Nurse D verified she did not actually discontinue the HCTZ or lisinopril from R40's MAR until 10/11/24. Administrative Nurse D stated she did write up the nurse who completed R40's readmission on 10/08/24 for not discontinuing the medications as ordered. On 11/18/24 at 10:40 AM, Administrative Nurse E stated she told Consultant GG that R40 had mistakenly received the medication before she found out for sure if he had received the medications. Administrative Nurse E stated she had looked at the active medication sheet and saw the medications were still on there, so she assumed R40 had received them. On 11/18/24 at 04:09 PM, CMA R stated she worked the morning of 10/09/24 and she administered R40 his morning medications that were active on the MAR. CMA R verified she had measured R40's blood pressure that morning, which was 133/76 mmHg, verified it was within normal limits, and then administered both the HCTZ and lisinopril. CMA R stated those two medications were the only medications she administered to R40 that day because he went to the hospital later that day. On 11/19/24 at 09:08 AM, Licensed Nurse (LN) G stated the float nurse was responsible for all the readmissions from the hospital and should verify the orders when the hospital called to give an update on the resident who was coming back. LN G further stated that once the resident returned to the facility, the float nurse re-verified the medications on the discharge paperwork and either added or discontinued medications. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The facility's Identifying and Managing Medication Errors and Adverse Consequences policy, dated 10/24, documented that staff and practitioners should try to prevent medication errors and adverse medication consequences and should strive to manage them appropriately when they occur. The staff shall report clinically significant medication consequences and medication errors with adverse clinical consequences to the resident's attending Physician immediately. In the event of a clinically significant adverse medication consequence, nursing staff shall implement and follow any related physician orders and shall monitor closely and document the resident's condition and response to any corrective intervention for at least the next 24 hours or as otherwise directed, Nursing staff would document appropriately detailed account of any incidents on an appropriate report form. The Medical Director, Director of Nursing, and Consultant Pharmacist shall review medication errors and adverse consequences as part of the facility's Quality Assurance process. The facility failed to prevent a significant medication error for R40 when staff failed to discontinue medications as ordered by the physician and then administered the medications in error. This deficient practice resulted in R40's rehospitalization and also placed R40 at risk for adverse medication effects and other related complications.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 27168 The facility had a census of 64 residents. The sample included 17 residents. Based on observation, record review, and interview, the facility failed to correctly prepare a pureed diet for two residents that retained both nutritive value and palatability. This placed the affected residents at risk for impaired nutrition or decreased quality of life. Findings included: - On 11/18/24 at 08:15 AM, observation revealed staff preparing and serving the breakfast meal to residents in the dining room. On 11/19/24 at 10:45 AM, observation revealed Dietary Staff (DS) CC prepared two pureed diets. DS CC placed two servings of California medley blend vegetables (cauliflower, broccoli, and carrots) into the Robot-coup blender (food processor) and added one tablespoon (tbsp) plus 1/8 teaspoon (tsp) of food thickener, one tbsp plus 3/4 tsp of left-over vegetable juice and blended the food to the correct consistency. DS CC then placed the food in a metal pan and placed the pan in the hot water well on the hot holding cart. Observation revealed DS CC then placed three three-ounce servings of meatloaf, topped with ketchup, in the Robot-coup and blended the food to the correct puree texture. DS DD then placed the food into a metal pan in the hot water well in the hot holding cart. (DS CC stated she added a little more because one of the residents may want an extra serving. The other food on the lunch menu, potatoes, and gravy, was at the correct puree texture. DS CC did not prepare the last menu item, a bread roll. On 11/19/24 at 02:00 PM, DS BB verified DS CC did not use a recipe when preparing the meatloaf and verified DS CC did use a recipe to puree the vegetables. An interview with DS BB verified DS CC did not puree the rolls for the residents like the other residents received. DS BB stated he realized that DS CC had not pureed and provided the bread roll and said that DS CC was corrected and had prepared two pureed bread rolls and provided them to the residents who received a pureed diet after the surveyor observation ended. DS BB stated the residents do not eat the pureed rolls due to the texture of the food. The facility's Food Preparation and Service policy, dated October 2024, documented that residents are provided meals that are prepared by methods that conserve value, flavor, and appearance. Residents are provided with food and drinks that are palatable, attractive, and at a safe and appetizing temperature. Food service employees shall prepare and serve food in a manner that complies with safe food handling practices. The policy lacked definitive guidelines for the preparation of the pureed diets. The facility failed to provide food prepared by methods that conserve nutritive value, flavor, and appearance while preparing a pureed diet. This placed the affected two residents at risk for impaired nutrition.