

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER Richmond Healthcare & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 340 E South Street Richmond, KS 66080	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>41121</p> <p>The facility reported a census of 45 residents with 22 residents selected for review, including 19 sampled for unnecessary medications. Based on record review and interview, the facility failed to ensure 19 residents, Resident (R) 3, R4, R5, R6, R8, R9, R11, R14, R15, R16, R17, R18, R19, R20, R21, R22, R23, R24, and R25 received their physician ordered medication scheduled on 04/08/24 during the 06:00 PM to 09:00 PM medication pass.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - The facility incident summary for the medication errors on 04/08/24, revealed on 04/08/24 at 06:00 PM, Administrative Nurse D was working as a charge nurse when Certified Medication Aide (CMA) R stated she needed to leave. Administrative Nurse D misunderstood CMA R thinking CMA R told her she had given all but one resident their medication. On 04/09/24 at 05:30 PM, Administrative Nurse D received a call from CMA S asking who administered medication last evening, in which she responded CMA R had. CMA S informed Administrative Nurse D several residents had not received their medication. Administrative Nurse D discovered CMA R had given a handful of medications for the evening pass. The summary revealed Administrative Nurse D called Administrative Nurse E, who said she had only given medications on the (specified) unit. The summary revealed on 04/09/24 Administrative Nurse D notified residents, families, and doctors explaining medications were missed. <p>The Medication Error Report Forms dated 04/09/24, revealed on 04/08/24 between 06:00 PM and 09:00 PM, staff failed to administer the following physician ordered medications to these residents:</p> <p>R3 did not receive:</p> <ol style="list-style-type: none"> 1. Eliquis (blood thinner), 2.5 milligrams (mg). 2. Lortab (used to treat moderate to severe pain), 5-325 mg. 3. Ibuprofen (NSAID - non-steroidal anti-inflammatory), 400 mg. 4. Miralax (laxative), 17 grams (gm). 5. Pravastatin (used to lower cholesterol), 40 (lacked units). 6. Melatonin (used for insomnia [difficulty sleeping]), five mg. <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R4 did not receive:</p> <ol style="list-style-type: none"> Galantamine (used to treat Alzheimer's disease [progressive mental deterioration characterized by confusion and memory failure]), lacked dosage. Memantine (used to treat Alzheimer's disease), 10 mg. Melatonin, lacked dosage. <p>R5 did not receive:</p> <ol style="list-style-type: none"> Atorvastatin (used to lower cholesterol), 20 mg. Tizanidine (used to relieve muscle spasms), lacked dosage. Eliquis, five mg. Oxybutynin (used to treat symptoms of overactive bladder), five mg. <p>R6 did not receive:</p> <ol style="list-style-type: none"> Budesonide -Formoterol inhaler (used to help control symptoms of asthma ([disorder of narrowed airways that caused wheezing and shortness of breath]), lacked dosage. Divalproex (used to treat types of seizures), 500 mg. Eliquis, five mg. Melatonin, three mg. Montelukast (can treat asthma), 10 mg. <p>R8 did not receive:</p> <ol style="list-style-type: none"> Atorvastatin, 40 mg. Gabapentin (can treat nerve pain or seizures), 800 mg. Tramadol (used to treat moderate to severe pain), 50 mg. <p>R9 did not receive:</p> <ol style="list-style-type: none"> Melatonin, three mg. Memantine, 10 mg. Montelukast, lacked dosage. <p>(continued on next page)</p>

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>41121</p> <p>The facility reported a census of 45 residents with 22 residents selected for review, including 19 sampled for unnecessary medications. Based on record review and interview, the facility failed to ensure 10 residents, Resident (R) 3, R4, R5, R6, R17, R20, R21, R22, R24, and R25 received their physician ordered psychotropic (alters mood or thought) medication scheduled on 04/08/24 during the 06:00 PM to 09:00 PM medication pass.</p> <p>Findings included:</p> <p>- The facility incident summary for the medication errors on 04/08/24, revealed on 04/08/24 at 06:00 PM, Administrative Nurse D was working as a charge nurse when Certified Medication Aide (CMA) R stated she needed to leave. Administrative Nurse D misunderstood CMA R thinking CMA R told her she had given all but one resident their medication. On 04/09/24 at 05:30 PM, Administrative Nurse D received a call from CMA S asking who administered medication last evening, in which she responded CMA R had. CMA S informed Administrative Nurse D several residents had not received their medication. Administrative Nurse D discovered CMA R had given a handful of medications for the evening pass. The summary revealed Administrative Nurse D called Administrative Nurse E, who said she had only given medications on the (specified) unit. The summary revealed on 04/09/24 Administrative Nurse D notified residents, families, and doctors explaining medications were missed.</p> <p>The Medication Error Report Forms dated 04/09/24, revealed on 04/08/24 between 06:00 PM and 09:00 PM, staff failed to administer the following physician ordered psychotropic medications to these residents:</p> <p>R3 did not receive:</p> <ol style="list-style-type: none"> 1. Duloxetine (antidepressant - class of medications used to treat mood disorders), lacked dosage. 2. Trazadone (antidepressant), lacked dosage. <p>R4 did not receive:</p> <ol style="list-style-type: none"> 1. Mirtazapine (antidepressant), 7.5 milligrams (mg). 2. Quetiapine (antipsychotic - class of medications used to treat major mental conditions which cause a break from reality), 25 mg. <p>R5 did not receive Trazadone, 100 mg.</p> <p>R6 did not receive:</p> <ol style="list-style-type: none"> 1. Clonazepam (benzodiazepine - class of depressant medications used to treat anxiety, insomnia, and seizures), lacked dosage. <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Risperidone (antipsychotic), 0.5 mg.</p> <p>R7 did not receive:</p> <p>1. Thioridazine (antipsychotic), 50 mg between 02:00 PM and 05:00 PM, and 100 mg at hour of sleep (HS).</p> <p>2. Sertraline (antidepressant), lacked dosage.</p> <p>R20 did not receive:</p> <p>1. Seroquel (quetiapine), 50 mg.</p> <p>2. Buspirone (antianxiety - class of medications that calm and relax people), 10 mg.</p> <p>3. Sertraline, 100 mg.</p> <p>R21 did not receive sertraline, lacked dosage.</p> <p>R22 did not receive:</p> <p>1. Buspirone, five mg.</p> <p>2. Trazadone, 150 mg.</p> <p>R24 did not receive mirtazapine, 7.5 mg.</p> <p>R25 did not receive Zyprexa (antipsychotic), lacked dosage.</p> <p>On 10/24/24 at 01:43 PM, Administrative Nurse D stated she thought CMA R had told her all of the medications had been given except for to one resident, and when she looked, that resident had received his medication. Administrative Nurse D stated she gave meds on the (specified hallways). Administrative Nurses D stated medications were not administered to the residents on (specified hallway). Administrative Nurse D stated the night shift charge nurse should look to see all medications were passed before the CMA left her shift.</p> <p>The facility policy Medication Administration dated 2024, revealed medications were to be administered as ordered by the physician. The staff were to review the Medication Administration Record to identify medication to be administered.</p> <p>The facility failed to ensure R3, R4, R5, R6, R17, R20, R21, R22, R24, and R25 received their physician ordered psychotropic medication scheduled on 04/08/24 during the 06:00 PM to 09:00 PM medication pass.</p>