STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175463	A. Building B. Wing	06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tanglewood Nursing & Rehabilitation	5015 SW 28th Street Topeka, KS 66614

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42966 The facility identified a census of 43 residents. The sample included five residents. Based on record review and interviews, the facility failed to ensure Resident (R) 1 received care consistent with the standards of practice when staff failed to notify and obtain physician involvement regarding R1's multiple medication refusals including medications used to control seizures (violent involuntary series of contractions of a group of muscles). R1 refused all morning doses for his twice-daily Keppra (medication used to treat seizures) from [DATE] through [DATE]. R1's clinical record lacked evidence the staff reported the refusals to the physician for medical evaluation. On [DATE] at 04:02 PM, R1 sat in the dining room, talking to staff, when his legs began to shake and extend outward. He received Ativan (medication used to treat seizures and anxiety [mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear]) 0.5 milligrams (mg) orally at 04:05 PM. At 04:07 PM, his full body stiffened, and staff took him to his room and assisted him into bed. At 04:10 PM, Consultant GG arrived at the facility and ordered an Ativan 2 mg injection for the seizure, which staff administered At 04:15 PM, staff administered an Ativan 4 mg injection for the ongoing seizure. At 04:16 PM, staff called Emergency Medical Services (EMS) and administered another dose of Ativan 2 mg via injection for the seizure. EMS arrived and transported R1 to the hospital. R1 admitted to the hospital and later died on [DATE]. The facility's failure to provide nursing care within the standards of practice including notification and involvement for medical oversight for repeated and ongoing seizure medication refusals placed R1 in immediate jeopardy. Findings included: - R1's clinical record documented a diagnosis of seizures and anxiety disorder. The Annual Minimum Data Set (MDS) dated [DATE], documented R1 had a Brief Interview for Mental Status (BIMS) score of five which indicated severe cognitive impairment. R1 had wandering behavior that occurred one to three days in the assessment period. R1 was independent with transfers; required set-up or clean-up assistance with eating, toileting hygiene, upper and lower body dressing, and putting on/taking off shoes; required supervision with oral hygiene; and required partial to moderate assistance with bathing and personal hygiene. R1's Care Plan dated [DATE], documented R1 had a seizure disorder and directed staff to administer seizure medications as ordered by the doctor, notify the nurse immediately if seizure activity occurred, and obtained labs as ordered and reported results to the doctor. (continued on next page)

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
	175463	A. Building B. Wing	06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tanglewood Nursing & Rehabilitation	5015 SW 28th Street Topeka, KS 66614

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Orders tab of R1's EMR documented an order with a start date of [DATE] for Keppra 1000 mg 1.5 tablets two times a day for seizures. Review of R1's Medication Administration Record (MAR) for [DATE] to [DATE] revealed R1 refused his Keppra medication the following scheduled morning doses: [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. R1's MAR documented he spit out meds for his morning Keppra dose on [DATE] and [DATE]. R1's clinical record lacked evidence that staff notified the physician of R1's Keppra refusals from [DATE] to [DATE]. R1's clinical record revealed a progress note from Consultant GG for [DATE] that documented R1 was seen for a seizure. Nursing staff reported R1 was having tremors around 04:00 PM and he was given oral Ativan 0. 5 mg. R1 went into full status epilepticus (a seizure that occurs continuously for much longer than usual or seizures that occur in quick succession with no time between the seizures for the person to recover) and Consultant GG gave an order for a 2 mg Ativan injection with no change in his seizure. The Ativan was repeated every 15 minutes until R1 was transferred to the emergency room by ambulance. Upon request, the facility provided Emergency Department (ED) Provider Notes for R1. The ED Provider Notes, dated [DATE], documented R1 presented from a nursing facility with concerns of seizures for the last hour and 15 minutes. R1's seizure activity apparently started around 04:00 PM. He was treated with oral lorazepam (Ativan) as well as lorazepam injections without improvement to seizure-like activity. EMS arrived at the facility and R1 continued to have seizure-like activity. EMS gave 4 mg intravenous (through a vein) lorazepam then phoned in indicating a code red patient was coming into the ED. Upon R1's arrival to the ED, he was nonresponsive and not responding to pain or verbal stimuli. The decision was made to intubate (tube inserted into a trachea [wind pipe] to assist with breathing) R1. On [DATE] at 12:56 PM, Certified Medication Aide (CMA) R stated if a resident refused a medication, she tried three more times then asked the nurse to try. She stated if a medication was refused a couple of days in a row, she let the nurse know. On [DATE] at 12:58 PM, Licensed Nurse (LN) G stated if a resident refused a medication, she tried to give it again, but it was their right to refuse. She stated the physician was notified daily if a resident refused medications or the provider was notified when they did rounds on Thursdays. LN G stated the physician notification was documented in medication notes which showed up with the progress notes. She stated she had not received any notification from any CMAs that R1 refused his Keppra medication. LN G stated she expected CMAs to notify the nurse if the resident refused any medications. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175463	A. Building B. Wing	06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tanglewood Nursing & Rehabilitation	5015 SW 28th Street Topeka, KS 66614

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 01:09 PM, Administrative Nurse D stated on [DATE], R1 was in the dining room for an activity before dinner when she heard staff yelled for help; R1 looked like he was having a seizure. She stated the right side of R1's body was jerking but he was still talking. Consultant GG came in and ordered Ativan then staff took R1 to his room where he started seizing again and kept seizing. Administrative Nurse D stated Consultant GG ordered more Ativan for R1 and told staff to send him to the ER. She stated the Ativan was not working but when the ambulance arrived, R1 stopped presenting as seizing at that point and he left with EMS. Administrative Nurse D stated nobody had reported to her that R1 refused his Keppra and R1 did have a history of seizures. She stated she did not review R1's MAR. Administrative Nurse D stated if a resident refused a medication, staff were to let the nurse know so the nurse could notify the physician. She expected the nurse to notify the physician after every missed dose and the physician notification should be documented in the progress notes. After reviewing R1's [DATE] MAR,, Administrative Nurse D stated the missed morning doses of Keppra were not good. On [DATE] at 01:20 PM, CMA S stated R1 constantly refused his medications and if he refused medications, she told the nurse and charted it. She stated she charted it by using the refused option in the MAR and sometimes she put the nurse notification in the notes. CMA S stated she followed up with the nurse if a resident missed a couple of doses. She stated she did not remember the period of [DATE] to [DATE] and if R1 refused his Keppra. On [DATE] at 02:55 PM, Administrative Staff A stated she expected the CMA to notify the nurse if a resident refused a medication and for the nurse to notify the physician then chart the notification in the progress notes. On [DATE] at 03:00 PM, Consultant GG stated on [DATE] she came into the facility and was asked for an order for Ativan. She stated she went to R1's room within five minutes and he was still seizing. She stated she told staff to call 911. Consultant GG stated Ativan was given every 15 minutes, but the seizure did not stop. She stated she had been told several times on and off that R1 refused medications, but she was not aware that he had not taken his Keppra from [DATE] to [DATE]. Consultant GG stated she was usually notified of refused medications and if a resident refused two doses, she expected to be notified. The facility's Change in a Resident's Condition or Status, dated [DATE], directed the nurse notified the resident's attending physician or physician on call when there had been a refusal of treatment or medications. The policy directed the nurse recorded in the resident's medical record information related to changes in the resident's medical or mental condition or status. The facility failed to ensure R1 received care consistent with the standards of practice when staff failed to notify and obtain physician involvement regarding R1's multiple medication refusals including medications used to control seizures. R1 refused all morning doses for his twice-daily Keppra from [DATE] through [DATE]. R1's clinical record lacked evidence the staff reported the refusals to the physician for medical evaluation. On [DATE], R1 experienced a seizure that required medical intervention including emergency transportation to the hospital for evaluation. He was transferred to another hospital where he was admitted and died on [DATE]. The facility's failure to provide nursing care within the standards of practice including notification and involvement for medical oversight for repeated and ongoing seizure medication refusals placed R1 in immediate jeopardy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175463	A. Building B. Wing	06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tanglewood Nursing & Rehabilitation	5015 SW 28th Street Topeka, KS 66614

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 03:15 PM, Administrative Staff A received a copy of the Immediate Jeopardy Template and was informed of the facility failure to notify and obtain physician involvement regarding R1's multiple medication refusals for Keppra leading up to a seizure on [DATE], that required emergent medical intervention and admission to the hospital, placed R1 in immediate jeopardy. On [DATE], the facility completed the following corrective actions: The facility educated the CMA and nurses in the facility on medication refusals and notifications following medication refusals. The facility completed an audit of all missed medications for [DATE] and the physician was notified during the Ad Hoc Quality Assurance and Performance Improvement (QAPI) meeting on [DATE]. The surveyor verified removal of the immediacy on [DATE] at 04:49 PM. The deficient practice remained at the scope and severity of a G.