STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175502	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Eudora	1415 Maple Street Eudora, KS 66025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 49 residents. The sample included 14 residents with one resident reviewed for dignity. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 4's urinary catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) drainage bag was placed in a privacy bag. This deficient practice placed R4 at risk for impaired dignity and decreased psychosocial well-being. Findings included: - R4's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of obstructive and reflux uropathy (a disorder of the urinary tract that occurs due to obstructed urinary flow and can be either structural or functional), muscle weakness, epilepsy (brain disorder characterized by repeated seizures), transient ischemic attack (TIA- temporary episode of inadequate blood supply to the brain), depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and dysplasia (abnormal development of tissues and organs). The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 14 which indicated intact cognition. The MDS documented that R4 had an indwelling catheter. The MDS documented R4 required staff assistance with care related to his catheter. R4's Urinary Incontinence and Indwell Catheter Care Area Assessment (CAA) dated 04/13/24 documented R4 had urinary incontinence and indwelling catheter. The CAA documented R4 needed nursing support for toileting hygiene and transfers. R4's Care Plan dated 04/10/23 documented R4 had a catheter, 22 French with a 10 milliliter (ml) balloon. The plan of care documented R4 would be infection free related to the catheter use; staff were to change the catheter bag weekly or if the bag was leaking. The plan directed staff to monitor R4's output from the catheter every shift, and the staff was to ensure R4 had a privacy bag when his catheter was attached to his walker. On 08/12/24 at 08:33 AM, R4 sat at the breakfast table with his peer. R4 had yellow urine visible in his catheter bag. R4 did not have a dignity bag covering his catheter bag. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/13/24 at 01:17 PM, R4 sat in the commons area playing Yahtzee with his peers. R4's catheter bag was half full of dark yellow urine. R4 did not have a dignity bag covering his catheter bag. On 08/14/24 at 08:00 AM, Certified Medication Aide (CMA) T stated all nursing staff should watch to ensure R4's catheter was always in a dignity bag. On 08/14/24 at 08:05 AM, Licensed Nurse (LN) H stated nursing staff should be more aware and remind R4 to put his catheter bag inside a dignity bag. LN H stated the nursing staff was responsible for ensuring R4's catheter bag was covered appropriately. On 08/14/24 at 12:58 PM Administrative Nurse D stated if a resident had a catheter bag, staff should always place a dignity bag over it when the resident was outside their room. Administrative Nurse D stated all nursing staff were responsible for ensuring a dignity bag was in place. The facility did not provide a policy for dignity, the facility uses the standard of practice. The facility failed to ensure R4's urinary catheter drainage bag was placed in a privacy bag. This deficient practice placed R4 at risk for impaired dignity and decreased psychosocial well-being.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 49 residents. The sample included 14 residents. One resident was sampled for reasonable accommodations of resident needs and preferences. Based on observation, record review, and interview, the facility failed to ensure Resident (R)24's call light was within her reach. This deficient practice left R24 at risk for unmet care needs due to the inability to call for staff assistance. Findings included: - R24's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, and emptiness), tardive dyskinesia (abnormal condition characterized by involuntary repetitive movements of the muscles of the face, limbs and trunk), schizophrenia (mental disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), muscle weakness, and dysphagia (swallowing difficulty). The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of zero which indicated severely impaired cognition, but no staff interview was completed. The MDS documented R24 was dependent on staff for all activities of daily living. The MDS documented R24 was incontinent of bowel and bladder, during the observation period. R24's Care Plan dated 02/18/22 documented R24 was at risk for falls due to psychotropic (alters mood or thoughts) drug use and episodes of confusion. R24's plan of care directed staff to place a pancake call light bedside her on the bed. On 08/13/24 at 07:36 AM R24 lay in bed. R24's pancake call light was clipped to the privacy curtain at the bottom of her bed, and a push call light was placed at R24's feet. R24 was unable to reach a call light. On 08/14/24 at 09:05 AM R24 lay in bed. Her pancake call light was clipped to the privacy curtain at the bottom of R24's bed, a push-button call light was draped over her lower legs out of reach. On 08/14/24 at 09:05 AM Licensed Nurse (LN) G stated the call light should never be clipped to the privacy curtain; the light should always be placed where the resident could reach her light. LN G placed R24's light on her chest where R24 could reach the call light. On 08/14/24 at 12:20 PM, Certified Nurses Aide (CMA) T stated the residents' call lights should always be placed within the residents' reach. On 08/14/24 at 12:58 PM Administrative Nurse D stated call lights should be placed within the residents' reach always. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility did not provide an accommodation of needs policy, the facility uses standard of practice. The facility failed to ensure R24's call light was within her reach. This deficient practice left R24 at risk for unmet care needs.

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility had a census of 48 residents. The sample included 14 residents, with one resident reviewed for physical restraint. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 42 was free of physical restraints when staff placed R42 in a recliner, and raised the footrest though R42 was unable to lower the footrest on her own. This placed the resident in a supine position in the recliner and impeded R42's freedom of movement and mobility. This deficient practice placed R42 at risk for impaired mobility, impaired resident rights and autonomy, and increased risk for restraint-related accidents. Findings Included: - R42's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of [NAME]-[NAME] syndrome (a genetic disorder usually caused by deletion of a part of chromosome 15 passed down by the father), cognitive-communication deficit (trouble reasoning and making decisions while comminating), and aphasia (a condition with disordered or absent language function). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of zero which indicated severely impaired cognition. The MDS documented R42 needed substantial to maximal assistance, where the helper did more than half of the effort when going from a sitting to a standing position. R42's Cognitive Loss/ Care Area Assessment (CAA) dated 06/27/24 documented R24 was memory impaired and was severely impaired in making decisions related to her disorder. The CAA documented that the nursing staff were to anticipate her needs. R42's CAA documented she was able to understand others and rarely others can understand her. R42's Care Plan date 06/29/23 documented R42 was at risk for falls related to cognitive developmental delay. The plan of care dated 10/29/23 documented that when R42 sat in the living room, do not put her feet up because R42 preferred to be able to walk around and sit when she wanted to. On 08/12/24 at 07:24 AM, R42 sat in a reclined chair with her feet elevated in the living room. R42 was holding a red stuffed animal. R42 was slid down on the recliner and thus laying almost flat. On 08/13/24 at 09:17 AM R42 sat in a reclined chair with her feet elevated in the living room, R42 was chewing on a red stuffed animal. R42 was wiggling back and forth in the reclined chair. On 08/13/24 at 12:19 PM, R42 sat in the reclined chair, with her feet elevated in the living room. R42 was wiggling herself down in the reclined chair. On 08/13/24 at 12:32 PM Certified Medication Aide (CMA) R stated she does know what the plan of care for R42 states, and all nursing staff were able to see the Kardex (a nursing tool that gives a brief overview of the care needs of each resident). CMA R stated she didn't know if R42 liked her feet up. She said when R42's feet were elevated, R42 was unable to get out of the recliner, unless she really tried. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/14/24 at 09:15 PM Licensed Nurse (LN) G stated R42 liked to walk around. LN G stated R42 should not have her feet elevated. LN G stated if R42's feet were elevated, she could not get up and that was a restraint since R42 would not be able to put the footrest down and get out of the reclined chair. On 08/14/24 at 12:58 PM Administrative Nurse D stated she did not believe R42 would be able to get out of a reclined chair by herself if the chair was reclined and the footrest were elevated. Administrative Nurse D stated the facility would educate staff on following R42's plan of care. The facility's Restraint policy documents residents have the right to be free from physical restraints imposed for the purpose of discipline or convenience. The facility failed to ensure R42 was free of physical restraints. This deficient practice placed R42 at risk for impaired mobility, impaired resident rights and autonomy, and increased risk for restraint-related accidents.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41713 The facility identified a census of 49 residents. The sample included 14 residents with one resident sampled for hospitalization Based on record review and interview the facility failed to provide a written notice of transfer as soon as practicable to Resident (R) 50 or their representative for their facility-initiated transfers. This deficient practice had the risk of miscommunication between the facility and resident/family and possible missed opportunity for healthcare service for R50. Findings included: - The Electronic Medical Record (EMR) for R50 documented diagnoses of falls, cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), atrial fibrillation (rapid, irregular heartbeat), and heart failure. R50's Admission Minimum Data Set (MDS) had yet not been completed. R50's Discharge MDS dated [DATE] documented she had an unplanned discharge to a short-term acute hospital with a return not anticipated. R50's Care Plan initiated on 07/02/24 directed staff that R50 planned to discharge home after the completion of her therapy services. R50 was working with therapy to build her strength and ability to care for herself in the community. Staff was directed to assist with the coordination of services in the community. R50's EMR documented a Nurse's Note dated 07/07/24 at 08:34 AM that R50's son returned a phone call regarding R50 being sent to the emergency room due to a change in vital signs with distress and having delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue). R50's EMR lacked documentation a written notification of transfer was provided to R50 or her representative. Upon request, the facility was unable to provide evidence the written notification of transfer or discharge for R50's facility-initiated transfer was provided. On 08/14/24 at 12:38 PM, Licensed Nurse (LN) G stated she normally just called the family member to notify them when a resident was being sent out to the hospital. LN G stated as far as she knew, a formal written notification was never mailed to a resident's family representative. The facility did not have a policy regarding written notification of transfer and or discharge. The facility failed to provide written notice of transfer as soon as practicable to R50 or their representative for their facility-initiated transfer. This deficient practice had the risk of miscommunication between the facility and resident/family and possible missed opportunity for healthcare service for R50.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41713 The facility identified a census of 49 residents. The sample included 14 residents with one resident sampled for hospitalization . Based on observations, record review, and interview the facility failed to provide a bed hold notice to Resident (R) 50 or their representative when R50 transferred to the hospital. This deficient practice placed R50 at risk for impaired ability to return to the facility or the same room. Findings included: - The Electronic Medical Record (EMR) for R50 documented diagnoses of falls, cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), atrial fibrillation (rapid, irregular heartbeat), and heart failure. R50's Admission Minimum Data Set (MDS) had yet not been completed. R50's Discharge MDS dated [DATE] documented she had an unplanned discharge to a short-term acute hospital with a return not anticipated. R50's Care Plan initiated on 07/02/24 directed staff that R50 planned to discharge home after the completion of her therapy services. R50 was working with therapy to build her strength and ability to care for herself in the community. Staff was directed to assist with the coordination of services in the community. R50's EMR documented a Nurse's Note dated 07/07/24 at 08:34 AM that R50's son returned a phone call regarding R50 being sent to the emergency room due to a change in vital signs with distress and having delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue). R50's EMR lacked documentation of a bed hold notice was provided to R50 or her representative. Upon request, the facility was unable to provide evidence the bed hold for R50's facility-initiated transfer was provided. On 08/14/24 at 12:38 PM Licensed Nurse (LN) G stated she normally would just call the family member to notify them when a resident was being sent out to the hospital. LN G stated a bed hold was normally completed at the time the resident was sent out unless it was on an emergency basis. On 08/14/24 at 01:18 PM Administrative Nurse D stated a bed hold was expected to be completed by a nurse upon a resident being sent out of the facility. Administrative Nurse D stated social services would typically follow up on the bed hold to make sure it had been completed. The facility did not have a policy regarding bed hold notification. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to provide a bed hold notice to R50 and her representative when R50 transferred to the hospital. This deficient practice placed R50 at risk for impaired ability to return to the facility or his same room.

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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** 41713 The facility identified a census of 49 residents. The sample included 14 residents sampled for care plan revision. Based on observation, record review, and interview, the facility failed to ensure staff revised Resident (R)151's Care Plan with staff direction for safe transfers. The facility failed to ensure staff revised R8's plan of care with interventions after a fall. This placed R151 and R8 at risk for impaired care due to uncommunicated care needs. Findings included: - R151's Electronic Medical Record (EMR) documented diagnoses of dementia (a progressive mental disorder characterized by failing memory, and confusion), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and intervertebral disc degeneration (the breakdown [degeneration] of one or more of the discs that separate the bones of the spine). R151's Admission Minimum Data Set (MDS) dated [DATE] documented she had both long and short-term memory loss. R151 required substantial to maximal staff assistance for transfers, mobility, toileting, and bathing. R151 utilized a wheelchair to assist with mobility. R151's Fall Care Area Assessment (CAA) dated 07/25/24 documented she had falls prior to admission and one fall after admission to the facility with a minor injury. R151 was unable to independently come to a standing position and required hands-on assistance to move from place to place. R151's Care Plan documented an intervention dated 07/15/24 that directed staff she required total assistance of two staff for transfers. R151's plan revised on 07/22/24 documented an intervention for transfers directing staff she needed total assistance of two staff with a Hoyer lift (total body mechanical lift). R151 did not ambulate and required staff to push her wheelchair. R151's Mechanical Lift Use assessment dated [DATE] documented she required supervision to limited physical assistance to fully bear weight but required substantial to maximal assistance to go from sitting to standing position. R151's Physical Therapy Therapy Progress Report documented she started care on 07/26/24 to increase the ability to stand supported, complete sit-to-stand transfers, stand pivot transfers, and increase bilateral lower extremity strength. On 08/13/24 at 02:35 PM R151 sat in a recliner in the sitting area near the 100/200 hall nurse's desk. Certified Medication Aide (CMA) S and CMA T came to assist R151 from the recliner to her wheelchair. CMA T placed a gait belt around R151's waist. CMA S and CMA T told R151 they would count to three and she would stand with their assistance. R151 was able to go from sitting position to standing and pivoting to be able to be seated in her wheelchair without difficulty. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/13/24 at 02:40 PM, CMA S stated that she normally worked on R151's hall and had assisted her many times with her transfers. CMA S stated that she had never been aware that R151 required the use of a Hoyer lift for her transfers. CMA S stated she did not have access to the care plans, but the aides do have the Kardex (a nursing tool that gives a brief overview of the care needs of each resident) that documented the required assistance a resident required. On 08/13/24 at 02:42 PM, Licensed Nurse (LN) G stated R151 had never used a Hoyer lift for her transfers. LN G stated R151 has always been a two-person transfer. LN G stated that the Hoyer lift transfer might have been from the previous facility R151 was at but could not say for certain. LN G stated that therapy had been working with R151 to build up her leg strength to be able to transfer better. On 08/14/24 at 12:58 PM Administrative Nurse D stated R151 had not been a Hoyer lift transfer and was not sure why her care plan said that. Administrative Nurse D stated R151 had been seen by physical therapy since her admission and had been working to improve her strength and ability to transfer. Administrative Nurse D stated she was not sure why the care plan had not been revised to reflect that R151 was a two-person assist with transfers and the intervention for the Hoyer lift was somehow overlooked by staff. The facility's Electronic Care Plan policy revised in December 2020 documented the resident's person-centered plan of care was an active working document that reflected the care needs and resident's voice. The MDS coordinator was to initiate a review of the plan of care. Care plan review and revisions were to be completed with the Wellness program. The interdisciplinary team (IDT) was to review, revise, and sign the person-centered plan of care related to their discipline. The MDS Coordinator was to complete the review of the care plan. The facility failed to ensure staff revised R151's Care Plan with the appropriate staff direction for safe transfers. This placed R151 at risk for impaired care due to uncommunicated care needs.

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41713 The facility identified a census of 49 residents. The sample included 14 residents with three residents reviewed for positioning. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 151 had interventions in place to avoid a further decrease in range of motion (ROM). This placed the resident at risk for decreased mobility and impaired quality of life. Findings included: - R151's Electronic Medical Record (EMR) documented diagnoses of dementia (a progressive mental disorder characterized by failing memory, and confusion), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and intervertebral disc degeneration (the breakdown [degeneration] of one or more of the discs that separate the bones of the spine). R151's Admission Minimum Data Set (MDS) dated [DATE] documented she had both long and short-term memory loss. R151 required substantial to maximal staff assistance for activities of daily living (ADLs) such as transfers, mobility, toileting, and bathing. R151 utilized a wheelchair to assist with mobility. R151's Fall Care Area Assessment (CAA) dated 07/25/24 documented she had falls prior to admission and one fall after admission to the facility with a minor injury. R151 was unable to independently come to a standing position and required hands-on assistance to move from place to place. R151's Care Plan documented an intervention dated 07/15/24 that directed staff she required total assistance of two staff for transfers. R151 did not ambulate and required staff to push her wheelchair. R151 used a footboard to help keep her hips and knees bent while she sat in her wheelchair to prevent contractures (abnormal permanent fixation of a joint or muscle). R151 required two-person staff assistance with positioning. R151's Care Plan lacked staff direction to ensure R15's upper body, head, and arms were positioned to avoid further decline or decrease in ROM. A Therapy Progress Report from Occupational Therapy (OT) dated 08/13/24 documented R151's wheelchair met the positioning needs. R151 had impairments in joint mobility and integrity deficits as well as decreased awareness. R151 needed training and caregiver training for ongoing assessment of self-feeding, wheelchair positioning, and sensory techniques for alertness at meals. R151 required continued OT services in order to design and implement a restorative nursing program in order to enhance her quality of life by improving the ability to increase her nutritional intake, improve functional use of upper extremities during ADLs, and improve functional use of lower extremities during ADLs. On 08/12/24 at 09:29 AM R151 sat in her wheelchair near the nurse's desk. Her head was slumped forward with her chin nearly touching her chest. On 08/13/24 at 07:09 AM R151 sat in her wheelchair in the dining room. R151's head hovered an inch or two above the table and her arms were dangling to the side of her wheelchair with her hands almost touching the floor. (continued on next page)

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Medicalodges Eudora	1415 Maple Street Eudora, KS 66025

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/13/24 at 07:23 AM R151 sat in her wheelchair at the dining table with her head resting the table. R151's arms dangled to the sides of the wheelchair. Staff addressed R151 and she raised her head; a staff member placed a clothing protector on her placed a blanket around her arms and then positioned R151's arms inside the wheelchair. On 08/13/24 at 02:12 PM, R151 was reclined in a recliner in the hallway across from the nurse's desk. R151 had a blanket covering her lap and legs. R151's head was raised from the pillow behind her head and her chin was close to her chest. On 08/14/24 at 12:24 PM Certified Medication Aide (CMA) T stated R151 was difficult to redirect at times for her positioning at the dining table. CMA T stated should not remain at the dining table for a long period of time with her head resting on the table. CMA T stated that at meals staff was busy getting the other residents to the assisted dining room and would do their best to make sure R151 was not resting her head on the table. CMA T stated R151 had a wedge that used to be put in her wheelchair for her arms to rest on but the CMA did not know what had happened to them. On 08/14/24 at 12:38 PM, Licensed Nurse (LN) G stated R151 had been working with therapies to gain her strength back. LN G stated she was not aware of interventions for R151 specific to repositioning her at the dining table or for staff to redirect R151 to reposition her head when she had been resting her head on the table. LN G stated she would maybe recommend the addition of a neck pillow. On 08/14/24 at 12:58 PM Administrative Nurse D stated the facility currently did not have a restorative nurse aide. Administrative Nurse D stated R151 had been working with the therapy department to work on her strength after having a fall. Administrative Nurse D stated she would have staff pay closer attention to R151 and speak with staff about assisting R151 in her head and neck positioning while in her wheelchair and in the recliner to make sure her positioning was correct. The Restorative Program Policy & Procedure last revised in December 2022 documented that the purpose and mission of the restorative program were to provide ongoing assessment of residents' functional abilities related to optimal physical functioning, mental, and psychosocial well-being. To identify a resident's potential for their highest practical level of physical functioning, mental abilities, and psychosocial well-being. Developing a restorative nursing program that was driven and specific and to aid in the design of programs that enabled each resident to maintain their highest level of functioning in the areas of physical, mental, and psychosocial well-being. Develop restorative nursing programs that motivate residents and facilitate each resident to perform at their best ability to function. Train the staff so that each staff member understands the techniques used to facilitate each resident performance at his or her highest level. Educate the staff so that each staff member understands the importance of enabling each resident to perform at his or her highest level. Assess the inherent strengths and weaknesses of their existing restorative nursing processes and performance, taking appropriate actions for continuous quality improvement. The facility failed to ensure that staff had interventions in place for staff direction regarding R151's ROM and positioning to avoid further decreased ROM and functionality. This placed R151 at risk for further decline and decreased ROM.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 49 residents. The sample included 14 residents with five residents reviewed for accidents. Based on observation, record review, and interviews, the facility failed to ensure meaningful interventions were implemented for Resident (R) 8 after falls. This deficient practice placed R8 at risk for future falls and possible injuries. Findings included: - R8's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of hemiparesis/hemiplegia (weakness and paralysis on one side of the body) affecting the left non-dominate side), transient ischemic attack (TIA- temporary episode of inadequate blood supply to the brain), cerebral infarction (stroke - the sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), dementia (a progressive mental disorder characterized by failing memory, confusion), unsteadiness on his feet, muscle weakness, cognitive-communication deficit, repeated falls, impulse disorder, orthostatic hypotension (blood pressure dropping with change of position), depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of eight which indicated moderately impaired cognition, The MDS documented R8 had two or more falls since admission with two or more injuries from falls. The MDS documented R8 needed supervision for transfers from a chair. R8's Falls Care Assessment (CAA) dated 03/08/24 documented R8 had impaired gait, mobility, and assistance required with transfers. R8 had a history of falls prior to admission. Risk factors included weakness affecting balance, gait, strength, and muscle endurance. R8's plan of care will be initiated/reviewed to improve or maintain current physical function as it relates to an activity of daily living (ADLs), gait stability, strength, endurance, mobility, decrease fall risk, and minimize injury related to falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R8's Care Plan dated 04/19/24 documented nursing staff would monitor R8's orthostatic blood pressure twice a day for three days. The plan of care dated 04/30/24 documented the physician had changed R8's antidepressant medication administration time from the hour of sleep (HS) to bedtime. The plan of care dated 05/22/24 documented the physician would review R8's antihypertensive medications. The plan of care dated 06/20/24 documented that the physician decreased R8's mood stabilizer medication. The plan of care documented that staff would place R8 in an area that was visible to staff so he could rest. The plan of care dated 06/26/24 and revised 07/12/24 documented for the falls on 06/23/24/and 06/25/24, staff would do one-hour checks to locate R8 and help prevent injuries from falls or self-harm. The plan of care dated 06/28/24 listed an intervention that the physician was to follow R8's medication management to make changes as needed. The plan of care dated 07/13/24 documented a fall intervention that staff would be hyperaware of R8's location when he was in an impulsive mood or had signs or symptoms of walking without his wheelchair unattended, scooting about in his wheelchair at a high rate of speed, or going in and out of other residents' rooms. Staff would redirect R8 as gently as possible during those periods of time. Staff would offer R8 a peanut butter and jelly sandwich or other snacks. Staff would attempt to keep him in their sight and enlist other staff if available to walk and chat with him. The plan of care dated 07/23/24 documented that staff have R8's recliner fixed or replaced. The plan of care dated 08/04/24 documented that staff would obtain a urinalysis (UA) related to R8's increase in confusion, restlessness, agitation ion, and frequency and urgency of urination. The plan of care dated 07/25/24 and revised on 08/14/24 documented that staff would ensure R8 wore Geri-sleeves (fabric sleeves to prevent skin injury) to prevent injuries to his arms. R8's EMR under the Assessment tab revealed Fall Risk Assessment completed on the following dated: 04/27/24, 05/01/24, 05/22/24, 06/02/24, 06/25/24, 07/13/24, 07/22/24, and 08/03/24 which indicated R8 was a high fall risk. R8's EMR under the Progress Notes tab revealed a Fall Note dated 04/18/24 at 02:35 PM documenting R8 had stood up from his wheelchair and had lost his balance. A Fall Note dated 04/27/24 at 11:30 PM documented R8 reported he had fallen while walking back to bed from the bathroom and hit his right arm on the air conditioner unit. R8's shoes and socks were everywhere. Intervention was R8 would wear Geri-sleeves on both arms and was educated to use his call light when he needed assistance. A Fall Note dated 05/1/24 at 01:47 AM R8 had leaned slowly forward and fell out of his wheelchair and hit his forehead on the floor in the assisted dining room. R8 had only one sock on and no shoes on. The fall intervention was to educate R8 when he was feeling tired. A Nurse's Note dated 05/22/24 at 09:59 AM R 8 was assisted with his ADLs and assisted into bed. Upon return to R8's room, he was found sitting on the floor in front of his recliner. R8 had a sock on his right foot and no shoes on. A Fall Note dated 06/21/24 at 00:12 AM R8 was found on the floor of the assisted doing room on his left side. He did not have his socks or shoes on. Fall intervention was staff would change the environment and position R8 into a recliner. A Fall Note dated 06/25/24 at 12:43 PM R8 attempted to ambulate unassisted and fell on to his right side and hit his head. No fall intervention was noted. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Fall Note dated 07/13/24 at 11:23 PM R8 had transferred himself and refused staff assistance for the transfer. R8 fell to the floor on his right side and complained his forehead hurt. R8 had received a small abrasion and bruising to the right elbow. Fall intervention was staff would educate R8 on the importance of accepting assistance with transfers. A Fall Note dated 07/22/24 at 08:48 AM R8 attempted to transfer himself from the recliner across from the nurse's station, lost his balance, and fell backward to the floor. R8 was unable to lower the footrest of the recliner. No new injuries were noted. He has multiple bruises over his body in various stages of healing. The fall intervention was to get the recliner footrest fixed or to have the recliner removed. A Fall Note dated 08/03/24 at 04:15 AM R8 was found on the floor in the hallway by the nurse's station and he had received a laceration on his left eyebrow. No fall intervention was noted. A Fall Note on 08/3/24 at 07:06 R8 had returned from the emergency room at 03:15 AM and was assisted into his bed, 15 minutes later R8 was found on the floor in front of his dresser, and he had multiple skin tears that bled profusely. The fall intervention was to cover the multiple skin tears with gauze and kerlix. On 08/13/24 at 07:42 AM R8 walked out of his bathroom without assistance. He had a purplish-blue bruise noted above his left eye. R8's wheelchair was next to his bed and his walker was across the room next to the wall. On 08/14/24 at 12:20 PM, Certified Medication Aide (CMA) T stated R8 was a high fall risk. CMA T stated that every staff member was required to fill out a witness statement after each fall. CMA T stated the change would be passed on the all the staff if a new fall intervention was implemented for each resident after their falls. On 08/14 24 at 12:40 PM, Licensed Nurse (LN) G stated R8 was identified as a high fall risk. LN G stated fall risk management would review every fall and determine the root cause of the fall, then ensure an appropriate intervention was in place. LN G stated Geri-sleeves would not be a good fall intervention. LN G stated R8's UA obtained 08/04/24 showed no infection and another intervention should have been implemented. LN G stated the intervention that documented that the physician should always be reviewing R8 medications and making changes when needed. On 08/14/24 at 01:00 PM, Administrative Nurse D stated everyone that was working with the resident on the day of a fall was expected to fill out a witness statement. She stated risk management would review the witness statements, determine the root cause, and implement an intervention. She also stated R8 was a high fall risk. Administrative Nurse D stated Geri-sleeves would be better for a skin preventive measure than a fall intervention. Administrative Nurse D stated the physician should always be monitoring a resident medication and making changes when needed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Fall Management policy revised 12/2022 documented, that residents are to be assessed in the first four hours of admission using a standardized fall risk assessment to identify individualized resident risk factors. Residents are to be reevaluated quarterly, with each fall, and any significant change. The facility's interdisciplinary team was to review residents with falls weekly. The director of nursing or designee was to be responsible for reviewing resident falls on a routine basis during Clinical Excellence. The resident's plan of care was to address individualized resident focus, goals, and interventions directed towards reducing the resident's risk of injury and potential reoccurrence of falls. The facility failed to ensure meaningful fall interventions were implemented and applied to R8 to prevent future falls. This deficient practice placed R8 at risk for future falls and possible further injuries.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 49 residents. The sample included 14 residents with two residents reviewed for nutrition and hydration. Based on observation, record review, and interviews, the facility failed to ensure fluids were within reach for Resident (R) 14 and failed to ensure weight loss interventions were provided for R24. These deficient practices placed R14 at risk for dehydration and R24 at risk for further weight loss or malnutrition. Findings included: - R14's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of dementia (a progressive mental disorder characterized by failing memory, and confusion), left-sided hemiplegia (paralysis of one side of the body), and seizure (violent involuntary series of contractions of a group of muscles). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 12 which indicated impaired cognition. The MDS documented R14 required supervision or touch assistance with eating her mechanically altered diet. The MDS documented R14 had a limitation in range of motion (ROM- the full movement potential of a joint, usually its range of flexion and extension) on one side of her body. R14's Functional Abilities Care Area Assessment (CAA) dated 06/14/24 documented she was able to communicate her needs. R14's Care Plan dated 09/04/22 documented she was able to eat independently. R14's EMR under the Orders tab revealed the following physician orders: Regular diet with a mechanical soft texture. No straws. Cranberry juice twice a day. R14 was to use a cup with a lid due to lack of coordination and increase oral intake of fluids dated 01/10/23. On 08/12/24 at 07:40 AM R14 lay on her bed with her call light attached to the quarter side rail on the right side of her bed. R14's over-bed side table with her water cup was pushed up against the wall above her head and out of her reach. On 08/13/24 at 09:00 AM R14 laid on her bed. Her cup of fluid sat on the over-bed side table that was pushed up against the wall above R14's head. R14 stated she was unable to reach her water. R14 placed her call light on, and the staff answered the call light and placed the table and water in R14's reach. On 08/13/24 at 02:55 PM, R14 lay on her bed, her side table was pushed up next to her bed and her left-hand splint was laid on the table. R14's lidded water cup sat on her bedside table across the room and out of her reach. R14 requested a soda, and the nursing staff provided a soda to drink. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/14/24 at 12:20 PM, Certified Medication Aide (CMA) T stated R14 had the ability to drink and eat without assistance. CMA T stated R14's fluids should have been within reach when she was in her bed. On 08/14/24 at 12:40 PM, Licensed Nurse (LN) G stated R14 was able to drink her fluids without assistance and that her fluids should be within her reach when she was in bed. LN G stated R14 enjoyed drinking soda and juice. LN G stated R14e required a lidded cup to prevent her from spilling the fluid on herself. On 08/14/24 at 12:40 PM, Administrative Nurse D stated she expected a resident's fluids to always be within their reach. The facility was unable to provide a policy related to hydration. The facility failed to ensure R14's water was within her reach. This deficient practice placed R14 at risk for dehydration and adverse effects. 49634 - R24's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, and emptiness), tardive dyskinesia (abnormal condition characterized by involuntary repetitive movements of the muscles of the face, limbs and trunk), schizophrenia (mental disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), muscle weakness, and dysphagia (swallowing difficulty). The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of zero which indicated severely impaired cognition, but no staff interview was completed. The MDS documented that R24 had a weight loss of five percent or more in the last month or a loss of ten percent in the last six months, with no physician-prescribed weight loss regimen. The MDS documented R24 was dependent on staff for all activities of daily living, including eating during the observation period. R24's Nutritional Status Care Area Assessment (CAA) dated 01/26/24 documented R24 had a five percent or more weight loss and was on a mechanical soft diet. R24 was to continue a mechanically altered diet with thin liquids, a divided plate, and a cup with a lid. The CAA documented nursing staff would continue to provide R24 with eating, and oral support, and nursing would continue to obtain weights as ordered. R24's Care Plan dated 07/31/24 documented R24 was on a fortified food diet, mechanical soft textured, pureed meat, and all other foods were mechanical soft. R24 needed staff assistance for dining. R24 drank from a cup with a lid and received milk with all meals. R24's plan of care directed staff to give a house supplement two times a day for weight loss; the Registered Dietician (RD) and physician were aware of her weight loss. R24's plan of care dated 02/17/23 documented R24 sat at assisted table, and staff needed to assist R24 with each meal and give her drinks, R24 was no longer able to consistently feed herself. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the EMR under the Orders tab revealed physician orders: Fortified food diet, mechanical soft texture, regular consistency, pureed meat, other foods mechanical soft. Staff was to assist with dining, use a cup with a lid, and add milk to all meals, dated 05/23/24. House supplements: give two times a day for weight loss, give 240 millimeters (ml) dated 06/12/24. On 07/27/23 at 10:19 PM a Registered Dietitian Assessment note documented the resident was at risk for alteration in nutrition status. She had a change in her wheelchair, which may contribute to changes in weight status. R24's weight had been maintained for two months but remained a concern. R24 required staff to feed her. The current diet order was mechanical texture, fortified foods, regular consistency, with pureed meat. R24 received a house supplement, 120 ml. twice a day. The note recommended changing the supplement to Boost (a high-calorie supplement) 240mls twice daily and continuing to monitor weight shifts. On 08/13/24 at 08:17 AM R24 sat in the dining room at the assisted table in her Broda chair (specialized wheelchair with the ability to tilt and recline). R24 had a cup with a l that contained orange juice. R24 was not served milk with this meal. On 08/13/24 at 11:57 AM R24 sat in the dining room at the assisted table in her Broda chair. R24 received a cup of apple juice with a lid. R24 was not offered or provided milk with this meal. On 08/14/23 at 07:33 AM R34 sat in the dining room at the assisted table in her Broda chair. R24 received apple juice with her breakfast tray. R24 was not offered or provided milk with this meal. On 08/14/23 at 07:50 AM Certified Medication Aide (CMA) R stated if a resident had special drinks ordered, nursing staff monitored to ensure the resident received exactly what she needed. CMA R stated the request would be placed on the CMA task or it would be on the CMA Medical Administration Record (MAR). CMA R stated special requests or orders were relayed by the nurse to the staff to monitor. CMA R stated there was nothing on the MAR that stated R24 should get milk with each meal. On 08/14/23 at 08:12 AM Licensed Nurse (LN) G stated if there was an order for R24 to have a specific drink or food, the order would go to the nurse and was communicated to dietary and all nursing staff by the nurse. LN G stated that R24's order for milk must have gotten lost in communication. On 08/14/24 at 12:58 PM Administrative Nurse D stated dietary orders go to the nurse, who entered the orders on the MAR and sent them out to all departments. Administrative Nurse D stated communication could be through word of mouth or an email. The facility's Weight Assessment and Intervention policy documented the interdisciplinary team will strive to prevent, monitor, and intervene in the undesirable weight change of residents. Nursing staff would record resident weight the day they move in and once a week for four weeks thereafter. If no weight concerns are noted, the resident's weight will be recorded monthly thereafter. Weights would be recorded in the electronic medical record. The Registered Dietitian will review weights monthly. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to provide R24's weight loss interventions when staff failed to provide milk at each meal and further failed to implement RD recommendations to change and increase R24's supplement to prevent further weight loss. This deficient practice placed R24 at risk of malnutrition and other negative outcomes.

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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** 49634 The facility identified a census of 49 residents. The sample included 14 residents with one person reviewed for side rails. Based on observation, record review, and interviews, the facility failed to attempt the use of alternative measures prior to installing Resident (R) 24's side rail and the facility further failed to complete a side rail safety assessment that acknowledged the presence of a low air loss mattress and the associated risks, prior to installation of the side rails for R24. This deficient practice placed R24 at risk of injury due to unidentified risks from the use of side rails. Findings included: - R24's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, and emptiness), tardive dyskinesia (abnormal condition characterized by involuntary repetitive movements of the muscles of the face, limbs and trunk), schizophrenia (mental disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), muscle weakness, and dysphagia (swallowing difficulty). The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of zero which indicated severely impaired cognition, but no staff interview was completed. The MDS documented R24 was dependent on staff for all activities of daily living (ADLs). The MDS did not document R24 had bed rails. The Cognitive Loss/ Dementia Care Assessment Area (CAA) dated 01/26/24 documented R24 to minimize risks. R24's Care Plan revised on 05/24/21 documented R24 required staff assistance with all ADLs. The plan of care revised on 02/17/23 documented she required two staff for bed mobility. The plan of care documented R24 had bed rails on both sides of her bed, to assist with repositioning in bed and to assist R24 with getting out of bed. R24's EMR under the Misc. tab dated 07/18/24 revealed a Restraint assessment/. The assessment included an option to declare side rails for repositioning. The Restraint assessment lacked a side rail assessment that identified R24's low air loss mattress. R24's EMR lacked evidence of risk versus benefits and education was provided to R24 or her representative regarding the risks associated with her use of side rails. On 08/13/24 at 07:36 AM R24 laid in her bed, on her back on a low air loss mattress. R24's side rails on both sides of the bed were up. (continued on next page)

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Medicalodges Eudora	1415 Maple Street Eudora, KS 66025

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/14/24 at 09:05 AM R24 laid in her bed on her back on a low air loss mattress. R24's side rails on both sides of the bed were up. On 08/14/24 at 09:10 AM Licensed Nurse (LN) G stated nursing does a restraint assessment each quarter, she stated side rails are part of the assessment. LN G stated she was not aware there were measurements involved when doing a side rail assessment with a low air loss mattress. On 08/14/24 at 12:58 PM Administrative Nurse D stated bed rails would be assessed quarterly. Administrative D stated bed rails were not being measured. She stated she was not aware the bed rails needed to be measured for gaps that could occur and create a risk. The facility did not provide a side rail policy. The facility failed to attempt the use of alternative measures prior to installing R24's side rail and the facility further failed to complete a side rail safety assessment that acknowledged the presence of a low air loss mattress and the associated risks, prior to installation of the side rails for R24. This deficient practice placed R24 at risk of injury due to unidentified risks from the use of side rails.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 41037 The facility identified a census of 49 residents. Based on observation, record review, and interview, the facility failed to provide Registered Nurse (RN) coverage eight consecutive hours a day, seven days a week. This placed all residents who resided in the facility at risk of lack of assessment and inappropriate care. Findings included: - The facility's January, February, March, and April 2024 nursing schedule lacked evidence of Registered Nurse coverage for eight consecutive hours a day, on the following dates: 01/20/24, 01/21/24, 02/17/24, 03/3/24, 03/16/24, and 04/7/24. The facility was unable to provide verifiable, auditable evidence of RN coverage. On 08/13/24 at 01:29 PM, Administrative Staff A stated she was unable to show evidence of RN coverage for the above days. The facility did not provide a policy related to Registered Nurse coverage. The facility failed to provide Registered Nurse coverage eight consecutive hours a day, seven days a week, as required. This placed the residents who resided in the facility at risk of lack of assessment and inappropriate care.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 41037 The facility identified a census of 49 residents. The sample included 14 residents and five Certified Nurse Aides (CNA) were reviewed for yearly performance evaluations and the associated in-service training. Based on record review and interview, the facility failed to ensure five of the five CNA staff reviewed had yearly performance evaluations completed. This placed the residents at risk for inadequate care. Findings included: - A review of the facility's staffing list revealed the following CNAs were employed with the facility for more than 12 months: CNA M, hired on 06/13/13, had no yearly performance evaluation upon request. CNA N, hired on 06/16/22, had no yearly performance evaluation upon request. CNA/Certified Medication Aide (CMA) R, hired 09/17/18, had no yearly performance evaluation upon request. CNA P, hired on 04/18/22, had no yearly performance evaluation upon request. CNA O, hired on 03/15/23, had no yearly performance evaluation upon request. On 08/14/24 at 10:05 AM, Administrative Staff A stated the director of nursing was responsible for performing the yearly performance evaluations for the nursing staff. On 08/14/24 at 01:00 PM, Administrative Nurse D stated she was responsible for the yearly performance evaluations for the nursing staff. Administrative Nurse D stated she had not performed the yearly performance evaluation yet. The facility was unable to provide a policy related to yearly performance evaluations. The facility failed to ensure any of the five CNA staff reviewed had the required yearly performance evaluations completed. This placed the residents at risk for inadequate care.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 41037 The facility identified a census of 49 residents. Based on observation, record review, and interviews, the facility failed to maintain the posted daily nurse staffing data for the required 18 months. The facility additionally failed to list the daily census on the provided daily staffing documentation. Findings included: - A review of posted staffing from 01/01/2023 to 08/15/2024 revealed the facility could not provide posted staffing documentation for 05/2024 and 06/2023 (two months). The provided posted staffing sheets lacked a daily census for the residents within the facility for the last 18 months. On 08/13/24 at 01:29 PM, Administrative Staff A stated the previous business office manager was responsible for ensuring the posted nursing hours were posted daily. Administrative Staff A stated the director of nursing was ultimately responsible for ensuring the daily nursing hours were posted and should include the facility census. On 08/14/24 at 01:00 PM, Administrative Nurse D stated she was the person responsible for ensuring the daily nursing hours were posted and included the information required. The facility's Benefit Improvements Protection Act (BIPA) Nurse Staff Posting policy revised 12/2019 indicated the facility will post staffing data each shift for the direct care and licensed nurses. The policy indicated the daily posted staffing will identify the census at the beginning of each shift to track the necessary staffing required. The facility failed to maintain the posted daily nurse staffing data for the required 18 months. The facility additionally failed to list the daily census on the provided daily staffing documentation.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 41037 The facility identified a census of 49 residents. The sample included 14 residents with five residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported the need for a physician-documented rationale for non-approved Center for Medicare and Medicaid Services (CMS) indications for the use of antipsychotic medications (class of medications used to treat major mental conditions which cause a break from reality) for Resident (R) 35, R20, R19, and R27. This deficient practice placed these residents at risk for adverse medication effects and medication errors. Findings included: - R35's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of dementia (a progressive mental disorder characterized by failing memory, and confusion), insomnia (inability to sleep), mood disorder (category of mental health problems, feelings of sadness, helplessness, guilt, wanting to die were more intense and persistent than what may normally be felt from time to time), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The Significant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R35 received antianxiety (class of medications that calm and relax people), antidepressant (class of medications used to treat mood disorders), antipsychotic medication, anticoagulant (class of medications used to prevent the formation of blood clots), diuretic (medication to promote the formation and excretion of urine), hypnotic (a class of medications used to induce sleep), and opioid (a class of medication used to treat pain) during the observation period. The MDS documented that a gradual dose reduction was not completed and lacked documentation a Monthly Medication Review (MMR) was completed during the observation period. The MDS documented R35 had dementia. The Quarterly MDS dated [DATE] documented a BIMS score of 10 which indicated moderately impaired cognition. The MDS documented that R35 had received antianxiety medication, antidepressant medication, antipsychotic medication, anticoagulant (medication, diuretic medication, hypnotic medication, and opioid medication during the observation period. The MDS documented that a gradual dose reduction was not completed and lacked documentation an MMR was completed during the observation period. R35's Psychotropic Drug Use Care Area Assessment (CAA) dated 04/09/24 documented R35 received antipsychotic medication, antianxiety medication, antidepressant medication, and hypnotic medication. R35's Care Plan revised on 08/04/24 documented that staff would administer medications as ordered. R35's EMR under the Orders tab revealed the following physician orders: Trazodone hcl tablet (antidepressant) 150 mg give one tablet by mouth at bedtime related to insomnia dated 01/17/23. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Abilify (antipsychotic) oral tablet 30mg give one tablet by mouth one time a day related to unspecified mood disorder dated 01/23/23. Belsomra tablet (hypnotic) 10mg give one tablet by mouth at bedtime related to insomnia dated 06/03/23. Clonazepam (antianxiety) oral tablet 0.5mg give one tablet by mouth three times a day related to insomnia dated 09/27/23. A review of the Monthly Medication Review (MMR) from August 2023 to July 2024 lacked evidence of CP recommendations for physician documentation for the rationale for a non-approved CMS indication for the continued use of the antipsychotic medication Abilify for R35. On 08/14/24 at 07:38 AM R35 walked with his walker in the hallway from his room to the dining room unassisted. His gait was steady, and he wore a pair of tennis shoes. On 08/14/24 at 12:40 PM, Licensed Nurse (LN) G stated she would fax the MMR to the physician, note the new orders, and make the changes upon the returned faxes from the physician. LN G stated she did talk with the physician to clarify the indication for the residents who received antipsychotic medications. LN G stated the approved indication for antipsychotic medication was for behaviors and mood disorders. On 08/14/24 at 01:00 PM, Administrative Nurse D stated she realized the process for MMR had not been successful with tracking the physician responses. Administrative Nurse D stated she realized on 08/14/24 that the process for the facility's monitoring antipsychotic medication had not been utilized correctly. The facility was unable to provide a policy related to the process of CP reporting irregularities. The facility failed to ensure the CP identified and reported the non-approved CMS indication for the use of antipsychotic medication. This deficient practice placed R35 at risk for unnecessary medications and related complications. - R20's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), aphasia (a condition with disordered or absent language function), muscle weakness, and depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). The Significant Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of zero which indicated intact severely impaired cognition. The MDS documented that a staff interview for cognition was not completed. The MDS documented R20 had received diuretic (medication to promote the formation and excretion of urine) medication, antidepressant (class of medications used to treat mood disorders) medication, and antipsychotic (class of medications used to treat major mental conditions which cause a break from reality). The MDS documented that a gradual dose reduction was not completed and lacked documentation a Monthly Medication Review (MMR) was completed during the observation period. The MDS documented R20 had Alzheimer's disease. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R20's Psychotropic Drug Use Care Area Assessment (CAA) dated 07/26/24 documented she received antipsychotic medication for anxiety. R20's Care Plan dated 08/06/24 documented that staff would administer her medications as ordered by the physician. R20's EMR under the Orders tab revealed the following physician orders: Risperdal (antipsychotic)tablet 0.5 milligrams (mg) give 0.5 mg by mouth at bedtime related to anxiety 07/20/22. A review of the Monthly Medication Review (MMR) from August 2023 to July 2024 lacked evidence of recommendations for physician documentation for a rationale for a non-approved CMS indication for the continued use of the antipsychotic medication Risperdal for R20. The December 2023 MMR revealed a recommendation for a dose reduction of antipsychotic medication Risperdal, mood stabilizer Depakote, and antidepressant medications citalopram and mirtazapine. The physician's response dated 12/27/23 to the CP's recommendation was to discontinue the antidepressant citalopram. The response did not address the other medications or include a rationale for continued use. The facility was unable to provide a physician-documented rationale for no GDR for Risperdal, Depakote, and mirtazapine. On 08/13/24 at 02:55 PM, R20 lay on her bed asleep with the head of her bed elevated. R20's call light was within reach. On 08/14/24 at 12:40 PM, Licensed Nurse (LN) G stated she would fax the MMR to the physician, note the new orders, and make the changes upon the returned faxes from the physician. LN G stated she did talk with the physician to clarify the indication for the residents who received antipsychotic medications. LN G stated the approved indication for antipsychotic medication was for behaviors and mood disorders. On 08/14/24 at 01:00 PM, Administrative Nurse D stated she was aware of the physician's orders on November 2023 MMR and that R35 had continued to receive the medications and was a medication error. Administrative Nurse D stated she had realized the process for MMR had not been successful in tracking the physician responses. Administrative Nurse D stated she realized on 08/14/24 that the process for the facility's monitoring antipsychotic medication had not been utilized correctly. The facility was unable to provide a policy related to the process of CP reporting irregularities. The facility failed to ensure the CP identified and reported the non-approved CMS indication for the use of antipsychotic medication for R20. The facility also failed to ensure the physician provided a documented rationale or risk-versus-benefit of continued use of R20's psychotropic medications without GDRs. This deficient practice placed R20 at risk for unnecessary medications and adverse side effects. 41713 (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- R19's Electronic Medical Record (EMR) documented diagnoses of dementia (a progressive mental disorder characterized by failing memory, confusion, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), hallucinations (sensing things while awake that appear to be real, but the mind created), psychotic disorder (any major mental disorder characterized by a gross impairment in reality perception), and hypertension (HTN-elevated blood pressure). R19's Significant Change Minimum Data Set (MDS) dated [DATE] documented he had a Brief Interview for Mental Status (BIMS) score of three which indicated severely impaired cognition. R19 required partial to moderated assistance from staff for activities of daily living (ADLs) and required substantial to maximal staff assistance with toileting. R19 received an antipsychotic on a routine basis as well as an antianxiety and antidepressant medication. No gradual dose reduction (GDR) had been attempted, and the MDS documented it was contraindicated. R19's Quarterly MDS dated [DATE] documented a BIMS score of three which indicated severely impaired cognition. R19 required partial to moderated assistance from staff for ADLs and required substantial to maximal staff assistance with toileting and bathing. R19 received an antipsychotic on a routine basis as well as an antianxiety and antidepressant medication. No GDR had been attempted and it was recorded as clinically contraindicated. The Psychotropic Drug Use Care Area Assessment (CAA) for R19 documented he triggered due to psychotropic drug use. He received antipsychotic, antianxiety, and antidepressant medications. R19's Care Plan directed staff he took Seroquel (an antipsychotic medication) for paranoia (a thought process believed to be heavily influenced by anxiety or fear to the point of irrational thinking) and hallucinations. The staff was directed to provide medications as ordered. R19's Orders tab of the EMR documented an order dated 01/10/22 for Seroquel, take one 50 milligram (mg) tablet by mouth at bedtime for psychotic disorder with hallucinations. R19's Orders tab of the EMR documented an order dated 03/05/22 for Seroquel, take one 25 mg tablet by mouth at bedtime for psychotic disorder with hallucinations. A review of the consultant pharmacist's monthly Medication Regimen Reviews (MRR) from January 2023 to the present lacked documentation of a recommendation for a CMS-approved indication for use for Seroquel. On 08/14/24 at 01:00 PM, Administrative Nurse D stated she realized the process for MMR had not been successful in tracking the physician responses. Administrative Nurse D stated she realized on 08/14/24 that the process for the facility's monitoring antipsychotic medication had not been utilized correctly. The facility was unable to provide a policy related to the process of CP reporting irregularities. The facility failed to ensure the CP identified and reported the non-approved CMS indication for the use of antipsychotic medication for R19. This placed R19 at risk for unnecessary medication administration and possible adverse side effects. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- R27's Electronic Medical Record (EMR) documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), dementia (progressive mental disorder characterized by failing memory, and confusion), and major depressive disorder (major mood disorder which causes persistent feelings of sadness). R27's Annual Minimum Data Set (MDS) dated [DATE] documented R27 had a Brief Interview for Mental Status (BIMS) score of zero which indicated severely impaired cognition. R27 displayed inattention and disorganized thinking that was present and fluctuated. R27 utilized a walker and a wheelchair for mobility. R27 was dependent on staff for all activities of daily living (ADLs) and functional abilities. R27 received an antipsychotic medication on a routine basis. A GDR had not been attempted and had not been documented by the physician as being contraindicated. R27 was on hospice services. R27's Quarterly MDS dated [DATE] documented a BIMS score of zero which indicated severely impaired cognition. R27 displayed inattention and disorganized thinking that was continuously present. R27 utilized a walker and a wheelchair for mobility. R27 was dependent on staff for all ADLs and functional abilities. R27 received an antipsychotic medication on a routine basis. A GDR had not been attempted and had been documented by the physician as being contraindicated. R27 was on hospice services. R27's Psychotropic Drug Use Care Area Assessment (CAA) dated 02/28/24 documented that she currently an antianxiety (class of medications that calm and relax people) and an antidepressant (class of medications used to treat mood disorders) medication with no adverse effects due to medication. R27 was noted with multiple falls during the lookback period since the last assessment. R27 was wandering at times. R27 had severely impaired cognition, and long-term and short-term deficits along with impaired decision-making, inattention, and disorganized thinking. R27 had a current diagnosis of dementia and had some refusal of care. Staff was to reapproach and encourage R27 with ADLs and daily care. Staff was to monitor for changes and notify the physician or psychiatrist to avoid complications and minimize risk. R27's Care Plan last revised 05/08/24 directed staff that she took Seroquel, an antipsychotic, for the behavior of agitation and lashing out at staff. The staff was directed to give medications as the physician ordered. Staff was directed to observe and report any changes in R27's cognitive status. R27's Orders tab of the EMR documented an order dated 08/17/23 for Seroquel 50 milligrams (mg) one tablet one time a day. The order lacked a diagnosis for use. R27's Orders tab of the EMR documented an order dated 02/21/24 for Seroquel 25 milligrams (mg) one table at bedtime for anxious behavior related to major depressive disorder and anxiety. A review of the consultant pharmacist's monthly medication regimen reviews (MRR) from August 2023 to present lacked documentation of a recommendation for a CMS-approved indication for the use of an antipsychotic medication. A 04/30/24 physician's response to the consultant pharmacist's 04/26/24 recommendation for a GDR for R27's antipsychotic Seroquel documented R27 had a good response to the medications. R27 was on hospice and was currently stable on the medication. R27 was monitored regularly by both facility staff and hospice. A change or reduction was likely to cause a reduced quality of life and increased symptoms. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/14/24 at 07:36 AM R27 sat in her Broda (specialized wheelchair with the ability to tilt and recline) at the dining table. Staff assisted R27 with eating. R27 displayed no behaviors. On 08/14/24 at 01:00 PM, Administrative Nurse D stated she realized the process for MMR had not been successful in tracking the physician responses. Administrative Nurse D stated she realized on 08/14/24 that the process for the facility's monitoring antipsychotic medication had not been utilized correctly. The facility was unable to provide a policy related to the process of CP reporting irregularities. The facility failed to ensure the CP identified and reported the non-approved CMS indication for the use of antipsychotic medication for R27. This placed R27 at risk for unnecessary medication administration and possible adverse side effects.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 41713 The facility identified a census of 49 residents. The sample included 14 residents with five residents reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 27, R19, R20, and R35 had an approved Centers for Medicaid and Medicare (CMS) indication or the required physician documentation for antipsychotic medications(class of medications used to treat major mental conditions which cause a break from reality). The facility failed to ensure a documented physician rationale which included the multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for continued use or gradual dose reduction (GDR). This placed the affected residents at risk for unnecessary psychotropic medication and possible adverse side effects. Findings included: - R27's Electronic Medical Record (EMR) documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), dementia (progressive mental disorder characterized by failing memory, and confusion), and major depressive disorder (major mood disorder which causes persistent feelings of sadness). R27's Annual Minimum Data Set (MDS) dated [DATE] documented R27 had a Brief Interview for Mental Status (BIMS) score of zero which indicated severely impaired cognition. R27 displayed inattention and disorganized thinking that was present and fluctuated. R27 utilized a walker and a wheelchair for mobility. R27 was dependent on staff for all activities of daily living (ADLs) and functional abilities. R27 received an antipsychotic medication on a routine basis. A GDR had not been attempted and had not been documented by the physician as being contraindicated. R27 was on hospice services. R27's Quarterly MDS dated [DATE] documented a BIMS score of zero which indicated severely impaired cognition. R27 displayed inattention and disorganized thinking that was continuously present. R27 utilized a walker and a wheelchair for mobility. R27 was dependent on staff for all ADLs and functional abilities. R27 received an antipsychotic medication on a routine basis. A GDR had not been attempted and had been documented by the physician as being contraindicated. R27 was on hospice services. R27's Psychotropic Drug Use Care Area Assessment (CAA) dated 02/28/24 documented she currently received antianxiety (a class of medications that calm and relax people) and an antidepressant (class of medications used to treat mood disorders) with no adverse effects due to medication. R27 was noted with multiple falls during the lookback period since the last assessment. R27 was wandering at times. R27 had severely impaired cognition, and long-term and short-term deficits along with impaired decision-making, inattention, and disorganized thinking. R27 had a current diagnosis of dementia and had some refusal of care. Staff was to reapproach and encourage R27 with ADLs and daily care. Staff was to monitor for changes and notify the physician or psychiatrist to avoid complications and minimize risk. (continued on next page)

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Medicalodges Eudora	1415 Maple Street Eudora, KS 66025

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R27's Care Plan last revised 05/08/24 directed staff that she took Seroquel, an antipsychotic, for the behavior of agitation and lashing out at staff. The staff was directed to give medications as the physician ordered. Staff was directed to observe and report any changes in R27's cognitive status. R27's Orders tab of the EMR documented an order dated 08/17/23 for Seroquel 50 milligrams (mg) one tablet one time a day. The order lacked a diagnosis for use. R27's Orders tab of the EMR documented an order dated 02/21/24 for Seroquel 25 milligrams (mg) one table at bedtime for anxious behavior related to major depressive disorder and anxiety. A 04/30/24 physician's response to the consultant pharmacist's recommendation for a GDR for R27's antipsychotic Seroquel documented R27 had a good response to the medications. R27 was on hospice and was currently stable on the medication. R27 was monitored regularly by both facility staff and hospice. A change or reduction was likely to cause a reduced quality of life and increased symptoms. On 08/14/24 at 07:36 AM R27 sat in her Broda (specialized wheelchair with the ability to tilt and recline) at the dining table. Staff assisted R27 with eating. R27 displayed no behaviors. On 08/14/24 at 12:37 PM, Licensed Nurse (LN) G stated that all medications should have an appropriate indication listed for use on the order. LN G had not realized that R27's Seroquel order did not have an indication listed. LN G stated she knew that antipsychotic medications required a specific diagnosis for use. On 08/14/24 at 12:58 PM Administrative Nurse D stated that the facility physician had been at the facility that day and he had changed some of the diagnoses on psychotropic medications but had been less successful with getting R27's diagnosis changed or a rationale for the use of her Seroquel by her psychiatry physician. Administrative Nurse D stated that she had never noticed that R27's Seroquel medication order lacked a diagnosis or indication for use. The Behavior Management & Psychotropic Medications policy last revised in December 2022 documented that residents are to be assessed for appropriate diagnosis, utilization, adverse effects, and target behaviors related to psychotropic medication use and off-label use of medication prescribed that affect brain activity. Psychotropic medications and off-label use of medication prescribed that affect brain activity were not to be initiated without prior communication between the physician, resident, or responsible party and the facility's interdisciplinary team. Off-label and as-needed (PRN) use of psychotropic medications and off-label use of medication prescribed that affects brain activity were discouraged for elderly residents with dementia. Physician orders to automatically reduce and discontinue an existing or newly initiated antipsychotic medication and off-label use of medication that affects brain activity were to be considered at the time the order was received. The facility failed to ensure R27 had an appropriate CMS-approved indication for use for antipsychotic medication. This placed R27 at risk for unnecessary medication administration and possible adverse side effects. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- R19's Electronic Medical Record (EMR) documented diagnoses of dementia (a progressive mental disorder characterized by failing memory, confusion, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), hallucinations (sensing things while awake that appear to be real, but the mind created), psychotic disorder (any major mental disorder characterized by a gross impairment in reality perception), and hypertension (HTN-elevated blood pressure). R19's Significant Change Minimum Data Set (MDS) dated [DATE] documented he had a Brief Interview for Mental Status (BIMS) score of three which indicated severely impaired cognition. R19 required partial to moderated assistance from staff for activities of daily living (ADLs) and required substantial to maximal staff assistance with toileting. R19 received an antipsychotic on a routine basis as well as an antianxiety and antidepressant medication. No gradual dose reduction (GDR) had been attempted, and the MDS documented it was contraindicated. R19's Quarterly MDS dated [DATE] documented a BIMS score of three which indicated severely impaired cognition. R19 required partial to moderated assistance from staff for ADLs and required substantial to maximal staff assistance with toileting and bathing. R19 received an antipsychotic on a routine basis as well as an antianxiety and antidepressant medication. No GDR had been attempted and it was recorded as clinically contraindicated. The Psychotropic Drug Use Care Area Assessment (CAA) for R19 documented he triggered due to psychotropic drug use. He received antipsychotic, antianxiety, and antidepressant medications. R19's Care Plan directed staff he took Seroquel (an antipsychotic medication) for paranoia (a thought process believed to be heavily influenced by anxiety or fear to the point of irrational thinking) and hallucinations. The staff was directed to provide medications as ordered. R19's Orders tab of the EMR documented an order dated 01/10/22 for Seroquel, take one 50 milligram (mg) tablet by mouth at bedtime for psychotic disorder with hallucinations. R19's Orders tab of the EMR documented an order dated 03/05/22 for Seroquel, take one 25 mg tablet by mouth at bedtime for psychotic disorder with hallucinations. On 08/14/24 at 12:37 PM, Licensed Nurse (LN) G stated that all medications should have an appropriate indication listed for use on the order. LN G stated she knew that antipsychotic medications required a specific diagnosis for use. On 08/14/24 at 12:58 PM Administrative Nurse D stated that the facility physician had been at the facility that day and he had changed some of the diagnoses on psychotropic medications which included R19. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Behavior Management and Psychotropic Medication revised 12/22 documented that residents were to be assessed for appropriate diagnosis, utilization, adverse effects, and target behaviors related to psychotropic medication use and off-label use of medication prescribed that affect brain activity. The facility was to assess for trauma-informed care experiences upon admission. The facility was to review residents exhibiting new or prolonged behaviors weekly. The facility's psychotropic medication regimens are to be reviewed routinely by the consultant pharmacist. Target behaviors were to be identified and monitored for residents receiving psychotropic medications and/or off-label use of medication prescribed that affects brain activity for the purposes of gradual dose reductions and the need for continued use. Each resident's plan of care will address individualized focus, goals, and interventions directed towards managing the resident's target behaviors, non-pharmacological interventions, psychotropic medication use, and gradual dose reductions and/or supporting documentation for continued use. Psychotropic medications and off-label use of medication prescribed that affect brain activity are not to be initiated without prior communication between the physician, resident, or responsible party and the facility's interdisciplinary team. Off-label and as-needed (PRN) use of psychotropic medications and off-label use of medication prescribed that affect brain activity are to be discouraged for elderly residents with dementia. Physician orders to automatically reduce and discontinue an existing or newly initiated antipsychotic medication and off-label use of medication that affects brain activity are to be considered at the time the order is received. The facility failed to ensure R19 had a CMS-approved indication, or the required physician documentation, for use for antipsychotic medication. This placed R19 at risk for unnecessary medication administration and possible adverse side effects. 41037 - R20's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), aphasia (a condition with disordered or absent language function), muscle weakness, and depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). The Significant Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of zero which indicated intact severely impaired cognition. The MDS documented that a staff interview for cognition was not completed. The MDS documented R20 had received diuretic (medication to promote the formation and excretion of urine) medication, antidepressant (class of medications used to treat mood disorders) medication, and antipsychotic (class of medications used to treat major mental conditions which cause a break from reality). The MDS documented that a gradual dose reduction was not completed and lacked documentation a Monthly Medication Review (MMR) was completed during the observation period. The MDS documented R20 had Alzheimer's disease. R20's Psychotropic Drug Use Care Area Assessment (CAA) dated 07/26/24 documented she received antipsychotic medication for anxiety. R20's Care Plan dated 08/06/24 documented that staff would administer her medications as ordered by the physician. R20's EMR under the Orders tab revealed the following physician orders: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Risperdal (antipsychotic)tablet 0.5 milligrams (mg) give 0.5 mg by mouth at bedtime related to anxiety 07/20/22. A review of the Monthly Medication Review (MMR) from August 2023 to July 2024 lacked evidence of recommendations for physician documentation for a rationale for a non-approved CMS indication for the continued use of the antipsychotic medication Risperdal for R20. The December 2023 MMR revealed a recommendation for a dose reduction of antipsychotic medication Risperdal, mood stabilizer Depakote, and antidepressant medications citalopram and mirtazapine. The physician's response dated 12/27/23 was to discontinue the antidepressant citalopram. The response did not address the other medications or include a rationale for continued use. The facility was unable to provide a physician-documented rationale for no GDR for Risperdal, Depakote, and mirtazapine. On 08/13/24 at 02:55 PM, R20 lay on her bed asleep with the head of her bed elevated. R20's call light was within reach. On 08/14/24 at 12:40 PM, Licensed Nurse (LN) G stated she did talk with the physician to clarify the indication for the residents who received antipsychotic medications. LN G stated an approved indication for antipsychotic medication was behaviors and mood disorder. On 08/14/24 at 01:00 PM, Administrative Nurse D stated she realized on 08/14/24 that the process for the facility's monitoring antipsychotic medication had not been utilized correctly. The facility's Behavior Management and Psychotropic Medication policy revised 12/2022 documented that residents were to be assessed for appropriate diagnosis, utilization, adverse effects, and target behaviors related to psychotropic medication use and off-label use of medication prescribed that affect brain activity. The facility was to assess for trauma-informed care experiences upon admission. The facility was to review residents exhibiting new or prolonged behaviors weekly. The facility's psychotropic medication regimens are to be reviewed routinely by the consultant pharmacist. Target behaviors were to be identified and monitored for residents receiving psychotropic medications and/or off-label use of medication prescribed that affects brain activity for the purposes of gradual dose reductions and the need for continued use. Each resident's plan of care would address individualized focus, goals, and interventions directed towards managing the resident's target behaviors, non-pharmacological interventions, psychotropic medication use, and gradual dose reductions and/or supporting documentation for continued use. Psychotropic medications and off-label use of medication prescribed that affect brain activity are not to be initiated without prior communication between the physician, resident, or responsible party and the facility's interdisciplinary team. Off-label and as-needed (PRN) use of psychotropic medications and off-label use of medication prescribed that affect brain activity are to be discouraged for elderly residents with dementia. Physician orders to automatically reduce and discontinue an existing or newly initiated antipsychotic medication and off-label use of medication that affects brain activity are to be considered at the time the order is received. The facility failed to ensure R20 had a CMS-approved indication for the use of an antipsychotic or the required physician documentation. The facility further failed to ensure a GDR was attempted or documented as contraindicated by the physician with a supporting rationale. These deficient practices placed R20 at risk for unnecessary medications and adverse side effects. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- R35's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of dementia (a progressive mental disorder characterized by failing memory, and confusion), insomnia (inability to sleep), mood disorder (category of mental health problems, feelings of sadness, helplessness, guilt, wanting to die were more intense and persistent than what may normally be felt from time to time), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The Significant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R35 received antianxiety (class of medications that calm and relax people), antidepressant (class of medications used to treat mood disorders), antipsychotic medication, anticoagulant (class of medications used to prevent the formation of blood clots), diuretic (medication to promote the formation and excretion of urine), hypnotic (a class of medications used to induce sleep), and opioid (a class of medication used to treat pain) during the observation period. The MDS documented that a gradual dose reduction was not completed and lacked documentation a Monthly Medication Review (MMR) was completed during the observation period. The MDS documented R35 had dementia. The Quarterly MDS dated [DATE] documented a BIMS score of 10 which indicated moderately impaired cognition. The MDS documented that R35 received antianxiety medication, antidepressant medication, antipsychotic medication, anticoagulant (medication, diuretic medication, hypnotic medication, and opioid medication during the observation period. The MDS documented that a gradual dose reduction was not completed and lacked documentation an MMR was completed during the observation period. R35's Psychotropic Drug Use Care Area Assessment (CAA) dated 04/09/24 documented R35 received antipsychotic medication, antianxiety medication, antidepressant medication, and hypnotic medication. R35's Care Plan revised on 08/04/24 documented that staff would administer medications as ordered. R35's EMR under the Orders tab revealed the following physician orders: Trazodone hcl tablet (antidepressant) 150 mg give one tablet by mouth at bedtime related to insomnia dated 01/17/23. Abilify (antipsychotic) oral tablet 30mg give one tablet by mouth one time a day related to unspecified mood disorder dated 01/23/23. Belsomra tablet (hypnotic) 10mg give one tablet by mouth at bedtime related to insomnia dated 06/03/23. Clonazepam (antianxiety) oral tablet 0.5mg give one tablet by mouth three times a day related to insomnia dated 09/27/23. Sertraline hcl (antidepressant) oral tablet 50mg give one tablet by mouth one time a day for depression dated 03/20/24. A review of the Monthly Medication Review (MMR) from August 2023 to July 2024 lacked evidence of recommendations for physician documentation for a rationale for a non-approved CMS indication for the continued use of the antipsychotic medication Abilify for R35. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R35's clinical record lacked physician documentation of a rationale for a non-approved CMS indication for the continued use of the antipsychotic medication Abilify and for the continued use of psychotropic medication with no gradual dose reduction for clonazepam, Belsomra, and Trazodone. The facility was unable to provide evidence of the above physician documentation. On 08/14/24 at 07:38 AM R35 walked with his walker in the hallway from his room to the dining room unassisted. His gait was steady, and he wore a pair of tennis shoes. On 08/14/24 at 12:40 PM, Licensed Nurse (LN) G stated she did talk with the physician to clarify the indication for the residents who received antipsychotic medications. LN G stated an approved indication for antipsychotic medication was behaviors and mood disorder. On 08/14/24 at 01:00 PM, Administrative Nurse D stated she realized on 08/14/24 that the process for the facility's monitoring antipsychotic medication had not been utilized correctly. The facility's Behavior Management and Psychotropic Medication policy revised 12/2022 documented that residents were to be assessed for appropriate diagnosis, utilization, adverse effects, and target behaviors related to psychotropic medication use and off-label use of medication prescribed that affect brain activity. The facility was to assess for trauma-informed care experiences upon admission. The facility was to review residents exhibiting new or prolonged behaviors weekly. The facility's psychotropic medication regimens are to be reviewed routinely by the consultant pharmacist. Target behaviors were to be identified and monitored for residents receiving psychotropic medications and/or off-label use of medication prescribed that affects brain activity for the purposes of gradual dose reductions and the need for continued use. Each resident's plan of care would address individualized focus, goals, and interventions directed towards managing the resident's target behaviors, non-pharmacological interventions, psychotropic medication use, and gradual dose reductions and/or supporting documentation for continued use. Psychotropic medications and off-label use of medication prescribed that affect brain activity are not to be initiated without prior communication between the physician, resident, or responsible party and the facility's interdisciplinary team. Off-label and as-needed (PRN) use of psychotropic medications and off-label use of medication prescribed that affect brain activity are to be discouraged for elderly residents with dementia. Physician orders to automatically reduce and discontinue an existing or newly initiated antipsychotic medication and off-label use of medication that affects brain activity are to be considered at the time the order is received. The facility failed to ensure R35 had a CMS-approved indication for the use of an antipsychotic or the required physician documentation. The facility further failed to ensure a GDR was attempted or documented as contraindicated by the physician with a supporting rationale. These deficient practices placed these residents at risk for unnecessary medications and adverse side effects.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 49634 The facility identified a census of 49 residents and one kitchen. Based on interviews and record reviews, the facility failed to provide the services of a full-time certified dietary manager for the 49 residents who resided in the facility and received their meals from the kitchen. This placed the residents at risk for inadequate nutrition. Findings included: - On 08/12/24 at 02:25 PM, Dietary Staff BB stated he had been with the facility a few days. He stated he had completed the classes but had not scheduled to take his certification exam. On 08/13/24 at 09:35 AM Dietary Staff BB stated the Registered Dietician (RD) came to the facility monthly. He stated staff could call the RD with any concerns. On 08/13/24 at 10:00 PM Administrative Staff A stated the facility had a certified dietary manager, but she had taken a different position and no longer worked in the kitchen. The facility did not provide a policy for the dietary manager position. The facility failed to employ a full-time certified dietary manager to evaluate residents' nutritional concerns and oversee the ordering, preparing, and storage of food, placing the residents at risk for inadequate nutrition.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 49 residents. The sample included 14 residents with one resident reviewed for hospice services. Based on observation, record review, and interviews, the facility failed to ensure a communication process was implemented, which included how the communication would be documented between the facility and the hospice provider, and a failed to provide a description of the services, medication, and equipment provided to Resident (R) 20 by hospice. This deficient practice created a risk of missed or delayed services and inadequate end-of-life care for R20. Findings included: - R20's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), aphasia (a condition with disordered or absent language function), muscle weakness, and depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). The Significant Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of zero which indicated intact severely impaired cognition. The MDS documented that a staff interview for cognition was not completed. The MDS documented R20 had received diuretic (medication to promote the formation and excretion of urine) medication, antidepressant (class of medications used to treat mood disorders) medication, and antipsychotic (class of medications used to treat major mental conditions which cause a break from reality). The MDS documented R20 received hospice services during the observation period. R20's Psychotropic Drug Use Care Area Assessment (CAA) dated 07/26/24 documented she received antipsychotic medication for anxiety. R20's Care Plan dated 06/27/24 documented she had started comfort measures and had received orders for as-needed comfort medications. The plan of care documented that staff would respect R20's choices. The plan of care documented the hospice nurse would visit weekly; the hospice certified nurse aide (CNA) would visit twice weekly. The plan of care documented the facility would communicate with the hospice provider as needed. The plan of care lacked the equipment provided by hospice, the medications covered by hospice, and what personal care items provided by hospice. R20's EMR under the Orders tab revealed the following physician orders: admitted to hospice services for Alzheimer's disease with a life expectancy of less than six months dated 06/27/24. R20's communication book provided by hospice lacked a hospice care plan, physician order with admitting diagnosis for hospice, list of medication covered by hospice provider, and durable equipment provided by hospice. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/13/24 at 02:55 PM, R20 lay on her bed asleep with her head of her elevated. R20's call light was within reach. On 08/14/24 at 12:20 PM, Certified Medication Aide (CMA) T stated the charge would let the staff know which residents were on hospice services and that information should also be listed on the resident's care plan. CMA T stated the hospice aide came out weekly to offer a bath to residents on hospice services. CMA T stated the hospice provider would just provide what the resident needed. On 08/14/24 at 12:40 PM, Licensed Nurse (LN) G stated the hospice provider would usually provide a communication book which would include a hospice care plan and any other information that was provided by hospice. LM G stated hospice was responsible for ensuring information was available. On 08/14/24 at 01:00 PM, Administrative Nurse D stated she was not aware that R20's hospice communication book lacked a hospice care plan that included the items provided by hospice, medication covered by hospice, and a signed physician order admitting R20 onto hospice services with a terminal diagnosis. Administrative Nurse D stated that hospice information should be included in R20's facility plans of care. Administrative Nurse D stated she was the person responsible for ensuring hospice provided the information needed for the calibration of care. Administrative Nurse D stated medical records would conduct an audit to help ensure the information needed was provided by the hospice provider. The facility was unable to provide a policy related to the collaboration between the facility and hospice. The facility failed to ensure a communication process was implemented, which included how the communication would be documented between the facility and the hospice provider and failed to provide a description of the services, medication, and equipment provided to R20 by hospice. This deficient practice created a risk of missed or delayed services and inadequate end-of-life care for R20.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 41713 The facility identified a census of 49 residents. Based on interviews, and record review the facility failed to submit accurate staffing information to the federal regulatory agency through Payroll Based Journaling (PBJ) when the facility failed to submit accurate registered nurse (RN) coverage hours. This placed the residents at risk for unidentified and ongoing inadequate staff. Findings included: - The PBJ report provided by the CMS for Fiscal Year (FY) 2023 quarter three, quarter four, and quarter one FY 2024 documented no triggered areas. The facility was unable to provide RN punch times for staff hours on 01/20/24, 01/21/24, 02/12/24, 02/17/24, 02/24/24, 03/3/24, 03/16/24, 04/7/24 as requested. On 08/14/24 at 02:00 PM Administrative Staff A stated she was unable to provide punch times for RN staff on the dates above. Administrative Staff A stated the facility did not have a policy regarding the PBJ reporting. Administrative Staff A stated the facility followed the Centers for Medicaid and Medicare (CMS) guidelines for payroll reporting. The facility did not provide a policy for PBJ reporting. The facility failed to ensure accurate staffing hour information was submitted to the federal regulatory agency through PBJ when the facility failed to submit accurate RN coverage hours. This placed the residents at risk for unidentified and ongoing inadequate staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175502	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Eudora	1415 Maple Street Eudora, KS 66025

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 49634 The facility identified a census of 49 residents. The facility identified one resident on transmission-based precautions (TBP-infection control procedures to limit the transmission of infectious agents). Based on record review, observations, and interviews, the facility failed to post clear signage for the TBP room and failed to implement Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms which employs targeted gown and glove use during high contact cares) for all residents requiring EBP. These deficient practices placed the residents at risk for infectious diseases. Findings Included: - An initial walkthrough of the facility was completed on 08/12/24 at 07:17 AM with the following observations noted: Observation revealed a bin containing personal protective equipment (PPE- includes gloves, gowns, and face masks) outside of Resident(R)16's room. There was no visible sign announcing if precautions were present or what PPE was required. On closer inspection, a laminated sign that stated Droplet Precautions was on top of the bin but was mostly covered by a box of gloves with the wording on the sign completely covered. According to R16's Electronic Medical Record (EMR), R16 had Methicillin-resistant Staphylococcus aureus (MRSA-a type of bacteria resistant to many antibiotics). R16 had a gastrostomy tube (PEG-a tube inserted through the wall of the abdomen directly into the stomach). Observation of R4's room revealed no signage for EBP or personal protective equipment (PPE) readily available. According to R4's EMR, R4 had a urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag). Observation of R45's room revealed no signage for EBP and PPE was unavailable. According to R45's EMR, R45 had a wound to the sacrum (large triangular bone/area between the two hip bones). Observation of R20's room revealed no signage for EBP and PPE was unavailable. According to R20's EMR, R20 had a fistula (abnormal passage from an internal organ to the body surface or between two internal organs) to the vagina. Observation of R31's room revealed no signage for EBP and PPE was unavailable. According to R31's EMR, R31 had a diabetic open ulcer on the left lower leg. On 08/14/24 at 09:27 AM Licensed Nurse (LN) G stated she was unaware the rooms needed any kind of signage or PPE. LN G stated it would be up to the infection prevention nurse to decide which rooms or residents required EBP. LN G stated the infection prevention nurse would let the nursing staff know if a resident required EBP, and the nursing staff would relay it to all other staff. On 08/14/24 at 12:58 PM Administrative Nurse D stated she would not apply the EHB or TBP to any resident unless the resident had an infection with bacteria in their wounds. Administrative Nurse D stated she would not apply EHB precautions for residents with catheters or internal feedings. She stated that under the new guidelines, only wounds with bacterial growth needed EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility did not provide an enhanced barrier precautions policy. The facility failed to post clear signage for the TBP room and failed to implement EBP for all residents requiring EBP. These deficient practices placed the residents at risk for infectious diseases.

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	175502	A. Building B. Wing	08/14/2024

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 49634 The facility identified a census of 49 residents. The sample included 14 residents with five residents reviewed for immunizations. Based on observation, record review, and interviews, the facility failed to provide Resident (R) 19 with the Pneumococcal Conjugate Vaccine (PCV20- vaccination for bacterial lung infections) as consented. This placed the resident at increased risk for complications related to pneumonia. Findings included: - R19's Electronic Medical Record (EMR) revealed he was eligible and within the required vaccination date range to receive the PCV20 vaccination. A review of the Resident Consent for Influenza, Pneumococcal, and COVID-19 Vaccination form for R19 dated 06/26/23 provided by the facility revealed a signed consent to receive the pneumococcal vaccination. The form indicated R19 was provided educational information related to the PCV 20 vaccination. R19's clinical record lacked evidence R19 received the PCV20 vaccination. Upon request, the facility was unable to provide evidence the PCV20 was administered to R19. On 08/13/24 at 10:22 AM Administrative Nurse D, the facility's Infection Preventionist, stated she did have a signed consent for the PCV20 for R19, but was unable to find any documentation where the vaccine was given. Administrative Nurse D stated the facility obtained vaccine consent but sometimes the facility must wait until the pharmacy gets the vaccine. She stated R19 must have been overlooked or missed. The facility's undated Pneumococcal Vaccine policy documented it was the facility's policy to offer residents and staff immunization against pneumococcal disease in accordance with current Centers for Disease Control and Prevention guidelines and recommendations. The facility failed to provide R19 with the PCV20 as consented. This placed the residents at increased risk for complications related to pneumonia.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 41037 The facility had a census of 49 residents. Five Certified Nurse Aides (CNAs) were sampled for required in-service training. Based on record review and interview, the facility failed to ensure three of the five CNA staff reviewed had the required 12 hours of in-service education. This placed the residents at risk for decreased quality of life and/or inadequate care. Findings included: - A review of the information facility's in-service records revealed the following CNAs were employed with the facility for more than 12 months: CNA M, hired on 06/13/13, had not completed any of the required in-services in the past 12 months. CNA O, hired 03/15/23, had completed six hours of the required yearly in-services in the past 12 months. CNA P, hired on 04/18/22, had completed six hours of the required yearly in-services in the past 12 months. On 08/14/24 at 01:00 PM, Administrative Nurse D stated human resources help ensure the nursing staff completes their 12 hours of required in-services are completed annually. She stated the required ins-services are assigned to certain courses and should be completed monthly. The facility was unable to provide a policy related to staff training. The facility failed to ensure three of the five CNA staff reviewed had the required 12 hours of in-service education. This placed the residents at risk for decreased quality of life and/or inadequate care.