STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175511	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montgomery Place Nursing Center	614 S 8th Street Independence, KS 67301

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360 The facility had a census of 38 residents. The sample included 12 residents, with two reviewed for dementia care. Based on observation, record review, and interview, the facility failed to revise one resident, Resident (R) 35's plan of care with individualized person-centered interventions for dementia (a progressive mental disorder characterized by failing memory and confusion). The facility further failed to monitor and document R35's behaviors as directed in his plan of care. This deficient practice placed the resident at risk for decreased quality of life due to uncommunicated care needs. Findings included: - The Electronic Medical Record (EMR) documented R35 admitted to the facility on [DATE]. R35 had diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), dementia, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling other fingers, masklike faces, shuffling gait, muscle rigidity, and weakness). The Admission Minimum Data Set (MDS), dated [DATE], documented R35 had intact cognition and required staff supervision for transfers. R35 required set-up assistance for eating, personal hygiene, and ambulation, and R35 did not ambulate. The MDS documented R35 had no behaviors and received an antidepressant (a class of medication to treat mood disorders) and a diuretic (a medication to promote the formation and secretion of urine) medication. The Psychotropic Drug Use Care Area Assessment (CAA), dated 09/16/24, documented a licensed nurse monitored the resident for side effects every shift, and the physician was to be notified of any abnormal findings. The CAA documented a pharmacist consultant would review medications monthly and the physician would review medications with each visit. The care plan would be developed to monitor the effectiveness of psychotropic medication and any adverse effects of medication. The Mood and Behavior CAA had not been triggered. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	The Quarterly MDS, dated [DATE], documented R35 had severely impaired cognition. R35 was independent with eating, mobility, transfers, and toileting. R35 had wandering for one to three days, delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), received antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), antidepressant, and diuretic medication. The Care Plan dated 12/10/24, initiated on 09/23/24, directed staff to monitor R35 for mood or behavior changes and document changes in progress notes including non-medicinal intervention used and the resident's response. The update, dated 10/01/24, directed staff to tell him that his spouse asked the facility to assist him when he refused care. The update, dated 10/14/24, directed staff to offer him a snack if he was out wandering, provide reorientation to surroundings within the environment and have R35 attend activities one to two times per week. The care plan lacked individualized interventions or a treatment plan when R35 had behaviors. The Physician's Order dated 09/10/24, directed staff to administer sertraline HCl (an antidepressant medication), 25 milligrams (mg), one by mouth, in the morning, for depression. The Physician's Order dated 10/30/24, directed staff to administer quetiapine fumarate (an antipsychotic medication), 25 mg, and give 0.5 tablet, by mouth at bedtime for Alzheimer's disease. This medication was increased on 11/27/24. The Physician's Order dated 11/27/24, directed staff to administer quetiapine fumarate, 25 mg, one tablet, at bedtime for major depressive disorder with psychotic features. This medication was increased on 01/16/25. The Physician's Order dated 01/16/25, directed staff to administer quetiapine fumarate, 25 mg, two tablets, at bedtime for major depressive disorder. The Nurse's Notes dated 10/12/2 at 01:30 AM, documented R35 continued to constantly get up during the night and wander. The Nurse's Notes dated 10/13/24 at 03:29 AM, documented R35 continued to ask for his wife and was up and down all night. R35 was confused about the time of day and situation, staff reassured him and reoriented him to the situation. The Nurse's Notes dated 11/15/24 at 05:40 PM, R35 went to the nurse's station without his walker and was very agitated. R35 stated his supper was not what he wanted to eat and that he wanted ice cream. The Nurse asked R35 where his walker was and R35 told her it was in his room. R35 was very agitated and demanded the nurse take him to the dining room and get him some ice cream. R35 was provided food and ice cream, and staff continued to monitor the resident. The Nurse's Notes dated 11/23/24 at 02:29 PM, documented R35 raised his hand to the Certified Medication Aide (CMA), and stated, You will call my wife now before you get what's coming to you. Staff redirected R35 to his room and showed him how to call his wife on his phone. (continued on next page)

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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	The Nurse's Notes dated 12/10/24 at 10:11 AM, documented R35 was hateful to the dietary staff when they removed his food from the table. Staff explained to R35 that they thought he was finished, and he stated he had just gone to the bathroom. R35 stated staff owed him $50.00 for his meal. Staff stated they would pay for another meal and provided R35 with another meal. On 02/05/25 at 08:45 AM, Certified Medication Aide R provided R35 with his medication at the dining room table without incident. On 02/05/25 at 08:50 AM, CMA R stated R35 required cues and redirection during the day but rarely had any behaviors. On 02/06/25 at 09:15 AM, Licensed Nurse (LN) H stated she heard R35 could be aggressive during the night and when she worked, he was usually pretty good during the day. She stated R35 was on an antipsychotic medication for his wandering at night and that staff should document in the progress notes when he had behaviors. LN G stated she was unsure what staff did at night when the resident had behaviors. On 02/06/25 at 09:30 AM, LN G stated, that staff should chart and monitor R35's behaviors and that the quetiapine fumarate was started per family request. LN G stated the family was in the building during the physician visits and had asked the medication to be increased. On 02/06/25 at 09:42 AM, Administrative Nurse D stated, staff should follow R35's plan of care to document his behaviors. Administrative Nurse D stated the staff were probably getting used to the behaviors as being normal for him and just didn't document as they should have. The facility's Resident Centered Care Plan Process, dated 03/28/18, documented the facility provided an individualized interdisciplinary plan of care for all residents that was appropriate to their needs, strengths, limitations, and goals. The care plan was based upon the initial, recurrent, and continual needs of the resident. The staff are all responsible to read, understand, and follow the comprehensive, person-centered care plan and report any changes to the team for immediate care plan revision. The facility failed to revise R35's plan of care with individualized person-centered interventions for dementia care and failed to follow his plan of care to monitor and document his behaviors. This placed R35 at risk for uncommunicated care needs.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360 The facility had a census of 38 residents. The sample included 12 residents, with two reviewed for dementia care. Based on observation, record review, and interview, the facility failed to develop and implement an individualized dementia (a progressive mental disorder characterized by failing memory and confusion) treatment plan that utilized non-pharmacological approaches to care for one resident, Resident (R) 35. This placed the resident at risk for abuse and decreased quality of life. Findings included: - The Electronic Medical Record (EMR) documented R35 admitted to the facility on [DATE]. R35 had diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), dementia, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling other fingers, masklike faces, shuffling gait, muscle rigidity, and weakness). The Admission Minimum Data Set (MDS), dated [DATE], documented R35 had intact cognition and required staff supervision for transfers. R35 required set-up assistance for eating, personal hygiene, and ambulation, and R35 did not ambulate. The MDS documented R35 had no behaviors and received an antidepressant (a class of medication to treat mood disorders) and a diuretic (a medication to promote the formation and secretion of urine) medication. The Psychotropic Drug Use Care Area Assessment (CAA), dated 09/16/24, documented a licensed nurse monitored the resident for side effects every shift, and the physician was to be notified of any abnormal findings. The CAA documented a pharmacist consultant would review medications monthly and the physician would review medications with each visit. The care plan would be developed to monitor the effectiveness of psychotropic medication and any adverse effects of medication. The mood and behavior CAA did not trigger. The Quarterly MDS, dated [DATE], documented R35 had severely impaired cognition. R35 was independent with eating, mobility, transfers, and toileting. R35 had wandering for one to three days, delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), and received antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) antidepressant, and diuretic medication. The Care Plan, dated 12/10/24, initiated on 09/23/24, directed staff to monitor R35 for mood or behavior changes and document changes in progress notes including non-medicinal intervention used and the resident's response. The update, dated 10/01/24, directed staff to tell him that his spouse asked the facility to assist him when he refused care. The update, dated 10/14/24, directed staff to offer him a snack if he was out wandering, provide reorientation to surroundings within the environment and have R35 attend activities one to two times per week. The care plan lacked individualized interventions or a treatment plan when R35 had behaviors. (continued on next page)

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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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Physician's Order, dated 09/10/24, directed staff to administer sertraline HCl (an antidepressant medication), 25 milligrams (mg), one by mouth, in the morning, for depression. The Physician's Order, dated 10/30/24, directed staff to administer quetiapine fumarate (an antipsychotic medication), 25 mg, and give 0.5 tablet, by mouth at bedtime for Alzheimer's disease. This medication was increased on 11/27/24. The Physician's Order, dated 11/27/24, directed staff to administer quetiapine fumarate, 25 mg, one tablet, at bedtime for major depressive disorder with psychotic features. This medication was increased on 01/16/25. The Physician's Order, dated 01/16/25, directed staff to administer quetiapine fumarate, 25 mg, two tablets, at bedtime for major depressive disorder. The Nurse's Notes, dated 10/12/2 at 01:30 AM, documented R35 continued to constantly get up during the night and wander. The Nurse's Notes, dated 10/13/24 at 03:29 AM, documented R35 continued to ask for his wife and was up and down all night. R35 was confused about the time of day and situation, staff reassured him and reoriented him to the situation. The Nurse's Notes, dated 11/15/24 at 05:40 PM, R35 went to the nurse's station without his walker and was very agitated. R35 stated his supper was not what he wanted to eat and that he wanted ice cream. The Nurse asked R35 where his walker was and R35 told her it was in his room. R35 was very agitated and demanded the nurse to take him to the dining room and get him some ice cream. R35 was provided food and ice cream, and staff continued to monitor the resident. The Nurse's Notes dated 11/23/24 at 02:29 PM, documented R35 raised his hand to the Certified Medication Aide (CMA), and stated, You will call my wife now before you get what's coming to you. Staff redirected R35 to his room and showed him how to call his wife on his phone. The Nurse's Notes dated 12/10/24 at 10:11 AM, documented R35 was hateful to the dietary staff when they removed his food from the table. Staff explained to R35 that they thought he was finished, and he stated he had just gone to the bathroom. R35 stated staff owed him $50.00 for his meal. Staff stated they would pay for another meal and provided R35 with another meal. On 02/05/25 at 08:45 AM, Certified Medication Aide (CMA) R provided R35 with his medication at the dining room table without incident. On 02/05/25 at 08:50 AM, CMA R stated R35 required cues and redirection during the day but rarely had any behaviors. On 02/06/25 at 09:15 AM, Licensed Nurse (LN) H stated she heard R35 could be aggressive during the night and when she worked he was usually pretty good during the day. She stated R35 was on an antipsychotic medication for his wandering at night and that staff should document in the progress notes when he had behaviors. LN G stated she was unsure what staff did at night when the resident had behaviors. (continued on next page)

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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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/06/25 at 09:30 AM, LN G stated, that staff should chart and monitor R35's behaviors and that the quetiapine fumarate was started per family request. LN G stated the family was in the building during the physician visits and had asked the medication to be increased. On 02/06/25 at 09:42 AM, Administrative Nurse D verified the EMR lacked consistent documentation of the resident's behaviors and stated staff should document any behaviors and what interventions were provided in response to the behaviors. Administrative Nurse D stated the family requested the increase in the quetiapine fumarate for R35's wandering at night. Administrative Nurse D stated the staff initialed every shift in the mar to confirm they monitored his behaviors, but there was nothing specifically to state what the behavior was. All behaviors were to be documented in the progress notes. The facility's Behavior Management for Dementia Care, undated policy, documented dementia care in the facility was to provide a quality of life with respect, dignity, and care in a friendly, clean, and non-abusive atmosphere. All behaviors related to any/all types of dementia would be monitored and documented to track and trend those behaviors to be included in the development of a person-centered, individualized dementia care plan. The care plan identified triggers of specific behaviors to assist staff members in avoiding those triggers. Identification of unmet needs which the resident was unable to verbalize or communicate, identification of the time of day to include need or rest periods for the resident. The development of care plan interventions that provide the resident with uninterrupted sleep periods and provide adequate rest. Staff monitor specifically identified behaviors continuously and document observed behaviors in the clinical record on a real-time basis along with interventions attempted and the success of those interventions, The charge nurse would report pertinent findings from the behavior assess, et to the physician and the representative as appropriate. The facility failed to adequately meet R35's mental health needs by failing to ensure pharmacological interventions were only used when non-pharmacological interventions were ineffective or when clinically indicated. This placed the resident at risk for a decreased quality of life.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360 The facility had a census of 38 residents. The sample included 12 residents, with five reviewed for unnecessary medications. Based on observation, record review, and interview, the Consultant Pharmacist (CP) failed to identify and report out-of-parameter blood pressures for one resident, Resident (R) 35. This placed the resident at risk for physical decline and medication related complications. Findings included: - The Electronic Medical Record (EMR) R35 had diagnoses of hypertension (high blood pressure), atrial fibrillation (rapid, irregular heartbeat), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling other fingers, masklike faces, shuffling gait, muscle rigidity, and weakness). The Admission Minimum Data Set (MDS), dated [DATE], documented R35 had intact cognition and required supervision of staff for transfers. R35 required set-up assistance for eating, personal hygiene, ambulation, and R35 did not ambulate. The MDS documented R35 received an antidepressant (a class of medication to treat mood disorders) and diuretic (a medication to promote the formation and secretion of urine) medication. The Quarterly MDS, dated [DATE], documented R35 had severely impaired cognition. R 35 was independent with eating, mobility, transfers, and toileting. R35 received antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), antidepressant, and diuretic medication. The Care Plan dated 12/10/24 initiated on 09/16/24, documented R35 received medications that had black box warnings (BBW - highest safety-related warning that medications can have assigned by the Food and Drug Administration). The care plan documented R35 received blood pressure medications and directed staff to follow orders and the parameters as set by the physician. The Physician's Order, dated 10/31/24, directed staff to administer metoprolol succinate ER 24 hour (high blood pressure medication), 100 milligrams (mg), one tablet, by mouth, daily for atrial fibrillation. Hold the medication if the systolic blood pressure (SBP - the top number, the force your heart exerts on the walls of your arteries each time it beats) is less than 110 millimeters of mercury (mmHg). R35's Medication Administration Record (MAR) for December 2024 documented the following days R35 received the metoprolol when the SBP was under the ordered parameters: 12/03/24-104/66 12/07/24-105/60 (continued on next page)

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/08/24-105/64 12/12/24-101/73 12/13/24-103/56 12/17/24-109/64 12/19/24-107/63 12/22/24-101/69 12/24/24-100/64 12/25/24-105/62 R35's Medication Administration Record (MAR) for January 2025 documented the following days R35 received the metoprolol when the SBP was under the ordered parameters: 01/09/25-108/69 01/20/25-101/62 01/21/25-103/68 R35's Medication Administration Record (MAR) for February 2025 documented the following days R35 received the metoprolol when the SBP was under the ordered parameters: 02/01/25 101/62 R35's Medication Regimen Review, dated 01/19/25, lacked documentation of the out-of-parameter blood pressures. On 02/05/25 at 08:45 AM, Certified Medication Aide (CMA) R provided R35 with his medication at the dining room table without incident. On 02/06/25 at 09:15 AM, Licensed Nurse (LN) H verified the blood pressure medications were administered when the SBP was out of parameters. LN H stated the CMAs should tell her if the medication was not given and that the SBP was out of the parameters. On 02/06/25 at 09:42 AM, Administrative Nurse D verified the medication was not held per physician orders and stated the Consultant Pharmacist (CP) had not notified her that they were administering the medication out of parameters. The facility's Consultant Pharmacist Services Provider Requirements undated policy, documented regular and reliable consultant pharmacist services were provided to elders. The consultant pharmacist reviewed the MAR and the physician orders monthly at the facility to ensure proper documentation of medication orders and administration of medications to elders. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to ensure the CP identified and reported that 35's metoprolol was administered outside of physician-ordered parameters. This placed R35 at risk for physical decline and medication related complications.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360 The facility had a census of 38 residents, the sample included 12 residents, with five reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to hold blood pressure medications per the physician ordered parameters for one resident, Resident (R) 35. This placed the resident at risk for physical decline and other related complications. Findings included: - The Electronic Medical Record (EMR) R35 had diagnoses of hypertension (high blood pressure), atrial fibrillation (rapid, irregular heartbeat), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling other fingers, masklike faces, shuffling gait, muscle rigidity, and weakness). The Admission Minimum Data Set (MDS), dated [DATE], documented R35 had intact cognition and required supervision of staff for transfers. R35 required set-up assistance for eating, personal hygiene, ambulation, and R35 did not ambulate. The MDS documented R35 received an antidepressant (a class of medication to treat mood disorders) and diuretic (a medication to promote the formation and secretion of urine) medication. The Quarterly MDS, dated [DATE], documented R35 had severely impaired cognition. R 35 was independent with eating, mobility, transfers, and toileting. R35 received antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), antidepressant, and diuretic medication. The Care Plan dated 12/10/24, initiated on 09/16/24, documented R35 received medications that had black box warnings (BBW - highest safety-related warning that medications can have assigned by the Food and Drug Administration). The care plan documented R35 received blood pressure medications and directed staff to follow orders and the parameters as set by the physician. The Physician's Order, dated 10/31/24, directed staff to administer metoprolol succinate ER 24 hour (high blood pressure medication), 100 milligrams (mg), one tablet, by mouth, daily for atrial fibrillation. Hold the medication if the systolic blood pressure (SBP - the top number, the force your heart exerts on the walls of your arteries each time it beats) is less than 110 millimeters of mercury (mmHg). R35's Medication Administration Record (MAR) for December 2024 documented the following days R35 received the metoprolol when the SBP was under the ordered parameters: 12/03/24-104/66 12/07/24-105/60 12/08/24-105/64 (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/12/24-101/73 12/13/24-103/56 12/17/24-109/64 12/19/24-107/63 12/22/24-101/69 12/24/24-100/64 12/25/24-105/62 R35's Medication Administration Record (MAR) for January 2025 documented the following days R35 received the metoprolol when the SBP was under the ordered parameters: 01/09/25-108/69 01/20/25-101/62 01/21/25-103/68 R35's Medication Administration Record (MAR) for February 2025 documented the following days R35 received the metoprolol when the SBP was under the ordered parameters: 02/01/25 101/62 On 02/05/25 at 08:45 AM, Certified Medication Aide (CMA) R provided R35 with his medication at the dining room table without incident. On 02/06/25 at 09:15 AM, Licensed Nurse (LN) H verified the blood pressure medications were administered when the SBP was out of parameters. LN H stated the CMAs should tell her if the medication was not given and that the SBP was out of the parameters. On 02/06/25 at 09:42 AM, Administrative Nurse D verified the medication was not held per physician orders and stated the Consultant Pharmacist (CP) had not notified her that they were administering the medication out of parameters. The facility's Medication Administration undated policy documented that all medication would be administered to every elder as ordered by a physician in a safe and sanitary manner. Each elder's drug regimen would be free from unnecessary drugs. The medications would be administered as ordered, documented, and followed holding/notification parameters as ordered. The facility failed to hold blood pressure medication for R35 when his blood pressure was out of the physician-ordered parameters. This placed the resident at risk for physical decline and other related complications.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360 The facility had a census of 38 residents. The sample included 12 residents, with five reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure an appropriate indication, or a documented physician rationale which included the unsuccessful attempts for non-pharmacological symptom management and risk versus benefit for the continued use for Resident (R) 35's antipsychotic (a class of medication used to treat major mental conditions that cause a break from reality). This placed R35 at risk for unintended side effects relate to psychotropic (alters mood or thought) drug medication. Findings included: - The Electronic Medical Record (EMR) documented R35 was admitted to the facility on [DATE]. R35 had diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), dementia (a progressive mental deterioration characterized by confusion and memory failure), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling other fingers, masklike faces, shuffling gait, muscle rigidity, and weakness). The Admission Minimum Data Set (MDS), dated [DATE], documented R35 had intact cognition and required supervision of staff for transfers. R35 required set-up assistance for eating, personal hygiene, and ambulation. The MDS documented R35 had no behaviors and received an antidepressant (a class of medication to treat mood disorders) and a diuretic (a medication to promote the formation and secretion of urine) medication. The Psychotropic Drug Use Care Area Assessment (CAA), dated 09/16/24, documented a licensed nurse monitored for side effects every shift, and the physician was to be notified of any abnormal findings. The CAA documented a pharmacist consultant would review medications monthly and the physician would review medications with each visit. The care plan would be developed to monitor the effectiveness of psychotropic medication and any adverse effects of medication. The Mood and Behavior CAA had not triggered. The Quarterly MDS, dated [DATE], documented R35 had severely impaired cognition. R 35 was independent with eating, mobility, transfers, and toileting. R35 had wandering for one to three days, delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), received antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) antidepressant, and diuretic medication. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175511	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montgomery Place Nursing Center	614 S 8th Street Independence, KS 67301

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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plan, dated 12/10/24, initiated on 09/23/24, directed staff to monitor for mood or behavior changes and document in progress notes including non-medicinal intervention used and the resident's response. The update, dated 10/01/24, directed staff to tell him that his spouse asked the facility to assist him when he refused care. The update, dated 10/14/24, directed staff to offer him a snack if he was out wandering, provide reorientation to surrounds within the environment, and have R35 attend activities one to two times per week. The care plan lacked individualized interventions or a treatment plan when R35 had behaviors. The Physician's Order, dated 09/10/24, directed staff to administer sertraline HCl (an antidepressant medication), 25 milligrams (mg), one by mouth, in the morning, for depression. The Physician's Order, dated 10/30/24, directed staff to administer quetiapine fumarate (an antipsychotic medication), 25 mg, and give 0.5 tablet, by mouth at bedtime for Alzheimer's disease. This medication was increased on 11/27/24. The Physician's Order, dated 11/27/24, directed staff to administer quetiapine fumarate, 25 mg, one tablet, at bedtime for major depressive disorder with psychotic features. This medication was increased on 01/16/25. The Physician's Order, dated 01/16/25, directed staff to administer quetiapine fumarate, 25 mg, two tablets, at bedtime for major depressive disorder. The Medication Regimen Review, dated 12/10/24, requested clarification for the diagnosis and indication for the quetiapine fumarate, 25 mg, by mouth, at bedtime. The physician documented dementia with depression. R35's EMR lacked a documented physician rationale which included the unsuccessful attempts for non-pharmacological symptom management and risk versus benefits for the quetiapine fumarate use. On 02/05/25 at 08:45 AM, Certified Medication Aide (CMA) R provided R35 with his medication at the dining room table without incident. On 02/05/25 at 08:50 AM, CMA R stated he required cues and redirection during the day but rarely had any behaviors. On 02/06/25 at 09:15 AM, Licensed Nurse (LN) H stated she had heard he could be aggressive during the night and when she worked, he was usually pretty good during the day. She stated R35 was on an antipsychotic medication for his wandering at night and that staff should document in the progress notes when he had behaviors. LN G stated she was unsure what staff did at night when the resident had behaviors. On 02/06/25 at 09:30 AM, LN G stated, that staff should chart and monitor R35's behaviors and that the quetiapine fumarate was started per family request. LN G stated the family was in the building during the physician visits and had asked the medication to be increased. On 02/06/25 at 09:42 AM, Administrative Nurse D verified the lack of a risk versus benefit or a rationale from the physician for the quetiapine fumarate use. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Antipsychotic drugs undated policy documented all physician orders for antipsychotic medications would be clear and accurate. The orders would include a diagnosis, condition, or indication for its use, and the consultant pharmacist would review the appropriateness of all medication orders to be administered by clinical staff. The facility failed to ensure R35 did not receive antipsychotic medication without an appropriate indication or the required physician documentation for its use. This deficient practice placed R35 at risk for adverse side effects.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 37450 The facility had a census of 38 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to employ a full-time Certified Dietary Manager for 38 residents who reside in the facility and received their meals from the kitchen. This placed the residents at risk of not receiving adequate nutrition. Findings included: - On 02/04/25 at 08:18 AM, observation revealed the kitchen staff finishing the morning meal and preparing the midday meal. Dietary Staff BB stated she was the dietary manager. Dietary Staff BB reported she was presently enrolled in a Certified Dietary Manager course but had not completed the course. The facility's undated Dietary Services policy states the facility will employ a qualified dietitian or other qualified nutritional professional on a full-time or consultant basis. A qualified dietitian or nutritionist who has completed at least 900 hours of supervised dietetics accredited by an appropriate national accreditation organization recognized for this purpose. The facility failed to employ a full-time Certified Dietary Manager for residents who reside at the facility. This deficient practice placed the 38 residents at risk of inadequate nutrition.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 37450 The facility had a census of 38 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to prepare and store food in a sanitary manner for 38 residents who received their meals from the kitchen. This deficient practice placed the residents at risk for foodborne illness. Findings included: - On 02/04/25 at 08:18 AM, during the initial tour of the kitchen, the double-door stainless steel refrigerator had sliced ham stored on a middle shelf with directly above gallons of milk and a large bowl of yellow pudding and unpasteurized eggs also stored on the middle shelf. The fluorescent plastic light cover above the food prep area was cracked through. The white window air conditioner above the small white freezer had a gray/blackish lint-type material on the air outlet levers. Directly in front of the window air conditioner, seated on the small white freezer was a fan that had grey/brown lint type of material on the front guard in which the airflow direction at a food prep area. On 02/05/25 at 01:51 PM, Dietary Staff BB verified the cracked fluorescent light cover, the air conditioner, and the fan had the grey/brown/black lint-type material directly blowing in the direction of a food prep area. The facility's undated Food Safety Requirements policy stated food would be stored, prepared, distributed, and served in accordance with professional standards for food service safety. Storage of food in a manner that helps prevent deterioration or contamination of food, including the growth of microorganisms. Strategies to prevent foodborne illness included but were not limited to proper refrigeration of meat, poultry, and pasteurized products. The facility's undated Dietary Cleaning Procedures stated the facility would store, distribute, and serve food under sanitary conditions to ensure that proper sanitation and food handling practices to prevent the outbreak of foodborne illness are attained continuously. The facility's undated Maintenance Inspection policy stated the facility utilized a maintenance inspection checklist to ensure a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. The facility failed to prepare and store food in a sanitary manner for 38 residents who reside at the facility and received meals from the facility's kitchen. This placed the residents at risk for foodborne illness.