STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Derby Health & Rehabilitation, LLC	731 Klein Circle Derby, KS 67037

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 61 residents. The sample included 15 residents with three residents reviewed for hospitalization. Based on observation, record review, and interviews, the facility failed to provide a written notification of transfer for facility-initiated transfers to Resident (R) 22, R77, and R78 and/or their representative for all applicable transfers/discharges. The facility further failed to notify the State Long Term Care Ombudsman (LTCO) of transfers/discharges for R22, R77, and R78. Findings included:- R22 admitted to the facility on [DATE], the facility transferred him to the hospital on [DATE], and he re-admitted to the facility on [DATE]. R77 admitted to the facility on [DATE], and the facility transferred her to the hospital on [DATE]. R77 did not readmit to the facility. R78 admitted to the facility on [DATE], and the facility transferred her to the hospital on [DATE]. R78 did not readmit to the facility. Upon request, the facility was unable to provide a written notification of transfer for R22, R77, and R78's hospital transfers. Upon request, the facility provided LTCO notification emails for discharges from March 2025 through February 2026. Review of the emails revealed the facility did not include the hospital transfers for R22, R77, and R78. On 03/11/26 at 07:47 AM, R22 sat in his wheelchair at the dining room table and ate breakfast. On 03/10/26 at 12:54 PM, Consultant GG stated the facility did not do written notification of transfers. On 03/11/26 at 11:34 AM, Licensed Nurse (LN) G stated that when a resident transferred to the hospital, she called their representative to notify them, but she did not do a written notification of transfer. On 03/11/26 at 11:38 AM, Social Services X stated that when a resident transferred to the hospital, she called and asked the family about a bed hold and completed a progress note. She stated she did not do a written notification of transfer and did not know what it was. Social Services X stated she completed an ombudsman report on the discharges from the facility, which included hospital transfers. She stated that if the resident admitted to the hospital after the transfer, then they would be discharged from the facility and would be included in the report. Social Services X stated she usually reviewed the list to make sure the report included the hospital transfers. The facility's Admission, Transfer, and Discharge Policy, dated 12/01/25, directed the facility to provide a 30-day advanced written notice, except in emergencies, that included the reason for the transfer/discharge, effective date, the receiving location, the LTCO contact, the State Agency (SA) contact, and the resident's appeal rights. The policy did not address a written notification of transfer for hospital transfers or LTCO notification of transfers.

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

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. The facility reported a census of 61 residents; the sample included five residents reviewed unnecessary medications. Based on observation, interview, and record review revealed the facility failed to obtain physician-ordered orthostatic blood pressures as part of an evaluation following complaints of dizziness and lightheadedness. Findings included:- R45's Electronic Medical Record (EMR) revealed the following diagnoses: anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) and hypotension (low blood pressure). R45's 02/18/26 admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) of 14, indicating intact cognition. R45's Care Plan documented that R45 used an antihypotensive medication for hypotension; initiated on 03/08/26. The plan directed staff to monitor and document side effects and the effectiveness of the medication. R45's Care Plan instructed staff to verify blood pressure and pulse prior to giving this medication; initiated on 03/08/26. R45's Progress Note had an Encounter note dated 02/27/26 at 12:00 AM that documented R45 had low blood pressure and R45 stated they have always been low. The provider ordered orthostatic blood pressure (measurements of blood pressure and pulse taken with the patient in the supine, sitting, and standing positions to assess low blood pressure and possible blood pooling in the lower extremities resulting in dizziness) two times a day for three days. R45's Physician Orders in the EMR documented an order for orthostatic blood pressure two times a day for three days. lying, sitting, and standing. Send the provider a message in the EMR with the results; started on 02/28/26. R45's Electronic Medication Administration Record (EMAR) documented on 02/28/26 one blood pressure reading of 100/64 millimeters of mercury (mm Hg). It lacked the lying, sitting, and standing blood pressures for the morning orthostatic blood pressures. R45's EMAR had no documentation for the evening orthostatic blood pressure order on 02/28/26. R45's EMAR documented NA for the lying, sitting, and standing blood pressures for the morning orthostatic blood pressure order on 03/01/26. R45's EMAR documented a 4 for the evening orthostatic blood pressure order on 03/01/26, which indicated to see the nurse's note. R45's Progress Note documented an eMAR- Medication Administration Note on 03/01/26 at 09:03 PM, for which the system would not allow her to enter the blood pressures in the boxes. The nurse documented a sitting blood pressure of 130/82 mm Hg, standing 125/78 mm Hg, and lying 126/70 mm Hg. R45's EMAR documented on 03/02/26 one blood pressure reading of 131/72 millimeters of mercury (mm Hg). It lacked the lying, sitting, and standing blood pressures for the morning orthostatic blood pressures. R45's EMAR had no documentation for the evening orthostatic blood pressure order on 03/02/26. On 03/11/26 at 10:31 AM, Certified Medication Aide (CMA) R stated the Certified Nurse Aide (CNA) got all the vital signs, including blood pressures, for residents in the mornings. The nurse later put the vital signs in the computer. CMA R stated that if a resident was on a heart medication, she would take vital signs before she gave the medication. She only had one resident who got vital signs before a medication, and it was not R45. On 03/11/26 at 10:49 AM, Licensed Nurse (LN) H stated that the CNAs usually got the vital signs, but she preferred to get the orthostatic blood pressures herself because the CNA did not always do it in the correct order. She wanted to make sure it was done correctly. When asked what the correct way to take an orthostatic blood pressure reading was, she said to take it lying, sitting, then standing, with no breaks in between. Have them lie down, then take the blood pressure, sit up, and immediately take the blood pressure, then stand and immediately take the blood pressure. On 03/11/26 at 12:28 PM, Administrative Nurse D stated that her expectation is that when the provider gave an order for orthostatic blood pressures, the nurse put the orders into the EMR. The nurse got the orthostatic blood pressure, then put it into the EMR. In the past, the provider had them send them to her, and she reviewed them. The documentation should be in PCC, and sometimes they go straight to Consultant HH. Unless it expires, they should be able to see the messages with the blood pressures. Staff were unable to find the messages with the blood pressure information. On 03/11/26 at 10:53 AM, Consultant HH stated she did not require blood pressure with (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	all blood pressure medications. Consultant HH did not require blood pressure with midodrine. R45's blood pressure was low enough from the orthostatic to give the midodrine. The nurses were to check the orthostatic blood pressure two times a day for three days and tell her the results. No policy was provided.