

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 07/18/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                              |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>175541                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                     | (X3) DATE SURVEY<br>COMPLETED<br><br>02/25/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Tallgrass Creek, Inc                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>13760 Metcalf Avenue<br>Overland Park, KS 66223 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                              |                                                 |
| <p>F 0880</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Some</p>                | <p>Provide and implement an infection prevention and control program.</p> <p>The facility had a census of 41 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to ensure a sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections when the facility failed to ensure Enhanced Barrier Precautions (EBP - infection control interventions designed to reduce transmission of resistant organism which employ targeted gown and glove use during high contact care) were used for Resident (R) 18, who had a Foley catheter (a tube inserted into the bladder to drain urine into a collection bag). Findings included: - On 02/24/26 at 10:30 AM, observation revealed Certified Nurse Aide (CNA) N donned clean gloves, placed a chuck (a disposable absorbent pad) on the floor, and placed a plastic container on top of it. She emptied the catheter bag and started to pick up the plastic container that was full of urine when CNA M told her to set it back down on the floor and handed her a yellow disposable gown. CNA N stated that she did not realize she needed a gown, but it was better late than never. Both CNA M and CNA N put on yellow gowns. CNA M did not tie hers in the back. CNA N emptied the urine into the toilet, went back, and drained more urine from the catheter bag. CNA M told R18 that she was going to do her catheter and peri-care, and as she started peri-care, her gown fell from her shoulders, and she tried to adjust it but did not tie it. After CNA M finished catheter care, she removed her soiled gloves, sanitized her hands, and donned clean gloves. CNA M asked R18 to roll to her right side so she could finish her personal care, and again the gown fell off of her shoulders. CNA M finished cares, removed the gloves, sanitized her hands, and donned clean gloves. CNA M and CNA N put a pair of clean pants on R18. CNA M removed her yellow gown, grabbed the sling to the full mechanical lift, and had R18 roll to her right side so she could put the sling under her. CNA M attached the sling to the lift, and she transferred R18 into her wheelchair. CNA M removed R18's pajama top and put a clean shirt on her while CNA N put R18's shoes on. CNA M left the resident room to get a towel to wash her face as CNA N combed her hair. On 02/24/26 at 10:50 AM, CNA M stated she was unaware that she had to keep the gown on, as she thought she only needed to wear it during catheter care. On 02/24/26 at 01:23 PM, Administrative Nurse E stated she had provided education to staff regarding EBP use and would provide further education. Administrative Nurse E stated she had pamphlets that she could give to staff to provide further education related to EBP and when they should wear it. The facility's Enhanced Barrier Precautions Standard Operating Procedure, dated 08/22, documented procedures to prevent the potential spread of Multi-Drug-Resistant Organisms (MDRO) during high-contact care activities of residents with increased risk. The following pertain to residents residing in neighborhoods licensed as Skilled Nursing. Enhanced Barrier Precautions expand the use of personal protective equipment (PPE-gowns, face shields, and/or eyeglasses/goggles, and gloves) and are used during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. High-contact care activities include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, assisting with toileting, urinary catheter, and wound care. Enhanced barrier signage should also clearly indicate the high-contact resident care activities that require the use of a gown and gloves. Discard PPR after removal, before exiting the room, or before providing care for another resident in the same room. Trash cans should be available in or near the resident's room. Hand hygiene should be performed before and after resident contact.</p> |                                                                                              |                                                 |

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

|                                                                          |                         |                                                                        |
|--------------------------------------------------------------------------|-------------------------|------------------------------------------------------------------------|
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER<br>REPRESENTATIVE'S SIGNATURE | TITLE                   | (X6) DATE                                                              |
| FORM CMS-2567 (02/99)<br>Previous Versions Obsolete                      | Event ID:<br><br>175541 | Facility ID:<br><br>175541<br><br>If continuation sheet<br>Page 1 of 3 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                              |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>175541                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                     | (X3) DATE SURVEY<br>COMPLETED<br><br>02/25/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Tallgrass Creek, Inc                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>13760 Metcalf Avenue<br>Overland Park, KS 66223 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                              |                                                 |
| <p>F 0605</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> The facility had a census of 41 residents. The sample included 12 residents, with five reviewed for unnecessary medications. Based on observation, interview, and record review, the facility failed to ensure an appropriate indication, or a documented physician rationale for the continued use of Resident (R) 13's antipsychotic (a medication used to treat any major mental disorder characterized by a gross impairment testing) medication. This placed R13 at risk for unintended effects related to psychotropic (alters mood or thought) drug medications. Findings included: - R13's Electronic Medical Record (EMR) recorded diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion) mood disturbance (category of mental health problems, feelings of sadness, helplessness, guilt, and 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). R13's Quarterly Minimum Data Set (MDS), dated [DATE], recorded R13 had severely impaired cognition. The MDS recorded R13 required staff assistance with most activities of daily living (ADL). The MDS recorded the resident received antipsychotic medication during the observation period. The Psychotropic Drug Use Care Area Assessment (CAA), dated 05/28/25, recorded R13 received antipsychotic medication and had diagnosis of depression and dementia with behaviors. R13's Care Plan, dated 12/09/25, recorded the nurse would administer medications as prescribed and monitor for side effects. The Physician's Order, order dated 12/08/25, directed the staff to administer Seroquel 25 milligrams (mg), one half tablet (12.5 mg) once daily for a diagnosis of mood disorder and Seroquel 25 mg at hour of sleep for a diagnosis of mood disorder. The EMR documented an indication for the use of Seroquel as R13 had excessive aggression during cares, and the non-pharmacological interventions directed staff to try again at a different time or utilize a different caregiver. On 02/24/26 at 09:10 AM observation revealed R13 sat up in bed and License Nurse (LN) G, administered the residents' morning medication which included Seroquel 12.5 milligrams (mg). On 02/24/26 at 11:00 AM, Administrative Nurse D verified the resident received Seroquel, an antipsychotic medication, with a diagnosis of mood disorder. Administrative Nurse D verified the facility would contact the physician for appropriate diagnoses for the resident on antipsychotic medications. The facility's Psychoactive Medications policy dated 4/2025, recorded the intent of the policy is to provide guidance to clinical team members on the use of psychoactive medication regimens with residents in Continuing Care (CC). The policy recorded Psychoactive Medications would only be ordered by a provider to treat a specific condition as diagnosed and documented in the medical record. The decision to order psychoactive medications would include the relative benefits and risks, including black box warnings, while also considering the treatment preference. Where required by state specific regulation, an informed consent would be completed and filed in the resident's medical record. The use of non-pharmacological approaches include behavioral interventions would be attempted, unless clinically contraindicated to 1) minimize the need for psychoactive medications, 2) administer the lowest possible dose, 3) to potentially discontinue the use of psychoactive medications.</p> |                                                                                              |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                              |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>175541                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                     | (X3) DATE SURVEY<br>COMPLETED<br><br>02/25/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Tallgrass Creek, Inc                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>13760 Metcalf Avenue<br>Overland Park, KS 66223 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                              |                                                 |
| <p>F 0756</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> The facility had a census of 41 residents. The sample included 12 residents, with eight reviewed for unnecessary medications. Based on observation, interview and record review, the facility failed to ensure the Consult Pharmacist identified and reported the lack of appropriate indication, or a required physician documentation, for Resident (R) 13's use of an antipsychotic (a class of medication used to treat any major mental disorder characterized by a gross impairment testing) medication. This placed R13 at risk for unintended effects related to psychotropic (alters mood or thoughts) drug medication. Findings include: - R13's Electronic Medical Record (EMR) recorded diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion) mood disturbance (category of mental health problems, feelings of sadness, helplessness, guilt, and 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). R13's Quarterly Minimum Data Set (MDS), dated [DATE], recorded R13 had severely impaired cognition. The MDS recorded R13 required staff assistance with most activities of daily living (ADL). The MDS recorded the resident received antipsychotic medication during the observation period. The Psychotropic Drug Use Care Area Assessment (CAA), dated 05/28/25, recorded R13 received antipsychotic medication and had diagnosis of depression and dementia with behaviors. R13's Care Plan, dated 12/09/25, recorded the nurse would administer medications as prescribed and monitor for side effects. The Physician's Order, order dated 12/08/25, directed the staff to administer Seroquel 25 milligrams (mg), one half tablet (12.5 mg) once daily for a diagnosis of mood disorder and Seroquel 25 mg at hour of sleep for a diagnosis of mood disorder. The EMR documented the indication for the use of Seroquel was R13 had excessive aggression during cares, and the non-pharmacological interventions directed staff to try again at a different time or utilizing a different caregiver. The monthly Pharmacist Consultant Reviews on 12/10/25, 01/14/26, and 02/13/26 did not request an approved diagnosis or indication for the use of 13's Seroquel. On 02/24/26 at 09:10 AM observation revealed R13 sat up in bed and License Nurse (LN) G, administered the residents' morning medication which included Seroquel 12.5 milligrams (mg). On 02/24/26 at 11:00 AM, Administrative Nurse D verified the resident received Seroquel, an antipsychotic medication, with a diagnosis of mood disorder. Administrative Nurse D verified the facility would contact the physician for appropriate diagnoses for the resident on antipsychotic medications. The facility's Psychoactive Medications policy, dated 4/2025, recorded the intent of the policy is to provide guidance to clinical team members on the use of psychoactive medication regimens with residents in Continuing Care (CC). The policy applies to all business lines within CC. The policy recorded Psychoactive Medications would only be ordered by a provider to treat a specific condition as diagnosed and documented in the medical record. The decision to order psychoactive medications would include the relative benefits and risks, including black box warnings, while also considering the treatment preference. Where required by state specific regulation, an informed consent would be completed and filed in the resident's medical record. The use of non-pharmacological approaches include behavioral interventions would be attempted, unless clinically contraindicated to 1) minimize the need for psychoactive medications, 2) administer the lowest possible dose, 3) to potentially discontinue the use of psychoactive medications. The facility's Pharmacy Services policy, dated 5/2021, documented in order to meet the needs of each resident the Continuing Care (CC) accurately and safely provides or obtains pharmaceutical services, including provisions of routine and emergency medications, and the services of a licensed pharmacist. The facility contracts with a preferred pharmacy vendor to provide all pharmaceutical services to include the licensed pharmacy consultant would complete a Medication Regimen Review upon admission and monthly for skilled nursing/long term care.</p> |                                                                                              |                                                 |