STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175554	A. Building B. Wing	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Citizens Medical Center Ltcu	1625 S Franklin Avenue Colby, KS 67701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360 The facility has a census of 43 residents. The sample included 12 residents, with three reviewed for skin conditions, not pressure-related. Based on observation, record review, and interview, the facility failed to revise the care plan for Resident (R) 3 to include the use of protective sleeves to prevent skin injury. This placed the resident at risk for further skin injury due to uncommunicated care needs. Findings included: - The Electronic Medical Record (EMR) for R3 documented diagnoses of vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), hypertensive heart disease (complications of high blood pressure that affect the heart), chronic kidney disease (longstanding disease of the kidneys leading to renal failure), psychotic disorder with hallucinations (a mental health condition that causes people to lose touch with reality), and atrial fibrillation (rapid, irregular heartbeat). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R3 had long-term and short-term memory problems with severely impaired decision-making skills. R3 was dependent upon staff for personal hygiene, dressing, mobility, and toileting, and did not ambulate. The MDS documented R3 had no skin issues. R3's Care Plan, dated 07/03/24 and initiated on 05/24/17, documented R3 was at risk for skin integrity injuries due to incontinence, low activity level, use of a lift, agitation, behaviors, and dementia. The update. dated 04/05/23, directed staff to inspect her skin daily, observe for redness, open areas, scratches, cuts, and bruises, and report changes to the nurse. The update, dated, 10/13/21, directed staff to keep fingernails smooth and trimmed to prevent jagged edges. The update, dated 11/10/23, documented R3 had sheepskin on her wheelchair arms. The update, dated 07/03/24, directed staff to use a trough pressure relief cushion in R3's wheelchair to help prevent pressure injuries and to ensure R3 did not slide out of the wheelchair. The care plan lacked direction for R3's Dermasaver sleeves. The Physician's Order, dated 03/20/23, directed staff to administer Eliquis (an anticoagulant), 2.5 milligrams (mg), by mouth, for atrial fibrillation. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Physician's Order, dated 06/20/23, directed staff to have the charge nurse to perform a full body skin assessment on the resident weekly, check fingernails, trim or file if broken or jagged, and document skin assessment in the progress notes. The Physician's Order, dated 01/19/24, directed staff to apply derma sleeves and remove them at bedtime. On 08/05/24 at 08:15 AM, observation revealed R3 had Dermasaver sleeves on both forearms. The sleeves were bunched up and were not pulled up to cover her elbows. Further observation revealed that R3's wheelchair arms did not have sheepskin on them. On 08/05/24 at 11:00 AM, observation revealed R3 did not have the Dermasaver sleeves on and the wheelchair arms did not have sheepskin on them. On 08/06/24 at 08:20 AM, observation revealed R3 had the Dermasaver sleeves on, the sleeves were not pulled up over her elbows and the wheelchair arms did not have sheepskin on them. On 08/06/24 at 11:15 AM, observation revealed R3 did not have the Dermasaver sleeves on or sheepskin on the arms of the wheelchair. Further observation revealed R3 continuously rubbed her left arm during the noon meal. On 08/06/24 at 12:11 PM, Certified Nurse Aide (CNA) O stated R3 had a recent skin tear on her right elbow and was supposed to have her Dermasaver sleeves on for protection and sheepskin on the arms of the wheelchair. CNA O further stated she did not know why R3 did not have them on as she was at risk for bruising and skin tears. On 08/06/24 at 12:12 PM, Administrative Nurse D stated that R3's Dermasaver sleeves were ordered for protection due to her fragile skin. Administrative Nurse D stated the sleeves had been on R3's Care Plan at one time but somehow got deleted. Administrative Nurse D said she expected staff to follow the care plan. The facility's Care Planning policy, dated 6/30/20, documented the plan of care shall be individualized based on the diagnosis, culture, resident assessment, personal goals of the resident, resident interests, preferences, strengths, and trauma-informed care plan. The plan of care shall be reviewed and revised quarterly by the MDS Coordinator and as resident needs change by any qualified individual, with revisions reflecting the reassessment of the needs of the resident. The resident and/or resident representative will review the changes and sign the plan of care. The facility failed to revise the care plan for R3 to include Dermasaver sleeves to prevent skin injury. This placed the resident at risk for further injury due to uncommunicated care needs.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37450 The facility had a census of 43 residents. The sample included 12 residents with one resident reviewed for discharge. Based on record review and interview the facility failed to complete a recapitulation (a concise summary of stay and course of treatment in the facility) of Resident (R) 45's stay in the facility. This placed the resident at risk of unmet care needs. Findings included: - The Electronic Medical Record (EMR), documented R45 admitted to the facility on [DATE] and documented diagnoses of Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness) with dyskinesia (inability to execute voluntary movements), unsteadiness on feet, weakness, urine retention, dementia (progressive mental disorder characterized by failing memory, confusion), altered mental status, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), acute cystitis (type of urinary tract infection that causes inflammation of the bladder), and malignant (the tendency of a medical condition, especially tumors, to become progressively worse, most familiar as a characteristic of cancer) neoplasm (tumor) of the prostate. The Admission Minimum Data Set (MDS), dated [DATE], documented R45 had intact cognition. He was dependent on staff assistance with oral hygiene, toileting hygiene, lower body dressing, putting on and taking off footwear, and mobility from lying to sitting and sitting to standing. R45 required substantial assistance with showers, upper body dressing, toilet transfers, rolling left and right in bed, sitting to lying, and chair-to-bed and bed-to-chair transfers. The discharge goal performance had not been completed. The MDS further documented R45 was always continent of urine and occasionally incontinent of bowel. R45 received an antibiotic, and speech, occupational and physical therapies. The Activity of Daily Living Care Area Assessment (CAA), dated 04/08/24, documented R45 had been admitted for short-term rehabilitation. The goal was to return home with family. but it depended on how well R45 responded to therapy. The CAA further documented R45 had Parkinson's disease, was admitted to the hospital because of weakness and g urine incontinence, and was found to have COVID-19 (a highly infectious, potentially fatal respiratory infection)19, urinary tract infection, and acute cystitis. R45's Care Plan dated 04/11/24 documented R45 had a goal of discharging back to an apartment with his spouse. The care plan directed staff to anticipate discharge with home health services and involve R45 and his family in the discharge process. The Physician Order, dated 05/29/24, directed staff to discharge R45 to home with his spouse. The Progress Note, dated 05/29/24 at 12:56 PM, documented R45 assisted by wheelchair to the front entrance and assisted into a vehicle with his spouse. R45's clinical record lacked a recapitulation of the stay. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/07/24 at 08:33 AM Administrative Nurse D reported the nurses, social services, and therapy each do their discharge summaries, but the facility had not done a recapitulation of R45's stay. The facility's Discharge policy, dated 12/12/16, documented the policy that the nursing department, social services, physicians, and care team work together towards the organized timely discharge of all residents. It is the purpose of the policy to outline the proper procedure for discharging residents upon the order of a physician and the resident's goals. The policy lacked the need for a recapitulation of the resident's course of stay. The facility failed to complete a recapitulation of R45's stay in the facility. This placed the resident at risk of unmet care needs.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360 The facility had a census of 43 residents. The sample included 12 residents, with three reviewed for skin conditions, not pressure-related. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 3, who received anticoagulant (medication that inhibits the coagulation of blood), received the care as required to prevent skin injuries including Dermasaver sleeves (protects fragile skin prone to skin tears and bruises) and sheepskin surface padding. This placed R3 at risk for further skin injury. Findings included: - The Electronic Medical Record (EMR) for R3 documented diagnoses of vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), hypertensive heart disease (complications of high blood pressure that affect the heart), chronic kidney disease (longstanding disease of the kidneys leading to renal failure), psychotic disorder with hallucinations (a mental health condition that causes people to lose touch with reality), and atrial fibrillation (rapid, irregular heartbeat). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R3 had long-term and short-term memory problems with severely impaired decision-making skills. R3 was dependent upon staff for personal hygiene, dressing, mobility, and toileting, and did not ambulate. The MDS documented R3 had no skin issues. R3's Care Plan, dated 07/03/24 and initiated on 05/24/17, documented R3 was at risk for skin integrity injuries due to incontinence, low activity level, use of a lift, agitation, behaviors, and dementia. The update. dated 04/05/23, directed staff to inspect her skin daily, observe for redness, open areas, scratches, cuts, and bruises, and report changes to the nurse. The update, dated, 10/13/21, directed staff to keep fingernails smooth and trimmed to prevent jagged edges. The update, dated 11/10/23, documented R3 had sheepskin on her wheelchair arms. The update, dated 07/03/24, directed staff to use a trough pressure relief cushion in R3's wheelchair to help prevent pressure injuries and to ensure R3 did not slide out of the wheelchair. The care plan lacked direction for R3's Dermasaver sleeves. The Physician's Order, dated 03/20/23, directed staff to administer Eliquis (an anticoagulant), 2.5 milligrams (mg), by mouth, for atrial fibrillation. The Physician's Order, dated 06/20/23, directed staff to have the charge nurse to perform a full body skin assessment on the resident weekly, check fingernails, trim or file if broken or jagged, and document skin assessment in the progress Note. The Physician's Order, dated 01/19/24, directed staff to apply derma sleeves and remove them at bedtime. On 08/05/24 at 08:15 AM, observation revealed R3 had Dermasaver sleeves on both forearms. The sleeves were bunched up and were not pulled up to cover her elbows. Further observation revealed R3's wheelchair arms did not have sheepskin on them. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/05/24 at 11:00 AM, observation revealed R3 did not have the Dermasaver sleeves on and the wheelchair arms did not have sheepskin on them. On 08/06/24 at 08:20 AM, observation revealed R3 had the Dermasaver sleeves on, the sleeves were not pulled up over her elbows and the wheelchair arms did not have sheepskin on them. On 08/06/24 at 11:15 AM, observation revealed R3 did not have the Dermasaver sleeves on or sheepskin on the arms of the wheelchair. Further observation revealed R3 continuously rubbed her left arm during the noon meal. On 08/06/24 at 12:11 PM, Certified Nurse Aide (CNA) O stated R3 had a recent skin tear on her right elbow and was supposed to have her Dermasaver sleeves on for protection and sheepskin on the arms of the wheelchair. CNA O further stated she did not know why R3 did not have them on as she was at risk for bruising and skin tears. On 08/06/24 at 12:12 PM, Administrative Nurse D stated R3's Dermasaver sleeves were ordered for protection due to her fragile skin and stated the sleeves had been on her care plan at one time but somehow got deleted. On 08/07/24 at -9:40 AM, Licensed Nurse (LN) I stated R3 had a risk of bruising her arms because she had hit her arms on things so the Dermasaver sleeves were put on her arms for protection. The facility's Skin Integrity Management policy, dated 02/20/18, documented it was the responsibility of all nursing, activity, dietary, and social service staff to report any abnormal skin conditions to the resident's charge nurse. Preventative methods, interventions, and treatment options for residents who are at risk for or who have abnormal skin conditions/breakdown, including application of derma arm and/or derma leg protectors. The facility failed to ensure R3 received the necessary interventions including Dermasaver sleeves and sheepskin surface padding to prevent skin injuries This placed the resident at risk for further skin injury.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32358 The facility had a census of 43 residents. The sample included 12 residents with two residents sampled for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). Based on observation, record review, and interview, the facility staff failed to implement interventions to prevent development and promote healing of pressure ulcers for Resident (R)26, who had a Stage 4 pressure ulcer (a deep pressure wound that reaches the muscles, ligaments, or even bone) when staff did not reposition R26 per the plan of care. This placed R26 at risk for the development of new pressure injuries or delayed healing of the existing pressure ulcer. Findings included: - R26's Electronic Medical Record (EMR) documented R26 had a diagnosis of Stage 4 pressure ulcer of the sacral (large triangular bone/area between the two hip bones) region. R26's Quarterly Minimum Data Set (MDS), dated [DATE], documented R26 had a Brief Interview of Mental Status (BIMS) score of 10, which indicated moderately impaired cognition. The MDS documented R26 was dependent on staff for most activities of daily living (ADLs). The MDS documented R26 had a stage 4 pressure ulcer. R26's Care Plan, revised 05/08/24 documented R26 had a stage four pressure ulcer and instructed staff to turn and reposition R26 every hour while sitting up in a chair. The plan directed staff that if R25 was in a recliner or wheelchair, staff were to stand R26 and encourage her to take a walk or lay down for 15 minutes, every hour, 12 times a day, starting at 08:00 AM and ending at 07:00 PM. On 08/05/24 at 01:30 PM, observation revealed R26 sat in a wheelchair in the activity room. Continued observation revealed R26 remained in the same position in the same place, without staff assisting the resident to stand or encourage her to lie down in bed. Continued observation revealed from 01:30 PM to 03:35 PM (two hours and five minutes) R26 remained in the same position in her chair without staff assisting her to stand, reposition, or encourage her to lie down in bed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/06/24 at 07:33 AM, observation revealed R26 sat in a wheelchair, leaning forward. R26 looked in a mirror and independently applied her makeup. Continued observation revealed at 07:49 AM Certified Nurse Aide (CNA) P entered R26's room and asked R26 if she was done putting on her makeup, and R26 replied Yes. CNA P told the resident he would take out the trash and come back and get her but did not offer to assist her to stand or encourage her to lie down in bed. At 07:58 AM CNA P came back to the room, placed the foot pedals on the resident's wheelchair, placed her feet up on the foot pedals and, without assisting R26 to stand or reposition, propelled R26 from her room to hallway. CNA Q then propelled R26 to the dining room table. Continued observation revealed from 08:13 AM to 08:55 AM R26 remained in the same position at the dining room table, without staff repositioning, standing her, or encouraging her to lie down. At 08:55 AM, observation revealed CNA R propelled R26 away from the table to the activity room and placed her facing the television. Staff did not attempt or offer to assist R26 to stand, reposition, or encourage her to lie down in bed. At 09:09 AM R26 remained in the wheelchair in the activity room; staff removed her foot pedals and R26 exercised by minimally lifting her legs one at a time up from the wheelchair. Continuous observation for one hour 39 minutes during which no staff assisted R26 with standing, repositioning, or encouraging her to lie down in bed. On 08/05/24 at 03:56 PM, Certified Nurse Aide (CNA) M stated staff were to assist R26 with changing position, every hour, while she was in her chair. CNA M stated she did not know how long R26 had been in her wheelchair due to the activity staff placed her in it. On 08/07/24 at 11:08 AM, Licensed Nurse (LN) J, the facility's wound care nurse, said she was uncertain if the lack of repositioning could delay the healing of R26's pressure ulcer since it was not expected to heal. LN J said the plan was just to maintain it. On 08/07/24 at 10:32 AM, Administrative Nurse D verified R26's Care Plan and instructed staff to reposition R26 every hour when in her chair. Admin Nurse D stated the CNA's ADL plan did not include those instructions. The facility's Care Planning Policy, revised 06/30/20, documented all associates were responsible for following the care plan. The facility's Skin Integrity Policy, revised 08/20/18, documented that staff would identify residents at risk for skin breakdown, reduce or relieve pressure, maintain skin integrity, and provide appropriate interventions to manage pressure injuries. The facility failed to implement interventions to prevent the development and promote the healing of pressure ulcers for R26, who had a Stage 4 pressure ulcer when staff did not reposition R26 per the plan of care. This placed R26 at risk for the development of new pressure injuries or delayed healing of the existing pressure ulcer.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26768 The facility had a census of 43 residents. The sample included 12 residents with five reviewed for unnecessary drugs. Based on observation, interview, and record review the facility failed to ensure the Consultant Pharmacist identified and reported to facility administration the lack of a documented physician rationale which included the multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the continued use of an antipsychotic (class of medications used to treat mental disorder characterized by gross impairment in reality testing) and/or for not attempting a gradual dose reduction (GDR) for psychotropic (alters mood or thought) medications and that staff had not administered the physician ordered as needed (PRN) blood pressure medication when the blood pressure was out of parameters, placing R7 at risk for further issues related to uncontrolled blood pressures and for receiving unnecessary psychotropic medications. Findings included: - R7's Electronic Medical Record (EMR) documented diagnoses of orthostatic hypotension (blood pressure dropping with change of position) and hypertension (high blood pressure). The Quarterly Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 11, indicating moderately impaired cognition. The MDS documented R7 was independent with eating and required supervision for upper body dressing, moderate staff assistance for transfers, walking, and donning footwear. R7 required maximum staff assistance for lower body dressing, toileting, and sitting to standing. The MDS documented R7 had one non-injury fall since the prior MDS. R7's Care Plan, dated 07/24/24, directed staff to give medications as ordered, monitor, document, and report any signs or symptoms of medication side effects. Encourage R7 to assume a standing position slowly, and avoid standing or transferring without assistance. The plan directed staff that when R7 reported feeling dizzy or was having symptoms of hypotension, assist her to sit down or sit with her head lowered between her legs. The Physician Order, dated 12/12/23 directed staff to administer an as-needed (PRN) dose of metoprolol (a drug to reduce blood pressure) 12.5 milligrams (mg) for systolic blood pressure (SBP- top number, the force your heart exerts on the walls of your arteries each time it beats) greater than (>) 160 millimeters of mercury (mm/Hg). The Physician Order, dated 04/05/23 directed staff to perform blood pressure checks three times per day (TID) and administer Midodrine (a drug to increase blood pressure) 2.5 mg PRN for SBP less than (<) 90 mm/Hg, three times daily. The Physician Order, dated 04/23/2023, directed staff to report blood pressures greater than 200/110 mm/Hg or less than 80/30 mm/Hg or if the resident was symptomatic. R7's May Medication Administration Record lacked documentation that staff administered Midodrine 2.5 mg for SBP <90 mm/HG six times. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R7's June Medication Administration Record lacked documentation staff administered PRN metoprolol 12.5 mg for SBP >160 mm/HG 42 times and lacked documentation that staff administered Midodrine 2.5 mg PRN for SBP <90 mm/HG two times. R7's July Medication Administration Record lacked documentation staff administered PRN metoprolol 12.5 mg for SBP >160 mm/HG 21 times the SBP exceeded the parameter and lacked documentation that the staff administered Midodrine 2.5 mg PRN for SBP <90 mmHG seven times. R7's August Medication Administration Record lacked documentation staff administered PRN Metoprolol 12. 5 mg for SBP >160 mm/HG four times the SBP exceeded the parameter. The Consultant Pharmacist Monthly Medication Reviews, dated 06/18/24 and 07/16/24, documented there were no irregularities in the medication record. The Physician Order, dated 01/16/23, directed staff to administer Trazodone 100 milligrams (mg) at bedtime, for insomnia. The Physician Order, dated 05/19/23, directed staff to administer clonazepam 0.5 mg every day upon rising, and at 02:30 PM, for anxiety disorder. The Physician Order, dated 10/17/23, directed staff to administer clonazepam 0.5 mg (3 tabs) at bedtime for anxiety disorder. The Physician Order, dated 10/18/23, directed staff to administer risperidone 0.25 mg twice daily (BID) for psychotic disorder with delusions. The Physician Order, dated 10/18/23, directed staff to administer Zoloft 150 mg upon rising, for recurrent depression. The Consultant Pharmacist Monthly Medication Review dated 03/19/24, recommended a GDR of risperidone. The physician wrote dose adjustment not advised without documenting an explanation of why the benefits of continuing the drug outweighed the risks. The Consultant Pharmacist Monthly Medication Review dated 04/23/24, recommended a GDR of Trazodone. The physician wrote, See if the family wants to decrease the dose. The physician did not provide an explanation of why the benefits of continuing the drug outweighed the risks. The Consultant Pharmacist Monthly Medication Review dated 05/22/24, recommended a GDR of clonazepam. The physician wrote no changes without documenting an explanation of why the benefits of continuing the drug outweighed the risks. The Consultant Pharmacist Monthly Medication Reviews dated 06/18/24, and 07/16/24, documented no irregularities. On 08/06/24 at 08:04 AM, observation revealed Licensed Nurse (LN) H administered medications to R7 after obtaining a blood pressure of 185/112 mm/Hg. The medications included metoprolol 12.5 mg, and PRN metoprolol 12.5 mg. R7 took the pills whole with much encouragement. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/07/24 at 903 AM, Administrative Nurse E verified the lack of risk versus benefit rationales for the continued use of clonazepam, risperidone, Trazodone, and Zoloft. and confirmed the pharmacist had not reported this to the facility. On 08/07/24 at 09:40 AM, Administrative Nurse D verified the facility's consultant pharmacist had failed to notify her of the lack of administration of the PRN metoprolol and the PRN Midodrine as the physician ordered numerous times in May, June, and July 2024. The facility's Pharmacy Review policy, dated 03/19/18, stated the pharmacist consultant would review the resident's Electronic Health Records (EHR) and Electronic Medical Record (EMR) of all residents on a monthly basis to ensure the residents were receiving appropriate medication therapy that was safe and efficacious. The pharmacist would review medication administration for timely administration and reasons for non-administration. The pharmacist would review for possible unnecessary medications where the resident might benefit from a gradual dose reduction to the lowest effective dose. The pharmacist would review for appropriate orders, diagnosis, and response to medications. The pharmacist would document a review of irregularities and what if any action was taken to address it. If no action was taken the physician must then document a rationale on the report. The Medical Director would review the pharmacy irregularities and omissions reviews monthly. The facility failed to ensure the Consultant Pharmacist identified and reported to facility administration the lack of a documented physician rationale which included the multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the continued use of an antipsychotic and/or for not attempting a GDR for psychotropic medications and that staff had not administered the physician ordered PRN blood pressure medication when the blood pressure was out of parameters, placing R7 at risk for further issues related to uncontrolled blood pressures and for receiving unnecessary psychotropic medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175554	A. Building B. Wing	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Citizens Medical Center Ltcu	1625 S Franklin Avenue Colby, KS 67701

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26768 The facility had a census of 43 residents. The sample included 12 residents with five reviewed for unnecessary drugs. Based on observation, interview, and record review the facility failed to administer two blood pressure medications based on the blood pressure monitoring per the physician's orders for Resident (R) 7. This placed the resident at risk for unnecessary medication resulting from abnormal blood pressure. Findings included: - R7's Electronic Medical Record (EMR) documented diagnoses of orthostatic hypotension (blood pressure dropping with change of position) and hypertension (high blood pressure). The Quarterly Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 11, indicating moderately impaired cognition. The MDS documented R7 was independent with eating and required supervision for upper body dressing, moderate staff assistance for transfers, walking, and donning footwear. R7 required maximum staff assistance for lower body dressing, toileting, and sitting to standing. The MDS documented R7 had one non-injury fall since the prior MDS. R7's Care Plan, dated 07/24/24, directed staff to give medications as ordered, monitor, document, and report any signs or symptoms of medication side effects. Encourage R7 to assume a standing position slowly, and avoid standing or transferring without assistance. The plan directed staff that when R7 reported feeling dizzy or was having symptoms of hypotension, assist her to sit down or sit with her head lowered between her legs. The Physician Order, dated 12/12/23 directed staff to administer an as-needed (PRN) dose of metoprolol (a drug to reduce blood pressure) 12.5 milligrams (mg) for systolic blood pressure (SBP- top number, the force your heart exerts on the walls of your arteries each time it beats) greater than (>) 160 millimeters of mercury (mm/Hg). The Physician Order, dated 04/05/23 directed staff to perform blood pressure checks three times per day (TID) and administer Midodrine (a drug to increase blood pressure) 2.5 mg PRN for SBP less than (<) 90 mm/Hg, three times daily. The Physician Order, dated 04/23/2023, directed staff to report blood pressures greater than 200/110 mm/Hg or less than 80/30 mm/Hg or if the resident was symptomatic. R7's May Medication Administration Record lacked documentation staff administered Midodrine 2.5 mg for SBP <90 mm/HG six times. R7's June Medication Administration Record lacked documentation staff administered PRN metoprolol 12.5 mg for SBP >160 mm/HG 42 times and lacked documentation that staff administered Midodrine 2.5 mg PRN for SBP <90 mm/HG two times. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R7's July Medication Administration Record lacked documentation staff administered PRN metoprolol 12.5 mg for SBP >160 mm/HG 21 times the SBP exceeded the parameter and lacked documentation that the staff administered Midodrine 2.5 mg PRN for SBP <90 mmHG seven times. R7's August Medication Administration Record lacked documentation staff administered PRN Metoprolol 12. 5 mg for SBP >160 mm/HG four times the SBP exceeded the parameter. On 08/06/24 at 08:04 AM, observation revealed Licensed Nurse (LN) H administered medications to R7 after obtaining a blood pressure of 185/112 mm/Hg. The medications included metoprolol 12.5 mg, and PRN metoprolol 12.5 mg. R7 took the pills whole with much encouragement. On 08/07/24 at 09:40 AM, Administrative Nurse D verified staff failed to administer the PRN metoprolol and the PRN Midodrine as the physician ordered numerous times in May, June, and July 2024. She stated some of the high blood pressure readings were obtained just prior to the resident receiving the scheduled dose of metoprolol. The facility's Medication Administration policy, dated 02/13/2017, stated staff would administer all medications to each resident as ordered by a physician or provider, and the drug regimen would be free from unnecessary drugs. The facility failed to administer blood pressure medications as the physician ordered, placing R7 at risk for high or low blood pressure effects.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26768 The facility had a census of 43 residents. The sample included 12 residents with five reviewed for unnecessary drugs. Based on observation, interview, and record review the facility failed to obtain a written risk versus benefit rationale from the physician for the continued use of four psychotropic (alters mood or thought) drugs for Resident (R) 7. This placed R7 at risk for unnecessary psychotropic medications and related side effects. Findings included: - R7's Electronic Medical Record (EMR) documented diagnoses of Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), recurrent major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), delusional (untrue persistent belief or perception held by a person although evidence shows it was untrue) disorders, psychotic (any major mental disorder characterized by gross impairment in reality perception) disorder, and insomnia (inability to sleep). The Quarterly Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 11, indicating moderately impaired cognition. The MDS documented R7 was independent with eating, required supervision for upper body dressing, moderate staff assistance for transfers, walking, donning footwear, and maximum staff assistance for lower body dressing, toileting, and sitting to standing. The MDS documented R7 had no behaviors and received antipsychotic (class of medications used to treat major mental conditions that cause a break from reality), antianxiety (class of medications that calm and relax people), and antidepressant (class of medications used to treat mood disorders) medications. R7's Care Plan, dated 07/24/24, directed staff to give medications as ordered, monitor, document, and report any signs or symptoms of medication side effects. The care plan for psychotropic drugs stated a gradual dose reduction (GDR) was to be attempted when clinically appropriate, within the first year of medication start, and two GDR attempts were to be trialed within two different quarters unless documentation for clinical contraindication was present. The care plan included the target behaviors for the use of risperidone (antipsychotic), clonazepam (antianxiety), Trazodone (antidepressant), and Zoloft (antidepressant). The Physician Order, dated 01/16/23, directed staff to administer Trazodone 100 milligrams (mg) at bedtime, for insomnia. The Physician Order, dated 05/19/23, directed staff to administer clonazepam 0.5 mg every day upon rising, and at 02:30 PM, for anxiety disorder. (continued on next page)

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	175554	A. Building B. Wing	08/07/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Physician Order, dated 10/17/23, directed staff to administer clonazepam 0.5 mg (3 tabs) at bedtime for anxiety disorder. The Physician Order, dated 10/18/23, directed staff to administer risperidone 0.25 mg twice daily (BID) for psychotic disorder with delusions. The Physician Order, dated 10/18/23, directed staff to administer Zoloft 150 mg upon rising, for recurrent depression. The Consultant Pharmacist Monthly Medication Review dated 03/19/24, recommended a GDR of risperidone. The physician wrote dose adjustment not advised without documenting an explanation of why the benefits of continuing the drug outweighed the risks. The Consultant Pharmacist Monthly Medication Review dated 04/23/24, recommended a GDR of Trazodone. The physician wrote, See if family wants to decrease dose. The physician did not provide an explanation of why the benefits of continuing the drug outweighed the risks. The Consultant Pharmacist Monthly Medication Review dated 05/22/24, recommended a GDR of clonazepam. The physician wrote no changes without documenting an explanation of why the benefits of continuing the drug outweighed the risks. The Consultant Pharmacist Monthly Medication Reviews dated 06/18/24, and 07/16/24, documented no irregularities. On 08/06/24 at 08:04 AM, observation revealed Licensed Nurse (LN) H administered medications including Zoloft, clonazepam, and risperidone to R7 who took the pills whole with much encouragement. On 08/07/24 at 903 AM, Administrative Nurse E verified the lack of risk versus benefit rationales for the continued use of clonazepam, risperidone, Trazodone, and Zoloft. The facility's Psychotropic Drug Use policy, dated 02/24/2021, stated residents who use psychotropic drugs would receive periodical gradual dose reductions and behavioral interventions unless clinically contraindicated. The MDS coordinator would review psychotropic medications with each MDS assessment and request the physician review the usage of psychotropic medications. The facility failed to obtain a written risk versus benefit rationale from the physician for the continued use of four psychotropic drugs for R7, placing R7 at risk for unnecessary psychotropic medications and related side effects.