STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E210	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Access Mental Health	500 Peabody Peabody, KS 66866

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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41713 The facility identified a census of 45 residents. The sample included 12 residents with four residents reviewed for hospitalization . Based on observation, record review, and interview, the facility failed to ensure staff had documented when, where, and why Resident (R) 39 was transferred to an acute hospital. This placed R39 at risk of risk for uninformed care choices. Findings included: - R39's Electronic Medical Record (EMR) documented diagnoses of post-traumatic stress disorder (PTSD - a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress), major depressive disorder (major mood disorder that causes persistent feelings of sadness), suicidal ideations (the thought process of having ideas, or ruminations about the possibility of completing suicide), bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and borderline personality disorder (a disorder characterized by disturbed and unstable interpersonal relationships and self-image along with impulsive, reckless, and often self-destructive behavior). R39's Admission Minimum Data Set (MDS) dated [DATE] documented she had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R39 was independent with her functional abilities and cares. R39 had active diagnosis of anxiety disorder, depression, and bipolar disorder. R39 received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) and an antidepressant (a class of medications used to treat mood disorders) medication on a routine basis. R39's Quarterly MDS dated [DATE] documented she had a BIMS score of 15 which indicated intact cognition. R39 was independent with her functional abilities and care. R39 had active diagnoses of anxiety disorder, depression, and bipolar disorder. R39 received an antipsychotic, antianxiety (a medication used to treat anxiety symptoms), and an antidepressant medication on a routine basis. R39's Discharge MDS dated [DATE] documented an unplanned discharge to an inpatient psychiatric facility with a return anticipated. R39's Entry MDS dated [DATE] documented a re-entry to the facility from an unlisted facility. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R39's Psychotropic Drug Use Care Area Assessment (CAA) dated 07/24/24 documented she was prescribed an antipsychotic, antianxiety, and antidepressant medication. R39 had diagnoses of major depressive disorder and bipolar disorder. R39 was having difficulty feeling safe at her prior facility. R39's Care Plan last revised on 11/25/24 directed staff that she wished to return to the community. Staff were directed to establish a pre-discharge plan with the resident/family/caregiver, evaluate the progress, and revise the plan as needed. Staff were directed to administer medications as ordered. Staff was directed to monitor the resident and document and report as needed any risk for harm to self: including increased depression, suicidal plan, past attempt at suicide, risky actions, giving away possessions, saying goodbye to family, intentionally harmed or tried to harm self, refusing to eat or drink, refusing meds or therapies, a sense of hopelessness, impaired judgment, or safety awareness. R39's Progress Notes in the EMR lacked staff documentation regarding her transfer or discharge to the psychiatric hospital on 12/06/24. On 01/13/25 at 10:00 AM, R39 was in her room. She did not want to be disturbed at this time. On 01/14/25, at 09:13 AM R39 stated she has had PTSD for a long time and has tried to harm herself in the past. R39 stated she did go on leave from the facility to go home with her mother. On 01/15/25, at 12:28 PM Administrative Nurse E stated when R39 was discharged she was not in the facility at the time she was on therapeutic leave with her mother. Administrative Nurse E stated R39 was on leave with her mother and had attempted suicide, then she was taken to the psychiatric hospital by her mother. Administrative Nurse E stated the facility did not even know R39 had been to a hospital or other facility. Administrative Nurse E stated that the facility received a call from the hospital stating R39 had been dismissed from their care and needed to be transported back to the facility. On 01/15/25 at 02:32 PM Administrative Nurse D stated R39 went out on leave to her mother's house and was not in the facility at the time of her transfer to the psychiatric hospital. Administrative Nurse D stated that typically when R39 did go out of the facility on leave to her mother's house staff would document that in her progress notes. Administrative Nurse D stated a transfer note had not been documented since the facility was not aware of R39's admission to the psychiatric hospital until a call was from the hospital that R39 had been discharged and needed to be picked up. The facility failed to provide a policy regarding transfer and discharge as requested. The facility failed to document when, where, and why R39 was transferred to a hospital for further care, placing R39 at risk for uninformed care choices.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41713 The facility identified a census of 45 residents. The sample included 12 residents with four residents reviewed for hospitalization . Based on observation, record review, and interview, the facility failed to provide written notification of transfer to Resident (R)39 and R20 for their facility-initiated transfers. This deficient practice placed R39 and R20 at risk for uninformed care choices. Findings included: - R39's Electronic Medical Record (EMR) documented diagnoses of post-traumatic stress disorder (PTSD - a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress), major depressive disorder (major mood disorder that causes persistent feelings of sadness), suicidal ideations (the thought process of having ideas, or ruminations about the possibility of completing suicide), bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods) (anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and borderline personality disorder (a disorder characterized by disturbed and unstable interpersonal relationships and self-image along with impulsive, reckless, and often self-destructive behavior). R39's Admission Minimum Data Set (MDS) dated [DATE] documented she had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R39 was independent with her functional abilities and care. R39 had active diagnoses of anxiety disorder, depression, and bipolar disorder. R39 received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), and an antidepressant (a class of medications used to treat mood disorders) medication on a routine basis. R39's Quarterly MDS dated [DATE] documented she had a BIMS score of 15 which indicated intact cognition. R39 was independent with her functional abilities and care. R39 had active diagnoses of anxiety disorder, depression, and bipolar disorder. R39 received an antipsychotic, antianxiety (a medication used to treat anxiety symptoms), and an antidepressant medication on a routine basis. R39's Discharge MDS dated [DATE] documented an unplanned discharge to an inpatient psychiatric facility with a return anticipated. R39's Entry MDS dated [DATE] documented a re-entry to the facility from an unlisted facility. R39's Psychotropic Drug Use Care Area Assessment (CAA) dated 07/24/24 documented she was prescribed an antipsychotic, antianxiety, and antidepressant medication. R39 had diagnoses of major depressive disorder and bipolar disorder. R39 was having difficulty feeling safe at her prior facility. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R39's Care Plan last revised on 11/25/24 directed staff that she wished to return to the community. Staff was directed to establish a pre-discharge plan with the resident/ family/caregiver, evaluate the progress, and revise the plan as needed. Staff were directed to administer medications as ordered. Staff was directed to monitor the resident, and document and report any risk for harm to self: including increased depression, suicidal plan, past attempt at suicide, risky actions, giving away possessions, saying goodbye to family, intentionally harmed or tried to harm self, refusing to eat or drink, refusing meds or therapies, a sense of hopelessness, impaired judgment, or safety awareness. R39's Progress Notes in the EMR lacked staff documentation regarding her transfer or discharge to the psychiatric hospital on 12/06/24. On 01/13/25 at 10:00 AM, R39 was in her room. She did not want to be disturbed at this time. On 01/14/25 at 09:13 AM, R39 stated she has had PTSD for a long time and has tried to harm herself in the past. R39 stated she did go on leave from the facility to go home with her mother. On 01/15/25 at 12:28 PM, Administrative Nurse E stated when R39 was discharged she was not in the facility at the time she was on therapeutic leave with her mother. Administrative Nurse E stated R39 was on leave with her mother and had attempted suicide, then she was taken to the psychiatric hospital by her mother. Administrative Nurse E stated written notification was not initiated for this transfer since R39's representative was who took R39 to the hospital for needed care. On 01/15/25 at 02:32 PM Administrative Nurse D stated R39 went out on leave to her mother's house and was not in the facility at the time of her transfer to the psychiatric hospital. Administrative Nurse D stated a written transfer note had not been completed due to R39 not being in the facility at the time of her transfer to the hospital. Administrative Nurse D stated that R39's representative was who took R39 to the hospital so the facility did not complete a written notification. Administrative Nurse D stated the facility received a call from the psychiatric hospital on 12/09/24 that R39 had been discharged and needed to be picked up. The facility failed to provide a policy as requested. The facility failed to provide written notification of transfer to R39 for his facility-initiated transfers. This deficient practice placed R39 at risk for uninformed care choices. 41037 - R20's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), epilepsy (brain disorder characterized by repeated seizures), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The Significant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. R20's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 10/24/24 documented he would become impatient related to his diagnosis. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R20's Care Plan dated 09/16/24 documented nursing staff would administer his medications as ordered, along with monitoring for side effects, and documenting the effectiveness. R20's EMR under the Progress Notes tab revealed: On 08/08/24 at 01:06 PM an Out of the Building Note revealed R20 was transferred to the hospital and was admitted . On 09/04/24 at 06:45 PM an Incident Note revealed R20 was transferred to the hospital and was admitted . On 09/27/24 at 08:00 PM a Health Status Note revealed R20 was transferred to the hospital and was admitted . R20 was admitted to the facility on [DATE] and discharged on [DATE] The facility was unable to provide evidence a written notice of transfer or discharge notification was provided to R20 or the legal representative when R20 transferred to the hospital on the above dates. On 01/16/25 at 09:42 AM, Administrative Nurse A stated the facility notified the resident's legal guardian or family legal representatives by phone. The facility was unable to provide a policy related to facility-initiated transfer. The facility failed to provide written notice of transfer/discharge as soon as practicable for R20's facility-initiated transfers. This deficient practice placed R20 at risk of uninformed choices and miscommunication regarding 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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37450 The facility had a census of 45 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to accurately code the Minimum Data Set (MDS) assessment for Resident (R) 28 who lacked the need of specialized services, and R39 to include the diagnosis of post-traumatic stress disorder (PTSD - a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress). This placed the residents at risk for inappropriate comprehensive care. Findings included: - Resident (R) 28's Electronic Medical Record (EMR) recorded diagnoses of schizoaffective disorder (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought) bipolar type (a major mental illness that causes people to have episodes of severe high and low moods), selective mutism (unable to speak when exposed to specific situations places or people), essential tremor, anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and long-term drug therapy. The Quarterly MDS, dated [DATE], documented R28 had intact cognition, hallucinations (sensing things while awake that appear to be real, but the mind created), no delirium (sudden severe confusion, disorientation, and restlessness), or exhibited behaviors. R28 was independent with functional abilities and mobility and received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), antianxiety (a class of medications that calm and relax people), and antidepressant (a class of medications used to treat mood disorders). The MDS further documented R28 received chemotherapy (treatment of cancer with powerful chemicals), radiation (a treatment kill or shrink cancer cells or tumors), oxygen, suctioning, tracheostomy care (opening through the neck into the trachea through which an indwelling tube may be inserted), invasive mechanical ventilator, intravenous (IV-catheter placed in a vein in order to administer medications or fluids directly into the bloodstream) access, and medications, transfusion (the process of transferring blood or components into the bloodstream), dialysis (a procedure where impurities or wastes are removed from the blood), hospice care (a program that provides comfort and support for the terminally ill), and isolation or quarantine for active infectious disease. The Care Plan dated 11/06/24, documented R28 had an Activity of Daily Living (ADL) self-care performance deficit r/t schizoaffective disorder bipolar type and anxiety. The Care Plan directs staff to encourage the resident to use a call bell to call for assistance and staff to discuss with the resident/family/power of attorney (POA) any concerns related to loss of independence or decline in function. The Progress Note, dated 11/29/25 at 11:02 AM, documented R28 had some problems sleeping at night, wanting to eat at night, was not a weight loss and staff instructed resident he should not be eating at night. R28 would get hateful with staff. He showered at least three times a week, ate meals in the dining room, had a good appetite, watched TV in his room, read, and visited with peers. On 01/15/25 at 11:14 AM, R28 sat in the commons area, waiting to go outside to smoke. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/13/25 at 08:19 AM, Licensed Nurse (LN) G reported R28 had not received dialysis, hospice, an IV, nor had a tracheostomy or ventilator. LN G reported that R28 was doing well at this time. On 01/14/25 at 12:32 PM, Administrative Nurse F reported Administrative Nurse D had completed the MDS for R28 on 10/20/24. Administrative Nurse F stated Administrative Nurse D had incorrectly coded the MDS and would submit a corrected MDS. On 01/15/24 at 02:35 PM, Administrative Nurse D reported she had made a mistake and coded the MDS incorrectly. Upon request, the facility failed to provide an MDS Accuracy policy. The facility failed to accurately submit R28's MDS which placed the resident at risk for accurate comprehensive care. 41713 - R39's Electronic Medical Record (EMR) documented diagnoses of post-traumatic stress disorder (PTSD - a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress), major depressive disorder (major mood disorder that causes persistent feelings of sadness), suicidal ideations (the thought process of having ideas, or ruminations about the possibility of completing suicide), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods)and borderline personality disorder (a disorder characterized by disturbed and unstable interpersonal relationships and self-image along with impulsive, reckless, and often self-destructive behavior). R39's Admission Minimum Data Set (MDS) dated [DATE] documented she had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R39 was independent with her functional abilities and care. R39 had active diagnoses of anxiety disorder, depression, and bipolar disorder. R39 received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), and an antidepressant (a class of medications used to treat mood disorders) medication on a routine basis. R39's MDS lacked the indication of her diagnosis of PTSD. R39's Quarterly MDS dated [DATE] documented she had a BIMS score of 15 which indicated intact cognition. R39 was independent with her functional abilities and care. R39 had active diagnoses of anxiety disorder, depression, and bipolar disorder. R39 received an antipsychotic, antianxiety (a medication used to treat symptoms of anxiety), and an antidepressant medication on a routine basis. R39's MDS lacked the indication of her diagnosis of PTSD. R39's Psychotropic Drug Use Care Area Assessment (CAA) dated 07/24/24 documented she was prescribed an antipsychotic, antianxiety, and antidepressant medication. R39 had diagnoses of major depressive disorder and bipolar disorder. R39 was having difficulty feeling safe at her prior facility. R39's Care Plan last revised on 11/25/24 documented that she had the potential for aggressive verbal and physical behaviors and staff was directed to: (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Identify triggers and times, the circumstances, and what de-escalated behaviors and document them. 2. Designate a quiet/secure area where the resident can be temporarily isolated during aggressive episodes. 3. When the resident exhibited aggressive behavior, attempt de-escalation, keep the situation calm, validate their complaint, give the resident time to vent, and don't argue. 4. See if a change of scenery would help, walk outside, and take a shower. Place the resident in a calm place to think. Engage her in a calm conversation. 5. Reward the Resident if they began to De-escalate. 6. If a weapon was brandished- Staff were to distance themselves and try to talk the resident to give up the weapon, then call for help. 7. Involve the resident in the care planning process, allowing, them to express their needs and preferences. 8. Administer meds as ordered and ensure medication compliance. 9. To ensure the safety of the resident, staff, and others: A. Remove any potential weapons from the environment. B. Maintain a safe distance from the resident during episodes of aggressive to present physical harm. C. In an acute crisis situation, the use of medications and physical means would be used to limit the aggressive behavior of the resident. The Medical and/or Psychiatric Provider would be notified of the situation. Orders are to be obtained as needed. 10. Teach coping skills to manage her anger and frustration. 11. Consider therapy in a formal setting to provide outlets for emotions, such as engaging in physical activities or expressing themselves through art and music. 12. Regular behavioral documentation, including but not limited to resident participation in activities, life skills, adherence to smoking rules, and sleeping habits. 13. Violence risk assessment to be completed on admission, annually, and with any significant change. R39's Care Plan last revised on 11/25/24 lacked a care area to address R39's PTSD to indicate known causes, triggers, or interventions to mitigate triggers or re-traumatization. On 01/13/25, at 10:00 AM, R39 was in her room. She did not want to be disturbed at this time. On 01/14/25 at 09:13 AM, R39 stated she had PTSD for a long time. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/15/25 at 12:28 PM, Administrative Nurse E stated the facility had trouble getting any documentation from R39's prior facility. Administrative Nurse E stated the facility did not receive information about R39's PTSD for about a month after she was admitted so her MDS was not marked for PTSD. Administrative Nurse D stated she was not the person who completed R39's MDS at admission. On 01/15/25 at 12:32 PM, Administrative Nurse F stated that R39's MDS's would be modified to address the PTSD. The facility failed to provide a policy as requested. The facility failed to ensure R39's admission and quarterly MDS section I6100 Post Traumatic Stress Disorder (PTSD) was accurately coded as required by the RAI Manual This placed R39 at risk for an inaccurate care plan and 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 45 residents. The sample included 12 residents with 12 residents reviewed for comprehensive care plans. Based on observation, record review, and interviews, the facility failed to develop a comprehensive care plan for Resident (R) 30 and R39 which included individualized person-centered interventions for their trauma-based care. This deficient practice placed these residents at risk for impaired care due to uncommunicated care needs. Findings included: - R30's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of posttraumatic stress disorder (PTSD - a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress), tardive dyskinesia (an abnormal condition characterized by involuntary repetitive movements of the muscles of the face, limbs, and trunk), schizoaffective (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R30 had verbal behaviors toward others one to three days during the observation period. The MDS documented R30 had received antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication, antidepressant (a class of medications used to treat mood disorders) medication, and antianxiety (a class of medications that calm and relax people) medication during the observation period. The Quarterly MDS dated [DATE] documented a BIMS score of 15 which indicated intact cognition. The MDS documented that R30 had behaviors during the observation period. The MDS documented R30 had received antianxiety medication, antipsychotic medication, and antidepressant medication during the observation period. R30's Psychotropic Drug Use Care Area Assessment (CAA) dated 11/01/24 documented she received antipsychotic medication daily. R30's Care Plan dated 02/15/24 documented she would be assessed for triggers for her delusions and educated or reassured. The plan of care lacked individualized triggered-specific interventions that identified ways to decrease exposure to triggers which could re-traumatize her. On 01/15/25 at 08:06 AM R30 walked around in her room as she listened to music. On 01/15/25 at 12:42 PM, Certified Medication Aide (CMA) R stated all of the staff had access to the residents care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CMA R stated she was not sure which residents had PTSD and had a trauma-based care plan to prevent re-traumatization. CMA R stated that would be helpful if that information was the resident's care plan with individualized interventions. On 01/15/25 at 01:32 PM, Licensed Nurse (LN) G stated all of the staff had access to the care plans. LN G stated she did not do trauma-based assessments. LN G stated she did not know which residents had a diagnosis of PTSD. LN G stated most of the residents in the facility had experienced some type of trauma. LN G stated she did not have time to review all of the resident's care plans and did not know if each of the residents had individualized trauma-based interventions to prevent re-traumatization of a resident who had a diagnosis of PTSD. On 01/15/25 at 02:05 PM Administrative Nurse F, the MDS coordinator, stated she had looked and there was no regulation that PSTD needed to be placed on the resident's care plan to address their past trauma. On 01/15/25 at 02:33 PM, Administrative Nurse D stated all of the staff had access to the care plans. Administrative Nurse D stated the department heads were responsible to update and make changes to the resident's care plans. Administrative Nurse D stated the facility did not need to care plan individualized interventions because the facility was small, and the staff knew each of the residents. Administrative Nurse D stated that trauma-based assessment would be completed by the social service staff which the facility did not have at this time. The facility was unable to provide a policy related to the development of a person-centered care plan. The facility failed to develop a comprehensive care plan for R30 which included individualized person-centered interventions for her PTSD. This deficient practice placed R30 at risk for impaired care due to uncommunicated care needs and re-traumatization. 41713 - R39's Electronic Medical Record (EMR) documented diagnoses of posttraumatic stress disorder (PTSD - a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress), major depressive disorder (major mood disorder that causes persistent feelings of sadness), suicidal ideations (the thought process of having ideas, or ruminations about the possibility of completing suicide), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), and borderline personality disorder (a disorder characterized by disturbed and unstable interpersonal relationships and self-image along with impulsive, reckless, and often self-destructive behavior). R39's Admission Minimum Data Set (MDS) dated [DATE] documented she had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R39 was independent with her functional abilities and care. R39 had an active diagnosis of anxiety disorder, depression, and bipolar disorder. R39 received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), and an antidepressant (a class of medications used to treat mood disorders) medication on a routine basis. R39's MDS lacked the indication of her diagnosis of PTSD. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R39's Quarterly MDS dated [DATE] documented she had a BIMS score of 15 which indicated intact cognition. R39 was independent with her functional abilities and care. R39 had active diagnoses of anxiety disorder, depression, and bipolar disorder. R39 received an antipsychotic, antianxiety (a medication used to treat symptoms of anxiety), and an antidepressant medication on a routine basis. R39's MDS lacked the indication of her diagnosis of PTSD. R39's Psychotropic Drug Use Care Area Assessment (CAA) dated 07/24/24 documented she was prescribed an antipsychotic, antianxiety, and antidepressant medication. R39 had diagnoses of major depressive disorder and bipolar disorder. R39 was having difficulty feeling safe at her prior facility. R39's Care Plan last revised on 11/25/24 documented that she had the potential for aggressive verbal and physical behaviors and staff was directed to: 1. Identify Triggers and times, circumstances, what de-escalates behavior, and document. 2. Designate a quiet/secure area where the resident can be temporarily isolated during aggressive episodes. 3. When the resident exhibited aggressive behavior, attempt de-escalation, keep the situation calm, validate their complaint, give the resident time to vent, and do not argue. 4. See if a change of scenery would help, walk outside, and take a shower. Place the resident in a calm place to think. Engage her in a calm conversation. 5. Reward the Resident if they began to De-escalate. 6. If a weapon was brandished- Staff were to distance self and try to talk with the resident to give up the weapon, then call for help. 7. Involve the resident in the care planning process; allowing them to express their needs and preferences. 8. Administer meds as ordered and ensure medication compliance. 9. To ensure the safety of the resident, staff, and others: A. Remove any potential weapons from the environment. B. Maintain a safe distance from the resident during episodes of aggressive to present physical harm. C. In an acute crisis situation, the use of medications and physical means would be used to limit the aggressive behavior of the resident. The Medical and/or Psychiatric Provider would be notified of the situation. Orders are to be obtained as needed. 10. Teach coping skills to manage her anger and frustration. 11. Consider therapy in a formal setting to provide outlets for emotions, such as engaging in physical activities or expressing themselves through art and music. 12. Regular behavioral documentation, including but not limited to resident participation in activities, life skills, adherence to smoking rules, and sleeping habits. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	13. Violence risk assessment to be completed on admission, annually, and with any significant change. R39's Care Plan last revised on 11/25/24 lacked a care area to address R39's PTSD to indicate known causes, triggers, or interventions to mitigate triggers or re-traumatization. On 01/13/25 at 10:00 AM, R39 was in her room. She did not want to be disturbed at this time. On 01/14/25 at 09:13 AM, R39 stated she had PTSD for a long time. On 01/15/25 at 12:28 PM, Administrative Nurse E stated that R39's care plan should have been updated with a care area to address her PTSD. Administrative Nurse E stated residents all had interventions to address behaviors and what staff should do when an incident occurred. Administrative Nurse E stated that R39's care plan was not individualized specific to her behaviors and their triggers. On 01/15/25 at 02:32 PM, Administrative Nurse D stated that R39's care plan should address her PTSD. Administrative Nurse D stated all residents have interventions to address their behaviors. The facility failed to provide a policy as requested. The facility failed to implement an individualized care plan to address R39's PTSD and behaviors with person-centered interventions to prevent re-traumatization and known triggers for behaviors. These deficient practices placed R39 at risk for decreased psychosocial well-being and ineffective treatment.

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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** 45668 The facility reported a census of 45 residents. The sample included 12 with 12 residents reviewed for care plan revisions. Based on observations, interviews, and record review, the facility failed to revise Resident (R) 3's Care Plan to reflect his identified care needs related to his incontinence, activities of daily living (ADLs), and behaviors. This deficient practice placed R3 at risk for impaired care due to uncommunicated care needs. Findings included: - The Medical Diagnosis section within R3's Electronic Medical Records (EMR) noted diagnoses of schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin) and asthma (a disorder of narrowed airways that causes wheezing and shortness of breath). R3's Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15 indicating intact cognition. The MDS noted he was independent with his bathing, toileting, transfers, dressing, personal hygiene, and eating. The MDS indicated he was occasionally incontinent of his bladder but had no toileting program. R3's Functional Abilities Care Area Assessment (CAA) completed 10/02/24 indicated he was resistive towards his activities of daily living (ADLs) care needs and required encouragement from staff. The CAA noted he required supervision during his ADLs and wore briefs due to incontinence. The CAA documented he was to start toilet training due to his incontinence. R3's Urinary Incontinence CAA completed 10/02/24 documented he was incontinent of bowel and bladder. The CAA documented he did not recognize the need to urinate or defecate. The CAA documented he was used to toileting outside due to homelessness. The CAA documented he may benefit from toileting training. R3's Behavioral Symptoms CAA completed 10/02/24 documented he had a history of neglectful towards his personal care. The CAA noted he rejected care related to bathing, showering, and toileting. R3's Care Plan was initiated on 10/14/24 The plan indicated he had self-care performance deficits. The plan lacked interventions related to his level of assistance and supervision to complete his ADLs. The plan noted he was incontinent of bowel. The plan instructed staff to observe for incontinence patterns and initiate a toileting schedule if indicated. The plan lacked instructions related to incontinent products or toileting training needed. The plan did not identify and provide interventions related to R3's defecation and urination habits in his room. The plan lacked individualized symptoms and triggers for staff to utilize related to R3's behaviors. On 01/14/25 at 08:10 AM R3 stated he was not sure he was ever on a toileting program. R3's clothes were clean, and his hair was combed. R3's fingernails were trimmed. R3 reported he showered the night before. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/16/24 at 12:42 AM Certified Medication Aide (CMA) R stated R3 had a history of rejecting care and not wanting to complete his bathing, personal hygiene, dressing, and toileting. She stated the care plan should identify each resident's individualized care needs and behaviors. She stated the care plan should provide interventions to help guide staff through behaviors and help prevent them. She stated that R3 had a history of intentionally defecating in the rooms or in trash cans due to his homelessness. She stated the care plans should include how to prevent this. On 01/16/24 at 02:34 PM Administrative Nurse D stated R3 had a history of homelessness and would defecate in his room. She stated most of his incontinence concerns were related to his previous lifestyle and staff were expected to provide reminders. She stated he could be resistant to staff assistance with his ADLs. She stated his incontinence and behavioral needs should be implemented and listed in the care plan. She stated the care plans should include all care needs, goals, and relevant care information. She stated his care plan should include the specific behaviors of each resident and interventions. The facility was unable to provide a policy related to the development of a person-centered care plan. The facility failed to revise R3's Care Plan to reflect his identified care needs related to his incontinence, ADLs, and behaviors. This deficient practice placed R3 at risk for impaired care due to uncommunicated care needs.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 45 residents. The sample included 12 residents with one resident reviewed for increase and prevent decrease in mobility or range of motion (ROM - the full movement potential of a joint, usually its range of flexion and extension). Based on observation, record review, and interviews, the facility failed to implement a ROM program to help maintain and prevent a potential decrease in ROM/mobility for Resident (R) 16. This deficient practice placed R16 at risk of loss of ability to perform activities of daily living (ADLs) and worsening or development of contractures (abnormal permanent fixation of a joint or muscle). Findings included: - R16's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), hemiplegia (paralysis of one side of the body), hemiparesis/hemiplegia (weakness and paralysis on one side of the body), chronic pain, insomnia (inability to sleep), and posttraumatic stress disorder (PTSD - a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress). The Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 12 which indicated moderately impaired cognition. The MDS documented R16 had received antidepressant (a class of medications used to treat mood disorders) and antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality). The MDS document R16 had limited ROM on one side of his upper and lower extremity. The MDS documented R16 required partial to moderate staff assistance with dressing. R16's Psychotropic Drug Use Care Area Assessment (CAA) dated 12/23/24 documented he had received psychotropic medication during the observation period to manage his disease process. R16's Care Plan dated 12/23/24 documented the nursing staff would administer his medication as ordered. The plan of care documented the staff would monitor and document the side effects along with the effectiveness. The plan of care dated 01/09/25 documented staff would reassure R16 that pain was time-limited and to encourage him to try different pain-relieving methods. Review of R16's EMR lacked evidence ROM or restorative care was provided to R16. On 01/15/25 at 11:42 AM, R16 walked in from smoking outside. R16 walked down the hallway to his room, his left arm hung down along his left side unsupported, and his left leg slid along the floor as he walked. R16 stated he would like to do something to prevent a decrease in mobility to remain independent as long as he can. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/15/25 at 12:42 PM, Certified Medication Aide (CMA) R stated Administrative Nurse D was in charge of monitoring and initiating the restorative programs. CMA R stated the direct care staff providing the restorative programs for the residents. CMA R stated the resident's restorative programs were listed under the point of care charting in the resident's EMR. CMA R stated R16 would probably benefit from a ROM program. On 01/15/25 at 01:32 PM, Licensed Nurse (LN) G stated Administrative Nurse D would assess each resident and she would determine if a resident needed a restorative program to help maintain their mobility. LN G stated that R16 would benefit from a mobility program to help maintain his independence. On 01/15/25 at 02:33 PM, Administrative Nurse D stated she was responsible for evaluating each resident at the time of admission to determine if a resident would benefit. Administrative Nurse D stated she had not had the time to evaluate R16 and related to his limited RPM he would benefit from a ROM program. The facility's undated Restorative Activities of Daily Living Care policy documented the facility believed that each elder would be provided with the opportunity to regain skills and abilities lost due to illness and disability. Therefore, each elder would be evaluated at move-in, return from another health care facility, and after a significant change in condition for the potential benefit of participating in a restorative nursing program. The facility failed to implement a ROM program to help maintain and prevent a potential decrease in ROM/mobility for R16. This deficient practice placed R16 at risk of loss of ability to perform ADL and worsening or development of contractures.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility reported a census of 45 residents. The sample included 12 with two reviewed for bowel and bladder incontinence. Based on record review, observations, and interviews, the facility failed to implement individualized toileting interventions to improve/maintain Resident (R) 3's bowel and bladder incontinence based on his incontinence evaluations. This deficient practice placed R3 at risk for complications related to incontinence. Findings included: - The Medical Diagnosis section within R3's Electronic Medical Records (EMR) noted diagnoses of schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin) and asthma (a disorder of narrowed airways that causes wheezing and shortness of breath). R3's Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15 indicating intact cognition. The MDS noted he was independent with his bathing, toileting, transfers, dressing, personal hygiene, and eating. The MDS indicated he was occasionally incontinent of bladder but no toileting program. R3's Functional Abilities Care Area Assessment (CAA) completed 10/02/24 indicated he was resistive towards his activities of daily living (ADLs) care needs and required encouragement from staff. The CAA noted he required supervision during his ADLs and wore briefs due to incontinence. The CAA noted he will start toilet training due to his incontinence. R3's Urinary Incontinence CAA completed 10/02/24 indicated he was incontinent of bowel and bladder. The CAA indicated he did not recognize the need to urinate or defecate. The CAA noted he was used to toileting outside due to homelessness. The CAA documented he may benefit from toileting training and wore incontinence briefs. R3's Care Plan initiated on 10/14/24 indicated he had bowel incontinence. The plan instructed staff to observe for incontinence patterns and initiate a toileting schedule if indicated. The plan lacked instructions related to incontinent products or toilet training. The plan failed to identify and provide interventions related to R3's history of defection and urination habits in his room due to his history of homelessness. R3's EMR under Assessments noted a Bowel and Bladder screen completed on 09/23/24. The screen documented he was a good candidate for retraining. The screen indicated he had no predisposing factors for his incontinence. The screen documented he was incontinent of stool one to three times a week. R3's EMR under Assessments noted a Bowel and Bladder screen completed on 10/07/24. The screen noted he was a good candidate for retraining. The screen indicated he had no predisposing factors for his incontinence. The screen noted he was incontinent of stool four to six times a week. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's EMR under Assessments noted a Bowel and Bladder screen completed on 01/08/25. The screen noted he was a good candidate for retraining. The screen indicated he had no predisposing factors for his incontinence. The screen noted he was incontinent of stool one to three times a week. R3's EMR revealed no bowel and bladder training or that he was on a toileting program to improve his incontinence. A review of R3's EMR under Documentation Survey Report revealed R3 had both bowel and bladder incontinence episodes occasionally since his admission. On 01/14/25 at 08:10 AM, R3 stated he was not sure he was ever on a toileting program. On 01/16/24 at 12:42 AM, Certified Medication Aide (CMA) R stated R3 had a history of incontinence. She stated staff were expected to provide reminders for his toileting every two hours. She stated R3 had a history of defecting in his room and in bags due to his history of homelessness. She stated his behaviors and incontinent needs should be listed in the care plan. She stated the facility did not have a retraining program for incontinence. On 01/16/24 at 02:34 PM, Administrative Nurse D stated R3 had a history of homelessness and would defecate in his room. She stated most of his incontinence concerns were related to his previous lifestyle and staff were expected to provide reminders. She stated he could be resistant to staff assistance with his ADLs. She stated his incontinence and behavioral needs should be implemented and listed in the care plan. She stated all residents were screened for incontinence and provided continued interventions. The facility's Bowel Retraining Protocol policy dated 08/2023 indicated all residents would be evaluated for bowel and bladder incontinence. The policy noted that pattern evaluations will be provided to residents for individualized continence management programs. The facility indicated that it would identify factors related to incontinence: including patterns, incontinence type, risk factors, and medically relevant diagnoses to provide effective treatment. The facility failed to implement individualized toileting interventions to improve/maintain R3's bowel and bladder incontinence based on his incontinence evaluations. This deficient practice placed R3 at risk for complications related to incontinence.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility identified a census of 45 residents. The sample included 12 residents with two reviewed for nutrition. Based on observation, record review, and interviews the facility failed to identify and implement nutritional interventions related to Resident (R) 27's significant weight loss between 01/01/24 to 06/07/24. The facility additionally failed to implement alternative nutritional interventions for R27's ongoing significant weight loss between 08/01/24 and 01/01/25. As a result of the deficient practice, R27 had a significant unplanned weight loss of 19.52 percent (%) and 16.84 % within two three-month periods. This also placed R27 at risk for malnourishment-related complications. Findings included: - The Medical Diagnosis section within R27's Electronic Medical Records (EMR) documented diagnoses of schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), asthma (a disorder of narrowed airways that causes wheezing and shortness of breath), abnormal weight loss, and history of fractures (broken bones). R27's Quarterly Minimum Data Set (MDS) completed 03/16/24 revealed she weighed 191 pounds (lbs.) and had no significant weight loss or physician-prescribed weight loss program. The MDS noted she required partial to moderate assistance with dressing, personal hygiene, bathing, and toileting. The MDS noted she required supervision during meals. R27's Quarterly MDS dated [DATE] indicated she weighed 170 lbs. The MDS noted no significant weight loss or physician-prescribed weight loss program. The MDS noted she required partial to moderate assistance with dressing, personal hygiene, bathing, and toileting. The MDS noted she required supervision during meals. R27's Significant Change MDS completed 08/21/24 indicated she weighed 169 lbs. The MDS indicated she had no significant weight loss or was on a physician-prescribed weight loss regimen. The MDS noted she required partial to moderate assistance with dressing, personal hygiene, bathing, and toileting. The MDS noted she required supervision during meals. R27's Quarterly MDS dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of zero indicating severe cognitive impairment. The MDS noted she required partial to moderate assistance with dressing, personal hygiene, bathing, and toileting. The MDS noted she required supervision during meals. The MDS indicated she weighed 145 lbs. The MDS noted she had weight loss without a physician-prescribed regimen. R27's Nutritional Status Care Area Assessment (CAA) completed 09/12/24 indicated she desired weight loss but had unintended weight loss noted. The CAA noted she ate less than 50 percent (%) of her meals and sometimes displayed psychotic symptoms that affected her ability to feel hungry and eat. The CAA noted weight improvement or stabilization was desired. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	R27's Functional Abilities CAA completed 09/15/24 indicated she required frequent assistance with her activities of daily living (ADLs). The CAA noted she required cueing and supervision for her ADLs. The CAA noted she required staff to cut her meals up and provide assistance during meals. R27's Care Plan initiated on 04/22/22 indicated she was at risk for an ADLs deficit related to her medical diagnoses. The plan instructed staff to provide her diet as ordered. The plan indicated she required assistance and encouragement during meals (04/24/22). The plan instructed staff to monitor for fatigue and weight loss (04/24/22). On 11/20/24 R27's plan was updated to reflect she had significant weight loss related to impaired thought processes. The updated plan indicated she required one-to-one staff assistance during meals (11/20/24). The plan instructed staff to provide supplemental shakes when the resident refuses or eats less than 50 % of her meal (11/20/24). The plan lacked indication she was on a weight loss program. The plan lacked preventative weight loss intervention prior to 11/20/24. R27's EMR under Orders revealed an active order, started 03/11/22. The order indicated she was on a regular diet with regular consistency and texture. R27's EMR lacked documentation she was on a prescribed weight loss program. R27's EMR revealed no orders for dietary supplementation between 03/11/22 through 11/20/24. R27's EMR lacked dietician-related documentation from 12/01/23 to 08/01/24. A review of R27's EMR under Weights revealed she weighed 209.4 lbs. on 01/01/24. The EMR revealed she had repeated weight losses of 201.6 lbs. on 02/01/24, 191.0 lbs. on 03/01/24, 180.6 lbs. on 04/01/24, 174 lbs. on 05/01/24, and 168.2 lbs. on 06/17/24. The EMR indicated R27 had a significant weight decline of 19. 52% from 01/01/24 to 06/17/24 (within six months). R27's EMR under Assessments revealed that Dietary Profiles were completed on 12/26/23, 03/29/24, 06/22/24, 09/24/24, and 12/17/24. The dietary profiles lacked documentation showing that R27 had a weight loss program. R27's EMR under the Progress note revealed a Nutrition / Dietary note completed on 08/29/24 by the Registered Dietician (RD). The note indicated the RD was notified of the significant weight loss. The RD documented R27 had varied appetites and consumed 25 to 75 % of her meal. The note indicated R27 was independent and could make her own meal choices. The note instructed staff to offer alternative meals or snacks if her meal intake was less than 50%. A review of R27's EMR under Weights revealed she weighed 169.4 lbs. on 08/01/24. The EMR noted she had repeated weight losses of 162 lbs. on 09/01/24, 157.8 lbs. on 10/01/24, 147.6 lbs. on 11/01/24, 145.2 lbs. on 12/01/24, and 140.2 lbs. on 01/01/24. The EMR indicated R27 had a significant weight decline of 16. 84% from 08/01/24 to 01/01/25 (within six months). R27's EMR under Orders noted an order (added 11/18/24) for staff to offer protein shakes when R27 ate less than 50% of her meals. The order noted she could have the protein shake up to three times daily as needed for abnormal weight loss. (continued on next page)

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Access Mental Health	500 Peabody Peabody, KS 66866

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F 0692 Level of Harm - Actual harm Residents Affected - Few	R27's EMR under Progress Notes revealed a Weight Change note completed on 11/03/24 indicating she had a weight loss of 5.1 % within 30 days. The note indicated she had a poor appetite and often refused meals or spit out her food. The note indicated she was on medication that decreased her appetite. The note recommended supplemental shakes twice daily for added calories. R27's EMR under Progress Notes revealed a Weight Change note completed on 12/16/24 indicating she had a weight loss of six percent within 30 days. The note recommended her supplemental shakes be increased to three times daily. On 01/13/25 at 08:00 AM an inspection of the facility's dietary department revealed the facility had no certified dietary manager. On 01/14/24 at 08:12 AM R27 sat in the dining room with staff. R27 was confused but able to communicate her needs as staff assisted her with breakfast. R 27 ate 75% of her meal with staff assistance. On 01/15/24 at 12:42 PM Certified Medication Aide (CMA) R stated R27 struggled with meal intake and often needed staff cueing and assistance for her meals. She stated R27 would often eat about 50% of her meals but also had behaviors that prevented her from finishing her meals. CMA R stated she should offer alternatives, be patient, offer snacks, and eliminate distractions during mealtimes. She stated R27 had significant weight loss due to behaviors during meals and refusal to eat. She stated she was not sure if R27 had been on a weight loss program. She stated staff would notify the dietician related to weight loss. She stated the RD came to the facility monthly to meet with the residents. On 01/15/24 at 01:33 PM Licensed Nurse G stated R27 needed constant supervision and assistance during mealtime. She stated R27 struggled with behaviors and needed staff to assist in feeding her. She stated she was recently put on one-to-one assistance for meals and provided supplementation in November. She stated R27 also refused to come out for meals and would sleep through breakfast. She stated staff were expected to provide supplement shakes if she consumed less than 50% of her meals. On 01/15/24 at 02:32 PM Administrative Nurse D stated R27's ability to eat meals varied from day to day due to her cognitive changes. She stated each resident's weight was revealed monthly by the RD. She stated R27 had a significant weight decline. She stated the facility placed her on supplemental shakes if her mal intake fell below 50%. She stated staff could also offer ice cream, pudding, and other snacks to supplement her calories. She stated staff often had to feed her due to her cognitive impairment. She stated the care plan should identify her risks for weight loss and provide fortified food alternatives to help prevent further loss. On 01/16/2025 at 11:30 AM the facility's Registered Dietician reported the facility did not communicate changes related to weights, intake, or status to her. She stated she had to go into the facility and look up the information herself. He stated she made recommendations but was not informed about R27's significant decline. She stated the facility did not include her in care plan meetings. She stated the facility currently did not have a fortified food program and only would provide shakes. She stated she had only been with the facility since 08/01/24 and was not able to find dietary notes for R27 from the previous dietician. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The facility's Nutritional Services policy (undated) indicated all residents will be screened for potential weight loss and nutritional impairments. The policy indicated residents at risk for significant weight loss will be care plan based on nutritional impairments to include special dietary requirements, medication review, health, and preferences. The policy noted interventions will be implemented to prevent further weight loss. The policy indicated all residents will be monitored by the registered dietician, pharmacist, and medical provider. The policy indicated the facility will provide appropriate dietary nutrition and supplementation. The facility failed to identify and implement nutritional interventions related to R27's significant weight loss between 01/01/24 to 06/07/24. The facility additionally failed to implement alternative nutritional interventions for R27's ongoing significant weight loss between 08/01/24 and 01/01/25. As a result of the deficient practice, R27 had a significant unplanned weight loss of 19.52 and 16.84 % within two three-month periods. This also placed R27 at risk for malnourishment-related complications.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 45 residents. The sample included 12 residents with three residents reviewed for trauma-informed care (treatment or care directed to prevent re-experiencing or reducing the effects of traumatic events). Based on observation, record review, and interviews, the facility failed to identify trauma-based triggers related to Resident (R) 30's, R16's, and R39's posttraumatic stress disorder (PTSD-mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress) and failed to implement individualized interventions to prevent re-traumatization. These deficient practices placed R30, R16, and R39 at risk for decreased psychosocial well-being and ineffective treatment. Findings included: - R30's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of posttraumatic stress disorder (PTSD - a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress), tardive dyskinesia (an abnormal condition characterized by involuntary repetitive movements of the muscles of the face, limbs, and trunk), schizoaffective (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R30 had verbal behaviors toward others one to three days during the observation period. The MDS documented R30 had received antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication, antidepressant (a class of medications used to treat mood disorders) medication, and antianxiety (a class of medications that calm and relax people) medication during the observation period. The Quarterly MDS dated [DATE] documented a BIMS score of 15 which indicated intact cognition. The MDS documented that R30 had behaviors during the observation period. The MDS documented R30 had received antianxiety medication, antipsychotic medication, and antidepressant medication during the observation period. R30's Psychotropic Drug Use Care Area Assessment (CAA) dated 11/01/24 documented she received antipsychotic medication daily. R30's Care Plan dated 02/15/24 documented she would be assessed for triggers for her delusions and educated or reassured. The plan of care lacked individualized triggered-specific interventions that identified ways to decrease exposure to triggers that could re-traumatize her. On 01/15/25 at 08:06 AM R30 walked around in her room as she listened to music. On 01/15/25 at 12:42 PM, Certified Medication Aide (CMA) R stated she was not sure which residents had PTSD and had a trauma-based care plan to prevent re-traumatization. CMA R stated that would be helpful if that information was the resident's care plan with individualized interventions. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/15/25 at 01:32 PM, Licensed Nurse (LN) G stated she did not do trauma-based assessments. LN G stated she did not know which residents had a diagnosis of PTSD. LN G stated most of the residents in the facility had experienced some type of trauma. LN G stated she did not have time to review all of the resident's care plans and did not know if each of the residents had individualized trauma-based interventions to prevent the re-traumatization of a resident who had a diagnosis of PTSD. On 01/15/25 at 02:05 PM Administrative Nurse F, the MDS coordinator, stated she had looked and there was no regulation that PSTD needed to be placed on the resident's care plan to address their past trauma. On 01/15/25 at 02:33 PM, Administrative Nurse D stated she would expect a trauma-based assessment would be completed at the time of admission and reassessed after each episode of PTSD. Administrative Nurse D stated the facility did not need to care plan individualized interventions because the facility was small, and the staff knew each of the residents. Administrative Nurse D stated that trauma-based assessment would be completed by the social service staff which the facility did not have at this time. The facility's undated Behavioral Health Services policy documented the facility would provide behavioral health care and services as an integral part of the person-centered environment involving an interdisciplinary approach to care, with qualified staff that demonstrate the competencies and skills necessary to provide appropriate services to each resident. The facility would ensure that a resident who displayed or is diagnosed with a mental or cognitive disorder or psychosocial adjustment difficulty or disorder, or who has a known and reported history of trauma and/or post-traumatic stress disorder (PTSD) received appropriate treatment and services to correct the assessed condition and to attain the highest practicable mental and psychosocial wellbeing. The facility failed to identify trauma-based triggers related to R30's history of trauma and implement individualized interventions to prevent re-traumatization. These deficient practices placed R30 at risk for decreased psychosocial well-being and ineffective treatment. - R16's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), cerebral infarction (stroke - the sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), hemiplegia (paralysis of one side of the body), hemiparesis/hemiplegia (weakness and paralysis on one side of the body), chronic pain, insomnia (inability to sleep), and posttraumatic stress disorder (PTSD - a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress). The Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 12 which indicated moderately impaired cognition. The MDS documented R16 had received antidepressant (a class of medications used to treat mood disorders) and antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality). R16's Psychotropic Drug Use Care Area Assessment (CAA) dated 12/23/24 documented he had received psychotropic medication during the observation period to manage his disease process. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R16's Care Plan dated 01/13/25 directed staff to keep his routine consistent and try to provide consistent care and try to provide consistent caregivers as much as possible to decrease confusion. The plan of care directed staff to present R16 with just one thought, idea, question, or command at a time. The plan of care lacked individualized triggered-specific interventions that identified ways to decrease exposure to triggers that could re-traumatize him. n 01/15/25 at 11:42 AM, R16 walked in from smoking outside. R16 walked down the hallway to his room, his left arm hung down along his left side unsupported, and his left leg slid along the floor as he walked. On 01/15/25 at 12:42 PM, Certified Medication Aide (CMA) R stated she was not sure which residents had PTSD and had a trauma-based care plan to prevent re-traumatization. CMA R stated that would be helpful if that information was the resident's care plan with individualized interventions. On 01/15/25 at 01:32 PM, Licensed Nurse (LN) G stated she did not do trauma-based assessments. LN G stated she did not know which residents had a diagnosis of PTSD. LN G stated most of the residents in the facility had experienced some type of trauma. LN G stated she did not have time to review all of the resident's care plans and did not know if each of the residents had individualized trauma-based interventions to prevent the re-traumatization of a resident who had a diagnosis of PTSD. On 01/15/25 at 02:05 PM Administrative Nurse F, the MDS coordinator, stated she had looked and there was no regulation that PSTD needed to be placed on the resident's care plan to address their past trauma. On 01/15/25 at 02:33 PM, Administrative Nurse D stated she would expect a trauma-based assessment would be completed at the time of admission and reassessed after each episode of PTSD. Administrative Nurse D stated the facility did not need to care plan individualized interventions because the facility was small, and the staff knew each of the residents. Administrative Nurse D stated that trauma-based assessment would be completed by the social service staff which the facility did not have at this time. The facility's undated Behavioral Health Services policy documented the facility would provide behavioral health care and services as an integral part of the person-centered environment involving an interdisciplinary approach to care, with qualified staff that demonstrate the competencies and skills necessary to provide appropriate services to each resident. The facility would ensure that a resident who displayed or is diagnosed with a mental or cognitive disorder or psychosocial adjustment difficulty or disorder, or who has a known and reported history of trauma and/or post-traumatic stress disorder (PTSD) received appropriate treatment and services to correct the assessed condition and to attain the highest practicable mental and psychosocial wellbeing. The facility failed to identify trauma-based triggers related to R16's history of trauma and implement individualized interventions to prevent re-traumatization. These deficient practices placed R16 at risk for decreased psychosocial well-being and ineffective treatment. 41713 (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- R39's Electronic Medical Record (EMR) documented diagnosis of posttraumatic stress disorder (PTSD - a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress), major depressive disorder (major mood disorder that causes persistent feelings of sadness), suicidal ideations (the thought process of having ideas, or ruminations about the possibility of completing suicide), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), and borderline personality disorder (a disorder characterized by disturbed and unstable interpersonal relationships and self-image along with impulsive, reckless, and often self-destructive behavior). R39's Admission Minimum Data Set (MDS) dated [DATE] documented she had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R39 was independent with her functional abilities and care. R39 had active diagnoses of anxiety disorder, depression, and bipolar disorder. R39 received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), and an antidepressant (a class of medications used to treat mood disorders) medication on a routine basis. R39's MDS lacked the indication of her diagnosis of PTSD. R39's Quarterly MDS dated [DATE] documented she had a BIMS score of 15 which indicated intact cognition. R39 was independent with her functional abilities and care. R39 had active diagnoses of anxiety disorder, depression, and bipolar disorder. R39 received an antipsychotic, antianxiety (a medication used to treat symptoms of anxiety), and an antidepressant medication on a routine basis. R39's MDS lacked the indication of her diagnosis of PTSD. R39's Psychotropic Drug Use Care Area Assessment (CAA) dated 07/24/24 documented she was prescribed an antipsychotic, antianxiety, and antidepressant medication. R39 had diagnoses of major depressive disorder and bipolar disorder. R39 was having difficulty feeling safe at her prior facility. R39's Care Plan last revised on 11/25/24 documented that she had the potential for aggressive verbal and physical behaviors and staff was directed to: 1. Identify Triggers and times, circumstances, what de-escalates behavior, and document. 2. Designate a quiet/secure area where the resident can be temporarily isolated during aggressive episodes. 3. When the resident exhibited aggressive behavior, attempt de-escalation, keep the situation calm, validate their complaint, give the resident time to vent, and do not argue. 4. See if a change of scenery would help, walk outside, and take a shower. Place the resident in a calm place to think. Engage her in a calm conversation. 5. Reward the Resident if they began to De-escalate. 6. If a weapon was brandished- Staff were to distance self and try to talk with the resident to give up the weapon, then call for help. 7. Involve the resident in the care planning process; allowing them to express their needs and preferences. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8. Administer meds as ordered and ensure medication compliance. 9. To ensure the safety of the resident, staff, and others: A. Remove any potential weapons from the environment. B. Maintain a safe distance from the resident during episodes of aggressive to present physical harm. C. In an acute crisis situation, the use of medications and physical means would be used to limit the aggressive behavior of the resident. The Medical and/or Psychiatric Provider would be notified of the situation. Orders are to be obtained as needed. 10. Teach coping skills to manage her anger and frustration. 11. Consider therapy in a formal setting to provide outlets for emotions; such as engaging in physical activities or expressing themselves through art and music. 12. Regular behavioral documentation, including but not limited to resident participation in activities, life skills, adherence to smoking rules, and sleeping habits. 13. Violence risk assessment to be completed on admission, annually, and with any significant change. R39's Care Plan last revised on 11/25/24 lacked a care area to address R39's PTSD to indicate known causes, triggers, or interventions to mitigate triggers or re-traumatization. The Misc. tab of R39's EMR had a scanned Behavioral Urgent Care Discharge Instructions document dated 12/09/24 that documented a diagnosis of PTSD dated 02/13/24. The facility failed to perform a Trauma-Informed Care Assessment on R39 upon admission. On 01/13/25 at 10:00 AM, R39 was in her room. She did not want to be disturbed at this time. On 01/14/25 at 09:13 AM, R39 stated she had had PTSD for a long time. On 01/15/25 at 12:28 PM, Administrative Nurse E stated the facility had trouble getting any documentation from R39's prior facility. Administrative Nurse E stated the facility did not receive information about R39's PTSD until about a month after R39 was admitted . On 01/15/25 at 02:32 PM, Administrative Nurse D stated R39 should have been assessed at admission or trauma-informed care. Administrative Nurse D stated staff had somehow missed getting the assessment completed. The facility failed to provide a policy as requested. The facility failed to identify trauma-based triggers related to R39's history of trauma and implement individualized interventions to prevent re-traumatization. These deficient practices placed R39 at risk for decreased psychosocial well-being and ineffective treatment.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility reported a census of 45 residents. The sample included 12 with five residents reviewed for behavioral services. Based on record review, observations, and interviews, the facility failed to implement individualized behavioral care intervention for Residents (R)3, R30, and R39. This deficient practice placed the residents at risk for continued behavioral episodes and unmet care needs. Findings included: - The Medical Diagnosis section within R3's Electronic Medical Records (EMR) documented diagnoses of schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin) and asthma (a disorder of narrowed airways that causes wheezing and shortness of breath). R3's Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15 indicating intact cognition. The MDS noted he was independent with his bathing, toileting, transfers, dressing, personal hygiene, and eating. The MDS indicated he was occasionally incontinent of his bladder but had no toileting program. The MDS indicated he exhibited rejection of care behaviors one to three days a week. The MDS indicated no verbal or aggressive behaviors were exhibited. R3's Functional Abilities Care Area Assessment (CAA) completed 10/02/24 indicated he was resistive towards his activities of daily living (ADLs) care needs and required encouragement from staff. The CAA noted he required supervision during his ADLs and wore briefs due to incontinence. The CAA noted he will start toilet training due to his incontinence. R3's Urinary Incontinence CAA completed 10/02/24 indicated he was incontinent of bowel and bladder. The CAA documented that he did not recognize the need to urinate or defecate. The CAA noted he was used to toileting outside due to homelessness. The CAA documented he may benefit from toileting training and wore incontinence briefs. R3's Behavioral Symptoms CAA completed 10/02/24 documented he had a history of neglect towards his personal care. The CAA noted he rejected care related to bathing, showering, and toileting. R3's Care Plan was initiated on 10/14/24 indicating he had potential for aggressive behaviors. The plan instructed staff to identify triggers, times, circumstances, and what de-escalates his behaviors. The plan instructed staff to invite him to assist with care planning, teach him coping skills, provide a change of scenery, remove potential weapons, document activity participation, and complete a Violence Risk assessment. The plan indicated he had self-care deficits related to his activities of daily living (ADLs) but lacked indications related to how much supervision and assistance he needed for ADLs. The plan lacked indication and interventions related to his refusals to complete self-care and be assisted by staff during ADLs. The plan lacked identification and interventions related to his defecation and urination behaviors in his room. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's EMR under Progress Note revealed a Weekly Behavioral note completed on 10/13/24. The note indicated he was very resistant to showering and having his labs drawn. The note indicated he would often defecate on the floor. The note lacked what behavioral interventions were used or provided during this episode. R3's EMR under Progress Note revealed a Weekly Behavioral note completed on 10/20/24. The note documented he was resistant to care. The note indicated staff used smoking incentives for toileting, smoking, and lab draws. The note indicated he often was reluctant to change his clothing and his clothes often smelled. R3's EMR under Progress Note revealed a Weekly Behavioral note completed on 10/27/24. The note indicated he was not always cooperative with care and often refused to shower. The note indicated he usually defecated on the bathroom floor instead of the toilet. The note lacked what behavioral interventions were used or provided during this episode. R3's EMR under Progress Note revealed a Weekly Behavioral note completed on 11/17/24. The note indicated he was observed urinating outside the closet door in his room. The note lacked what behavioral interventions were used or provided during this episode. R3's EMR under Progress Note revealed a Weekly Behavioral note completed on 11/24/24. The note indicated R3 had continued behaviors of placing feces throughout his room and sometimes voided in the closet. The note indicated he required physical staff assistance during showers. The note lacked what behavioral interventions were used or provided during this episode. R3's EMR under Progress Note revealed a Weekly Behavioral note completed on 12/05/24 staff found feces all over the room and on the resident. The note indicated she showered him and cleaned up the room. The note lacked what behavioral interventions were used or provided during this episode. On 01/14/25 at 08:10 AM R3 stated he was not sure he was ever on a toileting program. R3's clothes were clean, and his hair was combed. R3's fingernails were trimmed. R3 reported he showered the night before. On 01/16/24 at 01:30 PM, Licensed Nurse G stated R3 had a history of rejecting care and not wanting to complete his bathing, personal hygiene, dressing, and toileting. She stated he had a history of homelessness and often wouldn't let staff approach him about hygiene concerns. She stated he has improved behaviors recently but would defecate in the rooms. CMA R was not sure what behavioral interventions were in his care plan but stated the staff would have to reapproach him and give him time. She stated he lived with his behaviors most of his life and changing them would be difficult. On 01/16/24 02:32 PM, Administrative Nurse D stated most of R3's issues with incontinence were behaviors from being homeless. She stated he would defecate all over his room or in bags. She stated he was resistant to care including showering and changing his clothing. She stated the facility tried many approaches to improving his behaviors but was not sure they were added to the care plan. She stated he would often complete his ADLs if he was offered smoking incentives. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Access Mental Health	500 Peabody Peabody, KS 66866

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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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's undated Behavioral Health Services policy documented the facility would provide behavioral health care and services as an integral part of the person-centered environment involving an interdisciplinary approach to care, with qualified staff that demonstrate the competencies and skills necessary to provide appropriate services to each resident. The facility would ensure that a resident who displayed or is diagnosed with a mental or cognitive disorder or psychosocial adjustment difficulty or disorder, or who has a known and reported history of trauma and/or post-traumatic stress disorder (PTSD) received appropriate treatment and services to correct the assessed condition and to attain the highest practicable mental and psychosocial wellbeing. The facility failed to implement individualized behavioral care interventions for R3. This deficient practice placed R3 at risk for continued behavioral episodes and unmet care needs. 41037 - R30's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of posttraumatic stress disorder (PTSD - a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress), tardive dyskinesia (an abnormal condition characterized by involuntary repetitive movements of the muscles of the face, limbs, and trunk), schizoaffective (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R30 had verbal behaviors toward others one to three days during the observation period. The MDS documented R30 had received antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication, antidepressant (a class of medications used to treat mood disorders) medication, and antianxiety (a class of medications that calm and relax people) medication during the observation period. The Quarterly MDS dated [DATE] documented a BIMS score of 15 which indicated intact cognition. The MDS documented that R30 had behaviors during the observation period. The MDS documented R30 had received antianxiety medication, antipsychotic medication, and antidepressant medication during the observation period. R30's Psychotropic Drug Use Care Area Assessment (CAA) dated 11/01/24 documented she received antipsychotic medication daily. R30's Care Plan dated 02/15/24 documented she would be assessed for triggers for her delusions and educated or reassured. The plan of care lacked individualized triggered-specific interventions that identified ways to decrease exposure to triggers that could re-traumatize her. Review of R30's EMR under the Progress Notes tab revealed: On 12/21/24 at 04:37 AM a Sleep note documented R30 was asked to go to bed when she was on the couch. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/21/24 at 09:21 PM a Behavior Note documented R30 had propped the door to her room with the bottom of her bed. She was informed by staff that was a fire hazard. R30 became angry and used curse words. Staff redirected her. On 12/25/24 at 09:09 PM a Behavior Note documented R30 refused to take her medications because the water was nasty and she did not like it. R30 reported she was going to stay in bed and requested to be left alone. On 01/02/25 at 02:02 AM a Behavior Note documented R30 sat on the couch with her legs crossed. R30 refused to go to bed when asked and requested the staff to stop asking her questions. On 01/2/25 at 03:45 AM a Sleep note documented R30 sat on the couch and refused to go to bed. On 01/8/25 at 09:30 PM a Behavior Note documented R30 twilled a pendent on a chain around the table. R30 then smelled her medication and then rolled the pills in her hand before taking them. On 01/11/25 at 03:19 AM a Behavior Note documented R30 came to the office and became upset and agitated about the presential ignoration. On 01/11/25 at 08:35 PM a Behavior Note documented R30 had smelled her medication and the water prior to taking her medications. On 01/16/25 at 10:12 PM a Behavior Note documented R30 was pacing in the hallways as she listened to her music. On 01/15/25 at 08:06 AM R30 walked around in her room as she listened to music. On 01/15/25 at 12:42 PM, Certified Medication Aide (CMA) R stated R30 had just started the smelling her water and rolling her pills in her hand. CMA R stated she was not sure if there were individualized person-centered interventions to address her behaviors. CMA R stated that would be helpful if that information was in the resident's care plan with individualized interventions. On 01/15/25 at 01:32 PM, Licensed Nurse (LN) G stated she did not know if do know which residents had individualized person-centered interventions to address their behaviors. LN G stated she did not have time to review all of the resident's care plans. On 01/15/25 at 02:05 PM, Administrative Nurse F, the MDS coordinator, stated she had looked and there was no regulation that PSTD needed to be placed on the resident's care plan to address their past trauma. On 01/15/25 at 02:33 PM, Administrative Nurse D stated the facility did not need to care plan individualized interventions because the facility was small, and the staff knew each of the residents and their behaviors. Administrative Nurse D stated she would allow R30 to come into her office and scream. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's undated Behavioral Health Services policy documented the facility would provide behavioral health care and services as an integral part of the person-centered environment involving an interdisciplinary approach to care, with qualified staff that demonstrate the competencies and skills necessary to provide appropriate services to each resident. The facility would ensure that a resident who displayed or is diagnosed with a mental or cognitive disorder or psychosocial adjustment difficulty or disorder, or who has a known and reported history of trauma and/or post-traumatic stress disorder (PTSD) received appropriate treatment and services to correct the assessed condition and to attain the highest practicable mental and psychosocial wellbeing. The facility failed to implement individualized behavioral care interventions for R30. This deficient practice placed R30 at risk for continued behavioral episodes and unmet care needs. 41713 - R39's Electronic Medical Record (EMR) documented diagnosis of posttraumatic stress disorder (PTSD - a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress), major depressive disorder (major mood disorder that causes persistent feelings of sadness), suicidal ideations (the thought process of having ideas, or ruminations about the possibility of completing suicide), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), and borderline personality disorder (a disorder characterized by disturbed and unstable interpersonal relationships and self-image along with impulsive, reckless, and often self-destructive behavior). R39's Admission Minimum Data Set (MDS) dated [DATE] documented she had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R39 was independent with her functional abilities and care. R39 had active diagnoses of anxiety disorder, depression, and bipolar disorder. R39 received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), and an antidepressant (a class of medications used to treat mood disorders) medication on a routine basis. R39's MDS lacked the indication of her diagnosis of PTSD. R39's Quarterly MDS dated [DATE] documented she had a BIMS score of 15 which indicated intact cognition. R39 was independent with her functional abilities and care. R39 had active diagnoses of anxiety disorder, depression, and bipolar disorder. R39 received an antipsychotic, antianxiety (a medication used to treat symptoms of anxiety), and an antidepressant medication on a routine basis. R39's MDS lacked the indication of her diagnosis of PTSD. R39's Psychotropic Drug Use Care Area Assessment (CAA) dated 07/24/24 documented she was prescribed an antipsychotic, antianxiety, and antidepressant medication. R39 had diagnoses of major depressive disorder and bipolar disorder. R39 was having difficulty feeling safe at her prior facility. R39's Care Plan last revised on 11/25/24 documented that she had the potential for aggressive verbal and physical behaviors and staff was directed to: 1. Identify Triggers and times, circumstances, and what de-escalates behavior, and document. 2. Designate a quiet/secure area where the resident can be temporarily isolated during aggressive episodes. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. When the resident exhibited aggressive behavior, attempt de-escalation, keep the situation calm, validate their complaint, give resident time to vent, and do not argue. 4. See if a change of scenery would help, walk outside, and take a shower. Place the resident in a calm place to think. Engage her in a calm conversation. 5. Reward the Resident if they began to De-escalate. 6. If a weapon was brandished- Staff were to distance self and try to talk with the resident to give up the weapon, then call for help. 7. Involve the resident in the care planning process; allowing them to express their needs and preferences. 8. Administer meds as ordered and ensure medication compliance. 9. To ensure the safety of the resident, staff, and others: A. Remove any potential weapons from the environment. B. Maintain a safe distance from the resident during episodes of aggressive to present physical harm. C. In an acute crisis situation, the use of medications and physical means would be used to limit the aggressive behavior of the resident. The Medical and/or Psychiatric Provider would be notified of the situation. Orders are to be obtained as needed. 10. Teach coping skills to manage her anger and frustration. 11. Consider therapy in a formal setting to provide outlets for emotions, such as engaging in physical activities or expressing themselves through art and music. 12. Regular behavioral documentation, including but not limited to resident participation in activities, life skills, adherence to smoking rules, and sleeping habits. 13. Violence risk assessment to be completed on admission, annually, and with any significant change. R39's Care Plan last revised on 11/25/24 lacked a care area to address R39's PTSD to indicate known causes, triggers, or interventions to mitigate triggers or re-traumatization. On 01/13/25 at 10:00 AM, R39 was in her room. She did not want to be disturbed at this time. On 01/14/25 at 09:13 AM, R39 stated she had had PTSD for a long time. On 01/15/25 at 12:28 PM, Administrative Nurse E stated that R39's care plan should continually be updated with interventions specific to R39's diagnoses and triggers. Administrative Nurse E stated residents all had interventions to address behaviors and what staff should do when an incident occurred. Administrative Nurse E stated that R39's care plan was not individualized specific to her behaviors and their triggers. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/15/25 at 02:32 PM, Administrative Nurse D stated that R39's care plan should be more person-centered for her specific diagnoses. Administrative Nurse D stated all residents have interventions to address their behaviors. The Behavioral Health Services policy documented: that all residents would be screened for possible serious mental disorders or intellectual disabilities and related conditions prior to admission. Staff would ensure the necessary care and services were person-centered. Each resident's individualized behavioral health needs were met through the Resident Assessment Instrument (RAI) Process. An individualized, person-centered care plan development and implementation to address the individualized needs of the resident related to the mental disorder substance use disorder. The facility failed to provide person-centered care and have individualized interventions in place to address R39's behavioral diagnoses of anxiety, depression, and bipolar disorder. These deficient practices placed R39 at risk for decreased psychosocial well-being and ineffective treatment.

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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** 41713 The facility identified a census of 45 residents. The sample included 12 residents with five sample residents reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported Resident (R) 5 and R19's physician ordered diclofenac (a non-steroidal anti-inflammatory medication used to treat pain and inflammation) lacked a specified dosage. The CP further failed to identify and report when R19's pulse was outside the physician-ordered parameters. This placed the R5 and R19 at risk for unnecessary medications and related complications. Findings included: - R5's Electronic Medical Record (EMR) documented diagnoses of schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), anxiety disorder (a mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), delusional disorder (a mental illness that involves having persistent false beliefs), and a stress fracture of the tibia/fibula (a small crack in the shin bone or smaller bone of the lower leg). R5 's Admission Minimum Data Set (MDS) dated [DATE] documented he had a Brief Interview for Mental Status (BIMS) score of 14 which indicated intact cognition. R5 had impairment on one side of his lower extremities. R5 was independent to set up assistance from staff for oral care and bathing. R5 received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), antianxiety (a class of medications that calm and relax people), antidepressant (a class of medications used to treat mood disorders), and an anticoagulant (a class of medication used to prevent the blood from clotting). R5's Falls Care Area Assessment (CAA) dated 11/18/24 documented R5 was at high risk of falls due to a previous fall with a fracture. R5's Care Plan last revised on 11/09/24 directed staff to give analgesics (pain reliever) as ordered. Staff were directed to monitor for side effects and document effectiveness. R5's Orders tab of the EMR documented a physician's order dated 12/15/24 for diclofenac external topical gel to be applied to the right knee topically every four hours as needed for knee pain. R5's physician's order lacked a dosage amount to be applied. A review of the CP's November 2024 and December 2024 Medication Regimen Review (MRR) for R5 revealed the CP failed to identify and report that R5's diclofenac physician's order lacked an indicated dosage amount. On 01/14/25 at 01:30 PM, R5 stood in line with other residents waiting to be taken outside to smoke. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/15/25 at 12:411, PM Certified Medication Aide (CMA) R stated she did not have anything to do with the pharmacy reviews, but all medications should have a dosage amount on them. On 01/15/25 at 01:32 PM, Licensed Nurse (LN) G stated that Administrative Nurse D was responsible for reviewing the pharmacy reviews. LN G stated she would expect all medication to have a dosage amount but diclofenac has a stick thing that comes with it but there is no dosage amount that she knew of. On 01/15/25 at 02:32 PM, Administrative Nurse D stated any, and all ordered medications should have an indicated dosage amount. Administrative Nurse D stated diclofenac was a topical over-the-counter medication and did not need a dosage amount that she was aware of. The undated Drug Regimen Review policy documented the CP would perform a drug regimen review on each resident at the time of the resident's admission, and at least monthly. A review of the resident's clinical record included by was not limited to irregularities of any drug that meets the criteria for an unnecessary drug. All medication orders would be reviewed for the appropriateness of the medication, dose, frequency, and route of administration. Ensure appropriate monitoring by facility staff for efficacy and adverse side effects. The facility failed to ensure the CP identified and reported R5's physician ordered diclofenac had an indicated dosage. This placed R5 at risk for unnecessary medications and related complications. 41037 - R19's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin) and hypertension (HTN - elevated blood pressure). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 11 which indicated moderately impaired cognition. The MDS documented R19 had received insulin (medication to regulate blood sugar) and antidepressant (a class of medications used to treat mood disorders) during the observation period. The Quarterly MDS dated [DATE] documented a BIMS score of 13 which indicated intact cognition. The MDS documented that R19 had received insulin and antidepressant medication during the observation period. R19's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 03/11/24 documented R20 required assistance with her activities of daily living related to chronic pain. R19's Care Plan dated 03/03/21 documented nursing staff would administer diabetic medication as ordered. The plan of care documented staff would monitor and document any side effects and effectiveness. R19's EMR under the Orders tab revealed the following physician orders: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Lisinopril (antihypertensive) tablet five milligrams (mg) give one tablet by mouth in the evening related to HTN notify the physician if systolic blood pressure (SBP - relating to the phase of the heartbeat when the heart muscle contracts and pumps blood from the chambers into the arteries less than (<) 80 millimeters of mercury (mmHg) greater than (>) 200 mmHg and if the heart rate < 50 or > then 100 dated 12/05/21. Average amount of blood glucose (A1c - laboratory blood test that monitors the blood sugar for the past three months), Microalbumin urinalysis (UA) (urine test that monitors kidney function) every three months (January, April, July, and October) related to diabetes mellitus dated 10/20/22. Complete Blood Count (CBC - laboratory blood test), Comprehensive Metabolic Panel (CMP - laboratory blood test), Microalbumin UA, Lipid panel (laboratory blood test), and a Liver panel (laboratory blood test) yearly (October) dated 10/20/24. Review of R19's clinical record lacked evidence of the results of the physician-ordered laboratory tests. The facility was unable to provide signed copies of the results after requested for A1c in 01/2024 and 04/2024, Microalbumin in 04/2024, and Lipid panel in 10/2024. Review of the Medication Administration Record (MAR) in the EMR reviewed from 11/01/24 to 01/13/25 (73 days) revealed heart rate was outside the physician-ordered parameters 11 days on the following dates 11/05/24, 11/10/24, 11/23/24, 11/24/24, 12/08/24, 12/13/24, 12/22/24, 12/26/24, 12/27/24, 12/30/24, and 12/31/24. R19's EMR lacked documentation the physician was notified of the heart rate was outside the physician-ordered parameters. Review of the Monthly Medication Review (MMR) reviewed from January 2024 to December 2024 lacked evidence of the CP identified the lack of physician ordered laboratory testing was not available in R19's clinical as ordered and the physician was not notified of heart rate outside the physician-ordered parameters. The facility was unable to provide the physician-ordered laboratory test results upon request. On 01/14/25 at 12:12 PM, R19 walked down the hallway and into the dining room. On 01/15/25 at 08:12 AM, R19 laid on her bed with her eyes closed. On 01/15/25 at 12:42 PM, Certified Medication Aide (CMA) R stated she would report any vital signs that were outside the physician-ordered parameters. On 01/15/25 at 01:32 PM, Licensed Nurse (LN) G stated she would notify Administrative Nurse D of any out-of-parameter vital signs and she would notify the physician. LN G stated Administrative Nurse D would document that notification in the resident's EMR under the progress notes. LN G stated she did not address the MMRs. LN G stated she did not obtain the laboratory tests Administrative Nurse D monitored and tracked the resident's laboratory tests. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/15/25 at 02:33 PM, Administrative Nurse D stated she would expect the charge nurse to notify the physician of the out-of-parameter vital signs and document the notification under the resident's progress notes. The facility's undated Drug Regimen Review policy documented the consultant pharmacist would perform a drug regimen review on each resident living in the facility at the time of the resident's admission to the facility and at least monthly and when requested by team members of the facility. The facility failed to ensure the CP identified and reported the physician-ordered laboratory test for medication monitoring was not obtained as ordered. The facility also failed to ensure the CP had identified and reported the R19's heart rate was outside the physician's orders. These deficient practices placed R19 at risk for unnecessary medications and related complications.

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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** 41037 The facility identified a census of 45 residents. The sample included 12 residents with five residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure the physician order was followed for Resident (R) 19's laboratory tests to monitor for high-risk medications and that the physician was notified of values outside the physician-ordered parameters. The facility also failed to ensure dosing instructions for Voltaren (topical pain reliever medication) gel for R16 and R5. These deficient practices placed these residents at risk for unnecessary medication use and physical complications for the affected resident. Findings included: - R19's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin) and hypertension (HTN - elevated blood pressure). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 11 which indicated moderately impaired cognition. The MDS documented R19 had received insulin (medication to regulate blood sugar) and antidepressant (a class of medications used to treat mood disorders) during the observation period. The Quarterly MDS dated [DATE] documented a BIMS score of 13 which indicated intact cognition. The MDS documented that R19 had received insulin and antidepressant medication during the observation period. R19's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 03/11/24 documented R20 required assistance with her activities of daily living related to chronic pain. R19's Care Plan dated 03/03/21 documented nursing staff would administer diabetic medication as ordered. The plan of care documented staff would monitor and document any side effects and effectiveness. R19's EMR under the Orders tab revealed the following physician orders: Lisinopril (antihypertensive) tablet five milligrams (mg) give one tablet by mouth in the evening related to HTN notify the physician if systolic blood pressure (SBP - relating to the phase of the heartbeat when the heart muscle contracts and pumps blood from the chambers into the arteries less than (<) 80 millimeters of mercury (mmHg) greater than (>) 200 mmHg and if the heart rate < 50 or > then 100 dated 12/05/21. Average amount of blood glucose (A1c - laboratory blood test that monitors the blood sugar for the past three months), Microalbumin urinalysis (UA) (urine test that monitors kidney function) every three months (January, April, July, and October) related to diabetes mellitus dated 10/20/22. (continued on next page)

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Access Mental Health	500 Peabody Peabody, KS 66866

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Complete Blood Count (CBC - laboratory blood test), Comprehensive Metabolic Panel (CMP - laboratory blood test), Microalbumin UA, Lipid panel (laboratory blood test), and a Liver panel (laboratory blood test) yearly (October) dated 10/20/24. Review of R19's clinical record lacked evidence of the results of the physician-ordered laboratory tests. The facility was unable to provide the laboratory test results upon request. Review of the Medication Administration Record (MAR) in the EMR reviewed from 11/01/24 to 01/13/25 (73 days) revealed heart rate was outside the physician-ordered parameters 11 days on the following dates: 11/05/24, 11/10/24, 11/23/24, 11/24/24, 12/08/24, 12/13/24, 12/22/24, 12/26/24, 12/27/24, 12/30/24, and 12/31/24. R19's EMR lacked documentation the physician was notified of heart rates that were outside the physician-ordered parameters. On 01/14/25 at 12:12 PM, R19 walked down the hallway and into the dining room. On 01/15/25 at 08:12 AM, R19 laid on her bed with her eyes closed. On 01/15/25 at 12:42 PM, Certified Medication Aide (CMA) R stated she would report any vital signs out of physician-ordered parameters to the charge nurse. On 01/15/25 at 01:32 PM, Licensed Nurse (LN) G stated she would notify Administrative Nurse D of any vital signs out of physician-ordered parameters. LN G stated Administrative Nurse D would notify the physician. LN G stated Administrative Nurse D would document that notification in the resident's EMR under the progress notes. LN G stated she did not address the MMR's. LN G stated she did not obtain the laboratory tests Administrative Nurse D would monitor and tracked the resident's laboratory tests. On 01/15/25 at 02:33 PM, Administrative Nurse D stated she would expect the charge nurse to notify the physician of any vital signs that were outside the physician-ordered parameter. Administrative Nurse D stated she would expect the charge to document the physician notification under the resident's progress notes. The facility was unable to provide a policy related to physician orders. The facility failed to ensure the physician's order was followed for R19's laboratory tests to monitor for high-risk medications. The facility also failed to ensure the physician was notified heart rate was outside the ordered parameter These deficit practices placed R19 at risk of adverse side effects and unnecessary medications. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- R16's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), hemiplegia (paralysis of one side of the body), hemiparesis/hemiplegia (weakness and paralysis on one side of the body), chronic pain, insomnia (inability to sleep), and posttraumatic stress disorder (PTSD - a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress). The Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 12 which indicated moderately impaired cognition. The MDS documented R16 had received antidepressant (a class of medications used to treat mood disorders) and antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality). R16's Psychotropic Drug Use Care Area Assessment (CAA) dated 12/23/24 documented he had received psychotropic medication during the observation period to manage his disease process. R16's Care Plan dated 12/23/24 documented the nursing staff would administer his medication as ordered. The plan of care documented the staff would monitor and document side effects along with the effectiveness. The plan of care dated 01/09/25 documented staff would reassurance that pain was time-limited and to encourage him to try different pain-relieving methods. R16's EMR under the Orders tab revealed the following physician orders: Diclofenac sodium external gel one percent (%) (Voltaren) apply topically to bilateral ankles and back three times a day related to chronic pain dated 12/07/24. On 01/15/25 at 11:42 AM, R16 walked in from smoking outside. R16 walked down the hallway to his room, his left arm hung down along his left side unsupported, and his left leg slid along the floor as he walked. On 01/15/25 at 01:32 PM, Licensed Nurse (LN) G stated she was not sure if Voltaren gel required a dosage for application. LN G stated the gel had the paper strips in the box and it was applied by inches. LN G stated Administrative Nurse D was responsible to ensure to review the medication orders. On 01/15/25 at 02:33 PM, Administrative Nurse D stated Voltaren gel did not require a dosage for administration because the facility used generic medications. The facility was unable to provide a policy related to physician orders. The facility failed to ensure dosing instructions for Voltaren gel for R16. This deficient practice placed R16 at risk for unnecessary medication use, side effects, and physical complications. 41713 (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- R5's Electronic Medical Record (EMR) documented diagnoses of schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), anxiety disorder (a mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), delusional disorder (a mental illness that involves having persistent false beliefs), and a stress fracture of the tibia/fibula (a small crack in the shin bone or smaller bone of the lower leg). R5's Admission Minimum Data Set (MDS) dated [DATE] documented he had a Brief Interview for Mental Status (BIMS) score of 14 which indicated intact cognition. R5 had impairment on one side of his lower extremities. R5 was independent to set up assistance from staff for oral care and bathing. R5 received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), antianxiety (a class of medications that calm and relax people), antidepressant (a class of medications used to treat mood disorders), and an anticoagulant (a class of medication used to prevent the blood from clotting). R5's Falls Care Area Assessment (CAA) dated 11/18/24 documented R5 was at high risk of falls due to a previous fall with a fracture. R5's Care Plan last revised on 11/09/24 directed staff to give analgesics (pain reliever) as ordered. Staff was directed to monitor for side effects and document effectiveness. R5's Orders tab of the EMR documented a physician's order dated 12/15/24 for diclofenac external topical gel to be applied to the right knee topically every four hours as needed for knee pain. R5's physician's order lacked a dosage amount to be applied. A review of the CP's November 2024 and December 2024 Medication Regimen Review (MRR) for R5 revealed the CP failed to identify and report that R5's diclofenac physician's order lacked an indicated dosage amount. On 01/14/25 at 01:30 PM, R5 stood in line with other residents waiting to be taken outside to smoke. On 01/15/25 at 12:41 PM, Certified Medication Aide (CMA) R stated all medications should have a dosage amount on them. CMA R stated the nurse was responsible for the application of the diclofenac for R5. On 01/15/25 at 01:32 PM, Licensed Nurse (LN) G stated she would expect all medication to have a dosage amount but diclofenac has a stick thing that comes with it but there was no dosage amount that she knew of. On 01/15/25 at 02:32 PM, Administrative Nurse D stated any, and all ordered medications should have an indicated dosage amount. Administrative Nurse D stated diclofenac was a topical over-the-counter medication and did not need a dosage amount that she was aware of. The facility failed to provide a policy regarding unnecessary medications. The facility failed to ensure R5's physician ordered diclofenac had an indicated dosage. This placed R5 at risk for unnecessary medications and related complications.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 45 residents. The sample included 12 residents with five residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure the as needed (PRN) psychotropic (alters mood or thought) medication had a 14-day stop date or a specified duration with supporting physician documentation for Resident (R) 30's and R16's PRN psychotropic medications. This deficient practice placed these residents at risk for unnecessary medication administration and possible adverse side effects. Findings included: - R30's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of posttraumatic stress disorder (PTSD- a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress), tardive dyskinesia (an abnormal condition characterized by involuntary repetitive movements of the muscles of the face, limbs, and trunk), schizoaffective (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R30 verbal behaviors toward others one to three days during the observation period. The MDS documented R30 had received antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication, antidepressant (a class of medications used to treat mood disorders) medication, and antianxiety (a class of medications that calm and relax people) medication during the observation period. The MDS lacked evidence a drug regimen review was completed during the observation period. The Quarterly MDS dated [DATE] documented a BIMS score of 15 which indicated intact cognition. The MDS documented that R30 had behaviors during the observation period. The MDS documented R30 had received antianxiety medication, antipsychotic medication, and antidepressant medication during the observation period. The MDS documented lacked evidence a drug regimen review was completed during the observation period. R30's Psychotropic Drug Use Care Area Assessment (CAA) dated 11/01/24 documented she received antipsychotic medication daily. R 30's Care Plan dated 06/05/23 documented nursing staff would administer her psychotropic medication as ordered by the physician and monitor for side effects along with the effectiveness. R30's EMR under the Orders tab revealed the following physician orders: hydroxyzine (sedative) hcl tablet 50 Milligram (mg) give one tablet by mouth every 12 hours as needed for PTSD dated 10/04/22. The as needed sedative medication lacked a 14 day stop date or a physician ordered specific duration. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Seroquel (antipsychotic) oral tablet 25mg give one tablet by mouth every 12 hours as needed for anxiety dated 12/21/23. The as needed antipsychotic medication lacked a 14 day stop date or a physician ordered specific duration. Haloperidol (antipsychotic) oral tablet five mg give one tablet by mouth every 12 hours as needed for paranoia related to schizoaffective disorder dated 09/03/24. The as needed antipsychotic medication lacked a 14 day stop date or a physician ordered specific duration. Review of R30's EMR revealed a physician order dated 06/04/24 to continue the as needed Seroquel. Review of R30 Medication Administration Record for December 2024 the as needed Seroquel was not discontinued on 12/04/24 as ordered. On 01/15/25 at 08:06 AM R30 walked around in her room as she listened to music. On 01/15/25 at 01:32 PM, Licensed Nurse (LN) G stated she was not sure if an as needed psychotic medication required duration for administration in the order. LN G stated Administrative Nurse D would be responsible to ensure the psychotropic medication orders were correct. On 01/15/25 at 02:33 PM, Administrative Nurse D stated the facility did not utilize as needed psychotropic medications. Administrative Nurse D stated any as needed psychotropic medication would only be ordered for a one-time administration not for long term use. The facility was unable to provide a policy related to monitoring psychotropic medications. The facility failed to ensure R30's as needed Haldol, Seroquel, and hydroxyzine had a stop date, or a physician ordered specified duration for administration. This placed R30 at risk for unnecessary medication administration and possible adverse side effects. - R16's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), hemiplegia (paralysis of one side of the body), hemiparesis/hemiplegia (weakness and paralysis on one side of the body), chronic pain, insomnia (inability to sleep), and posttraumatic stress disorder (PTSD- a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress). The Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 12 which indicated moderately impaired cognition. The MDS documented R16 had received antidepressant (a class of medications used to treat mood disorders) and antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality). R16's Psychotropic Drug Use Care Area Assessment (CAA) dated 12/23/24 documented he had received psychotropic medication during the observation period to manage his disease process. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R16's Care Plan dated 12/23/24 documented the nursing staff would administer his medication as ordered. The plan of care documented the staff would monitor and document and side effects along with the effectiveness. R16's EMR under the Orders tab revealed the following physician orders: Trazodone (sedative) hci oral tablet 50 milligram (mg) give one tablet by mouth every 24 hours as needed for insomnia dated 12/06/24. The as needed sedative medication lacked a 14 day stop date or a physician ordered specific duration. On 01/15/25 at 11:42 AM, R16 walked in from smoking outside. R16 walked down the hallway to his room, his left arm hung down along his left side unsupported, his left leg slid along the floor as he walked. On 01/15/25 at 01:32 PM, Licensed Nurse (LN) G stated she was not sure if an as needed psychotic medication required duration for administration in the order LN G stated Administrative Nurse D would be responsible to ensure the psychotropic medication orders were correct. On 01/15/25 at 02:33 PM, Administrative Nurse D stated the facility did not utilize as needed psychotropic medications. Administrative Nurse D stated any as needed psychotropic medication would only be ordered for a one-time administration not for long term use. The facility was unable to provide a policy related to monitoring psychotropic medications. The facility failed to ensure R16's as needed Trazodone had a stop date, or a physician ordered specified duration for administration. This placed R16 at risk for unnecessary medication administration and possible adverse side effects.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 41713 The facility identified a census of 45 residents. The facility had one main kitchen and one main dining area. Based on observation, record review, and interview the facility failed to ensure the director of food and nutrition services had the required qualifications of a certified dietary manager (CDM). This placed residents at risk for unmet dietary and nutritional needs. Findings included: - On 01/13/25 at 07:17 AM, Dietary BB stated she did not have her CDM certification. Dietary BB stated she had completed her Safe Serv courses and had not been told she needed to get her CDM. Dietary BB stated the registered dietician was only at the facility once a month. On 01/15/25 at 03:42 PM, Administrative Staff A stated it was her understanding that as long as the facility had a registered dietician the dietary manager did not have to be certified. The facility did not provide a policy regarding the CDM as requested. The facility failed to ensure the director of food and nutrition services had the required qualifications of a CDM. This placed residents at risk for unmet dietary and nutritional needs.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41713 The facility identified a census of 45 residents. The facility had one main kitchen and one main dining area. Based on observation, record review, and interview the facility failed to ensure dietary staff safely thawed meat to prevent bacterial growth. This placed residents at risk for food-borne illnesses. Findings included: The initial tour of the kitchen on 01/13/25 at 07:17 AM revealed a pork loin in the three-bin wash sink thawing. The pork loin did not have water running over it. On 01/13/25 at 07:30 AM, Dietary BB stated meat should be thawed on the bottom shelf of the refrigerator or in a tub with running water over it if thawed in the sink. The facility failed to ensure dietary staff safely thawed meat to prevent bacterial growth. This placed residents at risk for food-borne illnesses.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 45 residents. The sample included 12 residents with five reviewed for immunization status. Based on record reviews, and interviews, the facility failed to offer or obtain informed declinations, consent, or a physician-documented contraindication for the influenza (highly contagious viral infection that attacks the lungs, nose, and throat and can be deadly in high-risk groups) vaccination Resident (R) 5, R16, R19, and R30. The facility also failed to offer or obtain informed declinations, consent, or a physician-documented contraindication for the Pneumococcal Conjugate Vaccine (PCV20- vaccination for bacterial infections) pneumococcal (type of bacterial infection) vaccination for R5, R16, R27, and R30. This placed the residents at an increased risk for influenza, pneumonia, and related complications. Findings included: - Review of R5's clinical record revealed he was admitted on [DATE]. Review of his EMR under the Immunization tab lacked documentation the influenza and PCV20 vaccination was offered or declined and lacked documentation of a historical administration or physician-documented contraindication. Review of R16's clinical record revealed he was admitted on [DATE]. Review of his EMR under the Immunization tab lacked documentation the influenza and PCV20 vaccination was offered or declined and lacked documentation of a historical administration or physician-documented contraindication. Review of R19's clinical record revealed she was admitted on [DATE]. Review of the EMR under the Immunization tab lacked documentation the influenza vaccination was offered or declined and lacked documentation of a historical administration or physician-documented contraindication. R19's EMR revealed the Pneumococcal Polysaccharide Vaccine (PPSV23) was administered on 02/02/23. Review of R30's clinical record revealed she was admitted on [DATE]. Review of the EMR under the Immunization tab lacked documentation the influenza and PCV20 vaccination was offered or declined and lacked documentation of a historical administration or physician-documented contraindication. Review of R27's clinical record revealed she was admitted on [DATE]. Review of the EMR under the Immunization tab lacked documentation the PCV20 vaccination was offered or declined and lacked documentation of a historical administration or physician-documented contraindication. R27's EMR revealed influenza vaccination was administered on 10/24/24. On 01/15/25 at 02:33 PM, Administrative Nurse E, the facility Infection Preventionist, stated the pharmacy came to the facility yearly to administer immunizations to the residents. Administrative Nurse D stated the residents were offered at the time of admission. Administrative Nurse D stated most of the resident or their legal guardians would inform the facility that the resident had received the immunization in the past. Administrative Nurse D stated she would not offer some of the residents the yearly vaccinations because their legal guardians would become upset. Administrative Nurse D stated the facility did not off the PCV-20 to the residents even if they were at risk of development of pneumonia because Medicaid did not pay for the vaccination. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's undated Immunizations Policy documented recognizing the major impact and mortality of influenza and/or pneumonia disease on residents of nursing home and the effectiveness of vaccines in reducing healthcare costs and preventing illness, hospitalization and death his facility has adopted the following policy statements: residents, staff and volunteers of this facility would be offered the influenza vaccine annually, unless there c1 documented contraindication or if the resident or representative refuses the vaccine(s) after appropriate education related to the risk of the conditions and the risk of failure to receive the vaccine(s). The facility failed to obtain influenza and pneumococcal vaccination consents, declinations, or administration information for R5, R16, R19, R27, and R30. This placed the residents at increased risk for influenza, pneumonia, and related complications.

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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 45 residents. The sample included 12 residents with five reviewed for immunization status. Based on record reviews, and interviews, the facility failed to offer or obtain informed declinations or a physician-documented contraindication for the COVID-19 (an acute respiratory illness in humans caused by coronavirus, capable of producing severe symptoms and in some cases death) vaccinations for Resident (R) 30 and R5. This deficient practice placed these residents at increased risk for COVID-19. Findings included: - Review of R16's clinical record reveled he was admitted on [DATE]. Review of R16's EMR under the Immunization tab lacked documentation the COVID-19 vaccination offered or declined and lacked documentation of a historical administration or physician-documented contraindication. Review of R5's clinical record reveled he was admitted on [DATE]. Review of R5's EMR under the Immunization tab lacked documentation the COVID-19 vaccination offered or declined and lacked documentation of a historical administration or physician-documented contraindication. Upon request for R16 and R5's record of declination or administration of COVID-19 vaccine, the facility was unable to provide a consent or declination for these residents. The facility was unable to provide a physician-documented contraindication. On 01/15/25 at 01:32 PM, Licensed Nurse (LN) G stated Administrative Nurse D kept track of the immunizations. On 01/15/25 at 02:33 PM, Administrative Nurse D, the facility Infection Preventionist, stated the pharmacy came to the facility yearly to administer immunizations to the residents. Administrative Nurse D stated the residents were offered at the time of admission. Administrative Nurse D most of the resident or their legal guardians would inform the facility that the resident had received the immunization in the past. The facility was unable to provide a policy related to administration of COVID -19 vaccination. The facility failed to offer and obtain signed consents or declinations for COVID-19 vaccinations for R16 and R5. This deficient practice increased R16's and R5's risk for COVID-19 and related complications.