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	06/23/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. The facility reported a census of 42 residents. The sample included 12 residents with five residents reviewed for psychotropic (alters mood or thoughts) medications. Based on interview, observation, and record review, the facility failed to inform Resident (R) 30 and R9 and/or their representatives regarding the risks related to psychotropic medications. These practices had the potential to lead to negative and unwarranted physical side effects. Findings included: - On 06/23/25 at approximately 10:00 AM, a review of the Psychoactive Medication Therapy Informed Consent Form logbook provided by Social Services X revealed the following: A consent form for Invega (paliperidone - a psychotropic medication) lacked a signature from R30. The document contained a signature of Administrative Nurse D as the person who obtained R30's consent, dated 08/01/24 at 02:15 PM. A consent form for Haldol (haloperidol - a psychotropic medication) lacked a signature from R30. The document contained a signature of Administrative Nurse D as the person who obtained R30's consent, dated 06/09/25 at 02:10 PM. A consent form for Abilify (aripiprazole - a psychotropic medication) lacked a signature from R9's guardian and was dated 10/09/24. A consent form for lithium (a psychotropic medication) lacked a signature from R9's guardian and was dated 10/08/24. A consent form for Ativan (lorazepam - a psychotropic medication) lacked a signature from R9's guardian and was dated 10/08/24. A consent form for trazodone (a psychotropic medication) lacked a signature from R9's guardian and was dated 12/19/24. A consent form for Zyprexa (olanzapine - a psychotropic medication) lacked a signature from R9's guardian and was dated 01/02/25. R30's Electronic Medical Record (EMR) lacked documentation of informed consent for the Invega or Haldol. (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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R9's EMR lacked documentation of informed consent for Abilify, lithium, Ativan, trazodone, or Zyprexa. During an interview on 06/23/25 at 10:15 AM, Social Services X revealed she was recently notified by the facility's administration that she was responsible for obtaining and maintaining consent for psychotropic medication use. During an interview on 06/23/25 at 11:45 AM, Social Services X revealed she was assigned the task of obtaining consent and signatures from the applicable residents on 06/16/25 and organizing the older consent forms. Social Services X said she was unaware that residents with a guardian could not sign consent forms without written permission from the guardian. During an interview on 06/23/25 at 12:34 PM, Administrative Nurse B confirmed the lack of signatures on the consent forms and revealed that she signed some of the consent forms and delegated the task of obtaining the consent signatures to another staff member. Administrative Nurse B stated the facility expected Social Services X to obtain consent signatures and sign as the person who obtained the signatures, but Social Services X refused to sign as a witness so Administrative Nurse B would sign the documents ahead of time. The facility's undated Psychotropic Medication Monitoring policy documented a discussion with the resident and/or responsible party regarding the risk versus benefit related to the use of medications.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 42 residents. The sample included 12 residents. Based on record review and staff interviews, the facility failed to complete Care Area Assessments (CAA) that addressed the individual underlying causes, contributing factors and risk factors for five residents. Resident (R)1, R8, R 9, R245, and R195. This placed the residents at risk for inadequate care due to unidentified care needs. Findings included: - R1's Electronic Health Record (EHR) recorded an Annual Minimum Data Set (MDS), dated [DATE] which triggered the Psychotropic Drug Use CAA documented R1 took psychotropic (alters mood or thought) medications to manage schizoaffective disorder (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), depression, and anxiety. The CAA lacked an analysis of the findings. R8's EHR recorded an annual MDS dated 05/18/25 which triggered the Dental Care CAA. The CAA documented R8 had potential for cavities related to the types of food the resident consumed but lacked an analysis of the findings. R9's EHR recorded an Annual MDS, dated 02/18/25 that triggered the Psychotropic Drug Use CAA. The CAA documented R9 took psychotropic medications for behavior management related to schizoaffective disorder and anxiety. The Behavioral Symptoms CAA documented R9 had a behavioral problem, used foul language, and urinated on the floor related to schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thoughts). Both CAAs lacked an analysis of the findings. R245's EHR recorded an admission MDS, dated 06/17/25 that triggered the Psychotropic Drug Use CAA The CAA documented R245 took psychotropic medications for schizoaffective disorder, and bipolar type (a major mental illness that causes people to have episodes of severe high and low moods) but lacked an analysis of findings. R195's EHR recorded an admission MDS, dated 06/17/25 that triggered the Psychotropic Drug Use CAA. The CAA documented R195 took psychotropic medications for schizoaffective disorder and bipolar type. The Behavioral Symptoms CAA documented the resident was a new admit struggling to adjust. The Cognitive Loss/Dementia CAA documented the resident was a new admit struggling with adjusting to the facility. All the listed CAAs lacked an analysis of findings. On 06/23/25 at 12:06 PM, Administrative Nurse E identified as the MDS Nurse and confirmed the CAA notes were not completed as they should have been and lacked analysis and risk findings. Administrative Nurse E revealed she was unsure on what to write for CAA notes as she really had not been educated on how to complete a CAA note. On 06/23/25 at 02:36 PM, Administrative Nurse D reported she expected the MDS to be completely accurate. Administrative Nurse D reported that she would review and sign off on MDS completed by Administrative Nurse F; she said she would review them carefully for any errors and communicate any concerns to Administrative Nurse F. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's undated policy Comprehensive Assessment including MDS and CAAs documented the resident assessment instrument system developed by the federal government and would be used as the basis for assessment, care planning, and documentation system. Each CAA area triggered is noted on the MDS Resident Assessment Protocol Summary and requirements are further assessed. After appropriate documentation on the MDS CAA summaries, the Registered Nurse would date and sign to verify all triggered CAAs had been applied to complete a detailed, comprehensive, individualized care plan.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 42 residents. The sample included 12 residents. Based on observation, interview, and record review, the facility failed to accurately complete the Minimum Data Set (MDS) for seven residents: Resident (R) 1 and R30 related to insulin (a hormone that lowers the level of glucose in the blood); R5 related to physical restraints; R9, R8, R245, and R195 related to Wander Guard alarm (a bracelet that helps monitor residents who are at risk of wandering). This deficient practice placed the affected residents at risk for impaired care due to unidentified care needs. Findings included: - R1's Electronic Health Record (EHR) recorded a Physician Order for metformin (a medication used to lower blood sugar levels) 500 milligram (mg) tablet dated 02/27/24 and an order for Ozempic (a hormone that plays a crucial role in regulating blood sugar levels by stimulating insulin secretion in response to elevated blood sugar) weekly dated 04/15/25. R1's Annual MDS, dated 04/22/25 inaccurately recorded R1 received one insulin injection, one time during the week of look back, and one order change during the week of look back. R1's MDS lacked documentation in Section N of R1's hypoglycemic (medications used to lower blood glucose levels in individuals with diabetes) medications including Ozempic and Metformin. R30's EHR recorded a Physician Orders for Trulicity (a hormone that plays a crucial role in regulating blood sugar levels by stimulating insulin secretion in response to elevated blood sugar) dated 05/03/24. R30's EHR recorded an Annual MDS, dated 05/26/25 that inaccurately recorded R30 received one insulin injection, one time the week of look back. During an interview on 06/23/25 at 12:06 PM, Administrative Nurse F (MDS Nurse) reported that she had made an error when she coded the Trulicity and Ozempic as insulin on R1's and R30's annual MDSs. Administrative Nurse F reported that R1 should have hypoglycemic medications checked off as a yes on the annual MDS. - R5's Electronic Health Record (EHR) recorded a Quarterly MDS, dated 05/05/25 that documented R5 had a bed rail used daily under the physical restraints (are any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body) section. During an observation on 06/17/25 at 12:00 PM, R5 had a bed positioning device located on the right side of his bed, secured to the bed frame. On 06/17/25 at 12:10 PM, R5 reported he used that bed positioning device to help his bed mobility and to assist with getting out of bed. On 06/23/25 at 12:06 PM, Administrative Nurse F reported that she had been instructed to code any bed rail as a restraint on the MDS. Administrative Nurse F reported that R5 used the bed positioning rail to assist him in being more independent with transfers and bed mobility and reported the bed positioning rail was not a restraint for R5. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- R9's Electronic Health Record (EHR) recorded a Physician Order to check R9's WanderGuard function every shift, two times a day, dated 08/26/24. R9's Annual MDS, dated [DATE], and Quarterly MDS, dated 05/18/25 inaccurately documented R9 had no WanderGuard alarm. R8's EHR recorded a Physician Order to check placement of R8's WanderGuard every shift, two times a day, dated 08/17/24. R8's EHR recorded an Annual MDS, dated 05/18/25 that inaccurately documented R8 had no Wander Guard alarm. R245's EHR recorded a Physician Order to check placement of R245's WanderGuard every shift, two times a day, dated 06/04/25. R245's EHR recorded an admission MDS, dated 06/17/25 that inaccurately documented R245 had no WanderGuard alarm. R195's EHR recorded a Physician Order to check placement of R195's WanderGuard every shift, two times a day, dated 06/04/25. R195's EHR recorded an admission MDS, dated 06/17/25 that inaccurately documented R195 had no WanderGuard alarm. On 06/23/25 at 12:06 PM, Administrative Nurse F reported that she had made an error when she did not check off yes for Wander/Elopement Alarm in Section P of the MDS for all the above residents. Administrative Nurse F reported that she worked part-time and came into the facility once a month. Additionally, she reported she may not always have enough time to complete them and that is how an error could occur. During an interview on 06/23/25 at 02:36 PM, Administrative Nurse D reported she expected the MDS to be completely accurate. Administrative Nurse D reported that she would review and sign off on MDS completed by Administrative Nurse F; she said she would review them carefully for any errors and communicate any concerns to Administrative Nurse F. The facility's policy Comprehensive Assessment including MDS and CAAs documented that the resident assessment instrument system developed by the federal government would be used as the basis for assessment, care planning, and documentation system. The assessment would accurately reflect the resident's status at the time of the assessment.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 42 residents. The sample included 12 residents, and three residents were reviewed for a baseline care plan. Based on interviews, observations, and record review, the facility failed to develop a person-centered baseline care plan within the required timeframe for Resident (R) 245. This deficient practice had the potential to lead to impaired care due to uncommunicated needs. Findings included: - R245's Electronic Health Record (EHR) revealed R245 was admitted to the facility on [DATE]. R245's Baseline Care Plan had one of five components, Functional Status completed on 06/04/25, one component, BCP [baseline care plan] Summary and Signatures was completed on 06/10/25 and one component, Dietary, Therapy and Social Services completed on 06/13/25. As of 06/17/25, two components, General Information and Initial Goals and Health Conditions remained incomplete. On 06/18/25 at 09:10 AM, R245 rested in bed under a blanket. On 06/23/25 at 01:30 PM, Administrative Nurse D revealed the nurse who admitted a resident to the facility was responsible for the immediate completion of the baseline care plan. Administrative Nurse D said if the nurse was unable to complete the baseline care plan, the task could be delegated to an administrative nurse for completion within the first 72 hours the resident was in the building. Administrative Nurse D verbalized she was unaware baseline care plans were required to be completed in the first 48 hours. Administrative Nurse D confirmed that R245's Baseline Care Plan was initiated but was not completed. The facility's undated Baseline Care Plan policy documented the facility would develop an initial person-centered care plan within the first 48 hours of a resident's admission to the facility for every resident.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. The facility had a census of 42 residents. The sample included 12 residents. Based on observation, interview, and record review the facility failed to ensure a medication error rate of less than five percent when 25 medication administration opportunities were observed with two insulin (a hormone that lowers the level of glucose in the blood) medication errors identified. This placed the residents who received insulin at risk for adverse medication reactions and ineffective medication regimens and resulted in a medication error rate of eight percent. Findings included: - Resident(R)38's Physician Orders recorded an order for insulin lispro (fast-acting insulin) subcutaneous (beneath the skin) solution pen-injector 100 unit/ milliliter (ml), administer six units subcutaneously two times a day for diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), date ordered 03/27/25. R38's Physician Orders recorded an order for insulin glargine (long-acting insulin) subcutaneous solution pen-injector 300 unit/ml, administer 32 units subcutaneously, one time a day for diabetes mellitus, date ordered 03/31/25. During an observation on 06/18/25 at 11:48 AM, Licensed Nurse (LN) G dialed the insulin glargine pen 32 units on the insulin pen. LN G then dialed the insulin lispro six units on the insulin pen. Neither insulin pen was primed. LN G did not verify the insulin order to a medication administration record when she prepared the insulin pens. Both insulin pens were labeled with the type of insulin, a date open of 06/10/25, and the resident's name on the pen insulin pens that she pulled from a bag from the top drawer of the treatment cart parked outside R38's room. LN G administered the insulin to R38. Additionally, LN G kept the insulin pen button pressed for only two seconds before removing the needle from the skin. Review of the manufacturer instructions for insulin lispro revealed the button should remain depressed for a count of approximately five seconds to ensure the full dose was administered. Review of manufacturer instructions for insulin glargine revealed the button should remain depressed for 10 seconds to ensure full dose was administered. During an interview on 06/18/25 at 11:52 AM, LN G reported that she always would have looked at the medication administration record on the computer screen in her office when she prepared the insulin pens, but she used the treatment cart today to administer the insulin. LN G reported she was unsure how long to keep an insulin needle from a pen inserted into the skin when insulin was administered. During an interview on 06/18/25 at 11:58 AM, Administrative Nurse D reported she expected the nurses to verify all medications orders with a medication administration record prior to administering medications. Administrative Nurse D reported that it depended on the dose of insulin that was administered as to how long the insulin needle from an insulin pen was kept in the skin when insulin was administered. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's undated policy Pen Devices for Insulin Administration documented that the facility will ensure that each elder received proper appropriate treatment and care for insulin administration per pen device as ordered by a physician. Prior to administration, the authorized clinical staff would verify that the medication selected matches the medication order and product label. Additionally, authorized clinical staff would verify that the medication is being administered at the proper time, in the prescribed dose, by the correct route. Inject the insulin by pushing the button on the insulin pen completely keep the button pressed and count to five before removing the needle from the skin.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. The facility reported a census of 42 residents. Based on observation, interview, and record review, the facility failed to ensure that meals were prepared in a way to preserve and/or promote palatability. This placed the residents at risk for decreased enjoyment of meals and related complications. Findings included: - A review of the facility's June 2025 menu revealed the 06/18/25 noon meal consisted of turkey, stuffing, mixed vegetables and a dinner roll. During an observation on 06/18/25 at approximately 11:45 AM, Dietary CC prepared the noon meal. Dietary CC stated that turkey needed to be served with gravy and combined one ounce of chicken base with approximately three quarts of water and an unknown quantity of corn starch. Dietary CC brought the mixture to a boil then transferred the water-thin liquid to a serving pan and placed the mixture on the steam table for serving. Dietary CC was unable to produce a recipe for the gravy and instead, pointed to her head and stated that she had been cooking for so long, she had memorized the recipe and did not need to look at it. On 06/18/25 12:30 PM, Administrative Staff B and Administrative Staff A were in the kitchen and observed the meal service in progress which included the water-thin mixture being placed over the turkey and dressing and then served to the residents. Administrative Staff A confirmed that gravy was not on the menu for the noon meal service. Administrative Staff A was unable to produce a gravy recipe and instructed Dietary CC to ask for approved recipes before preparing items to serve to the residents. On 06/18/25 at 04:00 PM, Administrative Staff B reported the mixture served to the residents for the noon service appeared to be a broth, not a gravy. Administrative Staff B stated the ingredients of the mixture were not appealing and would not make what is commonly known or identified as gravy. The facility did not provide a policy related to food palatability as requested on 06/18/25 and 06/23/25.

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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. The facility reported a census of 42 residents, one central kitchen, and one dining area. Based on observation, interview, and record review, the facility failed to follow sanitary dietary standards related to the storage of food. This deficient practice placed the residents at risk for food-borne illnesses. Findings included: - During an initial tour of the facility on 06/17/25 at 09:30 AM with Dietary BB revealed the following areas of concern: In the standing freezer, a package of shredded potatoes was open to air. In a chest freezer, a box of pork sausage patties was open to air. Observation in the dry storage area revealed the following: A package of lemon pudding mix was open to air. A large package of butterscotch chocolate chips was open to air. A large package of Italian dressing mix was open to air. A large can of sliced apples and a small can of sliced mushrooms were dented. In the standing refrigerator, a large package of yellow/white shredded cheese mixture was open to air. During an interview 06/17/25 at 09:45 AM, Dietary BB revealed he was not aware that food containers should be closed and not open to air. During an interview on 06/17/25 at 09:50 AM, Administrative Staff A reported that all food items stored in the kitchen area should be closed and dented cans should be returned to the supplier or discarded. The facility's undated Dietary Purchases, Receipt, and Storage policy documented that food and non-food supplies would be received and stored under sanitary and safe conditions as required by law. All cans with dents would be returned or destroyed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. The facility reported a census of 42 residents. Based on observation, record review, and interview the facility failed to maintain an effective infection control program related to a sanitary environment to help prevent cross-contamination and the spread of infections in the laundry, and to ensure appropriate handling, storage, processing, and transportation of linen for the residents of the facility. This placed the residents at risk for infectious disease. Findings included: - Observation on 06/18/25 at 09:33 AM revealed Certified Nurse Aide (CNA) N pushed an uncovered soiled/dirty laundry bin down the hallway with soiled laundry overflowing the container. On 06/18/25 at 09:43 AM CNA N pushed a closed dirty laundry bin with an open laundry basket overflowing with soiled laundry on top of the lid of the closed bin. Observation on 06/23/25 at 02:29 PM, with Laundry Staff U, revealed a wood table in the laundry used for folding resident's clean laundry and processing linen. The table had chipped laminate on the surface and bare wood around the edge of the table resulting in an unsanitizable surface that was in direct contact with resident personal laundry and linen. Laundry staff U confirmed the above findings and agreed the table needed repair to provide a sanitizable surface to handle, process, and prevent infection and cross-contamination of facility laundry and residents' clothing. On 06/18/25 at 09:45 AM, CNA N confirmed the above findings. She stated she was unaware the laundry was supposed to be covered while transporting soiled laundry down the hallway from the resident's room to the laundry area. On 06/18/25 at 09:50 AM, Administrative Nurse D confirmed that all laundry being transported in the facility should be in a covered container during transport through the hallways to prevent cross-contamination and prevent the spread of infection. The facility policy .Infection Surveillance, dated 02/19/25, documented cleansing and disinfection of products, equipment, or environmental surfaces for storage, handling, processing, and transporting linens according to facility procedures is a part of the surveillance program for prevention of infections.

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. The facility reported a census of 42 with five residents selected for review of vaccines. Based on record review and interview, the facility failed to offer the pneumococcal (type of bacterial infection) vaccine to three residents, Resident (R) 1, R11, and R9. This deficient practice placed the residents at increased risk for pneumococcal infections. Findings included: - R1's Electronic Medical Record (EMR) lacked evidence the facility offered and provided or obtained informed declination for a pneumococcal vaccine. R11's EMR lacked evidence the facility offered and provided or obtained informed declination for a pneumococcal vaccine. R9's EMR lacked evidence the facility offered and provided or obtained informed declination for a pneumococcal vaccine. On 06/23/25 at 03:45 PM, Administrative Nurse D verified the above findings. She reported the facility attempted to get the residents that qualify for the Pneumovax but sometimes the insurance company did not cover the cost. The facility policy, .Immunization Policy, dated 02/19/25, documentation included before offering influenza and pneumovax each resident and or representative will receive education current education regarding the benefits and potential side effects of the immunization.