STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E445	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stanton County Health Care Facility Ltcu	404 N Chestnut Johnson, KS 67855

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 22 residents. The sample included 12 residents, of whom six sampled residents were reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure that Resident (R) 2, R3, R16, and R18, were free from antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication use without an appropriate indication for use, a gradual dose reduction (GDR - tapering of a medication dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued), or ensure the physician provided the risk versus benefit for the continued use of antipsychotic medications. These deficient practices placed R2, R3, R16, and R18 at risk of unnecessary medication administration and related complications.Findings included:- R2’s Electronic Medical Record (EMR) documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion) with behavioral disturbance, major depressive disorder (major mood disorder that causes persistent feelings of sadness), pulmonary hypertension, and angina (chest pain). R2’s “Annual Minimum Data Set (MDS)” dated 12/29/24 documented she had a Brief Interview for Mental Status (BIMS) score of three, which indicated severely impaired cognition. R2 displayed physical and verbal behaviors directed toward others. R2 rejected care behavior during one to three days of the look-back period. R2 required substantial to maximal assistance from staff for her activities of daily living (ADL) care. R2 used a walker or a wheelchair to assist with mobility. R2 received an antipsychotic, an antianxiety (a class of medications that calm and relax people), and an antidepressant (a class of medications used to treat mood disorders). R2’s “Behavioral Care Area Assessment (CAA)” dated 01/13/25 documented that the resident often refused care. R2 would often refuse ADL care and exhibited behaviors towards staff. She did not like taking a shower. Staff needed to explain the task at hand to her before they began. At times, it may take three to four attempts to complete tasks with R2, with periods in between, so she did not become agitated. R2’s “Care Plan,” last revised on 04/30/25, directed staff that she received an antipsychotic medication related to increased behaviors of yelling, hitting, cursing, and refusal of care. R2 received Seroquel (an antipsychotic medication) to assist in improvement in the resident’s functional status. The Care Plan directed staff to explain to the resident what they were doing. The Care Plan directed staff to take time and be gentle with R2 to prevent her from becoming agitated. The Care Plan directed staff to assess and record the effectiveness of medication treatment. The Care Plan directed staff to monitor R2 for signs of sedation. The Care Plan directed staff to attempt a gradual dose reduction (GDR) yearly. (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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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R2’s “Orders” tab of the EMR documented an order dated 07/19/25 for Seroquel 200 milligrams (mg) daily for unspecified dementia with behavioral disturbance. R2’s “Orders” tab of the EMR documented an order dated 07/19/25 for quetiapine (Seroquel) 100 mg at bedtime for major depressive disorder. A review of the Consultant Pharmacist recommendations for R2 from January 2024 to July 2025 revealed no recommendations for an appropriate CMS indication for use of the antipsychotic Seroquel (quetiapine). A GDR had been recommended, but was declined by the physician due to R2’s increased behaviors. On 08/25/25 at 01:20 PM, R2 sat in her wheelchair and was swinging her arm to try to bat away staff as they attempted to assist her to perform cares. On 08/26/25 at 01:19 PM, Administrative Nurse D stated the facility had a monthly pharmacy and therapeutics meeting, which the pharmacist and physician were present, and a printout of antipsychotics and antibiotics was given to both the pharmacist and physician. Administrative Nurse D stated the Pharmacist did a monthly review, which was in the paper chart, but no report was sent to the physician. Administrative Nurse D stated the physician did review the information, but did not sign off to ensure the monitoring or concerns of the pharmacist were followed. Administrative Nurse D stated the facility did not have the physician do a risk versus benefit rationale with the use of psychotropic medication. Administrative Nurse D stated she assumed the physician knew the CMS's indications of use and the rationale for continued use of psychotropic medication and documentation. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility’s “Antipsychotic Drug Use” policy dated 03/06/25 documented antipsychotic drug therapy shall be used only when it was necessary to treat a specific condition. Antipsychotic medication should not be used for sedation or convenience. The attending physician must include a reason or symptoms with any order for antipsychotic drug therapy, along with failed attempts at nonpharmacological interventions. Nursing documentation must include a description of target symptom(s), their frequency, and expected outcomes so that the attending physician can determine if the medications are working effectively. Nurses will complete a consent for psychotropic medication use quarterly and before the initiation of any new psychotropic medications or dose changes. The attending physician will evaluate and document conclusions about the effectiveness of the medication and the need to continue or adjust the current dosage, or to discontinue or change the medication. Unless the resident’s medical record clearly indicates that the resident has one (1) or more of the following “specific conditions,” antipsychotic drugs should not be used. These “specific conditions” include: schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought); schizo-affective disorder(a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought); delusional disorder (untrue persistent belief or perception held by a person although evidence shows it was untrue); psychotic mood disorders (including mania and depression with psychotic features); acute psychotic episodes; brief reactive psychosis; schizophreniform disorder (a mental health condition characterized by symptoms similar to schizophrenia but of shorter duration) ; atypical psychosis (a group of mental health conditions characterized by psychotic symptoms that do not fully meet the diagnostic criteria for schizophrenia or other traditional psychotic disorders); Tourette’s disorder (condition of the nervous syndrome causing uncontrollable repetitive movements or unwanted sounds); Huntington’s disease (a rare abnormal hereditary condition characterized by progressive mental deterioration, a disabling central nervous system movement disorder); and organic mental syndromes (a group of conditions that cause changes in mental functioning due to an underlying physical or physiological cause) with associated psychotic and/or agitated behaviors. - R3’s Electronic Medical Record (EMR) included diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion) with other behavioral disturbance, urinary tract infection (UTI- an infection in any part of the urinary system), nausea with vomiting, major depressive disorder (major mood disorder that causes persistent feelings of sadness), dizziness, and giddiness. R3’s “Quarterly Minimum Data Set” (MDS), dated [DATE], documented that R3 had severe cognitive impairment, had no signs or symptoms of delirium (sudden severe confusion, disorientation, and restlessness), psychosis (any major mental disorder characterized by a gross impairment in reality perception), or exhibited behaviors. R3 rejected care behavior one to three days of the look-back period and wandered four to six days of the look-back period. R3 received an antipsychotic and an antidepressant (a class of medications used to treat mood disorders). The MDS further documented that R3 received an antipsychotic on a routine basis and had a GDR on 03/28/25, and the physician documented a GDR as clinically contraindicated. R3 required substantial/maximal assistance with toileting hygiene, sit-to-standing transfers, bathing, and had occasional incontinence of urine and bowel. The “Behavioral Symptoms Care Area Assessment” (CAA), dated 03/19/25, documented that R3 would exhibit behaviors when staff attempted to assist her with toileting needs in the mornings and staff to leave R3 alone even when incontinent in bed. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The “Psychotropic Medication Care Area Assessment” (CAA), dated 03/19/25, documented that R3 had increased behaviors when staff attempted to assist her with activities of daily living due to R3 not being independent any longer and not understanding why staff needed to help her. R3’s “Care Plan”, dated 06/24/25, documented that R3 received antipsychotic medication related to dementia and behaviors, and took quetiapine (antipsychotic) 100 milligrams (mg) at 03:00 PM. The Care Plan directed staff to redirect R3 by recalling her times as a Certified Nurse Aide (CNA), assess R3’s behavioral symptoms and present a danger to the resident or others, and to intervene as needed. The Care Plan further directed staff to assess/record R3’s functional status before initiation of drug use to serve as a baseline. Monitor R3’s behaviors and responses to medications and attempt a GDR quarterly. The “Physician Order” dated 04/23/25, directed staff to administer quetiapine 100 mg every evening due to increased behaviors for dementia with behavioral disturbance. The “Psychoactive Medication Physician Progress Note” dated 06/09/25 documented quetiapine 100 mg daily. Reduction is not clinically indicated for the following reasons: increased refusal of care, behavior issues, and combativeness despite alternative interventions. The “Pharmacist Medication Regimen Review” dated 01/31/25, 02/28/25, 03/31/25, 04/29/25, 05/29/25, 06/29/25, and 07/28/25 lacked mention of the appropriate indication of use for antipsychotic medication for R3. The “Progress Notes” dated 07/22/25 at 04:35 AM, documented that R3 had refused assistance from staff throughout the shift, was increasingly agitated as R3 requested to call family so they may take her home. R3 had refused to go to bed until the family came. R3 began walking the halls with her walker before accepting assistance to go to bed. The progress notes further documented that five minutes later, the alarm activated, and R3 was observed to be cleaning urine from the floor. Staff offered a shower, but she refused, became agitated, sat in her recliner, and verbally ordered staff to leave. The “Progress Note”, dated 06/29/25 at 08:32 PM, Licensed Master Social Worker (LMSW) reviewed quarterly cognition, PHQ2-9 (Patient Health Questionnaire-9, a screening tool to assess the severity and presence of depression in adults), and progress notes. The LMSW lacked specifics related to R3’s behavioral symptoms, medication use, or alternative therapies. On 08/26/25 at 01:53 PM, R3 was in her room, sitting in her wheelchair, with a bible in her hands. She reported she was reading. On 08/27/25 at 01:20 PM, R3 sat at the activity room door, in her wheelchair. The activity staff invited R3 to participate. On 08/28/25 at 09:03 AM, Social Service X reported that the LMSW was contracted, did not come to the facility, and reviewed the electronic charting. Social Service X reported she had not received guidance from the LMSW related to the behavioral aspects of the residents, and no mental health provider sees the resident in person or via telehealth consultations. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/27/25 at 03:00 PM, Administrative Nurse F stated the resident had been prescribed an antipsychotic and was unsure of the indications of use. Administrative Nurse F stated medication use was discussed at the monthly Pharmacy Therapeutics meetings, but had not received a recommendation related to the appropriate indication for the use of psychotropic medication from the pharmacist. The facility’s “Antipsychotic Drug Use” dated 03/06/25, documented that antipsychotic drug therapy would be used only when it is necessary to treat a specific condition. Antipsychotic medication should not be used for sedation or convenience. Antipsychotics should be used if one or more of the following is/are the only indications: wandering, poor self-care, restlessness, impaired memory, anxiety, depression (without psychotic features), insomnia, unsociability, indifference to surroundings, fidgeting, nervousness, uncooperativeness, or agitated behaviors which do not represent danger to the resident or others. - R16’s Electronic Medical Record (EMR) included diagnoses of major depressive disorder (major mood disorder that causes persistent feelings of sadness) with severe psychotic (any major mental disorder characterized by a gross impairment in reality perception) symptoms, Alzheimer’s disease (progressive mental deterioration characterized by confusion and memory failure), congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid), and pain. The “Quarterly Minimum Data Set” (MDS), dated [DATE], documented that R16 had moderately impaired cognition, had inattention and disorganized thinking, which fluctuated, and wandering behavior occurred daily. R16 required partial/moderate assistance with oral hygiene, showering, upper and lower body dressing, and toileting hygiene, and was independent with transfers and bed mobility. The MDS further documented that R16 received antipsychotics (a class of medications used to treat major mental conditions that cause a break from reality), antidepressants (a class of medications used to treat mood disorders), and the antipsychotics received on a routine basis. The physician documented a gradual dose reduction (GDR - tapering of a medication dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued) as clinically contraindicated on 03/27/25. R16’s “Care Plan” dated 06/26/25, documented that R16 received antipsychotic medication related to restlessness and agitation. Quetiapine 50 mg in the morning and quetiapine 100 milligrams (mg) every evening. The Care Plan directed staff to offer R16 to lie in bed to rest. Often, she is tired and restless. To make sure basic needs are met, offer the resident to look at pictures in her room and monitor R16’s behavior and response to medications. The “Physician Order” dated 06/26/25, directed staff to administer quetiapine 100 mg every evening and quetiapine 50 mg in the morning. The “Psychoactive Medication Physician Progress Note” dated 06/26/25, documented R16 quetiapine was not clinically indicated for the following reason, and no response was documented. The “Pharmacist Medication Regimen Review” dated 01/31/25, 02/28/25, 03/31/25, 04/29/25, 05/29/25, 06/29/25, and 07/28/25 lacked mention of the appropriate indication of use for antipsychotic medication for R16. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The “Progress Note” dated 07/22/25 at 04:30 AM, documented R16 had bouts of tearfulness, but would calm down when staff would interact with the resident. R16 continued to wander throughout the early evening, and staff assisted R16 into her recliner multiple times. R16 rubbed the left leg and grimaced, and medication was given. R16 was assisted to bed around 09:00 PM. On 08/28/25 at 09:03 AM, Social Service X reported that the Licensed Master Social Worker (LMSW) was contracted, did not come to the facility, and reviewed the electronic charting. Social Service X reported she had not received guidance from the LMSW related to the behavioral aspects of the residents, and no mental health provider sees the resident in person or via telehealth consultations. On 08/27/25 at 03:00 PM, Administrative Nurse F stated the resident had been prescribed an antipsychotic and was unsure of the indications of use. Administrative Nurse F stated medication use was discussed at the monthly Pharmacy Therapeutics meetings, but had not received a recommendation related to the appropriate indication for the use of psychotropic medication from the pharmacist. The facility’s “Antipsychotic Drug Use” dated 03/06/25, documented that antipsychotic drug therapy would be used only when it is necessary to treat a specific condition. Antipsychotic medication should not be used for sedation or convenience. Antipsychotics should be used if one or more of the following is/are the only indications: wandering, poor self-care, restlessness, impaired memory, anxiety, depression (without psychotic features), insomnia, unsociability, indifference to surroundings, fidgeting, nervousness, uncooperativeness, or agitated behaviors which do not represent danger to the resident or others. - R18’s Electronic Medical Record (EMR) documented diagnoses of congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid), delusional disorders(untrue persistent belief or perception held by a person although evidence shows it was untrue), pain, anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), dementia (a progressive mental disorder characterized by failing memory and confusion) in other diseases classified elsewhere, and insomnia (inability to sleep). The “Quarterly Minimum Data Set” (MDS), dated [DATE], document R17 had moderately impaired cognition, disorganized thinking, which fluctuated, and rejection of care behavior occurred four to six days of the look-back period. The MDS further documented that R18 required substantial/maximal assistance with oral care and toileting hygiene. R18 was dependent on dressing, bathing, transfers, and wheelchair mobility. R18 received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), antidepressant (a class of medications used to treat mood disorders), and diuretic (a medication to promote the formation and excretion of urine). The antipsychotic was received regularly; no GDR with the physician documented that the GDR (GDR - tapering of a medication dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued) was contraindicated on 07/24/25. The “Psychotropic Medication Use Care Area Assessment” (CAA), dated 11/08/25, documented R18 had been refusing her medications and spat them out. Staff encouraged R18 to take her medications and drink fluids. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R18’s “Care Plan” dated 07/21/25, documented that R18 received antipsychotic medication related to anxiety and yelling out. The Care Plan directs staff to assess/record the effectiveness of drug treatment, divert the resident’s behavior by offering her favorite snack, give redirection when the resident is having behavior monitor for behavior, and respond to medication. The “Physician Order” dated 07/15/25, instructed staff to administer haloperidol (an antipsychotic) liquid concentrate two milligrams (mg), three times a day in a drink for anxiety disorder. The “Pharmacist Medication Regimen Review” dated 01/31/25, 02/28/25, 03/31/25, 04/29/25, 05/29/25, 06/29/25, and 07/28/25 lacked mention of the appropriate indication of use for antipsychotic medication for R18. The “Progress Note” dated 06/16/25 at 07:30 PM, documented R18 very weakly moved extremities, responded to verbal stimuli, but refused to speak until staff squeezed the resident’s hand, where the resident responded by saying ouch loudly. R18 nods and shakes her head slightly but refuses to open her eyes. Previous staff stated the resident had been acting lethargic since the resident had taken the ordered haloperidol. On 08/26/25 at 09:04 AM, R18 was brought back from breakfast in the dining room to her room in her wheelchair. R18 was slumped forward, with her eyes closed. The staff used a full-body lift to transfer the resident to her recliner, elevated the leg rests, used pillows on her right side for positioning aides, and covered the resident with a blanket. The door was left open, and the call light was attached to the blanket covering the resident. On 08/28/25 at 09:03 AM, Social Service X reported that the Licensed Master Social Worker (LMSW) was contracted, did not come to the facility, and reviewed the electronic charting. Social Service X reported she had not received guidance from the LMSW related to the behavioral aspects of the residents, and no mental health provider sees the resident in person or via telehealth consultations. On 08/27/25 at 03:00 PM, Administrative Nurse F stated the resident had been prescribed an antipsychotic and was unsure of the indications of use. Administrative Nurse F stated medication use was discussed at the monthly Pharmacy Therapeutics meetings, but had not received a recommendation related to the appropriate indication for the use of psychotropic medication from the pharmacist. The facility’s “Antipsychotic Drug Use” dated 03/06/25, documented that antipsychotic drug therapy would be used only when it is necessary to treat a specific condition. Antipsychotic medication should not be used for sedation or convenience. Antipsychotics should be used if one or more of the following is/are the only indications: wandering, poor self-care, restlessness, impaired memory, anxiety, depression (without psychotic features), insomnia, unsociability, indifference to surroundings, fidgeting, nervousness, uncooperativeness, or agitated behaviors which do not represent danger to the resident or others.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 22 residents. The sample included 12 residents, with two sampled residents reviewed for hospitalization. Based on observation, record review, and interview, the facility failed to ensure that Resident (R) 8 and R20 and their representative were provided a written notification of transfer upon the residents' transfer to the hospital. This placed R8 and R20 at risk of miscommunication between the facility and the resident's representative, and the possible missed opportunity for healthcare services.Findings included: - R8’s Electronic Medical Record (EMR) documented diagnoses of atrial fibrillation (rapid, irregular heartbeat), chronic kidney disease (the kidneys have mild to moderate damage and are less able to filter waste and fluid out of your blood), heart failure (when the heart cannot pump enough blood to meet the body’s needs), and chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). R8’s “Discharge Minimum Data Set (MDS)” dated 10/02/24 documented an unplanned discharge to an acute hospital with a return anticipated. R8’s “Entry MDS” dated 10/14/24 documented a re-entry to the facility from an acute hospital. R8’s “Annual MDS” dated 12/16/24 documented he had a Brief Interview for Mental Status (BIMS) score of 13, which indicated intact cognition. R8 was independent with his cares. The overall goal for R8 was to remain in the facility. No active discharge planning was occurring. R8’s “Discharge MDS” dated 05/21/25 documented an unplanned discharge to an acute hospital with a return anticipated. R8’s “Entry MDS” dated 05/29/25 documented a re-entry to the facility from an acute hospital. The facility provided R8 and his representative a bed hold for his hospitalization on 10/02/24 and 05/21/25. The facility lacked the required written notification of transfer, which included where and why R8 was transferred, and was provided to R8 and his representative upon his transfer to the hospital on [DATE] and 05/21/25. On 08/26/25 at 10:15 AM, R8 sat in his recliner in his room watching television. On 08/27/25 at 03:10 PM, Social Services X stated that when a resident was transferred out to the hospital, the bed hold was completed, and a progress note was entered about the resident's transfer. Social Services X stated that no written notification was provided to the resident or their representative, but the representative was notified by phone of the transfer. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy “Notice of Transfer/Discharge” dated 01/24 documented should it become necessary to transfer or discharge a resident from our facility, a representative of the administration would provide the resident and family member (representative/sponsor) with a written thirty (30) day advance notice of the transfer or discharge. A transfer or discharge notice would include the following: The reason for the transfer or discharge; the effective date of the transfer or discharge; The location to which the resident is transferred or discharged ; an explanation of the resident’s right to appeal the transfer or discharge to the State; and the name, address, and telephone number of the state long-term care ombudsman. The reason(s) for a transfer or discharge will be recorded in the resident’s clinical record. - R20's Electronic Medical Record (EMR) included diagnoses of disorientation, urinary tract infection (UTI- an infection in any part of the urinary system), diarrhea, diabetes mellitus(DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), heart failure, and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). R20’s “Minimum Data Set” (MDS) dated [DATE] recorded a discharge return anticipated. On 08/11/25, the MDS recorded an entry into the facility. The “Progress Note” dated 08/09/25 at 11:11 AM documented a telephone order received by the provider to transfer R20 to the hospital for admission related to sepsis from urinary tract infection. The “Progress Note” dated 08/11/25 at 01:02 PM documented that R20 was readmitted to the long-term care unit, via wheelchair. On 08/26/25 at 08:20 AM, R20 sat in her wheelchair, dressed and groomed appropriately for the day. On 08/27/25 at 11:00 AM, Administrative Nurse F reported for the transfer of a resident from the long-term care unit to the hospital. The nurse would call report to the hospital about the resident’s condition, send a face sheet, and a CCD (Continuity of Care Document). Administrative Nurse F stated the residents’ representative would be notified via phone or in person if at the facility at the time of discharge. No written form was given to the resident or the resident’s representative of the reason for the transfer. The facility’s “Emergency transfer/discharge”, policy dated 01/22/25, documented should it become necessary to make an emergency transfer or discharge to a hospital or other related institution, the facility will implement the following procedure of prepare the resident for transfer, a transfer form to be sent with the resident, notify the durable power of attorney or other family member, and other as appropriate or as necessary.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. (continued on next page)

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	17E445	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stanton County Health Care Facility Ltcu	404 N Chestnut Johnson, KS 67855

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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 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 22 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to provide Resident (R) 3, who had a mental disorder and adjustment difficulties, with treatment and services to attain the highest practical mental and psychosocial well-being.Findings included:- R3's Electronic Medical Record (EMR) included diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion) with other behavioral disturbance, urinary tract infection (UTI- an infection in any part of the urinary system), nausea with vomiting, major depressive disorder (major mood disorder that causes persistent feelings of sadness), dizziness, and giddiness.R3's Quarterly Minimum Data Set (MDS), dated [DATE], documented that R3 had severe cognitive impairment, had no signs or symptoms of delirium (sudden severe confusion, disorientation, and restlessness), psychosis (any major mental disorder characterized by a gross impairment in reality perception), or exhibited behaviors. R3 rejected care one to three days of the look-back period and wandered four to six days of the look-back period. R3 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). The MDS further documented that R3 received an antipsychotic on a routine basis and had a GDR on 03/28/25, and the physician documented a GDR as clinically contraindicated. R3 required substantial/maximal assistance with toileting hygiene, sit-to-standing transfers, bathing, and had occasional incontinence of urine and bowel. The Behavioral Symptoms Care Area Assessment (CAA), dated 03/19/25, documented that R3 would exhibit behaviors when staff attempted to assist her with toileting needs in the mornings, and staff were to leave R3 alone, even when incontinent in bed. The Psychotropic Medication Care Area Assessment (CAA), dated 03/19/25, documented that R3 had increased behaviors when staff attempted to assist her with activities of daily living due to R3 not being independent any longer and not understanding why staff needed to help her. R3's Care Plan dated 06/24/25 documented R3 had social behavioral symptoms as evidenced by dementia with cognitive loss. The Care Plan directed staff to avoid confrontation, not to argue with the resident, to keep their voice calm, modulated, and firm, and not to shout. The Care Plan documented expressed concern and desire to protect R3 from harm. The Care Plan directed staff to acknowledge the resident's power to make decisions when behavior begins, encouraging the resident to recall and share memories. The Care Plan documented R3 tried to call family and would become very upset and depressed when calls were returned. The Care Plan informed staff that R3 would act out and try to leave at times. The Care Plan directed staff to divert behaviors by providing activities and one-on-one interactions, administering medication, and monitoring and recording effectiveness. The Care Plan directed staff not to engage R3 in sensitive topics such as going home. The Care Plan directed staff to observe and report socially inappropriate/disruptive behaviors around others. The Care Plan lacked social services-specific interventions.The Physician Order dated 04/23/25, directed staff to administer quetiapine (an antipsychotic) 100 mg every evening due to increased behaviors for dementia with behavioral disturbance. The Psychoactive Medication Physician Progress Note dated 06/09/25 documented quetiapine 100 mg daily. Reduction is not clinically indicated for the following reasons: increased refusal of care, behavior issues, and combativeness despite alternative interventions.The Progress Notes dated 07/22/25 at 04:35 AM documented that R3 had refused assistance from staff throughout the shift, was increasingly agitated as R3 requested to call family so they might take her home. R3 had refused to go to bed until the family came. R3 began walking the halls with her walker before accepting assistance to go to bed. The progress notes further documented that five minutes later, the alarm activated, and R3 was observed to be cleaning urine from the floor. Staff offered a shower, but she refused, became agitated, sat in her recliner, and verbally ordered staff to leave. On 08/26/25 at 01:53 PM, R3 sat in her wheelchair in her room, holding a bible in her hands. R3 reported she was reading. On 08/27/25 at 01:20 PM, R3 sat at the activity room door, in her wheelchair. She greeted visitors pleasantly, and the activity staff invited R3 in to participate.On 08/28/25 at 09:03 AM, Social Service X reported that the Licensed Master Social Worker (LMSW) was contracted, did not come to the facility, and reviewed the electronic charting. Social Service X reported she had not received guidance from the LMSW related to the behavioral aspects of the residents, and no mental health provider sees the resident in person or via telehealth consultations. The facility's Social Services policy, dated 02/2024, documented that the director of social services is a qualified social worker and is responsible for the oversight of the social services

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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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. The facility identified a census of 22 residents. The sample included 12 residents, with five residents reviewed for dementia care. Based on observation, record review, and interview, the facility failed to ensure staff provided the necessary person-centered activities and interventions to address Resident (R) 11's dementia (a progressive mental disorder characterized by failing memory, confusion) diagnosis. This deficient practice placed R11 at risk of ineffective treatment and decreased quality of care.Findings included:- R11's Electronic Medical Record (EMR) documented diagnoses of dementia with psychotic disturbance (a condition characterized by cognitive decline accompanied by psychotic symptoms such as hallucinations and delusions), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), delirium (sudden severe confusion, disorientation, and restlessness), congestive heart disease (CHF- a condition with low heart output and the body becomes congested with fluid), and atrial fibrillation (rapid, irregular heart beat).R11's Annual Minimum Data Set (MDS) dated 08/08/25 documented she had a Brief Interview for Mental Status (BIMS) score of three, which indicated severely impaired cognition. R11 required partial/moderate assistance from staff for most activities of daily living (ADL). R11 required substantial staff assistance with bathing. R11 received an antipsychotic and an antidepressant medication regularly.R11's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 08/21/25 documented R11 had a slow cognitive decline due to dementia.R11's Psychotropic Drug Use Care CAA dated 08/21/25 documented R11 had episodes of agitation and restlessness. The CAA documented staff attempted to redirect the resident and focus attention on something else when she became agitated. R11's Care Plan, revised on 08/24/24 for dementia care and on 11/21/22 for activities, directed staff to be alert to triggers (specific triggers not listed) that would create negative behaviors or responses. The Care Plan directed staff to engage R11 in conversation that was meaningful to her (R11's interests not listed). The Care Plan directed staff that R11 was not at ease joining other residents in activities, and directed staff to ensure R11 attended two group activities per week and mingled with other residents and staff daily. The Care Plan directed staff to do one-on-one visitation with R11 at least daily.On 08/26/25 at 01:15 PM, R11 sat in her wheelchair in the TV area with other residents. R11 was sleeping with her head down toward her chest. On 08/26/25 at 01:45 PM, Administrative Nurse D stated that staff had been working on the care plans. Administrative Nurse D stated R11, as well as other residents' care plans, would be updated with person-centered interventions for dementia and activities.On 08/27/25 at 02:35 PM, Certified Nurse Aide (CNA) O stated that staff completed dementia training and education on Relias, but she had not received specialized training on behaviors specific to dementia. CNA O stated she would just sit and talk and listen to the residents. CNA O stated she did not think R11's care plan specified activities of interest to her or triggers that might cause behaviors.On 08/27/25 at 02:54 PM, Licensed Nurse (LN) F stated that R11's care plan did list some activities to do with her, but that the care plan was not specific and person-centered. LN F stated that staff had been working on the care plans. LN F stated she would start working with the administrative nursing staff to ensure residents with dementia had a more person-centered care plan.The facility lacked a dementia care policy.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** The facility had a census of 22 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported to the Director of Nursing and the Medical Director for Residents (R) 2, R3, R16, and R18 for the appropriate use of antipsychotics (a class of medications used to treat major mental conditions that cause a break from reality). The facility furtherly failed to ensure the CP identified and reported to the Director of Nursing and the Medical Director the missed vital signs required for R10 and R11's heart medications. This placed the residents at risk for inappropriate use of medications and unnecessary medications.Findings included: - R2’s Electronic Medical Record (EMR) documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion) with behavioral disturbance, major depressive disorder (major mood disorder that causes persistent feelings of sadness), pulmonary hypertension, and angina (chest pain). R2’s “Annual Minimum Data Set (MDS)” dated 12/29/24 documented she had a Brief Interview for Mental Status (BIMS) score of three, which indicated severely impaired cognition. R2 displayed physical and verbal behaviors directed toward others. R2 rejected care behavior during one to three days of the look-back period. R2 required substantial to maximal assistance from staff for her activities of daily living (ADL) care. R2 used a walker or a wheelchair to assist with mobility. R2 received an antipsychotic, an antianxiety (a class of medications that calm and relax people), and an antidepressant (a class of medications used to treat mood disorders). R2’s “Behavioral Care Area Assessment (CAA)” dated 01/13/25 documented that the resident often refused care. R2 would often refused ADL care and exhibited behaviors towards staff. She did not like taking a shower. Staff needed to explain the task at hand to her before they began. At times, it may take three to four attempts to complete tasks with R2, with periods in between, so she did not become agitated. R2’s “Care Plan,” last revised on 04/30/25, directed staff that she received an antipsychotic medication related to increased behaviors of yelling, hitting, cursing, and refusal of cares. The Care Plan documented R2 received Seroquel (an antipsychotic medication) to assist in improvement in the resident’s functional status. The Care Plan directed staff to explain to the resident what they were doing. The Care Plan directed staff to take time and be gentle with R2 to prevent her from becoming agitated. The Care Plan directed staff to assess and record the effectiveness of medication treatment. The Care Plan directed staff to monitor R2 for signs of sedation. The Care Plan directed staff to attempt a gradual dose reduction (GDR) yearly. R2’s “Orders” tab of the EMR documented an order dated 07/19/25 for Seroquel 200 milligrams (mg) daily for unspecified dementia with behavioral disturbance. R2’s “Orders” tab of the EMR documented an order dated 07/19/25 for quetiapine (antipsychotic- Seroquel) 100 mg at bedtime for major depressive disorder. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Consultant Pharmacist recommendations for R2 from January 2024 to July 2025 revealed no recommendations for an appropriate CMS indication for use for the antipsychotic Seroquel (quetiapine). A GDR had been recommended but declined by the physician due to R2’s increased behaviors. On 08/26/25 at 01:19 PM, Administrative Nurse D stated the facility had a monthly pharmacy and therapeutics meeting, which the pharmacist and physician was present, and a printout of antipsychotics and antibiotics was given to both the pharmacist and physician. Administrative Nurse D stated the Pharmacist did a monthly review, which was in the paper chart, but no report was sent to the physician. Administrative Nurse D stated the physician was to look the review and review it but did not sign off to ensure the monitoring or concerns of the pharmacist was followed. Administrative Nurse D stated the facility did not have the physician do a risk versus benefit rationale with the use of psychotropic medication, nor did the pharmacist report the CMS indication of use. Administrative Nurse D stated she assumed the physician and pharmacist knew the CMS's indications of use and the rationale for continued use of psychotropic medication use and documentation. The “Consulting Pharmacist” policy dated 01/28/25, documented the consultant pharmacist agreed to render the required service in accordance with local, state, and federal laws, regulations, and guidelines; facility policies and procedures; community standards of practice; and professional standards of practice. The consultant pharmacist provides pharmaceutical care services, including but not limited to the following: Checking the emergency medication supply at least monthly to ascertain that it is properly sealed and stored and that the contents are not outdated. Reviewing the medication regimen (drug regimen review) of each elder in the health center at least monthly, incorporating federally mandated standards of care in addition to other applicable professional standards, and documenting the review and findings in the elder’s clinical record. Communicating potential or actual problems detected related to medication therapy orders to the responsible physician and the Director of Nursing. Reviewing medication administration records and physician orders monthly at the facility to ensure proper documentation of medication orders and administration of medication to elders. The appropriate review was documented in the elder’s clinical record. Communicating to the responsible physician and the facility Director of Nursing, potential or actual problems detected, and other findings relating to medication therapy orders. Communicating recommendations for changes in medication therapy and monitoring of medication therapy. Submitting a written report of findings and recommendations resulting from the review of medication therapy documentation as described above. Assisting in the assessment and improvement in nursing staff medication administration through medication pass observation, as required by nursing and administration, and through medication record reviews. Working with the provider pharmacy to establish a system of records of receipt and disposition of all controlled substances that produces an accurate reconciliation and account of use on a periodic basis. Assisting in the accounting, destruction, and reconciliation of unused controlled substances and non-controlled substances as required by state and federal law. Assisting the Director of Nursing in setting standards and developing, implementing, and monitoring policies and procedures for the safe and effective distribution, control, and use of medications and related equipment and services in the facility. - R3’s Electronic Medical Record (EMR) included diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion) with other behavioral disturbance, urinary tract infection (UTI- an infection in any part of the urinary system), nausea with vomiting, major depressive disorder (major mood disorder that causes persistent feelings of sadness), dizziness, and giddiness. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R3’s “Quarterly Minimum Data Set” (MDS), dated [DATE], documented that R3 had severe cognitive impairment, had no signs or symptoms of delirium (sudden severe confusion, disorientation, and restlessness), psychosis (any major mental disorder characterized by a gross impairment in reality perception), or exhibited behaviors. R3 rejected care behavior one to three days of the look-back period and wandered four to six days of the look-back period. R3 received an antipsychotic and an antidepressant (a class of medications used to treat mood disorders). The MDS further documented that R3 received an antipsychotic on a routine basis and had a GDR on 03/28/25, and the physician documented a GDR as clinically contraindicated. R3 required substantial/maximal assistance with toileting hygiene, sit-to-standing transfers, bathing, and had occasional incontinence of urine and bowel. The “Behavioral Symptoms Care Area Assessment” (CAA), dated 03/19/25, documented that R3 would exhibit behaviors when staff attempted to assist her with toileting needs in the mornings and staff to leave R3 alone even when incontinent in bed. The “Psychotropic Medication Care Area Assessment” (CAA), dated 03/19/25, documented that R3 had increased behaviors when staff attempted to assist her with activities of daily living due to R3 not being independent any longer and not understanding why staff needed to help her. R3’s “Care Plan”, dated 06/24/25, documented that R3 received antipsychotic medication related to dementia and behaviors, and took quetiapine (antipsychotic) 100 milligrams (mg) at 03:00 PM. The Care Plan directed staff to redirect R3 by recalling her times as a Certified Nurse Aide (CNA), assess R3’s behavioral symptoms, and if they present a danger to the resident or others, and intervene as needed. The Care Plan further directed staff to assess/record R3’s functional status before initiation of drug use to serve as a baseline, monitor R3’s behaviors and responses to medications, and attempt a GDR quarterly. The “Physician Order” dated 04/23/25, directed staff to administer quetiapine 100 mg every evening due to increased behaviors for dementia with behavioral disturbance. The “Psychoactive Medication Physician Progress Note” dated 06/09/25 documented quetiapine 100 mg daily. Reduction is not clinically indicated for the following reasons: increased refusal of care, behavior issues, and combativeness despite alternative interventions. The “Pharmacist Medication Regimen Review” dated 01/31/25, 02/28/25, 03/31/25, 04/29/25, 05/29/25, 06/29/25, and 07/28/25 lacked mention of the appropriate indication of use for antipsychotic medication for R3. The “Progress Notes” dated 07/22/25 at 04:35 AM, documented that R3 had refused assistance from staff throughout the shift, was increasingly agitated as R3 requested to call family so they might take her home. R3 had refused to go to bed until the family came. R3 began walking the halls with her walker before accepting assistance to go to bed. The progress notes further documented that five minutes later, the alarm activated, and R3 was observed to be cleaning urine from the floor. Staff offered a shower, but she refused, became agitated, sat in her recliner, and verbally ordered staff to leave. On 08/26/25 at 01:53 PM, R3 was in her room, sitting in her wheelchair, with a bible in her hands. She reported she was reading. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/27/25 at 01:20 PM, R3 sat at the activity room door, in her wheelchair. She greeted visitors pleasantly, and the activity staff invited R3 in to participate. On 08/27/25 at 03:00 PM, Administrative Nurse F stated the resident had been prescribed an antipsychotic and was unsure of the indications of use. Administrative Nurse F stated medication use was discussed at the monthly Pharmacy Therapeutics meetings, but had not received a recommendation related to the appropriate indication for the use of psychotropic medication from the pharmacist. The facility’s “Consultant Pharmacist” policy, dated 01/28/25, documented that the consultant pharmacist agrees to render the required services in accordance with local, state, and federal laws, regulations, and guidelines, facility policies, and procedures. The consultant pharmacist provides pharmaceutical care services, including but not limited to reviewing the medication regimen (drug regimen review) of each elder in the health center at least monthly, incorporating federally mandated standards of care in addition to other applicable professional standards, and documenting the review and findings in the elder’s clinical record. Communicating potential or actual problems detected related to medication therapy or errors to the responsible physician and the Director of Nursing. Communicating with the responsible physician and the facility Director of Nursing about potential or actual problems detected and other findings related to medication therapy orders. Communicating recommendations for changes in medication therapy and monitoring of medication therapy. Submit a written report of findings and recommendations resulting from the review of medication therapy documentation as previously described above. - R16’s Electronic Medical Record (EMR) included diagnoses of major depressive disorder (major mood disorder that causes persistent feelings of sadness) with severe psychotic (any major mental disorder characterized by a gross impairment in reality perception) symptoms, Alzheimer’s disease (progressive mental deterioration characterized by confusion and memory failure), congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid), and pain. The “Quarterly Minimum Data Set” (MDS), dated [DATE], documented that R16 had moderately impaired cognition, had inattention and disorganized thinking, which fluctuated, and wandering behavior occurred daily. R16 required partial/moderate assistance with oral hygiene, showering, upper and lower body dressing, and toileting hygiene, and was independent with transfers and bed mobility. The MDS further documented that R16 received antipsychotics (a class of medications used to treat major mental conditions that cause a break from reality), antidepressants (a class of medications used to treat mood disorders), and which antipsychotics received on a routine basis. The physician documented a gradual dose reduction (GDR - tapering of a medication dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued) as clinically contraindicated on 03/27/25. R16’s “Care Plan” dated 06/26/25, documented that R16 received antipsychotic medication related to restlessness and agitation. Quetiapine (antipsychotic) 50 mg in the morning and quetiapine 100 milligrams (mg) every evening. The Care Plan directed staff to offer R16 to lie in bed to rest. Often, she was tired and restless, to make sure basic needs are met, offer the resident to look at pictures in her room, and monitor R16’s behavior and response to medications. The “Physician Order” dated 06/26/25, directed staff to administer quetiapine 100 mg every evening and quetiapine 50 mg in the morning. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The “Psychoactive Medication Physician Progress Note” dated 06/26/25, documented R16 quetiapine was not clinically indicated for the following reason, and no response was documented. The “Pharmacist Medication Regimen Review” dated 01/31/25, 02/28/25, 03/31/25, 04/29/25, 05/29/25, 06/29/25, and 07/28/25 lacked mention of the appropriate indication of use for antipsychotic medication for R16.The “Progress Note” dated 07/22/25 at 04:30 AM, documented R16 had bouts of tearfulness, but would calm down when staff would interact with the resident. R16 continued to wander throughout the early evening, and staff assisted R16 into her recliner multiple times. R16 rubbed the left leg and grimaced, and medication was given. R16 was assisted to bed around 09:00 PM. On 08/27/25 at 03:00 PM, Administrative Nurse F stated the resident had been prescribed an antipsychotic and was unsure of the indications of use. Administrative Nurse F stated medication use was discussed at the monthly Pharmacy Therapeutics meetings, but had not received a recommendation related to the appropriate indication for the use of psychotropic medication from the pharmacist. The facility’s “Consultant Pharmacist” policy, dated 01/28/25, documented that the consultant pharmacist agrees to render the required services in accordance with local, state, and federal laws, regulations, and guidelines, facility policies, and procedures. The consultant pharmacist provides pharmaceutical care services, including but not limited to reviewing the medication regimen (drug regimen review) of each elder in the health center at least monthly, incorporating federally mandated standards of care in addition to other applicable professional standards, and documenting the review and findings in the elder’s clinical record. Communicating potential or actual problems detected related to medication therapy or errors to the responsible physician and the Director of Nursing. Communicating with the responsible physician and the facility Director of Nursing about potential or actual problems detected and other findings related to medication therapy orders. Communicating recommendations for changes in medication therapy and monitoring of medication therapy. Submit a written report of findings and recommendations resulting from the review of medication therapy documentation as previously described above. - R18’s Electronic Medical Record (EMR) documented diagnoses of congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid), delusional disorders(untrue persistent belief or perception held by a person although evidence shows it was untrue), pain, anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), dementia (a progressive mental disorder characterized by failing memory and confusion) in other diseases classified elsewhere, and insomnia (inability to sleep). The “Quarterly Minimum Data Set” (MDS), dated [DATE], document R18 had moderately impaired cognition, disorganized thinking, which fluctuated, and rejection of care behavior occurred four to six days of the look-back period. The MDS further documented that R18 required substantial/maximal assistance with oral care and toileting hygiene. R18 was dependent on dressing, bathing, transfers, and wheelchair mobility. R18 received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), antidepressant (a class of medications used to treat mood disorders), and diuretic (a medication to promote the formation and excretion of urine). The antipsychotic was received regularly; no GDR with the physician documented that the GDR (GDR - tapering of a medication dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued) was contraindicated on 07/24/25. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The “Psychotropic Medication Use Care Area Assessment” (CAA), dated 11/08/24, documented R18 had been refusing her medications and spat them out. Staff encouraged R18 to take her medications and drink fluids. R18’s “Care Plan” dated 07/21/25, documented that R18 received antipsychotic medication related to anxiety and yelling out. The Care Plan directed staff to assess and record the effectiveness of drug treatment, divert the resident’s behavior by offering her favorite snack, give redirection when the resident is having behavior monitor for behavior, and respond to medication. The “Physician Order” dated 07/15/25, instructed staff to administer haloperidol (an antipsychotic) liquid concentrate two milligrams (mg), three times a day in a drink for anxiety disorder. The “Pharmacist Medication Regimen Review” dated 01/31/25, 02/28/25, 03/31/25, 04/29/25, 05/29/25, 06/29/25, and 07/28/25 lacked mention of the appropriate indication of use for antipsychotic medication for R18. The “Progress Note” dated 06/16/25 at 07:30 PM, documented R18 very weakly moved extremities, responded to verbal stimuli, but refused to speak until staff squeezed the resident’s hand, where the resident responded by saying ouch loudly. R18 nods and shakes her head slightly but refuses to open her eyes. Previous staff stated the resident had been acting lethargic since taking the ordered haloperidol. On 08/26/25 at 09:04 AM, R18 was brought back from breakfast in the dining room to her room in her wheelchair. R18 was slumped forward, with her eyes closed. The staff used a full-body lift to transfer the resident to her recliner, elevated the leg rests, used pillows on her right side for positioning aides, and covered the resident with a blanket. The door was left open, and the call light was attached to the blanket covering the resident. On 08/27/25 at 03:00 PM, Administrative Nurse F stated the resident had been prescribed an antipsychotic and was unsure of the indications of use. Administrative Nurse F stated medication use was discussed at the monthly Pharmacy Therapeutics meetings but had not received a recommendation related to the appropriate indication for the use of psychotropic medication from the pharmacist. The facility’s “Consultant Pharmacist” policy, dated 01/28/25, documented that the consultant pharmacist agrees to render the required services in accordance with local, state, and federal laws, regulations, and guidelines, facility policies, and procedures. The consultant pharmacist provides pharmaceutical care services, including but not limited to reviewing the medication regimen (drug regimen review) of each elder in the health center at least monthly, incorporating federally mandated standards of care in addition to other applicable professional standards, and documenting the review and findings in the elder’s clinical record. Communicating potential or actual problems detected related to medication therapy or errors to the responsible physician and the Director of Nursing. Communicating with the responsible physician and the facility Director of Nursing about potential or actual problems detected and other findings related to medication therapy orders. Communicating recommendations for changes in medication therapy and monitoring of medication therapy. Submit a written report of findings and recommendations resulting from the review of medication therapy documentation as previously described above. (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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- R10’s Electronic Medical Record (EMR) recorded diagnoses of pleural effusion (a condition where excess fluid accumulates in the thin cavity between the lungs and the chest wall), hypertension (HTN- elevated blood pressure), chronic respiratory failure with hypoxia (a condition where the lungs are unable to provide enough oxygen to the body over a prolonged period, leading to low oxygen levels in the blood), and chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). R10’s “Annual Minimum Data Set (MDS)” dated 08/15/25 documented a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. R10 was independent with most activities of daily living (ADL), but required partial moderate assistance with bathing. R10 used a walker and a wheelchair to assist in mobility. R10 received an antidepressant (a class of medications used to treat mood disorder), an anticoagulant (a class of medications used to prevent the blood from clotting), a diuretic (a class of medications used to prevent the blood from clotting), and an opioid (a class of controlled drugs used to treat pain) medication regularly. R10’s “Functional Abilities Care Area Assessment (CAA)” dated 08/26/25 documented R10 had weakness and respiratory COPD that made it difficult for her with some cares. However, R10 was independent most of the time. R10 used supplemental oxygen constantly. R10 was able to call for assistance when needed. R10’s “Care Plan” last revised on 04/08/25, directed staff to monitor the pulse, blood pressure, and orthostatic (measurements of blood pressure and pulse taken with the patient in the supine, sitting, and standing positions to assess low blood pressure and possible blood pooling in the lower extremities resulting in dizziness) blood pressure. The Care Plan directed staff to report any signs and symptoms of adverse side effects to the provider. R10’s EMR “Orders” tab recorded an order, dated 09/02/24, for metoprolol succinate (an extended-release, beta-blocker used to treat high blood pressure) 50 milligrams (mg) orally once daily for atrial fibrillation (rapid, irregular heartbeat). R10’s EMR “Orders” tab recorded an order, dated 09/02/24, to notify the physician for systolic blood pressure (SBP- top number, the force your heart exerts on the walls of your arteries each time it beats) greater than 180 or less than 100 on two consecutive readings or a heart rate greater than 120 or less than 50. Review of R10’s May 2025 “Medication Administration Record (MAR)” revealed R10’s blood pressure and pulse had not been documented before administration of her physician-ordered metoprolol on 31 of 31 occasions. Review of R10’s June 2025 “MAR” revealed R10’s blood pressure and pulse had not been documented before administration of her physician-ordered metoprolol on 30 of 30 occasions. Review of R10’s July 2025 “MAR” revealed R10’s blood pressure and pulse had not been documented before administration of her physician-ordered metoprolol on 31 of 31 occasions. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R10’s August 2025 “MAR” revealed R10’s blood pressure and pulse had not been documented before administration of her physician-ordered metoprolol on 26 of 26 occasions. Review of the Consultant Pharmacist's written recommendations from January 2024 to July 2025 revealed the recommendations lacked a recommendation for blood pressure or pulse monitoring before the administration of R10’s metoprolol. On 08/26/25 at 01:19 PM, Administrative Nurse D stated the facility had a monthly pharmacy and therapeutics meeting, which the pharmacist and physician were present. Administrative Nurse D stated the Pharmacist did a monthly review, which was in the paper chart, but no report was sent to the physician. Administrative Nurse D stated the physician was to look at the review and respond to the review, but did not sign off to ensure the monitoring or concerns of the pharmacist were followed. The “Consulting Pharmacist” policy dated 01/28/25, documented the consultant pharmacist agrees to render the required service in accordance with local, state, and federal laws, regulations, and guidelines; facility policies and procedures; community standards of practice; and professional standards of practice. The consultant pharmacist provides pharmaceutical care services, including but not limited to the following: Checking the emergency medication supply at least monthly to ascertain that it is properly sealed and stored and that the contents are not outdated. Reviewing the medication regimen (drug regimen review) of each elder in health center at least monthly, incorporating federally mandated standards of care in addition to other applicable professional standards, and documenting the review and findings in the elder’s clinical record. Communicating potential or actual problems detected related to medication therapy orders to the responsible physician and the Director of Nursing. Reviewing medication administration records and physician orders monthly at the facility to ensure proper documentation of medication orders and administration of medication to elders. The appropriate review was documented in the elder’s clinical record. Communicating to the responsible physician and the facility Director of Nursing, potential or actual problems detected and other findings relating to medication therapy orders. Communicating recommendations for changes in medication therapy and monitoring of medication therapy. Submit a written report of findings and recommendations resulting from the review of medication therapy documentation as described above. Assisting in the assessment and improvement in nursing staff medication administration through medication pass observation, as required by nursing and administration, and through medication record reviews. Working with the provider pharmacy to establish a system of records of receipt and disposition of all controlled substances that produces an accurate reconciliation and account of use periodically. Assisting in the accounting, destruction, and reconciliation of unused controlled substances and non-controlled substances as required by state and federal law. Assisting the Director of Nursing in setting standards and developing, implementing, and monitoring policies and procedures for the safe and effective distribution, control, and use of medications and related equipment and services in the facility. - R11’s Electronic Medical Record (EMR) documented diagnoses of dementia with psychotic disturbance (a condition characterized by cognitive decline accompanied by psychotic symptoms such as hallucinations and delusions), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), delirium (sudden severe confusion, disorientation, and restlessness), congestive heart disease (CHF- a condition with low heart output and the body becomes congested with fluid), and atrial fibrillation (rapid, irregular heartbeat). (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R11’s “Annual Minimum Data Set (MDS)” dated 08/08/25 documented she had a Brief Interview for Mental Status (BIMS) score of three, which indicated severely impaired cognition. R11 required partial/moderate assistance from staff for most activities of daily living (ADL). R11 required substantial staff assistance with bathing. R11 received an antipsychotic and an antidepressant medication regularly. R11’s “Cognitive Loss/Dementia Care Area Assessment (CAA)” dated 08/21/25 documented R11 had a slow cognitive decline due to dementia. R11’s “Psychotropic Drug Use Care CAA” dated 08/21/25 documented R11 had episodes of agitation and restlessness. Staff attempted to redirect the resident and focus attention on something else when she became agitated. R11’s “Care Plan,” last revised 04/15/25, directed staff to give medications as directed. R11’s “Care Plan” lacked staff direction on her digoxin (a medication used to treat CHF and heart rhythm problems) or her carvedilol (a beta-blocker). R11’s “Orders” tab documented an order dated 01/10/24 for digoxin 125 micrograms (mcg) by mouth daily for atrial fibrillation. This order was discontinued on 05/01/25. R11’s “Orders” tab documented an order dated 05/01/25 for digoxin 125 mcg (0.125 mg) tablet to administer 0.625 mg by mouth daily for atrial fibrillation. Review of R11’s May 2025 “Medication Administration Record (MAR)” revealed that R11’s pulse rate was not obtained before the administration of digoxin on 31of 31 opportunities. R11’s blood pressure was not obtained before the administration of her carvedilol on 31 of 31 opportunities. Review of R11’s June 2025 “MAR” revealed that R11’s pulse rate was not obtained before the administration of digoxin on 30 of 30 opportunities. Review of R11’s July 2025 “MAR” revealed that R11’s pulse rate was not obtained before the administration of digoxin on 31of 31 opportunities. Review of R11’s August 2025 “MAR” revealed that R11’s pulse rate was not obtained before the administration of digoxin on 27of 27 opportunities. Review of the Consultant Pharmacist’s MRR lacked a recommendation for pulse monitoring for digoxin use. On 08/26/25 at 01:19 PM, Administrative Nurse D stated the facility had a monthly pharmacy and therapeutics meeting, which the pharmacist and physician were present. Administrative Nurse D stated the Pharmacist did a monthly review, which was in

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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. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility had a census of 22 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to identify the missed vital signs required for R10 metoprolol succinate (an extended-release, beta-blocker used to treat high blood pressure) medication and R11's digoxin (a medication used to treat CHF and heart rhythm problems) medication. This placed the residents at risk for unnecessary medications.Findings included:- R10's Electronic Medical Record (EMR) recorded diagnoses of pleural effusion (a condition where excess fluid accumulates in the thin cavity between the lungs and the chest wall), hypertension (HTN- elevated blood pressure), chronic respiratory failure with hypoxia (a condition where the lungs are unable to provide enough oxygen to the body over a prolonged period, leading to low oxygen levels in the blood), and chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing).R10's Annual Minimum Data Set (MDS) dated 08/15/25 documented a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. R10 was independent with most activities of daily living (ADL) cares but required partial moderate assistance with bathing. R10 used a walker and a wheelchair to assist in mobility. R10 received an antidepressant (a class of medications used to treat mood disorders), an anticoagulant (a class of medications sued to prevent the blood from clotting), a diuretic (a class of medications used to prevent the blood from clotting), and an opioid (a class of controlled drugs used to treat pain) medication regularly.R10's Functional Abilities Care Area Assessment (CAA) dated 08/26/25 documented R10 had weakness and respiratory COPD that made it difficult for her with some cares. However, R10 was independent most of the time. R10 used supplemental oxygen constantly. R10 was able to call for assistance when needed.R10's Care Plan last revised on 04/08/25, directed staff to monitor the pulse, blood pressure, and orthostatic (measurements of blood pressure and pulse taken with the patient in the supine, sitting, and standing positions to assess low blood pressure and possible blood pooling in the lower extremities resulting in dizziness) blood pressure. The Care Plan directed staff to report any signs and symptoms of adverse side effects to the provider.R10's EMR Orders tab recorded an order, dated 09/02/24, for metoprolol succinate 50 milligrams (mg) orally once daily for atrial fibrillation (rapid, irregular heartbeat). R10's EMR Orders tab recorded an order, dated 09/02/24, to notify the physician for systolic blood pressure (SBP- top number, the force your heart exerts on the walls of your arteries each time it beats) greater than 180 or less than 100 on two consecutive readings or a heart rate greater than 120 or less than 50.Review of R10's May 2025 Medication Administration Record (MAR) revealed R10's blood pressure and pulse had not been documented before administration of her physician-ordered metoprolol on 31 of 31 occasions.Review of R10's June 2025 MAR revealed R10's blood pressure and pulse had not been documented before administration of her physician-ordered metoprolol on 30 of 30 occasions.Review of R10's July 2025 MAR revealed R10's blood pressure and pulse had not been documented before administration of her physician-ordered metoprolol on 31 of 31 occasions.Review of R10's August 2025 MAR revealed R10's blood pressure and pulse had not been documented before administration of her physician-ordered metoprolol on 26 of 26 occasions.On 08/26/25 at 01:19 PM, Administrative Nurse D stated the physician did not monitor the pulse or blood pressure of every resident who was on an antihypertensive medication. Administrative Nurse D stated that all residents did get weekly vital signs taken, but not daily. Administrative Nurse D assumed the physician was aware of what medications required monitoring of the blood pressure or pulse according to the federal regulations, but could not be certain.The facility lacked a policy regarding unnecessary medications. - R11's Electronic Medical Record (EMR) documented diagnoses of dementia with psychotic disturbance (a condition characterized by cognitive decline accompanied by psychotic symptoms such as hallucinations and delusions), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), delirium (sudden severe confusion, disorientation, and restlessness), congestive heart disease (CHF- a condition with low heart output and the body becomes congested with fluid), and atrial fibrillation (rapid, irregular heartbeat).R11's Annual Minimum Data Set (MDS) dated 08/08/25 documented she had a Brief Interview for Mental Status (BIMS) score of three, which indicated severely impaired cognition. R11 required partial/moderate assistance from staff for most activities of daily living (ADL). R11 required substantial staff assistance with bathing. R11 received an antipsychotic and an antidepressant medication regularly.R11's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 08/21/25 documented R11 had a slow cognitive decline due to dementia R11's Psychotropic Drug Use Care

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. The facility had a census of 22 residents. The Sample included 12 residents. Based on observation, record review, and interview, the facility failed to store drugs and biologicals for Resident (R) 4 according to policy in the medication cart. This placed the resident at risk for an ineffective medication regimen.Findings included:- On 08/25/25 at 02:08 PM, during the medication room tour, the medication cart labeled with R4's name contained a Lantus insulin pen without a name or date the insulin pen was put into use. Licensed Nurse (LN) G verified that the insulin pen should have a label with R4's name and the date it was put into use.The facility's Medication Storage policy, dated 01/28/25, documented that no outdated or deteriorated medications are available for use in the facility. All such medications are destroyed. Drug containers having solid, illegible, worn, makeshift, incomplete, damaged, or missing labels will be returned to the pharmacy for proper labeling before storage.

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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. The facility had a census of 22 residents and one kitchen. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to employ a full-time Certified Dietary Manager for 22 residents who reside in the facility and received their meals from the kitchen. This placed the residents at risk of not receiving adequate nutrition.Findings included:- On 08/25/25 at 10:45 AM, Dietary staff preparing for the noon meal, Dietary Staff (DS) BB present in the kitchen. DS BB identified herself as the Dietary Manager, was enrolled in a Dietary Manager Certification course, but had not yet finished the course. DS BB reported that the Registered Dietitian came to the facility monthly.The facility's Dietitian policy, dated 01/2025, documented that a qualified dietitian would help oversee clinical nutritional dietary services in the facility. A dietitian's qualification shall be based upon: Registration by the Commission on Dietetic Registration of the American Dietetic Association, or demonstrated education, training, or experience in the identification of dietary needs, planning, and implementation of dietary programs.

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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 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 had a census of 22 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to implement Enhanced Barrier Precautions (EBP- infection control interventions designed to reduce transmission of resistant organisms, which employ targeted gown and glove use during high contact care) for Resident (R) 1, who had an indwelling urinary catheter (tube placed in the bladder to drain urine into a collection bag) and shared use of a full body lift sling. This deficient practice placed the residents who reside in the facility at risk of infectious disease processes.Findings included:- R1's Electronic Medical Record (EMR), documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), urinary tract infection (UTI- an infection in any part of the urinary system), right thigh blister, neuromuscular dysfunction of the bladder(the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying), edema(swelling resulting from an excessive accumulation of fluid in the body tissues), acute cystitis (inflammation of the bladder) with hematuria (blood in the urine), and chronic pain.R1's Quarterly Minimum Data Set dated 07/11/25, documented that R1 had severe cognitive impairment, an altered level of consciousness that fluctuated, and had not exhibited behaviors. R1 was dependent on staff for all functional abilities and mobility. The MDS further documented that R1 had an indwelling catheter and was frequently incontinent of bowel. R1 also received an antibiotic (a class of medications used to treat infections).R1's Care Plan dated 07/14/25, documented R1 had a risk for healthcare-acquired infections due to a medical device, as evidenced by an indwelling catheter. The Care Plan directed staff to change the catheter monthly, drain the catheter bag every shift, as needed, and continue to adhere to other infection prevention measures. The Care Plan directed gowns and gloves were to be used during high-contact activities with increased risk for Multidrug-resistant organisms (MDRO- common bacteria that have developed resistance to multiple types of antibiotics) transmission, during dressing, bathing, transfers, providing hygiene, changing briefs, and assisting with toileting.The Physician Order dated 07/23/24, directed staff to implement Enhanced Barrier Precautions.The Physician Order dated 07/03/25, directed staff to change the catheter monthly, using sterile technique.The Progress Note dated 08/15/25 at 11:34 AM, documented two blisters with one intact and one open under the catheter secure adhesive.The Progress Note dated 08/17/25, documented R1's brief was wet, the catheter was advanced, and ten milliliters of sterile saline were used to inflate the balloon. On 08/26/25 at 09:36 AM, Certified Nurse Aide (CNA) M and CNA N took R1 to her room and donned disposable gloves and gowns. Staff utilized a full-body mechanical lift to transfer R1 from her wheelchair to the toilet, pulling the brief loose, and sat R1 on the toilet. CNA M and CNA N provided R1 with toileting hygiene, reattached the brief, and then placed R1 in bed. Once finished with positioning the resident, CNA M took the lift and sling out of the room. CNA M reported the sling used with R1 was also utilized for two other residents. On 08/27/25 at 10:14 AM, Administrative Nurse E reported the facility should purchase a sling lift for single use of R1, who had an indwelling catheter.The facility's Enhanced Barrier Precautions policy, dated 03/27/25, documented that the facility follows recommendations and guidance from the Centers for Disease Control in order to keep residents as safe from Healthcare Acquired Infections (HAI). Multidrug-resistant organism (MDRO) transmission is common in nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs. Enhanced Barrier Precautions (EBP) are implemented as one intervention this facility uses to reduce transmission of resistant organisms, which employs targeted Personal Protective Equipment (PPE) use during high-contact resident care activities. Standard Precautions continue to apply to the care of all residents, regardless of suspected or confirmed infection or colonization status.