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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E577	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anderson County Hospital Ltcu	421 S Maple Street Garnett, KS 66032

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. 45668 The facility identified a census of 27 residents. The sample included 12 residents. Based on observation, record review, and interviews, the facility failed to provide direct, interactive activities based on resident preferences for the residents on weekends. This deficient practice placed the affected residents at risk for decreased psychosocial well-being, boredom, and isolation. Findings Included: - A review of the facility's Activity Calendars for December 2024, January 2025, and February 2025 was completed. The calendars revealed religious services provided at 09:00 AM and 03:15 PM for Saturdays but lacked staff-led activities. The calendars revealed a devotional group was held at 09:00 AM on Sundays. The calendar revealed the residents were provided music and coloring pages on Sundays but lacked staff-led activity groups. The council reported the weekends were sometimes slow without activities. On 02/11/25 at 10:30 AM, the facility provided manicures for the residents. On 02/12/25 at 11:40 AM, the facility's Resident Counsel reported that staff-led activities rarely occurred on weekends. The council reported that the facility's previous Activity Coordinator (AC) quit in December 2024. The council reported that the facility provided religious activities on Saturdays and Sundays but lacked staff-led activities. On 02/13/25 at 12:01 PM, the Certified Nurse's Aide (CNA) M stated that the facility staff completed activities on weekdays but was not sure what activities were available on weekends outside of church services. She stated that the facility provided coloring pages, board games, and puzzles that the residents could complete on their own but was not sure of any staff-led activities. On 02/13/25 at 12:16 PM, Licensed Nurse (LN) G stated the facility provided puzzles and games for the residents on the weekends. On 02/13/25 at 12:30 PM, Administrative Nurse D stated the facility provided religious services on weekends. She stated the residents could play board games, puzzles, and self-led activities. She stated she was not sure of any staff-led activities outside of church services on the weekends. (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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	17E577	A. Building B. Wing	02/13/2025

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Activities Evaluation policy (undated) indicated the facility would provide ongoing individualized and group activities that promote goals, strengths, and social, and emotional support for each resident. The facility failed to provide consistent activities on the weekends which reflected the residents' interests and preferences. This deficient practice placed the affected residents at risk for boredom, isolation, and decreased quality of life.

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	17E577	A. Building B. Wing	02/13/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 45668 The facility had a census of 27 residents. The sample included 12 residents, with two reviewed for accidents. Based on observation, record review, and interview, the facility failed to secure 15 pressurized medical oxygen tanks in a safe, locked area, and out of reach of the nine cognitively impaired independently mobile residents. This deficient practice placed the residents at risk for preventable accidents and injuries. Findings Included: - On 02/11/25 at 07:20 AM, an inspection of the facility's oxygen storage room revealed that the door was not secured. An inspection of the room revealed 15 full supplemental oxygen cylinders in the storage rack. The door closed and locked upon exit. On 02/13/25 at 08:22 AM the facility identified it had nine cognitively impaired independently mobile residents. On 02/13/25 at 12:01 PM, Certified Nurse's Aide (CNA) M stated the room was to be locked at all times due to the oxygen tanks. She stated the door had an electronic lock and staff were to ensure the door was fully closed and locked upon exiting the room. On 02/13/25 at 12:30 PM, Administrative Nurse D stated staff were expected to ensure the door was locked upon entering and exiting the room. The facility's Medical Gas Usage and Storage policy revised 02/2025 stated all pressurized containers and potentially hazardous medical equipment will be locked within a secure temperature-controlled room. The facility failed to secure 15 pressurized medical oxygen tanks in a safe, locked area, and out of reach of the nine cognitively impaired independently mobile residents. This deficient practice placed the residents at risk for preventable accidents and injuries.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility identified a census of 27 residents. The sample included 12 residents, with one reviewed for dementia (a progressive mental disorder characterized by failing memory, and confusion) care. Based on interviews, record reviews, and observations, the facility failed to provide dementia-related care services for Resident (R) 10 to promote the resident's highest practicable level of well-being. This deficient practice placed R10 at risk for decreased quality of life, isolation, and impaired dignity. Findings Included: - The Medical Diagnosis section within R10's Electronic Medical Records (EMR) included diagnoses of Parkinson's Disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), generalized weakness, dementia, chronic heart failure, hypertension (high blood pressure), and osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain) in both knees. R10's Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of seven. The score indicated severe cognitive impairment. The MDS indicated he required substantial staff assistance for dressing, personal hygiene, bathing, bed mobility, toileting, and transfers. The MDS noted he was frequently incontinent of bowel and bladder. R10's Functional Abilities Care Area Assessment (CAA) completed 06/13/24 revealed he required assistance from staff to complete his activities of daily living (ADL). The CAA indicated he required two staff and a Sit-to-Stand lift for all transfers. The CAA noted a care plan was developed to minimize his risks. R10's Dementia CAA completed 06/13/24 revealed he was at risk for cognitive loss due to his medical diagnoses. The plan instructed staff to allow him time to communicate his needs and process his thoughts. R10's Care Plan initiated 05/29/23 revealed he had required assistance and supervision with his ADLs. The plan noted he used a manual wheelchair and could propel himself. The plan noted he had dementia and Parkinson's disease but was alert and oriented and could make his needs known. The plan noted he had difficulty hearing and wore hearing aids. The plan instructed staff to give him time to process his thoughts. The plan noted he had a history of falls. The plan noted he had difficulty during mealtimes and required a plate guard for meals. The plan noted he did not like scrambled eggs but preferred hard-fried eggs. The plan lacked interventions related to his wandering and sun-downing (a condition where a person tends to become confused or disoriented toward the end of the day) behaviors. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/12/25 at 02:45 PM, R10 sat in his wheelchair in the dining room. R10 was confused and kept repeating Where's the visitor parking lot as he wheeled himself around the dining and television area. R10 continually circled the room asking other residents and staff Where's the visitor's lot and stated, he needed to leave. R10 was not offered activities or interventions for his sun-downing behaviors. Staff only pointed to the parking lot and did not attempt to reorient him during this episode. On 02/13/25 at 08:40 AM, R10 sat for breakfast at the dining room table. R10's plate had a large amount of scrambled eggs. R10's plate had no plate guard on it, but his silverware had adapted silverware for easy gripping. R10 received no assistance during his meals and continually yelled out Down we go as he looked at his food. At 10:10 AM, R10 remained in the same spot at the dining room table. The dining room was empty. His food remained un-eaten, and his water glass was spilled over the right side of his wheelchair onto the floor. R10's scrambled eggs remained untouched. R10 attempted multiple times to reposition his wheelchair to leave the table but his wheelchair was stuck on the table's leg. R10 indicated he did not like scrambled eggs when asked about his breakfast. At 10:28 AM, staff came into the dining room from the nurse's station and repositioned his wheelchair so he could move. R10 wheeled himself towards the center hall and sat. R10 fell asleep in his wheelchair until lunch service. On 02/13/25 at 11:20 AM, R10 was moved back to his dining room spot. R10 provided his lunch meal with no plate guard in place. R10 was given adaptive silverware. On 02/13/25 at 12:01 PM, the Certified Nurse's Aide (CNA) M stated that R10 enjoyed watching television. She stated his family provided him with a television streaming service device on his room's television. She stated that R10 has not had wandering or sundowning behaviors recently. She stated staff should attempt to reorient him and provide activities for him to prevent behaviors or disruptions. She stated staff were to help during meals and check in with him to see if he needed anything. She stated that R10 was able to wheel himself around the facility. On 02/13/25 at 12:16 PM, Licensed Nurse (LN) G stated staff was expected to provide activities for him, take him on walks, and visit with him. She stated that R10 should not be left alone during mealtimes or allowed to exhibit sundowning behaviors without staff attempting to assist him. On 02/13/25 at 12:30 PM, Administrative Nurse D stated that R10 had not displayed sundowning behaviors in a while. She stated staff were expected to engage in conversation and activities with him. She stated staff should reorient him to his surroundings and prevent behaviors from occurring. The facility's Person-Centered Dementia Care policy (undated) revealed the facility was to provide dementia-related services designed to focus on the resident's abilities and provide memory enhancement. The policy noted each resident would be provided specialized activities, nutrition, and environmental modifications. The facility failed to provide dementia-related care services for R10 to promote the resident's highest practicable level of well-being. This deficient practice placed R10 at risk for decreased quality of life, isolation, and impaired dignity.

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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** 41037 The facility identified a census of 27 residents. The sample included 12 residents, with five residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure the Consultant Pharmacist (CP) recommendations were acknowledged and/or acted upon for Resident (R) 2, R20, and R25. The facility failed to ensure the CP identified and reported the non-approved indication for R10's antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication. These deficient practices placed the residents at risk for unnecessary medication use and physical complications. Findings included: - R2's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of dementia (a progressive mental disorder characterized by failing memory), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest and confusion), and short-term memory loss. The Significant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of six which indicated severely impaired cognition. The MDS documented R2 had received an antidepressant (a class of medications used to treat mood disorders) medication, a diuretic (a medication to promote the formation and excretion of urine), and an opioid (a class of controlled drugs used to treat pain). The MDS lacked indication of physician documentation that a gradual dose reduction was clinically contraindicated for R2. The MDS lacked documentation a drug regimen review was completed during the observation period for R2. The Quarterly MDS dated [DATE] documented a BIMS score of 99 which indicated severely impaired cognition. The MDS documented that R2 had received an antidepressant medication, an antianxiety (a class of medications that calm and relax people) medication, a diuretic, and an opioid. The MDS lacked indication of physician documentation that a gradual dose reduction was clinically contraindicated for R2. The MDS lacked documentation a drug regimen review was completed during the observation period for R2. R2's Psychotropic Drug Use Care Area Assessment (CAA) dated 04/23/24 documented she currently took Zoloft (antidepressant) 50 milligrams (mg) daily. R2's Care Plan dated 10/28/24 documented she would not experience adverse effects related to medications. R2's EMR under the Orders tab revealed the following physician orders: Sertraline (Zoloft) tablet 100 mg, one tablet, daily for anxiety with depression dated 09/19/24. Review of R2's EMR under the Notes tab revealed a Pharmacy Review note dated 03/28/24 at 01:32 PM documented the recommendation pending. The facility provided an unaddressed and unsigned Monthly Medication Review (MMR) dated 03/28/24 upon request. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/11/25 at 03:30 PM, R2 walked with her walker in the hallway to the common area by the front entrance door. On 02/13/25 at 12:04 PM, Licensed Nurse (LN) G stated she made changes for any new medication orders on the MRRs when they were returned from the physician's office. On 02/13/25 at 12:26 PM, Administrative Nurse D stated the CP would email the MMRs to her, and she printed them from the email. Administrative Nurse D stated she would fax the MMRs to the resident's physician for a response. Administrative Nurse D stated if the physician failed to respond to the MMRs, the facility's medical director was responsible for following up on the unaddressed MMR. Administrative Nurse D stated if there was no response from the physician or medical director, she was not sure what the next plan of action was. The facility's Medication Regimen Review policy last revised 02/01/24 documented the purpose of this policy was to minimize or prevent adverse consequences by identifying irregularities including syndromes potentially related to medication therapy, emerging or existing adverse medication consequences, as well as the potential for adverse drug reactions, and medication errors. Medication Regimen Review (MRR) consists of the pharmacist reviewing each resident's medication regimen including psychotropic drugs and review of the resident's medical chart at least once a month in order to identify irregularities; and to identify clinically significant risks and/or adverse consequences resulting from or associated with medications. It may be necessary for the pharmacist to conduct the MRR more frequently, for example weekly, depending on the resident's condition and the risks for adverse consequences related to current medications. Findings and recommendations are reported to the Director of Nursing and the attending physician. The facility failed to ensure the physician reviewed and addressed the CP recommendations for R2. This deficient practice placed R2 at risk for unnecessary medication use, side effects, and physical complications. - R20's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), cognitive impairment, and diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin). The Significant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of six which indicated severely impaired cognition. The MDS documented R20 had received a hyperglycemic (medication that raises blood sugar levels) medication, an opioid (a class of controlled drugs used to treat pain) medication, a diuretic (a medication to promote the formation and excretion of urine) medication, an anticoagulant (a class of medications sued to prevent the blood from clotting) medication, an antidepressant (a class of medications used to treat mood disorders) medication, and an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication. The MDS lacked indication of physician documentation that a gradual dose reduction was clinically contraindicated for R20. The MDS lacked documentation a drug regimen review was completed during the observation period for R20. R20's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 12/31/24 documented she had a diagnosis of Alzheimer's disease and a recent functional decline following a fall at home. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R20's Care Plan dated 01/01/25 documented she would refuse her medication at times. The plan of care documented R20 would pocket her medication in her mouth at times. R20's EMR under the Orders tab revealed the following physician orders: Quetiapine (antipsychotic) (Seroquel) tablet 25 milligrams (mg) give one tablet by mouth daily for generalized anxiety dated 12/18/24. Review of R20's EMR under the Notes tab revealed a Pharmacy Review note dated 05/24/24 at 12:14 PM documented the recommendation pending. The facility provided an unaddressed and unsigned Monthly Medication Review (MMR) dated 05/24/24 upon request. On 02/12/25 at 03:09 PM, R20 sat at the dining room table and had her fingernails painted by the nursing staff. On 02/13/25 at 12:04 PM, Licensed Nurse (LN) G stated she made changes for any new medication orders on the MRRs when they were returned from the physician's office. On 02/13/25 at 12:26 PM, Administrative Nurse D stated the CP would email the MMRs to her, and she printed them from the email. Administrative Nurse D stated she would fax the MMRs to the resident's physician for a response. Administrative Nurse D stated if the physician failed to respond to the MMRs, the facility's medical director was responsible for following up on the unaddressed MMR. Administrative Nurse D stated if there was no response from the physician or medical director, she was not sure what the next plan of action was. The facility's Medication Regimen Review policy last revised 02/01/24 documented the purpose of this policy was to minimize or prevent adverse consequences by identifying irregularities including syndromes potentially related to medication therapy, emerging or existing adverse medication consequences, as well as the potential for adverse drug reactions, and medication errors. Medication Regimen Review (MRR) consists of the pharmacist reviewing each resident's medication regimen including psychotropic drugs and review of the resident's medical chart at least once a month in order to identify irregularities; and to identify clinically significant risks and/or adverse consequences resulting from or associated with medications. It may be necessary for the pharmacist to conduct the MRR more frequently, for example weekly, depending on the resident's condition and the risks for adverse consequences related to current medications. Findings and recommendations are reported to the Director of Nursing and the attending physician. The facility failed to ensure the physician reviewed and addressed the CP recommendations for R2. This deficient practice placed R2 at risk for unnecessary medication use, side effects, and physical complications. 49634 - R25's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of hypertension (high blood pressure), dementia (a progressive mental disorder characterized by failing memory and confusion), seizure (violent involuntary series of contractions of a group of muscles), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and hypothyroidism (a condition characterized by decreased activity of the thyroid gland). (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of three which indicated severely impaired cognition. The MDS documented R25 was independent with oral hygiene and eating but required supervision or touching assistance for bathing, dressing, and toileting The MDS documented R25 exhibited no behaviors. The MDS documented R25 took an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication during the observation period. The Admissions MDS dated [DATE] documented a BIMS of three which indicated severely impaired cognition. The MDS documented R25 was independent with eating and required supervision or touching for oral hygiene and dressing. The MDS documented R25 took an antianxiety (a class of medications that calm and relax people) medication during the look back period. R25's Behavioral Symptoms Care Area Assessment (CAA) dated 05/08/24 documented R25's was admitted to long term care on 5/6/24. R25 had a diagnosis of dementia and currently took Namenda (dementia medication). R25 also had a diagnosis of anxiety and had orders for Xanax (antianxiety medication) as needed (PRN). R25 had been tearful and sad at times since her admission. She scored a one on her MDS mood interview as she voiced, she was just occasionally (2-6 days) sad during the lookback period. R25's Care Plan dated 05/08/24 documented she had a Black Box Warning (BBW - highest safety-related warning that medications can have assigned by the Food and Drug Administration), R25 took an antipsychotic, and her first appointment with the physician would be the week after her admission. R25's EMR under the Orders tab documented: Seroquel (antipsychotic medication) 25 milligrams (mg) give 0.5mg tablet by mouth nightly for anxiety disorder dated 05/10/24. R25's Consultant Pharmacist Recommendation to Physician dated 11/27/24 documented the physician to assess R25's Seroquel (Quetiapine) for a potential gradual dose reduction (GDR). R25's Physician/Prescriber response dated 12/11/24 documented the physician agreed and would assess a dose reduction at R25's next appointment. R25's medical record lacked documentation that the physician had addressed R25's Quetiapine. On 02/12/25 at 09:33 AM, R25 sat at the breakfast table, talking to peers. On 02/13/25 at 09:24 AM, R25 sat in the day room, looking at the puzzle pieces. On 02/13/25 at 12:04 PM, Licensed Nurse (LN) G stated she made changes for any new medication orders on the MRRs when they returned from the physician's office. On 02/13/25 at 12:26 PM, Administrative Nurse D stated the Consult Pharmacist (CP) would email the MMRs to her, and she printed them from the email. Administrative Nurse D stated she would fax the MMRs to the resident's physician for a response. Administrative Nurse D stated if the physician did not respond to the MMRs, the facility's medical director was responsible for following up on the unaddressed MMR. Administrative Nurse D stated if there was no response from the physician or medical director, she was not sure what was the next plan of action. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Medication Regimen Review policy last revised 02/01/24 documented the purpose of this policy was to minimize or prevent adverse consequences by identifying irregularities including syndromes potentially related to medication therapy, emerging or existing adverse medication consequences, as well as the potential for adverse drug reactions, and medication errors. Medication Regimen Review (MRR) consists of the pharmacist reviewing each resident's medication regimen including psychotropic drugs and review of the resident's medical chart at least once a month to identify irregularities; and to identify clinically significant risks and/or adverse consequences resulting from or associated with medications. It may be necessary for the pharmacist to conduct the MRR more frequently, for example weekly, depending on the resident's condition and the risks for adverse consequences related to current medications. Findings and recommendations are reported to the Director of Nursing and the attending physician. The facility failed to ensure the physician addressed the CP recommendations for R25. This deficient practice placed R25 at risk for unnecessary medication use, side effects, and physical complications. 45668 - The Medical Diagnosis section within R10's Electronic Medical Records (EMR) included diagnoses of Parkinson's Disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), generalized weakness, dementia (a progressive mental disorder characterized by failing memory and confusion), chronic heart failure, hypertension (high blood pressure), and osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain) in both knees. R10's Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of seven. The score indicated severe cognitive impairment. The MDS indicated he required substantial staff assistance for dressing, personal hygiene, bathing, bed mobility, toileting, and transfers. The MDS noted she took an antipsychotic medication (a class of medications used to treat major mental conditions that cause a break from reality) on a routine basis. R10's Psychotropic (alters mood or thought) Medication Care Area Assessment (CAA) completed 06/18/24 revealed he was at risk for adverse side effects and complications related to his psychotropic medication. The CAA noted he took antipsychotic medications. The CAA noted a care plan was developed to minimize his risks. R10's Care Plan initiated 05/29/23 revealed he took antipsychotic medications. The plan noted his medications had a Black Box Warning (BBW - high-risk medications with potential adverse effects). R10's EMR under Physician's Orders revealed an active order (dated 12/23/24) for staff to administer 2.5 milligrams (mg) of Olanzapine (an antipsychotic medication) by mouth daily with dinner. The order revealed the antipsychotic medication was given for dementia. R10's EMR indicated he had been on Olanzapine since 02/28/24. A review of R10's Monthly Medication Reviews (MMR) from 02/01/24 through 02/01/25 revealed no recommendations from the Consulting Pharmacist (CP) to review the appropriate indication for the use of R10's antipsychotic medication. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/13/25 at 07:45 AM, R10 took his morning medications without behaviors or issues. On 02/13/25 at 12:16 AM, Licensed Nurse (LN) G stated antipsychotic medications were to be used for potentially violent residents or aggressive behaviors. She stated they were not to be used for dementia-related behaviors. She stated dementia was not an accepted indication for Olanzapine. She stated the pharmacy reviewed each resident's orders and should have made recommendations. On 02/13/25 at 12:30 PM, Administrative Nurse D stated she was not sure if antipsychotics were used for dementia but stated the facility would use the medication for aggressive behaviors. She stated the medical director was responsible for reviewing the monthly pharmacy recommendations. The facility's Medication Regimen Review policy revised 02/2024 indicated the consulting pharmacist was to complete monthly medication reviews to identify irregularities to minimize the risks of medication errors and adverse drug reactions. The policy revealed the consulting pharmacist would make recommendations to the facility's medical provider and director of nursing. The facility's CP failed to identify and report an inappropriate indication for R10's Olanzapine medication. This placed R10 s at risk for unnecessary psychotropic medications and related complications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E577	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER: Anderson County Hospital Ltcu		STREET ADDRESS, CITY, STATE, ZIP CODE: 421 S Maple Street Garnett, KS 66032	

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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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 49634 The facility identified a census of 27 residents. The sample included 12 residents, with two residents reviewed for hospice. Based on observation, record review, and interviews, the facility failed to ensure a coordinated plan of care, which coordinated care and services provided by the facility with the care and services provided by hospice, was developed and available for Resident (R) 22. This placed the resident at risk for inappropriate end-of-life care. Finding Included: - R22's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of assistance with personal needs, urinary retention, diabetes mellitus (when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), sinus tachycardia(normal rhythm, heart beating too fast), dysphagia (swallowing difficulty), and anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues). The Significant Change in Status Minimum Data Set (MDS) for R22 dated 11/26/24 recorded a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. The MDS documented R22 was independent in oral hygiene, and eating, and needed staff touching or verbal cues for bathing and toileting. The MDS documented R43 received hospice services during the observation period. The Admission MDS for R22 dated 02/16/24 documented a BIMS of eight which indicated a modernly impaired cognition. The MDS documented R22 required substantial to maximum assistance for toileting, bathing, and oral hygiene. The MDS documented R22 was continent during the lookback period. R22's Activities of Daily Living (ADLs) - Functional status/Rehabilitation Potential Care Area Assessment (CAA) dated 11/26/24 documented R22 was admitted to long-term care from the local hospital for generalized weakness. R22 needed the assistance of one for transfers, ambulation, and daily care. The CAA documented R22 received Physical and occupational therapy due to generalized weakness. R22's Care Plan dated 11/19/24 documented R22 had a do not resuscitate code status and was receiving hospice services. R22's plan of care documented if R22 needed any specific supplies, the facility should reach out to hospice. R22's plan of care documented hospice would assist with R22's pain management and communicate with R22's physician. A review of the hospice-provided communication binder revealed R22 was admitted to hospice services on 10/31/24. On 02/11/24 at 11:44 AM, R22 sat at the dining room table visiting with peers. On 12/12/24 at 02:42 AM, R22 sat at the dining room table visiting with peers. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E577	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/13/24 at 11:53 AM, Certified Nursing Aide (CNA) M stated all staff had access to the resident's care plans. CNA M stated she was unsure if all supplies should be put in the resident's care plan, she stated hospice had everything the residents were receiving and when the aides and nurses came in to provide services in the hospice care plan. CNA M stated all staff could always look in the hospice binder. On 02/13/24 at 12:04 PM, Licensed Nurse (LN) G stated all residents on hospice services have a binder. LN G stated if she could not find the information in the resident's care plan, she could look in the resident's hospice binder. LN G stated oxygen and wheelchairs should be care planned. On 02/13/24 at 12:29 PM, Administrated Nurse D stated the resident's care plan should state what was provided by hospice, what equipment, what supplies, and when the hospice staff would be in the building. Administrative Nurse D stated all the supplies and equipment provided could be found in the hospice's binder. The facility failed to provide a policy related to hospice services as requested on 02/13/25. The facility failed to ensure a coordinated plan of care, which coordinated care and services provided by the facility with the care and services provided by hospice, was developed and available for R22. This deficient practice placed the resident at risk for inappropriate end-of-life care.

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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 - Some	Provide and implement an infection prevention and control program. 49634 The facility identified a census of 27 residents. The facility identified four residents on Enhanced Barrier Precautions (EBP - infection control interventions designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact care). Based on record reviews, observations, and interviews, the facility failed to implement adequate hand hygiene. This deficient practice placed the residents at risk for infectious diseases. Findings included: - On 02/11/25 at 08:33 AM, Certified Nurse Aide (CMA) R failed to perform hand hygiene and donned a pair of gloves, CMA R removed R10's hearing aids from the medication cart. CMA R changed the battery in one hearing aid. CMA R placed R10's hearing aids in each ear at the dining room table. CMA R doffed her gloves and failed to perform hand hygiene. CMA R pushed R10 into an area across from the dining room. CMA R failed to perform hand hygiene and donned a pair of gloves from her uniform pocket. CMA R then administered R10's inhalation medication by assisting R10 with one puff into each nostril. CMA R failed to perform hand hygiene or change gloves. CMA R then instilled R10's eye drops, she held R10's eye open and then instilled one eye drop into each eye. On 02/13/24 at 12:29 PM, Administrated Nurse D stated staff were expected to complete hand hygiene before, during, and after touching the residents. She stated staff were expected to complete hand hygiene in between glove changes and changing personal protective equipment (PPE). The Infection Prevention and Control policy revised 02/12/2025 documented the facility's health system shall establish and maintain an infection prevention and control plan including the appropriate policies and procedures for surveillance, prevention, and control of infection that reflect the hospital's mission statement. The facility was dedicated to minimizing infection risks to prevent infections in patients, personnel, volunteers, and visitors. The facility would ensure the infection prevention and control program was managed effectively: represents relevant components and functions with the hospital to implement the infection prevention and control programs to reduce, eliminate, or prevent healthcare-acquired infections and ensure that hospital leaders allocate adequate resources for the implantation and education of the infection prevention program. The facility failed to implement adequate hand hygiene. This deficient practice placed the residents at risk for infectious diseases.