STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E619	A. Building B. Wing	09/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Russell Regional Hospital Ltcu	200 S Main Street Russell, KS 67665

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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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. The facility had a census of 19 residents. Based on record review and interview, the facility failed to submit complete and accurate staffing information through the Payroll Based Journal (PBJ) as required. Findings included:- The PBJ report provided by the Centers for Medicare & Medicaid Services (CMS) for Fiscal Year (FY) 2025 Quarter (Q) 1 indicated no RN hours for 31 days for October 2024, 30 days for November 2024, and 31 days for December 2024.The PBJ report for FY 2025 Q2 recorded the facility failed to submit data for the quarter.The PBJ report for FY 2025 Q3 recorded the facility failed to submit data for the quarter.The PBJ report for FY 2024 Q4 recorded the facility failed to submit data for the quarter.Review of the facility licensed nurse and registered nurse data for the dates above for Q1 revealed that a licensed nurse was on duty for 24 hours a day, seven days a week, and a registered nurse was on duty at least 8 hours of the day, seven days a week. The staffing data further documented that adequate staffing was provided on the weekends of the above quarters.On 09/14/25 at 09:00 AM, Administrative Staff A stated that he did not realize there was still a problem with the PBJ, as he had thought they had fixed the problem.On 09/16/25 at 05:48 PM, Administrative Nurse D stated the coordinator was responsible for sending in the PBJ information. The facility utilized the internal clocking system for the employees to generate a report, and for agency staff, their time was reported and then submitted. Upon request, a policy for PBJ was not provided by the facility.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly The facility had a census of 19 residents. The sample included eight residents. Based on observation, record review, and interview, the facility failed to ensure the Medical Director attended the Quality Assessment and Assurance (QAA) Committee meetings at least quarterly as required.Findings included:- The facility provided QAA committee attendance dates of 09/25/24, 10/30/24, 11/27/24, 12/18/24, 01/29/25, 02/26/25, 03/26/25, 04/30/25, 05/28/25, 06/25/25, 07/30/25, and 08/28/25. The documentation lacked evidence that the medical director attended any of the meetings.On 09/16/25 at 02:30 PM, Administrative Staff B stated that since she had taken over the QAA position in March, the Medical Director had not attended any of the meetings. Administrative Staff B stated that she organized and ran all the meetings and that they work on performance improvement regarding information brought forth by staff, and if they find a problem, they make it their project to work on.On 09/16/25 at 03:00 PM, Administrative Staff A stated the Medical Director did not attend every meeting, but thought he had at least quarterly, but would need to look at his notes to make sure.On 09/17/25 at 01:39 AM, Administrative Staff A verified the Medical Director had not attended any of the QAA meetings for the last year.The facility's Quality Assurance and Performance Improvement Plan (QAPI), dated 09/13/23, documented that QAPI consisted of two mutually reinforcing aspects of a quality management system: Quality Assurance (QA) and Performance Improvement (PI). The facility would maintain and improve safety and quality while involving all departments in practical and creative problem-solving. The QAPI program would ensure a consistent focus on the delivery of health care and responsive customer service. The Quality Manager would be responsible for organizing QAPI meetings, at least quarterly, collecting and organizing data and quality reports from each department and service. Data would be collected from a variety of sources and reported to the appropriate regulatory and quality improvement entities. The Quality Manager would ensure that the quality efforts are focused and effective by: ongoing monitoring and data collection, problem prevention, identification, and data analysis, Identification of corrective actions, evaluation of corrective actions, and measures to improve quality continuously.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. The facility had a census of 19 residents. The sample included eight residents. Based on observation, record review, and interview, the facility failed to implement a water management program for Legionella disease (Legionella is a bacterium spread through mist, such as from air-conditioning units for large buildings. Adults over the age of 50 and people with weak immune systems, chronic lung disease, or heavy tobacco use are most at risk of developing a pneumonia caused by Legionella). Findings Included:- On 09/16/25 at 09:20 AM, Maintenance Staff U stated the last maintenance supervisor was no longer with the facility and the facility was unable to locate or retrieve the information regarding the legionella water testing or water management regarding if or when it had been completed, and the testing results. Maintenance Staff U had the information material when the facility implemented a policy for the water management; however, it lacked documentation the process was completed.On 09/16/25 at 02:00 PM, Administrative Staff A verified the facility was unable to find the information on the Legionella policy or the book that maintenance staff had documented the water management for Legionella's. Upon request, the facility failed to provide a policy for Legionella disease prevention and maintenance.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. The facility had a census of 19 residents. Based on record review and interview, the facility failed to ensure the staff member designated as the Infection Preventionist, who was responsible for the facility's Infection Prevention and Control Program, completed the specialized training in infection prevention and control. Findings included: - On 09/15/25 at 04:30 PM, Administrative Nurse D stated she was responsible for the Infection Prevention and Control Program, but lacked certification as an Infection Preventionist. Administrative Nurse D stated the facility had an Infection Preventionist a few months ago, but they had resigned. The facility has been unable to fill the position, and she assumed the job and lacked certification.The facility's Infection Preventionist (IP) policy, dated 08/2024, documented the Infection Control Preventionist would assist the Director of Nursing to ensure that administration, management, and clinical services are properly controlling the spread of infection throughout the facility. The IP would maintain surveillance of the infection of both residents and employees. The IP would comply with all regulations and licensing standards, develop and maintain departmental policies and procedures to interpret them to personnel, residents, medical staff, and the public. The IP would maintain accurate records, report and statistical data regarding services provided, and perform a continual needs analysis and assessment of the Infection Control Department. The IP would develop and implement an ongoing quality assurance program for the Infection Control Department under the supervision of the Director of Nursing and have the ability to maintain correct and continuous identification of all residents.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 19 residents. The sample included eight residents, with five reviewed for unnecessary medications. Based on observations, interviews, and record review, the facility failed to ensure an appropriate indication, or a documented physician rationale, which included the unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the continued use of Resident (R) 7's antipsychotic (a medication used to treat any major mental disorder characterized by a gross impairment testing) medication. Findings include: - R7's Electronic Medical Record (EMR) recorded diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), major depressive disorder (major mood disorder that causes persistent feelings of sadness), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and normal pressure hydrocephalus (excess cerebrospinal (a clear, colorless fluid that surrounds and protects the brain and spinal cord) fluid builds up in the ventricles, leading to normal or slightly elevated cerebrospinal fluid pressure). R7's Quarterly Minimum Data Set (MDS), dated [DATE], recorded R7 had severely impaired cognition. The MDS recorded R7 required staff assistance with most activities of daily living (ADL). The MDS recorded the resident was inattentive and had disorganized thinking and received antipsychotic medication during the observation period.The Psychotropic Drug Use Care Area Assessment (CAA), dated 07/30/25, recorded R7 received antipsychotic medication and had dementia, delirium (sudden severe confusion, disorientation, and restlessness), and depression diagnoses.R7's Care Plan, dated 07/16/25, recorded R7 was at risk for increased behaviors and other adverse effects, including delirium related to a diagnosis of dementia with a history of psychosis with delusional disorder, normal pressure hydrocephalus, restless and agitation, depression, anxiety, and taking medication with black box warnings. The care plan documented staff would consult the provider for psychiatric medication use and the pharmacist for dose reductions. The care plan documented the nurse would assess the resident, and staff would report any behaviors, adverse reactions, or side effects of medications.The Physician's Order, initial order date 07/12/25, directed the staff to administer Seroquel (antipsychotic) 50 milligrams (mg), one tablet, three times a day for diagnosis of normal pressure hydrocephalus.R7's EMR lacked a documented physician rationale, which included the unsuccessful attempts for nonpharmacological symptom management and a risk versus benefits statement for the Seroquel use.On 09/15/25 at 09:00 AM, observation revealed R7 sat in a wheelchair, dressed in street clothes and nicely groomed, in her room. Continued observation revealed Certified Medication Aide (CMA) R administered the residents' morning medication, including the Seroquel. On 09/16/25 at 10:00 AM, Administrative Nurse D verified the resident received Seroquel, with a diagnosis of normal pressure hydrocephalus. Administrative Nurse D verified the diagnosis was inappropriate for the medication and would contact the provider for the appropriate diagnosis for the medication and certify that medication. The facility's Psychotropic Medication Use in Residents policy, dated 05/18/23, documented the facility would administer psychotropic medications appropriately, working with an interdisciplinary team to ensure appropriate use, evaluation, and monitoring. The facility would make every effort to comply with State and Federal regulations related to the use of psychopharmacological medications in the facility, include regular review for continued need, appropriate dosage, side effects, risk, and/or benefits. The facility supports the appropriate use of psychotropic medications that are therapeutic and enabling for the residents suffering from mental illness, while recognizing that the use of psychopharmacologic medications for dementia-related behaviors is inappropriate in most cases, but rather the use of non-pharmacological interventions based on individual resident needs, preferences, and routines is the most appropriate and first-line (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	treatment for dementia-related behaviors. The attending physician must have a qualifying diagnosis for the medication and certify a psychotropic medication was necessary to treat a specific condition/behavior. All antipsychotics would be tapered as a gradual dose reduction unless clinically contraindicated.

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. The facility had a census of 19 residents. Based on observation, record review, and interview, the facility failed to provide background checks for three Certified Nurse Aides (CNA), who had been employed with the facility since 2023 and 2024. Findings included: - Review of the background checks revealed the facility failed to complete a background check for CNA P, hired on 03/07/23, CNA Q, hired on 08/08/23, and CNA MM, hired on 02/13/24.The Nursing Schedule, dated 09/15/25, documented CNA MM was scheduled as a bath aide for the Long-Term Care Unit.On 09/15/25 at 11:06 AM, CNA MM assisted R1 with her shower.On 09/15/25 at 01:26 PM, Administrative Staff A stated he had checked the CNAs' files and was unable to find that a background check had been completed before the CNAs were hired.On 09/16/25 at 01:45 PM, Administrative Staff C stated that prior to anyone being hired, the person was sent a letter of intent to hire. If they accepted the position, they were asked to fill out information so that they could run a background check. Administrative Staff C further stated that she was unable to find a background check for the three CNAs, and it was decided that they would run background checks for all staff to make sure there were not any others that were missed.On 09/16/25 at 02:00 PM, Administrative Nurse D stated all staff should have a background check completed before hire, and had not had any concerns with the three CNAs who had not had a background check.The facility's Suspected Abuse, Neglect, and Exploitation policy, dated 09/13/23, documented that all applicants for employment shall, at a minimum, have the following screening checks conducted.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 18 residents. The sample included eight residents, with three reviewed for abuse. Based on observation, record review, and interview, the facility failed to ensure staff investigated potential allegations of abuse, including injuries of unknown origin, and report to the administrator immediately to investigate the allegation. Findings included: - R2's Electronic Medical Record (EMR) documented the resident had diagnoses of peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel), hypertension (HTN- elevated blood pressure), and gastroesophageal reflux (GERD- backflow of stomach contents to the esophagus).R2's Quarterly Minimum Data Set (MDS) dated [DATE], recorded R2 had a Brief Interview for Mental Status (BIMS) of 11, indicating moderately impaired cognition. The MDS recorded R2 was dependent on staff for most activities of daily living (ADL). The MDS recorded R2 required substantial staff assistance with transfers and used a wheelchair for mobility.The Braden (a standardized assessment tool to assess and document a resident's risk for pressure ulcers) Assessment, dated 06/09/25, recorded a score of 18, indicating R2 was at risk for pressure ulcers.R2's Care Plan, dated 06/25/25, directed two staff to assist with all transfers, and the resident used a wheelchair for locomotion. The care plan documented that the bed would be in the lowest position while occupied. R2's care plan directed staff to monitor the resident for pain and intervene as warranted/ordered. The care plan directed staff would provide reality orientation when she exhibited signs and symptoms of confusion. The care plan documented R2 had half rails to assist with bed mobility, and staff would observe for injury or entrapment related to the side rail usage.The Nurses Note, dated 05/11/25 at 05:50 AM, documented R2 had a dark purple discoloration to the right forearm; no reports of pain or discomfort were noted, and the resident did not know how it occurred.The Nurses Notes, dated 05/14/25 at 07:07 AM, documented R2 had an area approximately 4 inches by 4 inches with a dark purple center with yellowing edges. The resident denies pain and even exhibited so by gripping it and stating, 'It never hurt.The Nurses Notes, dated 05/15/25 at 10:20 AM, documented R2's bruising continued to fade on the right forearm. The Nurses Notes, dated 05/17/25 at 05:21 PM, documented R2's purple discoloration to her forearm was fading, denied pain, and was able to use her arm freely.R2's EHR lacked any investigative notes regarding the incident, including witness statements, root cause, or investigation.On 09/14/25 at 12:00 PM, observation revealed the resident sat in the living room in a wheelchair, dressed in street clothes.On 09/16/24 at 10:00 AM, Administrative Nurse D stated the medical records documented the resident had a discoloration/bruise on the right forearm on 05/11/25. Administrative Nurse D was unaware of how the injuries occurred and verified that the facility did not investigate or gather witness statements, and they would with this type of occurrence. The facility's Injury of Unknown Origin policy, dated 06/21/19, documented the facility would ensure the resident was not in danger of misconduct when an injury of unknown source was discovered. It is the responsibility of the Director of the facility, Chief Executive Officer, Risk Manager, and the facility Board Chair to approve the policy. An injury to the resident should be classified as an injury of unknown source when both of the following conditions are met: the source of the injury was not observed by any person, or the source of the injury could not be explained by the resident or staff, and the injury is suspicious because of the extent of the injury or the location of the injury (the injury is located I an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or incidents of injuries over time. At the time the injury is discovered, it is not known how the resident hurt themselves; caregiver misconduct cannot be ruled out. All incidents of unknown source must be reported immediately to the director of the facility or the nurse on call. The director or charge nurse on duty at the time must ensure that the resident/residents are not in danger of subsequent incidents of injury or misconduct. The risk manager or social service staff would initiate an internal investigation and take whatever steps are necessary to ensure residents are (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	protected while a determination of the matter is pending. An internal investigation would determine what, if anything, happened. The resident's guardian or Durable Power of Attorney (DPOA) would be notified. The risk manager or social service would document the results of the investigation and report the results within five working days of the incident, if deemed appropriate. Any incident in which a crime may have occurred would be forwarded to the appropriate law enforcement agency. Failure to report incidents may result in immediate termination of employment.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 19 residents. The sample included eight residents, with four reviewed for accidents. Based on observation, record review, and interview, the facility failed to implement individualized person-centered interventions to prevent falls for one resident, Resident (R) 3, after a fall. Findings included:- The Electronic Medical Record (EMR) for R3 documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), major depressive disorder (major mood disorder that causes persistent feelings of sadness), and hypertension (high blood pressure).The Quarterly Minimum Data Set (MDS), dated [DATE], documented R3 had long and short-term memory problems and moderately impaired decision-making skills. The MDS documented R3 was dependent upon staff for toileting hygiene, showers, dressing, and personal hygiene. The MDS further documented R3 required substantial staff assistance for mobility, transfers, and ambulation. The MDS documented R3 had upper and lower extremity functional impairment on both sides, was frequently incontinent of bladder and bowel, and had one fall with injury.R3's Care Plan dated 08/17/25, initiated on 11/26/24, directed staff to assist her to and from activities as needed with her wheelchair/ambulation as tolerated, and monitor for increased falls. The update, dated 04/16/25, directed staff to toilet R3 frequently throughout the day. The update, dated 05/28/25, directed staff to walk to dine with R3 with a walker and the wheelchair to follow. The care plan lacked resident-centered interventions to prevent further falls.The EMR lacked documentation of a Fall Risk Assessment (an assessment that identifies older adults who are likely to fall by evaluating their health, medications, environment, and functional abilities) that was completed for R3 before or after her fall.The Facility Incident Report dated 05/17/25 at 04:00 PM, documented that a Certified Nurse Aide (CNA) walked R3 with her walker out of the bathroom. R3 lost her balance and started to fall, when the CNA turned to toss a laundry bag she carried to the floor. The CNA lowered her to the floor as R3 hit the nightstand. The report further documented R3 sustained three skin tears to her right elbow and one skin tear to her left elbow. The skin tears on her right elbow measured #1- 1 centimeter (cm), #2- 0.5 cm, and #3- 1 cm in length. The left elbow measured 4 cm in length x 0.5 cm width. The skin tears were cleansed, steri-strips (adhesive wound closures) applied, and covered with a Telfa (non-stick gauze) dressing and wrapped with Kling (a type of conforming stretch gauze bandage). The report documented the CNA should not multitask while ambulating with a resident.On 06/15/25 at 08:30 AM, CNA M placed a gait belt around R3's waist and placed the walker in front of her. R3 stood up as CNA M held onto the gait belt. CNA O walked behind R3 with the wheelchair. CNA M stated R3 was a fall risk and had a few falls. CNA M further stated that R3 would try to get up on her own, so they checked her frequently.On 09/16/25 at 12:45 PM, Licensed Nurse (LN) G stated R3 was a risk for falls, and two staff members were with her when she ambulated. R3 was on a restorative walk to dine plan and had been working with therapy. LN G stated that one staff member should not walk with R3, and she would make sure she updated the care plan with interventions to prevent further falls.On 09/16/25 at 01:30 PM, Administrative Nurse D stated that the care plan should be updated with fall interventions to prevent further falls. The facility's Resident Assessment-Comprehensive policy, dated 05/18/23, documented that the clinical record contained information about the resident's care, treatment, and services needed to provide continuity of care among providers. The policy further documented that the nursing plan of care would be implemented on admission and reviewed for any needed changes. The plan of care must be based on the resident's comprehensive assessment, as the Minimum Data Set (MDS) would trigger all elements that need to be addressed in the resident's plan of care.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 19 residents. The sample included eight residents. Based on observation, record review, and interview, the facility failed to complete a physical assessment on Resident (R) 1, who displayed signs of choking during the supper meal.Findings included:- The Electronic Medical Record (EMR) for R3 documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), major depressive disorder (major mood disorder that causes persistent feelings of sadness), and hypertension (high blood pressure).The Quarterly Minimum Data Set (MDS), dated [DATE], documented R3 had severely impaired cognition. R3 required setup assistance for eating and oral hygiene. The MDS further documented R3 had no functional limitation in range of motion and required a mechanically altered diet.R3's Care Plan dated 08/17/25, initiated on 11/26/24, directed staff to monitor food and fluid intake for meals, offer and encourage fluids and snacks, and provide direct supervision at mealtimes. The care plan documented R3 had swallowing issues and required a drinkable pureed (food that is blended, ground, or strained to a soft, smooth, uniform texture) diet. The update, dated 04/04/25, directed staff to provide a regular diet, liquidized texture, nectar thick (thicker than water but thinner than honey), mildly thick diet.The facility's Incident Report dated 03/09/25 at 05:00 PM, documented Certified Nurse Aide (CNA) N noticed R3 at the dinner table and looked to be drooling (excessive accumulation or unintentional loss of saliva from the mouth). CNA N reported this to Licensed Nurse (LN) H. LN H looked at R3 and asked her to take a drink of her milk and then put food into R3's mouth. CNA N documented LN H stated R3 was fine and walked to another area of the dining room. CNA N documented R3 continued to drool and had a blank stare. CNA N donned (put on) gloves, went over to R3, and asked her a question, to which R3 grunted. CNA N told R3 to spit out the food that was in her mouth, and R3 was unable to. CNA N documented she put her finger into R3's mouth to help get the food out. CNA N documented she did this multiple times until R3's mouth was empty, and documented LN H stood by and did not assist her.Review of R3's EMR lacked documentation that a physical assessment of the resident had been completed after the incident or continued concern. The facility's Initial Investigation Report, dated 03/09/25, documented Administrative Nurse D watched the video and observed LN H attempt to give R3 more to drink when R3 was already drooling. LN H wiped R3's mouth, then moved the drink in front of the resident. LN H left the resident and proceeded to clean off more items on a different dining room table. Administrative Nurse D then observed CNA N donning gloves, bending down, and CNA N asked R3 to open her mouth. CNA N then proceeded to finger sweep and pulled out multiple chunks of food from her mouth. Administrative Nurse D then observed LN H leaning against a cabinet and did not assist CNA N. On 09/15/25 at 11:41 AM, R3 sat at the dining table with her drink in front of her. R3 was able to drink independently, and staff sat down with her to cue and encourage her to eat her meal that had been given to her in several different cups. R3 did not have any episodes of drooling and did not appear to be holding food in her mouth.On 09/15/25 at 12:49 PM, CNA N stated she saw R3 did not look right, appeared to be drooling, and went and got the nurse on duty. CNA N stated that LN H put more food into R3's mouth. LN H told her that there was nothing wrong with her. CNA N stated she put gloves on and put her finger into R3's mouth, which she knows she should not have, knelt on the floor, and pulled out handfuls of food. CNA N further stated LN H just stood there and watched her. CNA N stated R3's voice sounded raspy but otherwise did not have any further problems after that and reported it to the nurse who came on duty.On 09/15/25 at 01:01 PM, Administrative Staff B stated she was a CNA but was also the Quality Assurance Director. Administrative Staff F stated she had sent this incident to the state agency and also to the State Board of Nursing. Administrative Staff B further stated that the video was difficult to see what had happened, but could see that LN H did not assist CNA N. Administrative Staff B further stated R3 did not appear to be in distress, and LN H no (continued on next page)

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	17E619	A. Building B. Wing	09/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Russell Regional Hospital Ltcu	200 S Main Street Russell, KS 67665

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	longer worked at the facility. Administrative Staff B stated the investigation was closed.On 09/16/25 at 12:45 PM, LN G stated R3 required supervision and cuing with her meals. LN G further stated that she was not aware of any time R3 choked on her food or had concerns with drooling.On 09/16/25 at 02:30 PM, Administrative Nurse D stated that LN H had not reported the incident to her, and she no longer worked at the facility. Administrative Nurse D stated she had seen the video, and she could see that LN N had not assisted CNA N to retrieve food from R3's mouth. Administrative Nurse D stated both LN H and CNA N were wrong in how the situation was handled. Administrative Nurse D stated that there were no assessments of R3's lungs completed by the nurse, except for her blood pressure and pulse, and the incident was not documented in the EMR or the follow-up of the incident in the EMR. The facility's Condition Change of the Resident policy, dated 06/01/19, documents that staff are to observe, record, and report any condition change to the attending physician so proper treatment can be implemented. After all resident falls, injuries, or changes in physical or mental function, monitor the following: alterations in consciousness, sensory weakness, generalized weakness, and speech disorder. Staff are directed to take vital signs and include temperature, complete an incident, accident, or risk management report per facility policy. The policy documents staff would notify the resident's responsible party and monitor the resident's condition frequently until stable. Staff documents the date, time, and condition change was identified, observes the resident, notifies the physician, and responsible party. Document observation of the resident at least every shift until the condition was stable.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 19 residents. The sample included eight residents, with four reviewed for accidents. Based on observation, record review, and interview, the facility failed to provide a safe environment when the facility failed to assess Resident (R) 8 for safe use of an electric recliner and failed to prevent a fall for R3 that resulted in skin tears. Findings included:- R8's Electronic Medical Record (EMR) recorded diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), diabetic neuropathy (weakness, numbness, and pain from nerve damage, usually in the hands and feet), major depressive disorder (major mood disorder that causes persistent feelings of sadness), weakness, and repeated falls. R8's admission Minimum Data Set (MDS), dated [DATE], recorded a Brief Interview for Mental Status (BIMS) score of seven, which indicated severe cognitive impairment. The MDS recorded R8 required substantial to maximal staff assistance with chair to bed transfers, sit to stand transfers, and falls before being admitted to the facility, and one that resulted in a fracture. R8's Fall Care Plan, dated 07/02/25, recorded R8 was at risk for falls due to poor gait balance, deconditioning, psychoactive drug use, and had a history of past falls. The care plan recorded staff would encourage R8 to use his call light for assistance as needed, and R8 needed a prompt response to all requests for assistance. R8's care plan documented staff would educate the resident about safety reminders and what to do if a fall occurred. The facility would review information on past falls and attempt to determine the cause of the falls, record the root cause, and remove any potential cause if possible. R8's clinical record lacked evidence that the facility assessed the resident for safe use of an electric lift recliner. The Nurses Note, dated 09/09/25 at 01:15 AM, recorded R8 had an unwitnessed fall from his electric lift recliner. R8 had slid out of the chair when elevated all the way in the up position, and R8 landed on his bottom on the floor. R8 had no complaints of pain or discomfort noted during the transfer from the floor to the recliner, per two staff and a manual sit-to-stand lift. On 09/15/25 at 07:35 AM, observation revealed R8 sat in his electric lift recliner in the room, and Certified Medication [NAME] (CMA) R administered his morning medications. On 09/15/25 at 11:00 AM, Administrative Nurse D verified R8 had the electric lift recliner since admission. Administrative Nurse D verified that an electric lift chair safety assessment had not been completed on the resident's safe use of the chair, and physical therapy had not completed an assessment for the safe use of the chair. The facility's Falls policy, dated 05/18/25, directed staff to observe, assess, document, and report any condition change from a fall. The policy further directed staff to obtain a set of vital signs and monitor for injury, or changes, notify the responsible party, and the Director of Nursing. Staff were to complete an incident report and document all assessments and neurological checks if indicated. - The Electronic Medical Record (EMR) for R3 documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), anxiety (mental or emotional reaction (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	characterized by apprehension, uncertainty, and irrational fear), major depressive disorder (major mood disorder that causes persistent feelings of sadness), and hypertension (high blood pressure). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R3 had long and short-term memory problems and moderately impaired decision-making skills. The MDS documented R3 was dependent upon staff for toileting hygiene, showers, dressing, and personal hygiene. The MDS further documented R3 required substantial staff assistance for mobility, transfers, and ambulation. The MDS documented R3 had upper and lower extremity functional impairment on both sides, was frequently incontinent of bladder and bowel, and had one fall with injury. R3's Care Plan dated 08/17/25, initiated on 11/26/24, directed staff to assist her to and from activities as needed with her wheelchair/ambulation as tolerated, monitor for increased falls. The update, dated 04/16/25, directed staff to toilet R3 frequently throughout the day. The update, dated 05/28/25, directed staff to walk to dine with R3 with a walker and the wheelchair to follow. The care plan lacked resident-centered interventions to prevent further falls. The EMR lacked documentation of a Fall Risk Assessment (an assessment that identified older adults who are likely to fall by evaluating their health, medications, environment, and functional abilities) that was completed for R3 before or after her fall. The Facility Incident Report dated 05/17/25 at 04:00 PM, documented that a Certified Nurse Aide (CNA) walked R3 with her walker out of the bathroom. R3 lost her balance and started to fall, when the CNA turned to toss a laundry bag she carried to the floor. The CNA lowered her to the floor as R3 hit the nightstand. The report further documented R3 sustained three skin tears to her right elbow and one skin tear to her left elbow. The skin tears on her right elbow measured 1 centimeter (cm), 0.5 cm, and 1 cm in length. The left elbow measured 4 cm in length x 0.5 cm in width. The skin tears were cleansed, steri-strips applied (adhesive wound closures), and covered with a Telfa (non-stick gauze) dressing and wrapped with Kling (a type of conforming stretch gauze bandage. The report documented the CNA should not multitask while ambulating with a resident. On 06/15/25 at 08:30 AM, CNA M placed a gait belt around R3's waist and placed the walker in front of her. R3 stood up as CNA M held onto the gait belt. CNA O walked behind R3 with the wheelchair. CNA M stated R3 was a fall risk and had a few falls. CNA M further stated that R3 would try to get up on her own, so they checked her frequently. On 09/16/25 at 12:45 PM, Licensed Nurse (LN) G stated R3 was a risk for falls, and two staff members were with her when she ambulated. R3 was on a restorative walk to dine plan and had been working with therapy. LN G stated that one staff member should not walk with R3, and she would make sure she updated the care plan with interventions to prevent further falls. On 09/16/25 at 01:30 PM, Administrative Nurse D stated that staff should not try to multitask when ambulating with a resident and follow gait belt protocol. Administrative Nurse D verified that she was unable to find documentation that any fall risk assessments were completed. Administrative Nurse D further stated R3 was a fall risk and that fall risk assessments should have been completed before any falls and after a fall. The facility's Falls policy, dated 05/18/25, directed staff to observe, assess, document, and report any condition change from a fall. The policy further directed staff to obtain a set of vital signs and monitor for injury, or changes, notify the responsible party, and the Director of Nursing. Staff were to complete an incident report and document all assessments and neurological checks if indicated.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 19 residents. The sample included eight residents, with five reviewed for unnecessary medication. Based on observation, record review, and interview, the facility failed to notify the physician when Resident (R) 1's blood sugar was out of the physician-ordered parameters and failed to hold R1's hypertension (high blood pressure) medication when her diastolic blood pressure was out of parameters. Findings included:- R1's Electronic Medical Record (EMR) documented diagnoses of diabetes mellitus (DM-when the boy cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), hypertension, and heart failure.R1's Quarterly Minimum Data Set (MDS), dated [DATE], documented R1 had intact cognition. The MDS documented R1 required substantial staff assistance with showers, dressing, mobility, and transfers. The MDS further documented R1 received hypoglycemic (low blood sugar) and diuretic (a medication to promote the formation and excretion of urine) medications.R1's Care Plan dated 08/16/25, initiated on 11/20/24, directed staff to obtain Accu-checks (blood glucose monitoring) as ordered by the physician and report any abnormal values, labs as ordered, and administer insulin per order. The care plan directed staff to obtain her blood pressure, notify the physician of any abnormal values promptly, and alert the nurse if they note any signs and symptoms of cardiac distress.The Physician's Order, dated 09/03/25, directed staff to administer lisinopril (antihypertension medication), 5 milligrams (mg), one tablet, per mouth, daily for hypertension. The order further directed staff to hold the medication if the systolic (SBP- top number, the force your heart exerts on the walls of your arteries each time it beats) was less than 100 millimeters of mercury (mmHg) or diastolic (DBP- minimum level of blood pressure measured between contractions of the heart; the bottom number of a blood pressure reading) was less than 60 mmHg.R1's Medication Administration Record (MAR), dated July 2025, documented the following days R1 received the lisinopril when the SBP and the DBP were out of the ordered parameter:07/01/25 - 95/52 mmHg07/30/25 - 106/50 mmHgR1's MAR, dated August 2025, documented the following days R1 received the lisinopril when the DBP was out of the ordered parameter:08/07/25 - 115/53 mmHgR1's MAR, dated September 2025, documented the following days R1 received the lisinopril when the DBP was out of the ordered parameter:09/07/25 - 111/52 mmHgThe Physician's Order, dated 02/03/25, directed staff to notify the physician if her blood sugar was lower than 80 milligrams (mg) per deciliter (dl).R1's MAR, dated July 2025, documented the following days R1's blood sugar was out of parameters:07/05/25 - 54 mg/dlR1's MAR, dated August 2025, documented the following days R1's blood sugar was out of parameters:08/08/25 - 63 mg/dlReview of R1's EMR lacked physician notification related to the bp being out of parameters. R1's MAR, dated September 2025, documented the following days R1's blood sugar was out of parameters:09/02/25 at 10:00 AM - 59 mg/dl and at 02:00 PM - 62 mg/dl09/07/25 at 06:00 AM - 55 mg/dl09/09/25 at 02:00 PM- 45 mg/dlReview of R1's EMR lacked physician notification related to R1's blood sugar being out of parameters.On 09/15/25 at 08:15 AM, observation revealed Certified Medication Aide (CMA) R administered R1 her morning medications without concern and stated the nurse would monitor her blood sugars and administered the insulin. CMA R further stated R1's blood pressure medication was administered on the evening shift.On 09/16/25 at 12:45 PM, Licensed Nurse (LN) G stated R1's blood sugars were high and low, and staff were aware of how she reacted to the different blood sugars. LN G further stated she would contact the physician to reevaluate the blood sugar parameters. LN G stated staff should follow the physician's orders for her blood pressure medication and hold it if it was out of parameters. LN G stated they should have contacted the physician about the low blood sugars.On 09/16/25 at 01:30 PM, Administrative Nurse D stated that staff should follow the physician and notify him when the blood sugars and medications are out of the physician-ordered parametersThe facility's Nursing Care Guidelines for the Resident with Diabetes Mellitus policy, dated 05/18/23, directed staff to assess and identify risk factors and complications (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the resident. The guideline directed staff to monitor unusual observations and report any to the physician.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 19 residents. The sample included eight residents and one medication cart. Based on observation, interview, and record review, the facility failed to label Resident (R) 1's insulin (a hormone that lowers the level of glucose in the blood) flex pens when initially opened for use and when expired. Findings included: - On [DATE] at 10:15AM, observation of the facility's treatment cart revealed R1's Novolog (fast-acting insulin) flex pen was labeled with an opened date of [DATE]. The insulin is good for 28 days and expired on [DATE].On [DATE] at 10:20 AM, License Nurse (LN) G verified the nurses should label and date the insulin flex pens with the date opened and discard the expired insulin flex pens.Medlineplus.gov directs open, unrefrigerated Novolog can be used within 28 days; after that time, they must be discarded.The facility's Labeling of Medications policy, dated [DATE], documented inspection of medication was done to determine that medications are stored under proper conditions, and all outdated medications are removed and replaced with a usable supply of medications.