STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175492	A. Building B. Wing	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Villa	114 S High St Clyde, KS 66938

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 35 residents. The sample included 12 residents, with five reviewed for unnecessary medications. Based on observation, interview, and record review, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported the lack of a 14-day stop date or the required physician documentation and specified duration, for Resident (R)10's ongoing as-needed (PRN) antianxiety (class of medications that calm and relax people) medication. This placed R10 at risk for unintended effects related to psychotropic drug medications. Findings include: - R10's Electronic Health Record (EHR) revealed diagnosis of Alzheimer's (progressive mental deterioration characterized by confusion and memory failure), dementia (progressive mental disorder characterized by failing memory, confusion), and cerebrovascular accident (CVA-stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain). R10's Significant Change Minimum Data Set (MDS), dated [DATE], recorded R10 had severely impaired cognition. The MDS recorded she required extensive assistance from two staff with bed mobility and transfers. The MDS lacked documentation R10 received an antianxiety medication during the observation period. R10's Care Plan, dated 06/10/24, recorded R10 required extensive assistance with most activities of daily living (ADL) care. R10's Care Plan lacked documentation for the resident's antianxiety medication and the indication for the use of the medication. The Physician's Order, dated 05/31/24, directed the staff to administer lorazepam (antianxiety) 0.5 milligram (mg). Give 0.5 mg every six hours as needed for anxiety. The order lacked a stop date. R10's EHR lacked evidence of a specified duration which included a physician's rationale for the extended use. R10's consultant pharmacist monthly reviews, completed on 06/30/24, lacked evidence that the CP had identified the PRN lorazepam with no stop date. On 07/23/24 at 07:45 AM, R10 sat in a Broda chair (special chair with tilt and recline capability) at the dining room table. Certified Medication Aide (CMA) MM administered the resident's morning medications. (continued on next page)

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

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

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/22/24 at 03:00 PM, Administrative Nurse D verified the resident received lorazepam PRN that lacked a stop date. Administrative Nurse D verified the pharmacist had sent monthly reviews to the facility for concerns that lacked a recommendation for a stop date for the lorazepam. The facility's Consult Pharmacist Services Provider Requirements dated 06/01/2023, documented that regular and reliable consult pharmacist services are provided to elders. The pharmacist would review 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 documentation of the reviews and findings in the elders' clinical record. The facility failed to ensure the CP identified and reported the lack of a 14-day stop date for the use of PRN lorazepam for R10. This placed the resident at risk for unnecessary antipsychotic medication with side effects.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 35 residents. The sample included 12 residents, with five reviewed for unnecessary medications. Based on observations, interviews, and record review, the facility failed to ensure a 14-day stop date or a specified duration with rationale for R10's ongoing as-needed (PRN) antianxiety (class of medications that calm and relax people) medication. This placed R10 at risk for unintended effects related to psychotropic (alters mood or thought) drug medications. Findings include: - R10's Electronic Health Record (EHR) revealed diagnosis of Alzheimer's (progressive mental deterioration characterized by confusion and memory failure), dementia (progressive mental disorder characterized by failing memory, confusion), and cerebrovascular accident (CVA-stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain). R10's Significant Change Minimum Data Set (MDS), dated [DATE], recorded R10 had severely impaired cognition. The MDS recorded she required extensive assistance from two staff with bed mobility and transfers. The MDS lacked documentation R10 received an antianxiety medication during the observation period. R10's Care Plan, dated 06/10/24, recorded R10 required extensive assistance with most activities of daily living (ADL) care. R10's Care Plan lacked documentation for the resident's antianxiety medication and the indication for the use of the medication. The Physician's Order, dated 05/31/24, directed the staff to administer lorazepam (antianxiety) 0.5 milligram (mg). Give 0.5 mg every six hours as needed for anxiety. The order lacked a stop date. R10's EHR lacked evidence of a specified duration which included a physician's rationale for the extended use. R10's consultant pharmacist monthly reviews, completed on 06/30/24, lacked evidence that the CP had identified the PRN lorazepam with no stop date. On 07/23/24 at 07:45 AM, R10 sat in a Broda chair (special chair with tilt and recline capability) at the dining room table. Certified Medication Aide (CMA) MM administered the resident's morning medications. On 07/22/24 at 03:00 PM, Administrative Nurse D verified the resident received lorazepam PRN that lacked a stop date. The facility's Unnecessary Drugs and Psychotropic Drug Use policy, dated 10/12/2-022, documented the resident would be administered psychotropic medication only when necessary to treat specific diagnoses and document conditions. The facility would limit the timeframe for PRN psychotropic medications, to 14 days, unless a longer timeframe is deemed appropriate by the attending physician or the prescribing Practitioner. Limiting PRN psychotropic medications, which are antipsychotic medications, (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to 14 days and not entering a new order without first evaluating the resident. The interdisciplinary team would identify and document the resident's indication for use. Orders for PRN psychotropic and or antipsychotic medications that are not prescribed to treat a diagnosis-specific condition or do not meet the PRN requirements for psychotropic and antipsychotic medications. The facility failed to ensure R10's PRN lorazepam had a 14-day stop date or specified duration placing R10 at risk for adverse side effects.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. The facility had a census of 35 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to employ a full-time certified dietary manager for the 35 residents who resided in the facility and received meals from the facility kitchen. This placed the residents at risk for inadequate nutrition. Findings included: - On 07/23/24, a review of the noon meal consisted of barbeque meatballs, red potato salad, creamy sweet corn, dinner roll, and chocolate pudding. On 07/23/24 at 11:30 AM, observation revealed Dietary Staff BB in the kitchen overseeing the preparation of the noon meal. On 07/22/24 at 12:30 PM, Dietary Staff BB verified he was not a certified dietary manager. Dietary Staff BB stated he had not started the certified dietary manager classes. On 07/24/24 at 10:58 AM, Administrative Staff A verified Dietary Staff BB had no dietary manager certification. The facility's undated Dietary Supervisor Certified Dietary Manager (CDM) Policy, documented the CDM qualifications and position requirements were the following: Successful completion of the state's CDM certification course. Ability to read and write English but not necessary for English primary language Ability to do simple math Ability to learn special diets Good personal hygiene ServSafe Certification required Membership in the state association of nutritional and food service professionals 2 years experience in food service in a healthcare setting preferred Exceptional interpersonal skills. Exceptional organizational skills. Ability to meet the dietary needs of the facility's diverse census. The facility failed to employ a full-time certified dietary manager for 35 residents who resided in the facility and received meals from the kitchen. This placed the residents at risk of not (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	receiving adequate nutrition.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. The facility had a census of 35 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety, in one of one kitchen. This placed the residents who received their meals from the facility's kitchen at risk for foodborne illness. Findings included: - On 07/22/24 at 07:50 AM, observation in the kitchen revealed the following: The refrigerator had an unlabeled, undated half-full plastic bag of chicken strips, an unlabeled and undated plastic bag with five hamburger patties, an uncovered metal pan of blueberry crisp, and an unsealed plastic bag of yellow cheese slices. The dry storage area had an unlabeled, undated five-pound plastic bag of white cake mix, half full, and an unlabeled, undated five-pound plastic bag of Devil's Food cake mix, half full. The chest-style deep freezer located in the dry storage area had approximately one-quarter to one-half inch (in) of ice buildup all around the inside of it. On 07/22/23 at 7:55 AM, Dietary Staff (DS) CC verified the issues in the kitchen. On 07/23/24 at 10:30 AM, observation in the kitchen revealed one-floor tile located in the dry storage room, in front of the white chest deep freezer, had a missing piece in the lower corner approximately one-quarter to one-half inch wide and five inches long; a piece was also missing in the upper right corner of the same tile approximately one-half inch wide by four inches long. On 07/23/24 at 01:15 PM, Dietary Manager (DM) BB verified the issue with the ice in the white chest deep freezer and the tile in the dry storage room and stated the deep freeze needed to be defrosted. DM BB stated staff should make sure food items are in a sealed container, labeled and dated before they place them in the refrigerator and dry storage area. The facility's Dietary Purchases, Receipt, and Storage Policy, revised 10/24/22, documented all products would be labeled with the date received in the facility. The facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for the 35 residents who received their meals from the facility's kitchen. This placed the 35 residents at risk for foodborne illness.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 35 residents. The sample included 12 residents with one reviewed for hospice (a type of health care that focuses on the terminally ill patient's pain and symptoms and attending to their emotional and spiritual needs at the end of life) services. Based on observation, record review, and interview, 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)10. This placed R10 at risk for inappropriate end-of-life care. Findings included: - R10's Electronic Health Record (EHR) revealed diagnosis of Alzheimer's (progressive mental deterioration characterized by confusion and memory failure), dementia (progressive mental disorder characterized by failing memory, confusion), and cerebrovascular accident (CVA-stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain). R10's Significant Change Minimum Data Set (MDS), dated [DATE], recorded R10 had severely impaired cognition. The MDS recorded she required extensive assistance from two staff with bed mobility and transfers. The MDS documented the resident received hospice services. R10's Care Plan, dated 06/10/24, recorded R10 required extensive assistance with most activities of daily living (ADL) care. R10's Care Plan documented the resident received hospice services due to a terminal prognosis and directed staff to adjust the provision of ADLs to compensate for R10's change in needs and consult a physician and social services to have hospice care for the resident. The care plan directed the staff to observe the resident closely for signs of pain, administer pain medications ordered, and notify the physician if there is breakthrough pain. The care plan lacked instruction on the services provided by hospice including hospice staff visits, supplies and medical equipment provided by hospice, and medications covered by hospice. R10's medical records revealed the resident was admitted to hospice care on 05/31/24 but lacked evidence of coordination of care between the hospice and the facility. The facility had received a hospice plan of care dated 06/03/24. The review revealed there was no communication book or external document. On 07/23/24 at 07:45 AM, R10 sat in a Broda chair (special chair with tilt and recline capability) at the dining room table. Certified Medication Aide (CMA) MM administered the resident's morning medications. On 07/24/24 at 12:00 PM, Administrative Nurse E verified the facility lacked specific information on the facility care plan that coordinated with the hospice care plan. The Hospice Policy and Procedure policy, dated 06/01/23, documented the facility's goal of palliative and end-of-life care is to prevent and relieve suffering and to support the best possible quality of life for residents and the resident's family members regardless of the stage of the disease or the need for other therapies. End-of-life care would be provided based on a comprehensive and systematic delivery of care and services. Quality end-of-life care would include medical treatment that is (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	appropriate and evidenced-based, continuity of comprehensive care, care customized to the resident's and family member's preference, care adapted to serve the residents and families, and assisting the resident to live as fully as possible. The care plan is based on the ongoing assessment and reflects goals set by the resident's family or surrogate in collaboration with the interdisciplinary team (IDT) including the resident's physician. In collaboration with the resident, family, and other involved health care professionals, the IDT develops the care plan with additional input, when indicated, from other community providers such as community services, and spiritual leaders. Changes in the care plan are based on the evolving needs and preferences of the resident and family, with recognition of the complex, competing, and shifting priorities in the goals of care. The IDT provides services to the resident and family consistent with the care plan to include chaplains, nurses, physicians, social workers, and other therapeutic disciplines who provide palliative care services to residents and family members. The IDT communicates regularly -at least weekly or more often as required by the clinical situation to plan, review, evaluate, and update the care plan, with input from both the resident and the family. The facility failed to coordinate care between the facility and the hospice provider for R10, who received hospice services. This deficient practice placed her at risk for inappropriate end-of-life care.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. The facility identified a census of 35 residents. The sample included 12 residents with five residents reviewed for immunizations, Resident (R)10, R2, R1, R3, and R18, to include pneumococcal (a disease that refers to a range of illnesses that affect various parts of the body and are caused by infection) vaccinations. Based on record review and interviews, the facility failed to evaluate for eligibility and offer or obtain an informed declination or a physician-documented contraindication for the pneumococcal PCV20 vaccination per the latest guidance from the Centers for Disease Control and Prevention (CDC). This placed the residents at risk for pneumococcal infection and related complications. Findings included: - Review of R10, R2, R1, R3, and R18's clinical medical records lacked evidence the facility or the resident representative received or signed a consent or informed declination for the pneumococcal vaccine PCV20. On 07/23/24 at 03:00 PM, Administrative Nurse F stated residents were offered the pneumonia vaccines on admission, and as indicated; the facility sent out the Centers for Disease Control and Prevention (CDC) vaccination sheets and a sheet the facility had formatted that included multiple vaccinations at the top of the form and the resident or the residents representative were to circle the one they authorize the resident to receive. The form had the choice of a pneumonia vaccine but did not specify if the resident should receive the PVC13, PVC20, or PVC23. On 07/23/24 at 03:00 PM, when asked for a list of residents who were eligible for the Prevnar 20 (PCV20) vaccination, Administrative Staff A verified they would have the consultant pharmacist provide them with the residents who would be eligible for the PVC20, which was all but two residents in the facility who already received the PVC20. The facility's Immunization Policy, undated, documented all residents would be offered the pneumococcal vaccination on admission and as approved by the primary care physician after investigating/inquiry related to current immunization status, The policy documented the CDC recommends two vaccines for all adults over 65 years or older. The policy documented the resident received the PVC 13 and the PVC 23 but lacked guidance on when to administer the PVC20. The facility failed to offer the PCV20 pneumococcal vaccination. This deficient practice placed the residents at risk of acquiring, spreading, and experiencing complications from pneumonia.