

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/29/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175240	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/27/2023
NAME OF PROVIDER OR SUPPLIER KPC PROMISE SKILLED NURSING FACILITY OF OVERLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 6505 W 103RD STREET OVERLAND PARK, KS 66212		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	F 000			
F 577 SS=C	The following citations represent the findings of a Health Resurvey and Complaint Investigation #KS00182414. The 2567 was sent electronically on 09/29/23. Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: The facility identified a census of 27 residents. The sample included 12 residents. Based on	F 577			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

09/29/2023

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.

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F 577	Continued From page 1 observation, record review, and interviews, the facility failed to post the previous state inspection information in a location accessible to residents and visitors. Findings included: - On 09/26/23 at 01:30 PM unable to locate previous survey results for the facility. On 09/26/23 at 01:45 PM Administrative Nurse D stated she had the past survey results in a folder in her office that was available to residents and their representatives upon request. Administrative Nurse D stated prior to the COVID-19 (highly contagious respiratory virus) health emergency, the survey results were available out in the common area. On 09/26/23 at 01:49 PM Administrative Staff A stated she had a copy of the past survey results available in her office for residents or their representatives to review upon request. Administrative Staff A stated she would place the past survey results in a common area for visitors. The facility was unable to provide a policy related to past survey results availability. The facility failed to make the current survey results readily accessible to residents, and family members and legal representatives of residents.	F 577			
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If	F 700			

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F 700	Continued From page 2 a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: The facility identified a census of 27 residents. The sample included 12 residents with one resident reviewed for accidents. Based on observation, record review, and interviews, the facility failed to routinely reassess the continued use of upper half siderails to assure safety for Resident (R) 13. This placed the resident at risk for injury related to incorrect or unsafe use of side rails. Findings included: - R13's clinical medical record documented diagnoses of multiple sclerosis (MS- progressive disease of the nerve fibers of the brain and spinal cord), hypertension (elevated blood pressure), and encephalopathy (inflammatory condition of the brain).	F 700			

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F 700	Continued From page 3 The "Admission Minimum Data Set" (MDS) dated 09/27/22 documented a Brief Interview of Mental Status (BIMS) score of zero which indicated severely impaired cognition and R13 was unable to complete the interview. The MDS documented that R13 was dependent on one staff member for assistance with activities of daily living (ADLs). The "Quarterly MDS" dated 06/30/23 documented a BIMS score of zero which indicated severely impaired cognition and R13 was unable to complete the interview. The MDS documented that R13 was dependent on one staff member for assistance with ADLs. R13's " Cognitive Loss/Dementia Care Area Assessment" (CAA) dated 09/28/22 documented R13 was alert and oriented to person and familiar faces, with periods of confusion. R13's "Care Plan" dated 09/28/22 documented R13 used the siderail for positioning. The facility was able to provide a "Bed Rail Evaluation" dated 09/20/22 which documented R13 would use two upper half rails for safety. R13's clinical record lacked a recent side rail assessment for safety. On 09/25/23 at 11:48 AM R13 laid on her bed on the left side. R13's upper two half siderails were pulled up and R13's head rested on left siderail. head rested on the upper left siderail. On 09/26/23 at 08:40 AM R13 laid on her back in bed, upper two siderails were pulled up in place.	F 700			

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F 700	Continued From page 4 On 09/27/23 at 09:15 AM Certified Nurse Aide (CNA) M stated almost all the residents used siderails for safety. CNA M stated R13 was able at times to assist with repositioning in bed. On 09/27/23 at 09:25 AM Licensed Nurse (LN) H stated every resident, or their legal representative was asked at the time of admission if they wanted to use siderails. LN H stated if the resident declined to use siderails, f the facility utilized other devices such as low beds with floor mats. LN H stated if residents signed the permission for the siderails, a "Bed rail Evaluation" was completed. LN H stated she was not aware of any re-evaluation for siderail other than admission or readmission. On 09/27/23 at 09:34 AM Administrative Nurse D stated every new admission was asked to sign a consent for use of siderails. Administrative Nurse D stated each resident had evaluation for siderails at admission and readmission only. Administrative Nurse D stated the facility did not reevaluate the siderails for safety. The facility was unable to provide a policy related to siderail evaluation. The facility failed to routinely reassess for the continued use of upper half siderails being used to assure safety for R13. This placed the resident at risk for injury related to incorrect or unsafe use of side rails.	F 700			
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with	F 726			

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F 726	Continued From page 5 the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: 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 staff possessed the appropriate competencies to safely administer medications per the standards of practice when licensed nursing staff failed to clarify Resident (R) 19's antihypertensive (class	F 726			

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F 726	Continued From page 6 of medication used to treat high blood pressure) medication order. This deficient practice placed R19 at risk for medication errors. Findings included: - R19's clinical record documented diagnoses of hypertension (elevated blood pressure), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and schizophrenia (mental disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought). The "Admission Minimum Data Set" (MDS) dated 02/17/23 documented R19's cognition was severely impaired. The MDS documented that R19 was dependent on one staff members assistance for activities of daily living (ADLs). The MDS documented R19 had received antidepressant (class of medications used to treat mood disorders), antipsychotic (class of medications used to treat major mental conditions which cause a break from reality), and anticoagulant (class of medications used to prevent the formation of blood clots) for seven days during the look back period. The "Quarterly MDS" dated 08/20/23 documented R19's cognition was severely impaired. The MDS documented that R19 was dependent on one staff member for ADLs. The MDS documented R19 had received antidepressant medication, antipsychotic medication, and anticoagulant medication for seven days during the look back period. R19's "Psychotropic Drug Use Care Area	F 726			

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F 726	Continued From page 7 Assessment" (CAA) dated 02/21/23 documented R19 had a diagnosis of schizophrenia and was taking an antipsychotic medication. R19's "Care Plan" dated 09/21/23 documented the pharmacist would review R19's medication frequently and make any recommendations to the physician to review and make any changes. Review of the clinical record under "Orders" tab revealed the following physician orders: Amlodipine besylate (antihypertensive) 10 milligrams (mg) take one tablet by mouth daily. Hold for systolic blood pressure (SBP- top number, the force your heart exerts on the walls of your arteries each time it beats) greater than (>) 115 millimeters of mercury (mmHg) dated 08/16/23. Review of "Medication Administration Record" (MAR) from 08/16/23 thru 09/25/23 (41 days) revealed the antihypertensive medication was administered daily for SBP both greater than (>) or less than (<) 115 mmHg. Review of the hospital discharge orders from 08/16/23 documented amlodipine besylate 10 mg take one tablet by mouth daily. Hold for SBP < 115 mmHg. R19's clinical record lacked evidence staff identified the discrepancy and notified the physician for clarification. On 09/26/23 at 08:08 AM R19 laid on the bed, the TV was on in the room, his eyes were open, and he smiled. On 09/25/23 at 04:00 PM Administrative Nurse D	F 726			

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F 726	Continued From page 8 stated the physician ordered hold parameter for SBP >115 mmHg on R19's antihypertensive medication was correct. On 09/25/23 at 04:30 PM Licensed Nurse (LN) G stated R19's amlodipine besylate medication order did not sound correct and said she would clarify the order with physician. On 09/25/23 at 04:45 PM Administrative Nurse D stated the physician order for amlodipine besylate did not sound correct once read out loud. LN G was going to clarify the order with physician. On 09/27/23 at 09:34 PM Administrative Nurse D stated she would review the physician orders after admission and readmission orders entered into the resident clinical record. Administrative Nurse D stated R19's amlodipine besylate hold parameter had been clarified and was now ordered to hold for SBP < 115mmHg. On 09/27/23 at 11:47 AM Licensed Nurse (LN) I stated every medication should have an indication and route for administration. LN I stated if she thought a physician order was in question she would call the physician for clarification. The facility's "Staffing, Sufficient and Competent Nursing" policy revised 08/2022 documented "Competency " was a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needed to perform work roles or occupational functions successfully. All nursing staff must meet the specific competency requirements of their respective licensure and certification requirements defined by state law. Staff must demonstrate the skills and techniques necessary	F 726			

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F 726	Continued From page 9 to care for resident needs including (but not limited to) the following areas: Basic nursing skills; Medication management. Competency requirements and training for nursing staff are established and monitored by nursing leadership with input from the medical director to ensure that: programming for staff training results in nursing competency; gaps in education are identified and addressed; education topics and skills needed are determined based on the resident population.	F 726			
F 756 SS=D	The facility failed to ensure staff possessed the appropriate competencies to safely administer medications per the standards of practice when licensed nursing staff failed to clarify R19's antihypertensive medication order. This deficient practice placed R19 at risk for medication errors. Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a	F 756			

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F 756	Continued From page 10 separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: The facility identified a census of 27 residents. The sample included 12 residents with five residents reviewed unnecessary medications. Based on observation, record review, and interviews, the facility failed to acknowledge and follow the Consultant Pharmacist's (CP) recommendations to complete a gradual dose reduction (GDR) or provide an indicated rationale for Resident (R)17's psychotropic (a class of medications which affect mood or thoughts) medications. This deficient practice placed R17 at risk for ineffective treatment and unnecessary side effects. Findings Included: - The "Medical Diagnosis" section within R17's			F 756			

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F 756	Continued From page 11 medical record included diagnoses of conversion disorder (a mental condition in which a person experiences blindness, paralysis or other nervous system symptoms that cannot be explained by illness or injury), seizures (involuntary series of contractions of a group of muscles), major depressive disorder (major mood disorder), and chronic respiratory failure. R17's "Annual Minimum Data Set (MDS)" completed 06/28/23 noted a Brief Interview for Mental Status (BIMS) assessment could not be completed due to severe impairment. The MDS indicated no behaviors. The MDS noted he required total assistance from for his activities of daily living (ADLs). The MDS indicated he was given antipsychotic medication on a routine basis. The MDS indicated a gradual dose reduction (GDR) was not attempted due to being documented as clinically contraindicated. The MDS did not indicate a date the GDR was documented as clinically contraindicated. R17's "Psychotropic Medication Care Area Assessment (CAA)" completed 06/29/23 indicated he suffered cognitive loss related to a stroke. The CAA noted he had psychotropic medication related to psychotic symptoms secondary to his stroke. R17's "Care Plan" initiated 06/29/23 indicated he had potentially aggressive behaviors. The plan instructed staff to observe for signs of pain or distress, provide a quiet environment, speak clearly, and give him time to understand. The plan instructed staff to administer his Seroquel (antipsychotic medication) as ordered and monitor for side effects.	F 756			

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F 756	Continued From page 12 R17's medical record under "Physician's Order" revealed an order dated 04/05/23 for staff to administer 100 milligrams of Seroquel per his feeding tube twice daily for depression. R17's "Medication Regimen Review" dated 06/16/23 noted the CP indicated guidelines for dose reduction of antipsychotic medications be completed in two separate quarters or for a new admission. The CP requested a risk vs benefit rationale for continued use of the Seroquel medication. The physician response indicated he disagreed with the recommendation but did not provide a rationale. R17's "Medication Regimen Review" (MRR) dated 08/16/23 indicated the recommended GDR be attempted within two separate quarters for R17's antipsychotic medications or document a reason for contraindication. The report had no response from the physician. The facility could not to provide documentation related to R17's Seroquel's risk vs benefit rationale for contraindication to GDR for the Seroquel. On 09/27/23 at 11:45AM Licensed Nurse I stated antipsychotic medications were generally used for schizophrenia (mental disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), and psychotic disorders (any major mental disorder characterized by a gross impairment in reality perception). She stated depression alone would not be an accurate diagnosis for an antipsychotic medication. She			F 756			

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F 756	Continued From page 13 stated if a medication's diagnosis did not look appropriate, she would notify the prescribing physician for verification of it's use. On 09/27/23 at 12:05PM Administrative Nurse D reported she was unable to find documentation related to R17's Seroquel risk vs benefits. She stated the MMR report dated 06/16/23 noted the physician's response for the contraindication of the GDR. She was unable to provide risk vs benefit documentation or rationale indicating the appropriate continued use of R17's Seroquel medication. She stated the monthly pharmacy recommendation were sent to and she distributed them to the assigned physician. She stated she would review the physician's responses and enter the order based on what the physician's orders. A review of the facility's "Psychotropic Medication" policy revised 01/2019 indicated residents that received psychotropic medication would receive gradual dose reductions unless clinically contraindicated. The facility failed to acknowledge and follow the CP's recommendations to complete a GDR or provide risk vs benefit rationale for R17's Seroquel medication. This deficient practice placed R17 at risk for ineffective treatment and unnecessary side effects.			F 756			
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-			F 757			

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F 757	Continued From page 14 §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: 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 Resident (R) 19's medications had an indication for administration. This deficient practice placed R19 at risk for unnecessary medication use and unwarranted side effects. Findings included: - R19's clinical record documented diagnoses of hypertension (elevated blood pressure), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and schizophrenia (mental disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought).			F 757			

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F 757	Continued From page 15 The "Admission Minimum Data Set" (MDS) dated 02/17/23 documented R19's cognition was severely impaired. The MDS documented that R19 was dependent on one staff members assistance for activities of daily living (ADLs). The MDS documented R19 had received antidepressant (class of medications used to treat mood disorders), antipsychotic (class of medications used to treat major mental conditions which cause a break from reality), and anticoagulant (class of medications used to prevent the formation of blood clots) for seven days during the look back period. The "Quarterly MDS" dated 08/20/23 documented R19's cognition was severely impaired. The MDS documented that R19 was dependent on one staff member for ADLs. The MDS documented R19 had received antidepressant medication, antipsychotic medication, and anticoagulant medication for seven days during the look back period. R19's "Psychotropic Drug Use Care Area Assessment" (CAA) dated 02/21/23 documented R19 had a diagnosis of schizophrenia and was taking an antipsychotic medication. R19's "Care Plan" dated 09/21/23 documented the pharmacist would review R19's medication frequently and make any recommendations to the physician to review and make any changes. Review of the clinical record under "Orders" tab revealed the following physician orders: Amlodipine besylate (antihypertensive) 10 milligrams (mg) take one tablet by mouth daily. Hold for systolic blood pressure (SBP- top			F 757			

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F 757	Continued From page 16 number, the force your heart exerts on the walls of your arteries each time it beats) greater than (>) 115 millimeters of mercury (mmHg) dated 08/16/23. The medication lacked an indication for administration. Lovastatin 20mg tablet (statin used to treat hyperlipidemia (condition of elevated blood lipid levels) take one tablet by mouth daily dated 08/16/23. The medication lacked an indication for administration. Polyethylene glycol 3350 (laxative) dissolve one capful 17grams (gm) in eight ounces of water and take per take per tube daily dated 08/16/23. The medication lacked an indication for administration. Famotidine (reduces gastric acid) 20mg tablet take one tablet per tube two times a day on an empty stomach dated 08/16/23. The medication lacked an indication for administration. Cyclobenzaprine (muscle relaxant) five mg tablet take one tablet by mouth three times a day as needed dated 08/16/23. The medication lacked an indication for administration. Oxycodone hcl (opioid used to treat pain) five mg tablet take one tablet every eight hours as needed dated 08/16/23. The medication lacked an indication for administration. Janumet (used to treat elevated blood sugar) 50-1,000mg tablet take one tablet by mouth two times a day dated 08/16/23. The medication lacked an indication for administration. Metoprolol (antihypertensive) 25mg take one	F 757			

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F 757	Continued From page 17 tablet by mouth two times daily dated 08/16/23. The medication lacked an indication for administration. Senna plus tablet (laxative) take one tablet by mouth two times a day. Hold for loose stools dated 08/16/23. The medication lacked an indication for administration. On 09/26/23 at 08:08 AM R19 laid on the bed, the TV was on in the room, his eyes were open, and he smiled. On 09/27/23 at 09:34 PM Administrative Nurse D stated the pharmacist would write a recommendation to the physician if a medication did not have an indication for administration and the physician would determine why and how the medication was administered. Administrative Nurse D stated she would review the physician orders after admission and readmission orders entered into the resident clinical record. On 09/27/23 at 11:47 AM Licensed Nurse (LN) I stated every medication should have an indication and route for administration. LN I stated if she thought a physician order was in question she would call the physician for clarification. The facility's "Order Transcription" policy with approval date of 07/27/21 documented to ensure accurate transcription of orders. A complete medication order consisted of name of medication; dose of medication; frequency of administration; and route of administration. Otherwise, the physician must be contacted, and clarification order written on order sheet. The facility failed to ensure R19's medications	F 757			

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F 757	Continued From page 18 had an indication for administration. This deficient practice placed R19 at risk for unnecessary medication use and unwarranted side effects.	F 757			
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and	F 758			

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F 758	Continued From page 19 §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: The facility identified a census of 27 residents. The sample included 12 residents with five residents reviewed unnecessary medications. Based on observation, record review, and interviews, the facility failed to complete a gradual dose reduction (GDR) or provide a rationale for contraindication related to Resident (R)17 and R19's psychotropic (a class of medications which affect mood or thoughts) medications. The facility additionally failed to provide an indication for use on R19's Haldol (antipsychotic medication- used to treat major mental conditions which cause a break from reality) medication and Lexapro (depression medication). This deficient practice placed both at risk for ineffective treatment and unnecessary side effects. Findings Included: - The "Medical Diagnosis" section within R17's medical record included diagnoses of conversion disorder (a mental condition in which a person experiences blindness, paralysis or other nervous	F 758			

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F 758	Continued From page 20 system symptoms that cannot be explained by illness or injury), seizures (involuntary series of contractions of a group of muscles), major depressive disorder (major mood disorder), and chronic respiratory failure. R17's "Annual Minimum Data Set (MDS)" completed 06/28/23 noted a Brief Interview for Mental Status (BIMS) assessment could not be completed due to severe impairment. The MDS indicated no behaviors. The MDS noted he required total assistance from for his activities of daily living (ADLs). The MDS indicated he was given antipsychotic medication on a routine basis. The MDS indicated a gradual dose reduction (GDR) was not attempted due to being documented as clinically contraindicated. The MDS did not indicate a date the GDR was documented as clinically contraindicated. R17's "Psychotropic Medication Care Area Assessment (CAA)" completed 06/29/23 indicated he suffered cognitive loss related to a stroke. The CAA noted he had psychotropic medication related to psychotic symptoms secondary to his stroke. R17's "Care Plan" initiated 06/29/23 indicated he had potentially aggressive behaviors. The plan instructed staff to observe for signs of pain or distress, provide a quiet environment, speak clearly, and give him time to understand. The plan instructed staff to administer his Seroquel (antipsychotic medication) as ordered and monitor for side effects. R17's medical record under "Physician's Order" revealed an order dated 04/05/23 for staff to administer 100 milligrams of Seroquel per his	F 758			

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F 758	Continued From page 21 feeding tube twice daily for depression. R17's "Medication Regimen Review" dated 06/16/23 noted the CP indicated guidelines for dose reduction of antipsychotic medications be completed in two separate quarters or for a new admission. The CP requested a risk vs benefit rationale for continued use of the Seroquel medication. The physician response indicated he disagreed with the recommendation but did not provide a rationale. R17's "Medication Regimen Review" (MRR) dated 08/16/23 indicated the recommended GDR be attempted within two separate quarters for R17's antipsychotic medications or document a reason for contraindication. The report had no response from the physician. The facility could not to provide documentation showing rationale for continued use of R17's Seroquel including risk vs benefits, non-pharmacological options attempted and failed, and alternative interventions attempted. On 09/27/23 at 11:45AM Licensed Nurse I stated antipsychotic medications were generally used for schizophrenia (mental disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), and psychotic disorders (any major mental disorder characterized by a gross impairment in perception of reality). She stated depression alone would not be an accurate diagnosis for an antipsychotic medication. She stated if a medication's diagnosis did not look appropriate, she would notify the prescribing	F 758			

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F 758	Continued From page 22 physician for verification of its use. On 09/27/23 at 12:05PM Administrative Nurse D reported she was unable to find documentation related to R17's Seroquel risk vs benefits. She stated the MMR report dated 06/16/23 noted the physician's response for the contraindication of the GDR. She was unable to provide risk vs benefit documentation or rationale indicating the appropriate continued use of R17's Seroquel medication. She stated appropriate diagnoses for antipsychotic medication would include bi-polar disorder, schizophrenia, and some depression related to psychotic disorders. A review of the facility's "Psychotropic Medication" policy revised 01/2019 indicated residents that received psychotropic medication would receive gradual dose reductions unless clinically contraindicated. The facility failed to complete a GDR or provide rationale of contraindication and failed to ensure an appropriate indication for use or the required physician documentation for the continued use of R17's Seroquel. This deficient practice placed R17 at risk for ineffective treatment and unnecessary side effects. - R19's clinical record documented diagnoses of hypertension (elevated blood pressure), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and schizophrenia (mental disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought). The "Admission Minimum Data Set" (MDS) dated	F 758			

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F 758	Continued From page 23 02/17/23 documented R19's cognition was severely impaired. The MDS documented that R19 was dependent on one staff members assistance for activities of daily living (ADLs). The MDS documented R19 had received antidepressant (class of medications used to treat mood disorders), antipsychotic (class of medications used to treat major mental conditions which cause a break from reality), and anticoagulant (class of medications used to prevent the formation of blood clots) for seven days during the look back period. The "Quarterly MDS" dated 08/20/23 documented R19's cognition was severely impaired. The MDS documented that R19 was dependent on one staff member for ADLs. The MDS documented R19 had received antidepressant medication, antipsychotic medication, and anticoagulant medication for seven days during the look back period. The MDS documented a gradual dose reduction (GDR) was not attempted and a GDR had not been documented by a physician as clinically contraindicated for R19 during the look back period. R19's "Psychotropic Drug Use Care Area Assessment" (CAA) dated 02/21/23 documented R19 had a diagnosis of schizophrenia and was taking an antipsychotic medication. R19's "Care Plan" dated 09/21/23 documented the pharmacist would review R19's medication frequently and make any recommendations to the physician to review and make any changes. Review of the clinical record under "Orders" tab revealed the following physician orders: Haloperidol (antipsychotic) five milligrams (mg)	F 758			

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F 758	Continued From page 24 take one tablet at bedtime per tube dated 08/16/23. The medication lacked an indication for administration. Lexapro (antidepressant) 10mg take one tablet by mouth dated 08/16/23. The medication lacked an indication for administration. The facility could not to provide documentation showing rationale for of the lack of a gradual dose reduction for R19's Lexapro. On 09/27/23 at 11:45AM Licensed Nurse I stated antipsychotic medications were generally used for schizophrenia, delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), and psychotic disorders (any major mental disorder characterized by a gross impairment in perception of reality). LN I stated every medication should have an indication for administration. On 09/27/23 at 12:05PM Administrative Nurse D stated she was unable to find physician documentation related to R19's Lexapro gradual dose reduction recommendation of why it was marked as disagree on the "Monthly Medication Review" from August 2023. A review of the facility's "Psychotropic Medication" policy revised 01/2019 indicated residents that received psychotropic medication would receive gradual dose reductions unless clinically contraindicated. The facility failed to ensure R19's psychotropic medications had an indication for administration and failed to provide physician documentation for the rationale to not attempt a gradual dose	F 758			

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NAME OF PROVIDER OR SUPPLIER KPC PROMISE SKILLED NURSING FACILITY OF OVERLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 6505 W 103RD STREET OVERLAND PARK, KS 66212		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 758	Continued From page 25 reduction for Lexapro. This deficient practice placed R19 at risk for ineffective treatment, unnecessary medication uses and unwarranted side effects.	F 758			
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal	F 883			

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F 883	Continued From page 26 immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: The facility identified a census of 27 residents. The sample included 12 residents with five reviewed for influenza (highly contagious viral infection) and pneumococcal (type of bacterial infection) immunizations. Based on record review and interviews, the facility failed to provide pneumococcal vaccinations or informed refusals for Residents (R)19. This deficient practice placed R19 at risk for complication related to pneumonia. Findings included: - On 09/26/23 at 03:45 PM a review of influenza and pneumococcal immunizations was completed for R9, R17, R19, R23, and R78. The review	F 883			

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F 883	Continued From page 27 revealed that R19 lacked evidence indicating he or his representative was offered, consented, refused, or had received the pneumonia vaccination. On 09/27/23 at 10:58AM Administrative Nurse D stated R19's pneumonia vaccination documentation could not be found. She stated she called R19's representative and completed the consent/declination form on 09/27/23. She stated R19's representative declined for him to receive the pneumonia vaccination. A review of the facility's "Patient Immunization" policy revised 02/2023 indicated the pneumococcal vaccination will be provided to residents over 65 years old or with medical indications. The policy noted the vaccination consent or declination will be completed and maintained in the medical records. The facility failed to provide pneumococcal vaccination or informed refusal for R19. This deficient practice placed the residents at risk for complication related to pneumonia.			F 883			