STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175386	A. BUILDING _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCHOWALTER VILLA	200 W CEDAR HESSTON, KS 67062

(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 The following citations represent the findings of a health resurvey and complaint investigation KS00191102, KS00188575, AND KS00188208. The 2567 was sent electronically on 11/18/24.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced	F 657		

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175386	A. BUILDING _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCHOWALTER VILLA	200 W CEDAR HESSTON, KS 67062

(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 657	Continued From page 1	F 657		

by:
The facility reported a census of 95 residents. The sample included 19 residents reviewed for care plan revisions. Based on observations, interviews, and record review, the facility failed to revise Resident (R)82's "Care Plan" to include her identified behaviors toward male residents. This deficient practice placed R82 at risk for impaired care due to uncommunicated care needs.

Findings Included:

- R82's "Medical Diagnosis" section within the Electronic Medical Record (EMR) noted diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), a need for assistance with personal cares, and unsteadiness on her feet.

R82's "Quarterly Minimum Data Set (MDS) completed 07/31/24 revealed a Brief Interview for Mental Status (BIMS) assessment could not be completed due to severe cognitive impairment. The MDS noted no behaviors were observed. The MDS indicated she required partial to moderate assistance with toileting, bathing, transfers, bed mobility, dressing, and personal hygiene.

R82's "Functional Abilities Care Area Assessment (CAA)" completed 08/12/24 noted she required supervision and staff assistance with her activities of daily living (ADLs). The CAA noted she was at risk for a decline in her ADLs related to her impaired cognition and limited mobility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175386	A. BUILDING _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCHOWALTER VILLA	200 W CEDAR HESSTON, KS 67062

(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 657	Continued From page 2	F 657		

R82's "Dementia CAA" completed 08/12/24 indicated she had deficits with her short- and long-term memory. The CAA noted she required cueing from staff due to her disorganized thinking and inattention. The CAA noted a care plan will be implemented to reduce the risk associated with her impaired cognition.

R82's "Care Plan" initiated on 09/01/23 indicated she had wandering behaviors and a risk for elopement. The plan instructed staff to anticipate her needs, complete routine fall and elopement assessments, provide pleasant diversion during wandering, provide walks with staff, identify patterns of wandering, and intervene as appropriate. The plan noted she had a WanderGuard (a bracelet that helps monitor residents who are at risk of wandering) bracelet on her left wrist to prevent building elopements. The plan did not address R82's behaviors towards male peers.

R82's EMR under "Progress Notes" revealed a behavior note completed on 01/29/24. The note indicated that R82 walked around the unit holding hands with a male resident. The note indicated both residents were observed entering three other resident rooms with R82 leading the male resident.

R82's EMR under "Progress Notes" revealed a communication note completed on 02/07/24. The note indicated that R82's representative was contacted related to R82's behaviors towards male residents. The communication noted staff were providing distractions when R82 initiated intimate contact with male residents but also respected the resident's wishes. The note indicated that R82's family will discuss concerns

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175386	A. BUILDING _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCHOWALTER VILLA	200 W CEDAR HESSTON, KS 67062

(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 657	Continued From page 3	F 657		

and report back to the facility.

R82's EMR under "Progress Notes" revealed a communication note completed on 02/08/24. The note indicated her representative felt uncomfortable with R82's intimate actions with male residents and requested the facility not allow her to behind closed doors with male peers, touching private parts, or undressing in front of each other. The note indicated the representative approved of hand-holding, kissing, and visits with male peers.

On 11/06/24 at 07:34 AM R82 sat in the television area of the 500 Hallway.

On 11/05/24 at 09:01 AM R82's representative stated R82 had a history of wandering with male residents. She stated she met with the facility to ensure R82 was never left alone with male peers and was always supervised in the presence of male residents.

On 11/07/24 at 09:48 AM Certified Medication Aide (CMA) R stated all staff had access to the care plans. She stated the plans should note resident-specific behaviors and provide interventions to help staff prevent behaviors and calm the residents when upset.

On 11/07/27 at 10:01 AM Licensed Nurse (LN) G stated R82 had a history of wandering the facility with both staff and residents. She stated that R82 was easily redirected when confused. LN G stated residents with specific behaviors towards peers should be documented in the care plans.

On 11/07/24 at 10:31 PM Administrative Nurse D stated the care plans are reviewed and updated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175386	A. BUILDING _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCHOWALTER VILLA	200 W CEDAR HESSTON, KS 67062

(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 657	Continued From page 4 monthly by the interdisciplinary team and updated as needed. She stated residents with specific behaviors should be provided with interventions that address the identified behaviors to prevent further incidents. The facility's "Care Plan Meetings" policy revised 05/2024 indicated the facility will hold meetings upon admission, quarterly, annually, and at times of significant changes. The policy indicates the facility reviews, revises, and updates each resident's plan as their needs change. The facility failed to revise R82's "Care Plan" to include her identified behaviors toward male residents. This deficient practice placed R82 at risk for impaired care due to uncommunicated care needs.	F 657		
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: The facility identified a census of 95 residents. The sample included 19 residents. Based on observation, record review, and interviews, the facility failed to provide activities on the weekends	F 679		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175386	A. BUILDING _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCHOWALTER VILLA	200 W CEDAR HESSTON, KS 67062

(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 679	Continued From page 5	F 679		

that reflected the residents' interests and preferences. This deficient practice placed the affected residents at risk for decreased psychosocial well-being, boredom, and isolation.

Findings Included:

- A review of the facility's "Activity Calendar" for September, October, and November 2024 revealed no activities were scheduled on any Saturdays for all months reviewed. The calendars indicated the residents had church services on Sunday mornings and a reading activity on Sunday afternoons.

On 11/06/24 at 10:04 AM, observation revealed a daycare visit activity held with the residents.

On 11/06/24 at 01:05 PM, the Resident Council reported the facility did not provide activities on Saturdays. The council reported they were unaware if the facility had any activities on Saturdays but stated they would like some weekend activities other than just Church.

On 11/07/24 at 09:35 AM Certifed Medication Aide (CMA) R stated sometimes the life enrichment staff would hold groups on the weekends but she was not sure who held groups on Saturdays. She stated the calendars did not show activities on Saturdays due to the possible changes with staff designated to come in.

On 11/07/24 at 10:00 AM Activities Staff Z stated each household in the facility had a designated life enrichment coordinator that ensured activities were completed. She stated a weekend staff member would be designated to come in and hold activities, but the calendars may not reflect

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175386	A. BUILDING _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCHOWALTER VILLA	200 W CEDAR HESSTON, KS 67062

(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 679	Continued From page 6 the activities provided on the weekends. The facility's "Activities Services" policy revised 04/2018 indicated the facility will ensure residents are provided with activities that reflect their choices and interests. The policy indicates the facility will encourage each resident to attend activities that meet each resident's interests, hobbies, worship, beliefs, and social needs. The facility failed to provide activities on the weekends which reflected the residents' interests, and preferences. This placed the affected residents at risk for boredom, isolation, and decreased quality of life.	F 679		
F 756 SS=D	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 separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175386	A. BUILDING _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCHOWALTER VILLA	200 W CEDAR HESSTON, KS 67062

(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 756	Continued From page 7	F 756		

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 95 residents. The sample included 19 residents with five residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication used without a Centers for Medicare and Medicaid Services (CMS) approved indication for use for Resident (R)31, R48, and R59. These deficient practices placed the residents at risk for adverse medication effects and unnecessary medications.

Findings included:

- R31's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of urinary incontinence, a need for assistance with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175386	A. BUILDING _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCHOWALTER VILLA	200 W CEDAR HESSTON, KS 67062

(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 756	Continued From page 8	F 756		

personal care, hypertension (HTN-elevated blood pressure), dysphagia (swallowing difficulty), cognitive communication deficit, congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), venous insufficiency (poor circulation), weakness, major depressive disorder (major mood disorder that causes persistent feelings of sadness), anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues), dementia (a progressive mental disorder characterized by failing memory and confusion), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), sleep apnea (a disorder of sleep characterized by periods without respirations), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and psychotic disorder (a disorder that involves delusions, which are false beliefs that are not based in reality).

The "Quarterly Minimum Data Set" (MDS) dated 09/11/24 documented a Brief Interview of Mental Status (BIMS) score of 13 which indicated intact cognition. The MDS documented R31 received a diuretic (a medication to promote the formation and excretion of urine), anticoagulant (a class of medications used to prevent the blood from clotting), hypoglycemia (less than normal amount of sugar in the blood), opioid (a class of controlled drugs used to treat pain), antipsychotic medication, and antidepressant (a class of medications used to treat mood disorders) medication. The MDS did not indicate if a drug regimen review was completed.

.

R31's "Psychotropic Drug Use Care Area

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175386	A. BUILDING _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCHOWALTER VILLA	200 W CEDAR HESSTON, KS 67062

(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 756	Continued From page 9	F 756		

Assessment" (CAA) dated 06/25/24 documented the CAA triggered due to R31 receiving antidepressant and antipsychotic medication. R31 had a diagnosis of dementia and had increased issues with mood and behaviors. R31 scored a five on a brief, self-administered questionnaire that screens for and assesses the severity of depression (PHQ-9), indicating that R31 has mild depression symptoms. R31 was provided with one-to-one emotional support, redirection, reorientation, validation, and chaplain visits. R31 required set-up assistance with oral hygiene and personal hygiene; supervision with toilet transfers and sit-to-stand; moderate assistance with upper and lower body dressing, bed mobility, and chair and bed transfers; and was dependent on staff for toileting hygiene and donning and doffing footwear. R31 performs a pivot transfer to move from surface to surface and was independent with wheelchair mobilization. R31 was non-ambulatory. The medications were routinely reviewed by a pharmacist.

R31's "Care Plan" dated 01/19/23 documented that R31 received an antipsychotic medication and was at risk for adverse effects from the medication. Staff was to watch for changes in cognition mood changes, and functional decline. R31's plan of care revised on 03/04/24 documented that nursing was to work with the physician on a gradual dose reduction (GDR)to obtain the lowest effective dose, and nursing was to document all communication with physicians regarding GDRs.

R31's EMR under the "Orders" tab revealed the following physician order:
Seroquel (antipsychotic medication) oral tablet 25 milligrams (mg) give 25 mg by mouth in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175386	A. BUILDING _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCHOWALTER VILLA	200 W CEDAR HESSTON, KS 67062

(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 756	Continued From page 10	F 756		

morning for delusion (a fixed false belief that persists even when there was evidence to the contrary) related to depression, give one tablet dated 07/02/24.
Seroquel oral tablet 100 mg. Give 100 mg by mouth at bedtime related to psychotic disorder with delusions due to known physiological condition dated 07/02/24.

A review of the CP "Monthly Medication Review" (MMR) from November 2023 through October 2024 lacked evidence or documentation that the CP identified the unapproved p) indication for R31's Seroquel.

On 11/06/24 at 09:28 AM R31 sat in her wheelchair asleep with her brush in her hand.

On 11/07/24 at 09:54 AM Licensed Nurse (LN) G stated she was unsure what an approved indication for the use of an antipsychotic would be. LN G stated nursing staff had been working with the MDS person and getting training for approved diagnoses. She stated staff have also been working with the physician and the pharmacist, to ensure the residents had the appropriate indication for use of an antipsychotic medication.

On 11/07/24 at 10:25 AM Administrative Nurse D stated nursing was working with the physician and the pharmacist to ensure antipsychotic medications were not ordered for residents unless the medication, reasoning, and diagnosis were discussed with administrative nursing staff. Administrative Nurse D stated the pharmacist reviews all medication and indications monthly.

The facility did not provide a policy related to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175386	A. BUILDING _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCHOWALTER VILLA	200 W CEDAR HESSTON, KS 67062

(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 756	Continued From page 11	F 756		

"Monthly Medication Review" (MMR) reviews.

The facility failed to ensure the CP identified and reported the non-CMS-approved indication for R31's antipsychotic medication. This deficient practice placed R31 at risk for adverse medication effects and unnecessary medications.

- R48's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of difficulty walking, major depressive disorder (major mood disorder that causes persistent feelings of sadness), hypertension (HTN-elevated blood pressure), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), need for assistance with personal care, cognitive communication deficit, muscle weakness, mood disorder (category of mental health problems, feelings of sadness, helplessness, guilt, and wanting to die were more intense and persistent than what may normally be felt from time to time), dysphagia (swallowing difficulty), vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), sleep apnea (a disorder of sleep characterized by periods without respirations), and psychosis (any major mental disorder characterized by a gross impairment in reality perception) with hallucination (sensing things while awake that appear to be real, but the mind created).

The "Quarterly Minimum Data Set" (MDS) dated 10/02/24 documented a Brief Interview of Mental Status (BIMS) score of seven which indicated severely impaired cognition. The MDS documented R48 had received an antipsychotic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175386	A. BUILDING _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCHOWALTER VILLA	200 W CEDAR HESSTON, KS 67062

(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 756	Continued From page 12	F 756		

(a class of medications used to treat major mental conditions that cause a break from reality), antidepressant (a class of medications used to treat mood disorders), antianxiety (a class of medications that calm and relax people), and opioid (a class of controlled drugs used to treat pain) during the observation period. The MDS documented no gradual dose reduction.

R48's "Psychotropic Drug Use Care Area Assessment" (CAA) dated 07/17/24 documented the CAA was triggered due to the resident taking an antipsychotic, antianxiety, and antidepressant medication. R48 required long-term care due to a progression of diagnoses, and R48 ' s need for assistance with daily care and medication management. The resident was at risk for a decline in her functional and cognitive abilities. The resident was noted to have a significant change from her prior MDS as the resident was noted to have increased anxiety and tearfulness. The resident required staff assistance with ambulation over short distances, used a wheelchair with staff assistance for mobility in her room and in the halls, and required staff assistance and supervision with daily care. R48 was noted to have difficulty at times with safety awareness, memory, decision-making, and orientation to time. R48 expressed having little interest or pleasure in doing things and feeling down and depressed. R48 had a diagnosis of dementia. R48 ' s medications were also routinely reviewed by a pharmacist.

R48's "Care Plan" revised 07/17/24 documented that nursing was to administer antipsychotic medications as ordered by the physician. Nursing were to discuss with the physician and family and review the ongoing need for the use of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175386	A. BUILDING _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCHOWALTER VILLA	200 W CEDAR HESSTON, KS 67062

(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 756	Continued From page 13	F 756		

medication. Nursing was to review R48 ' s behaviors and interventions and alternative therapies attempted and their effectiveness as per facility policy.

R48 ' s EMR under the "Orders" tab revealed the following physician orders:
Seroquel (antipsychotic medication) oral tablet 25 milligrams (mg) give 25 mg by mouth at bedtime for depression with psychotic features, and refractory severe depression dated 05/23/24.

The CP "Monthly Medication Review" (MMR) from November 2023 through October 2024 lacked evidence or documentation that the CP identified the unapproved per Centers for Medicare and Medicaid Services (CMS) indication for R48 ' s Serquel.

On 11/06/24 at 10:11 AM R48 sat in her recliner outside of the beauty shop, waiting to have her hair done.

On 11/07/24 at 09:54 AM Licensed Nurse (LN) G stated she was unsure what an approved indication for the use of an antipsychotic would be. She stated staff have also been working with the physician and the pharmacist, to ensure the residents had the appropriate indication for use of an antipsychotic medication.

On 11/07/24 at 10:25 AM Administrative Nurse D stated nursing was working with the physician and the pharmacist to ensure antipsychotic medications were not ordered for residents unless the medication, reasoning, and diagnosis were discussed with administrative nursing staff. Administrative Nurse D stated the pharmacist reviews all medication and indications monthly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175386	A. BUILDING _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCHOWALTER VILLA	200 W CEDAR HESSTON, KS 67062

(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 756	Continued From page 14	F 756		

The facility did not provide a policy related to "Monthly Medication Review" (MMR) reviews.

The facility failed to ensure the CP identified and reported the non-CMS-approved indication for R48 ' s antipsychotic medication. This deficient practice placed R48 at risk for adverse medication effects and unnecessary medications. - R59's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), major depressive disorder (major mood disorder that causes persistent feelings of sadness), and dementia (a progressive mental disorder characterized by failing memory and confusion).

The "Annual Minimum Data Set" (MDS) dated 10/02/24 documented a Brief Interview of Mental Status (BIMS) score of two which indicated severely impaired cognition. The MDS documented R59 received antipsychotic medication, antidepressant (a class of medications used to treat mood disorders) medication, antianxiety (a class of medications that calm and relax people) medication, and opioid (a class of controlled drugs used to treat pain) medication.

R59's "Psychotropic Drug Use Care Area Assessment" (CAA) dated 10/16/24 documented he had received antipsychotic, antianxiety, and antidepressant medications. R59 had a diagnosis of severe dementia. The CAA documented he had severe cognitive impairment and displayed inattention, disorganized thinking, and an altered level of consciousness that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175386	A. BUILDING _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCHOWALTER VILLA	200 W CEDAR HESSTON, KS 67062

(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 756	Continued From page 15	F 756		

fluctuated. R59's medications were also routinely reviewed by a pharmacist with no changes recommended.

R59's "Care Plan" last revised on 12/01/23 documented that nursing staff would administer his medications as ordered. The plan of care directed the nursing staff to monitor and document any side effects and the effectiveness of the medication.

R59's EMR under the "Orders" tab revealed the following physician orders:
Lorazepam (antianxiety) oral tablet one milligram (mg) give one tablet by mouth four times a day for restlessness or anxiety dated 03/30/24.
Lorazepam oral tablet one mg give one tablet by mouth every four hours as needed for restlessness for six months dated 09/13/24.
Haloperidol (antipsychotic) oral tablet one mg give one tablet by mouth three times a day for agitation, restlessness, combativeness, and hallucinations dated 10/03/24.

A review of R59's EMR under the "Progress Notes" revealed a "Pharmacy Review Note dated 11/27/23 at 04:40 PM that documented chart review with no current recommendation.
On 12/21/23 at 10:21 AM a" Pharmacy Review Note" documented a chart review with no current recommendation.
On 01/23/24 at 1157 AM a "Pharmacy Review Note" documented a chart review with no current recommendation. R59 continued on hospice.
On 02/23/24 at 10:10 AM a "Pharmacy Review Note" documented a chart review with no current recommendation.
On 03/19/24 at 04:26 PM a "Pharmacy Review Note" documented a chart review with no current

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175386	A. BUILDING _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCHOWALTER VILLA	200 W CEDAR HESSTON, KS 67062

(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 756	Continued From page 16	F 756		

recommendation.
On 04/26/24 at 02:25 PM a "Pharmacy Review Note" documented a chart review with no current recommendation.
On 05/21/24 at 03:20 PM a "Pharmacy Review Note" documented a chart review with no current recommendation.
On 06/28/24 at 01:40 PM a "Pharmacy Review Note" documented a chart review with no current recommendation. R59 remained on hospice.
On 07/23/24 at 10:53 AM a "Pharmacy Review Note" documented a chart review with no current recommendation.
On 08/23/24 at 01:42 PM a "Pharmacy Review Note" documented a chart review with no current recommendation. R59 remained on hospice.

On 09/27/24 at 01:30 PM a "Pharmacy Review Note" documented a chart review with no current recommendation.
On 10/31/24 at 11:05 AM a "Pharmacy Review Note" documented a chart review with no current recommendation.

A review of R59's EMR lacked evidence of physician-documented rationale including the risk versus benefits for R59's antipsychotic medication without a CMS-approved indication. R59's EMR also lacked a physician-documented rationale for the extended duration of the as-needed lorazepam.

On 11/06/24 at 08:34 AM R59 sat reclined in his Broda chair (specialized wheelchair with the ability to tilt and recline) chair as the staff pushed him from his room to the dining room for breakfast.

On 11/07/24 at 09:54 AM Licensed Nurse (LN) G

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175386	A. BUILDING _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCHOWALTER VILLA	200 W CEDAR HESSTON, KS 67062

(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 756	Continued From page 17 stated she was unsure what an approved indication for the use of an antipsychotic would be. LN G stated nursing staff had been working with the MDS person and getting training for approved diagnoses. She stated staff have also been working with the physician and the pharmacist, to ensure the residents had the appropriate indication for use of an antipsychotic medication. On 11/07/24 at 10:25 AM Administrative Nurse D stated nursing was working with the physician and the pharmacist to ensure antipsychotic medications were not ordered for residents unless the medication, reasoning, and diagnosis were discussed with administrative nursing staff. Administrative Nurse D stated the pharmacist reviews all medication and indications monthly. The facility did not provide a policy related to "Monthly Medication Review" (MMR) reviews. The facility failed to ensure the CP identified and reported the non-CMS-approved indication for R59's antipsychotic medication. This deficient practice placed R59 at risk for adverse medication effects and unnecessary medications.	F 756		
F 758 SS=E	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;	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175386	A. BUILDING _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCHOWALTER VILLA	200 W CEDAR HESSTON, KS 67062

(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 18 (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 §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.	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175386	A. BUILDING _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCHOWALTER VILLA	200 W CEDAR HESSTON, KS 67062

(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 19	F 758		

This REQUIREMENT is not met as evidenced by:
The facility identified a census of 95 residents. The sample included 19 residents with five residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure a Centers for Medicare and Medicaid Services (CMS) approved indication of use or a documented physician rationale and risk versus benefits for the continued use of an antipsychotic (class of medications used to treat a mental disorder characterized by gross impairment in reality testing) for Resident (R)31, R48, R12 and R59. The facility additionally failed to ensure a physician documented rationale for the extended duration of R59's as-needed psychotropic (alters mood or thoughts) medication. These deficient practices placed the residents at risk for adverse medication effects and unnecessary medications.

Findings included:

- R31's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of urinary incontinence, a need for assistance with personal care, hypertension (HTN-elevated blood pressure), dysphagia (swallowing difficulty), cognitive communication deficit, congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), venous insufficiency (poor circulation), weakness, major depressive disorder (major mood disorder that causes persistent feelings of sadness), anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues), dementia (a progressive mental disorder characterized by failing memory and confusion), diabetes mellitus (DM-when the body cannot use

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175386	A. BUILDING _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCHOWALTER VILLA	200 W CEDAR HESSTON, KS 67062

(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 20	F 758		

glucose, not enough insulin is made, or the body cannot respond to the insulin), sleep apnea (a disorder of sleep characterized by periods without respirations), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and psychotic disorder (a disorder that involves delusions, which are false beliefs that are not based in reality).

The "Quarterly Minimum Data Set" (MDS) dated 09/11/24 documented a Brief Interview of Mental Status (BIMS) score of 13 which indicated intact cognition. The MDS documented R31 received a diuretic (a medication to promote the formation and excretion of urine), anticoagulant (a class of medications used to prevent the blood from clotting), hypoglycemic (less than normal amount of sugar in the blood), opioid (a class of controlled drugs used to treat pain), antipsychotic medication, and antidepressant (a class of medications used to treat mood disorders) medication.

R31's "Psychotropic Drug Use Care Area Assessment" (CAA) dated 06/25/24 documented the CAA triggered due to R31 receiving antidepressant and antipsychotic medication. R31 had a diagnosis of dementia and had increased issues with mood and behaviors. R31 scored a five on a brief, self-administered questionnaire that screens for and assesses the severity of depression (PHQ-9), indicating that R31 has mild depression symptoms. R31 was provided with one-to-one emotional support, redirection, reorientation, validation, and chaplain visits. R31 required set-up assistance with oral hygiene and personal hygiene; supervision with toilet transfers and sit-to-stand; moderate assistance with upper

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175386	A. BUILDING _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCHOWALTER VILLA	200 W CEDAR HESSTON, KS 67062

(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 21	F 758		

and lower body dressing, bed mobility, and chair and bed transfers; and was dependent on staff for toileting hygiene and donning and doffing footwear. R31 performs a pivot transfer to move from surface to surface and was independent with wheelchair mobilization. R31 was non-ambulatory. The medications were routinely reviewed by a pharmacist.

R31's "Care Plan" dated 01/19/23 documented that R31 received an antipsychotic medication and was at risk for adverse effects from the medication. Staff was to watch for changes in cognition mood changes, and functional decline. R31's plan of care revised on 03/04/24 documented that nursing was to work with the physician on a gradual dose reduction (GDR) to obtain the lowest effective dose, and nursing was to document all communication with physicians regarding GDRs.

R31's EMR under the "Orders" tab revealed the following physician orders:
Seroquel (antipsychotic medication) oral tablet 25 milligrams (mg) give 25 mg by mouth in the morning for delusion (a fixed false belief that persists even when there was evidence to the contrary) related to depression, give one tablet dated 07/02/24.
Seroquel oral tablet 100 mg. Give 100 mg by mouth at bedtime related to psychotic disorder with delusions due to known physiological condition dated 07/02/24.

A review of R31's EMR lacked evidence of physician-documented rationale including the risk versus benefits for R31's antipsychotic medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175386	A. BUILDING _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCHOWALTER VILLA	200 W CEDAR HESSTON, KS 67062

(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 22	F 758		

On 11/06/24 at 09:28 AM R31 sat in her wheelchair asleep with her brush in her hand.

On 11/07/24 at 09:54 AM Licensed Nurse (LN) G stated she was unsure what an approved indication for the use of an antipsychotic would be. LN G stated nursing staff had been working with the MDS person and getting training for approved diagnoses. She stated staff have also been working with the physician and the pharmacist, to ensure the residents had the appropriate indication for use of an antipsychotic medication.

On 11/07/24 at 10:25 AM Administrative Nurse D stated nursing was working with the physician and the pharmacist to ensure antipsychotic medications were not ordered for residents unless the medication, reasoning, and diagnosis were discussed with administrative nursing staff. Administrative Nurse D stated the pharmacist reviews all medication and indications monthly.

The facility's "Antipsychotic Medication Administration" policy dated 09/26/23 documented a resident who had not used antipsychotic drugs was not given an antipsychotic drug unless antipsychotic drug therapy was necessary to treat a specific condition as diagnosed and documented in the resident's clinical record. Any resident who uses an antipsychotic drug receives routine dose reductions, and behavioral interventions, unless clinically contraindicated, to discontinue these drugs to ensure the resident does not receive unnecessary medications and the lowest possible dose is administered for the shortest amount of time. All physician orders for antipsychotic medications will be clear and accurate and will

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175386	A. BUILDING _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCHOWALTER VILLA	200 W CEDAR HESSTON, KS 67062

(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 23	F 758		

include a diagnosis, condition, or indicated for use.

The facility failed to ensure an appropriate indication of use or a documented physician rationale and risk versus benefits for the continued use of an antipsychotic for R31. This placed the resident at risk for unnecessary medication effects.

- R48's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of difficulty walking, major depressive disorder (major mood disorder that causes persistent feelings of sadness), hypertension (HTN-elevated blood pressure), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), need for assistance with personal care, cognitive communication deficit, muscle weakness, mood disorder (category of mental health problems, feelings of sadness, helplessness, guilt, and wanting to die were more intense and persistent than what may normally be felt from time to time), dysphagia (swallowing difficulty), vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), sleep apnea (a disorder of sleep characterized by periods without respirations), and psychosis (any major mental disorder characterized by a gross impairment in reality perception) with hallucination (sensing things while awake that appear to be real, but the mind created).

The "Quarterly Minimum Data Set" (MDS) dated 10/02/24 documented a Brief Interview of Mental Status (BIMS) score of seven which indicated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175386	A. BUILDING _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCHOWALTER VILLA	200 W CEDAR HESSTON, KS 67062

(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 24	F 758		

severely impaired cognition. The MDS documented that R48 had received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), antidepressant (a class of medications used to treat mood disorders), antianxiety (a class of medications that calm and relax people), and opioid (a class of controlled drugs used to treat pain) during the observation period. The MDS documented no gradual dose reduction.

R48's "Psychotropic Drug Use Care Area Assessment" (CAA) dated 07/17/24 documented the CAA was triggered due to the resident taking an antipsychotic, antianxiety, and antidepressant medication. R48 required long-term care due to a progression of diagnoses, and R48's need for assistance with daily care and medication management. The resident was at risk for a decline in her functional and cognitive abilities. The resident was noted to have a significant change from her prior MDS as the resident was noted to have increased anxiety and tearfulness. The resident required staff assistance with ambulation over short distances, used a wheelchair with staff assistance for mobility in her room and in the halls, and required staff assistance and supervision with daily care. R48 was noted to have difficulty at times with safety awareness, memory, decision-making, and orientation to time. R48 expressed having little interest or pleasure in doing things and feeling down and depressed. R48 had a diagnosis of dementia. R48's medications were also routinely reviewed by a pharmacist.

R48's "Care Plan" revised 07/17/24 documented that nursing was to administer antipsychotic medications as ordered by the physician. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175386	A. BUILDING _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCHOWALTER VILLA	200 W CEDAR HESSTON, KS 67062

(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	F 758		

nursing staff was to discuss with the physician and family and review the ongoing need for the use of medication. Nursing was to review R48's behaviors and interventions and alternative therapies attempted and their effectiveness as per facility policy.

R48's EMR under the "Orders" tab revealed the following physician orders:
Seroquel (antipsychotic medication) oral tablet 25 milligrams (mg) give 25 mg by mouth at bedtime for depression with psychotic features, and refractory severe depression dated 05/23/24.

A review of R48's EMR lacked evidence of a physician-documented rationale including the risk versus benefits for R48's antipsychotic medication.

On 11/06/24 at 10:11 AM R48 sat in her recliner outside of the beauty shop, waiting to have her hair done.

On 11/07/24 at 09:54 AM Licensed Nurse (LN) G stated she was unsure what an approved indication for the use of an antipsychotic would be. LN G stated nursing staff had been working with the MDS person and getting training for approved diagnoses. She stated staff have also been working with the physician and the pharmacist, to ensure the residents had the appropriate indication for use of an antipsychotic medication.

On 11/07/24 at 10:25 AM Administrative Nurse D stated nursing was working with the physician and the pharmacist to ensure antipsychotic medications were not ordered for residents unless the medication, reasoning, and diagnosis

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175386	A. BUILDING _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCHOWALTER VILLA	200 W CEDAR HESSTON, KS 67062

(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 26	F 758		

were discussed with administrative nursing staff. Administrative Nurse D stated the pharmacist reviews all medication and indications monthly.

The facility's "Antipsychotic Medication Administration" policy dated 09/26/23 documented a resident who had not used antipsychotic drugs was not given an antipsychotic drug unless antipsychotic drug therapy was necessary to treat a specific condition as diagnosed and documented in the resident's clinical record. Any resident who uses an antipsychotic drug receives routine dose reductions, and behavioral interventions, unless clinically contraindicated, to discontinue these drugs to ensure the resident does not receive unnecessary medications and the lowest possible dose is administered for the shortest amount of time. All physician orders for antipsychotic medications will be clear and accurate and will include a diagnosis, condition, or indicated for use.

The facility failed to ensure an appropriate indication for use or a documented physician rationale and risk versus benefits for the continued use of an antipsychotic for R48. This placed the resident at risk for unnecessary medication effects.

- R12's "Medical Diagnosis" section within the Electronic Medical Record (EMR) noted diagnoses of cognitive communication disorder, dementia (a progressive mental disorder characterized by failing memory and confusion), heart failure, and anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175386	A. BUILDING _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCHOWALTER VILLA	200 W CEDAR HESSTON, KS 67062

(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 27	F 758		

R12's "Quarterly Minimum Data Set (MDS) completed 09/18/24 revealed a Brief Interview for Mental Status (BIMS) score of eight indicating moderate cognitive impairment. The MDS indicated he was totally dependent on staff assistance for toileting, bathing, dressing, bed mobility, and personal hygiene. The MDS indicated he took antipsychotic medication on a routine basis. The MDS indicated a gradual dosage reduction (GDR) was clinically contraindicated on 02/22/22.

R12's "Psychotropic Medication Care Area Assessment (CAA)" completed 09/26/24 indicated he was at risk for complications related to his antipsychotic medication use. The CAA noted he took Seroquel three times daily (TID) for delusions. The CAA noted he was verbally and physically aggressive. The CAA noted he rejected care. The CAA noted that R12's medications were reviewed by the pharmacist on 09/16/24 with no noted concerns. The CAA noted staff will continue to work with R12's representative, medical provider, and hospice services (end-of-life services) to ensure dignity and comfort.

R12's "Care Plan" initiated 06/02/21 indicated he received antipsychotic medications. The plan instructed staff to monitor him for adverse reactions. The plan instructed staff to monitor him for changes in mood and cognition. The plan noted that a gradual dose reduction would be completed to obtain the lowest effective dose.

R12's EMR under "Physicians Orders" revealed an order (started 01/03/24) for staff to administer 50 milligrams (mg) of Seroquel three times a day by mouth for depression, morbid thoughts,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175386	A. BUILDING _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCHOWALTER VILLA	200 W CEDAR HESSTON, KS 67062

(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 28	F 758		

irritability, and paranoia.

R12's EMR under "Progress Notes" for pharmacy review from 11/01/23 through 11/01/24 lacked documentation of any concern related to his Seroquel medication.

A review of R12's EMR revealed no physician-documented rationale for the use of Seroquel medication with the indication of depression, morbid thoughts, irritability, and paranoia.

On 11/07/24 at 12:21 PM, R12 sat in the dining hall for lunch. He had compression socks on both feet. His indwelling urinary catheter (a tube inserted into the bladder to drain urine into a collection bag) collection bag was positioned under his wheelchair in a privacy bag.

On 11/07/24 at 10:20 AM Licensed Nurse (LN) G stated antipsychotic medication should only be used for indications related to schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought) or behavioral-related mental illnesses.

On 11/07/24 at 11:05 AM Administrative Nurse D stated antipsychotic medication should only be used for CMS-approved indications. She stated the facility's nursing team recently reviewed all medications with the pharmacy to ensure accurate diagnoses and indications for psychotropic medications. She stated medications would not be added unless administrative nursing staff reviewed the indications. She stated approved indications for antipsychotic medications included schizophrenia,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175386	A. BUILDING _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCHOWALTER VILLA	200 W CEDAR HESSTON, KS 67062

(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 29	F 758		

Huntington's disease (a rare abnormal hereditary condition characterized by progressive mental deterioration, a disabling central nervous system movement disorder), Tourette's (condition of the nervous syndrome causing uncontrollable repetitive movements or unwanted sounds), and delusional disorders (untrue persistent belief or perception held by a person although evidence shows it was untrue).

The facility's "Antipsychotic Medication Administration" policy 09/2023 indicated all residents with antipsychotic medications will receive routine clinical reviews and dose reductions to achieve the lowest possible therapeutic dose. The policy indicates the physician orders will be clear and accurate and include an approved indication.

The facility failed to ensure a physician-documented rationale which included risks versus benefits for R12's Seroquel medication given without a CMS-approved indication. This placed the resident at risk for unnecessary psychotropic medications and related complications.
- R59's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), major depressive disorder (major mood disorder that causes persistent feelings of sadness), and dementia (a progressive mental disorder characterized by failing memory and confusion).

The "Annual Minimum Data Set" (MDS) dated 10/02/24 documented a Brief Interview of Mental Status (BIMS) score of two which indicated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175386	A. BUILDING _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCHOWALTER VILLA	200 W CEDAR HESSTON, KS 67062

(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 30	F 758		

severely impaired cognition. The MDS documented R59 received antipsychotic medication, antidepressant (a class of medications used to treat mood disorders) medication, antianxiety (a class of medications that calm and relax people) medication, and opioid (a class of controlled drugs used to treat pain) medication.

R59's "Psychotropic Drug Use Care Area Assessment" (CAA) dated 10/16/24 documented he had received antipsychotic, antianxiety, and antidepressant medications. R59 had a diagnosis of severe dementia. The CAA documented he had severe cognitive impairment and displayed inattention, disorganized thinking, and an altered level of consciousness that fluctuated. R59's medications were also routinely reviewed by a pharmacist with no changes recommended.

R59's "Care Plan" last revised on 12/01/23 documented that nursing staff would administer his medications as ordered. The plan of care directed the nursing staff to monitor and document any side effects and the effectiveness of the medication.

R59's EMR under the "Orders" tab revealed the following physician orders:
Lorazepam (antianxiety) oral tablet one milligram (mg) give one tablet by mouth four times a day for restlessness or anxiety dated 03/30/24.
Lorazepam oral tablet one mg give one tablet by mouth every four hours as needed for restlessness for six months dated 09/13/24.
Haloperidol (antipsychotic) oral tablet one mg give one tablet by mouth three times a day for agitation, restlessness, combativeness, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175386	A. BUILDING _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCHOWALTER VILLA	200 W CEDAR HESSTON, KS 67062

(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 31	F 758		

hallucinations dated 10/03/24.

A review of R59's EMR lacked evidence of physician-documented rationale including the risk versus benefits for R59's antipsychotic medication with non-approved CMS indication. R59's EMR also lacked a physician-documented rationale for the extended duration of the as-needed lorazepam.

On 11/06/24 at 08:34 AM R59 sat reclined in his Broda chair (specialized wheelchair with the ability to tilt and recline) chair as the staff pushed him from his room to the dining room for breakfast.

On 11/07/24 at 09:54 AM Licensed Nurse (LN) G stated she was unsure what an approved indication for the use of an antipsychotic would be. LN G stated nursing staff had been working with the MDS person and getting training for approved diagnoses. She stated staff have also been working with the physician and the pharmacist, to ensure the residents had the appropriate indication for use of an antipsychotic medication.

On 11/07/24 at 10:25 AM Administrative Nurse D stated nursing was working with the physician and the pharmacist to ensure antipsychotic medications were not ordered for residents unless the medication, reasoning, and diagnosis were discussed with administrative nursing staff. Administrative Nurse D stated the pharmacist reviews all medication and indications monthly.

The facility's "Antipsychotic Medication Administration" policy dated 09/26/23 documented a resident who had not used

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175386	A. BUILDING _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCHOWALTER VILLA	200 W CEDAR HESSTON, KS 67062

(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 32 antipsychotic drugs was not given an antipsychotic drug unless antipsychotic drug therapy was necessary to treat a specific condition as diagnosed and documented in the resident's clinical record. Any resident who uses an antipsychotic drug receives routine dose reductions, and behavioral interventions, unless clinically contraindicated, to discontinue these drugs to ensure the resident does not receive unnecessary medications and the lowest possible dose is administered for the shortest amount of time. All physician orders for antipsychotic medications will be clear and accurate and will include a diagnosis, condition, or indicated for use. The facility failed to ensure a CMS-approved indication of use or a documented physician rationale and risk versus benefits for the use of Haldol for R59. The facility also failed to ensure the physician documented a rationale for the extended use of as-needed lorazepam. This placed R59 at risk for possible adverse effects and unnecessary medications.	F 758		
F 849 SS=D	Hospice Services CFR(s): 483.70(n)(1)-(4) §483.70(n) Hospice services. §483.70(n)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services	F 849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175386	A. BUILDING _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCHOWALTER VILLA	200 W CEDAR HESSTON, KS 67062

(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 849	Continued From page 33	F 849		

when a resident requests a transfer.

§483.70(n)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:
(i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.
(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:
(A) The services the hospice will provide.
(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175386	A. BUILDING _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCHOWALTER VILLA	200 W CEDAR HESSTON, KS 67062

(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 849	Continued From page 34	F 849		

responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175386	A. BUILDING _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCHOWALTER VILLA	200 W CEDAR HESSTON, KS 67062

(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 849	Continued From page 35 (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(n)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient.	F 849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175386	A. BUILDING _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCHOWALTER VILLA	200 W CEDAR HESSTON, KS 67062

(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 849	Continued From page 36 (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: The facility identified a census of 95 residents. The sample included 19 residents with one resident reviewed for hospice services. Based on observation, record review, and interviews, the facility failed to ensure collaboration regarding Resident (R) 59's care between the nursing home and the hospice. This deficient practice created a risk for impaired end-of-life care for R59. Findings included:	F 849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175386	A. BUILDING _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCHOWALTER VILLA	200 W CEDAR HESSTON, KS 67062

(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 849	Continued From page 37	F 849		

- R59's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), major depressive disorder (major mood disorder that causes persistent feelings of sadness), and dementia (a progressive mental disorder characterized by failing memory and confusion).

The "Annual Minimum Data Set" (MDS) dated 10/02/24 documented a Brief Interview of Mental Status (BIMS) score of two which indicated severely impaired cognition. The MDS documented that R59 received hospice services during the observation period.

R59's "Psychotropic Drug Use Care Area Assessment" (CAA) dated 10/16/24 documented he received psychotropic (alters mood or thoughts) medications. R59 remained on hospice services.

R59's "Care Plan" dated 11/16/23 documented he received hospice services and was at risk for unmet needs, along with alterations in his comfort. The plan of care also directed the staff to assist him with activities of daily living (ADL) as needed. The plan of care directed the nursing staff to follow R59's "Care Plan" that was in place. The plan of care directed the staff to encourage a support system of family and friends. The plan of care directed the staff to keep his environment calm and quiet. The plan documented that staff would keep R59's linens clean, dry, and wrinkle-free. The plan of care also documented the staff would keep his lighting low and familiar objects near him. The plan of care documented comfort medications would be administered as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175386	A. BUILDING _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCHOWALTER VILLA	200 W CEDAR HESSTON, KS 67062

(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 849	Continued From page 38	F 849		

ordered as needed and oral suction provided as needed. The plan of care also documented the staff would monitor him for pain, administer pain medications as ordered, and would notify the physician of any breakthrough pain. The plan of care also directed the staff to use alternative techniques to relieve his pain such as to help him relax and promote his comfort (back rubs, massage, application of lotion, soothing music, conversation, a soft pillow for positioning, and a cup of warm tea. The plan of care directed the staff to document the alternative technique used and its effectiveness. The plan of care directed the staff to always think of comfort when providing care for R59. The plan of care documented that staff would monitor his respiratory status, administer oxygen as needed for comfort, and notify hospice and physician if no relief. The plan of care directed staff to monitor R59's skin for any changes, notify the physician, and treat as ordered. The plan of care directed staff to work with the hospice provider to ensure R59's spiritual, emotional, intellectual, physical, and social needs were met. The plan of care lacked which medications were provided by the hospice, what equipment the hospice supplied, the frequency and dates hospice would assist with bathing, and the frequency of hospice nurse visits.

R59's EMR under the "Orders" tab revealed the following physician orders:
Admit to hospice dated 11/16/23.

A review of the book provided by hospice for communication and collaboration of care lacked a current hospice care plan.

On 11/06/24 at 08:34 AM R59 sat reclined in his

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175386	A. BUILDING _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCHOWALTER VILLA	200 W CEDAR HESSTON, KS 67062

(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 849	Continued From page 39	F 849		

Broda chair (specialized wheelchair with the ability to tilt and recline) chair as the staff pushed him from his room to the dining room for breakfast.

On 11/07/24 at 09:47 AM, Certified Medication Aide (CMA) R stated she was not sure where to locate the information for a list of what equipment was provided by the hospice provider. CMA R stated she knew that the hospice provided cleansing wipes and incontinent products. She stated she would look at the communication book provided by the hospice to find out the day's hospice provided R59's baths.

On 11/07/24 at 09:54 AM, Licensed Nurse (LN) G stated she updated most of the care plans. LN G stated the items covered or provided by R59's hospice provider were not included in his plan of care. She stated staff had access to the communication book provided by the hospice provider for any information about what was covered or provided.

On 11/07/24 at 10:31 AM, Administrative Nurse D stated the communication book provided by the hospice provider contained all the information of what the hospice provided and covered. Administrative Nurse D stated some items covered or provided by the hospice provider may be listed on R59's "Care Plan" but primary information would be found only in the hospice communication book.

The facility's "End of Life" policy last revised on 12/13/23 documented it was their policy to provide comfort care when the physician, resident, and/or family decide that it was time to move from a treatment mode to addressing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175386	A. BUILDING _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCHOWALTER VILLA	200 W CEDAR HESSTON, KS 67062

(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 849	Continued From page 40 symptoms that caused discomfort. At the time this was decided, the physician would be consulted regarding offering the option to use their hospice benefit, if they qualify. The care plan would specify coordination of care with the hospice provider. The hospice case manager would participate in interdisciplinary care plan meetings. Hospice staff would perform contracted services such as bathing, ADLs, activities, and spiritual support. All new orders from physicians would be coordinated with the hospice case manager. Nursing staff would notify hospice for pain control and changes in the resident's condition. The facility failed to ensure a collaborative process was in place to communicate necessary information regarding R59's care between the nursing home and the hospice. This placed R59 at risk for impaired end-of-life care.	F 849		
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	F 883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175386	A. BUILDING _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCHOWALTER VILLA	200 W CEDAR HESSTON, KS 67062

(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 883	Continued From page 41 (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 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:	F 883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175386	A. BUILDING _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCHOWALTER VILLA	200 W CEDAR HESSTON, KS 67062

(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 883	Continued From page 42	F 883		

The facility identified a census of 95 residents. The sample included 19 residents with five reviewed for immunization status. Based on record reviews, and interviews, the facility failed to offer and administer, or obtain an informed declination for the Pneumococcal Conjugate Vaccine (PCV20- vaccination for bacterial pneumonia infections) vaccination for Resident (R) 31. This placed the resident at increased risk for complications related to pneumonia (an infection in the lungs).

Findings included:

- Review of R31's clinical record revealed the PCV13 was administered on 12/10/10, and the PSV23 was administered on 10/28/13. R31's clinical record lacked documentation the PCV20 was discussed and offered. The EMR lacked documentation of a historical administration, informed declination, or a physician-documented contraindication.

On 11/07/24 at 10:09 AM Administrative Nurse E stated the facility followed the Centers for Disease Control and Prevention guidelines (CDC). Administrative Nurse E stated the CDC had a program that would tell the facility if the resident needed their next vaccination. Administrative Nurse E stated the immunization staff talked to all residents when the resident was admitted to the facility about immunizations, and the facility would then follow up as needed.

The facility's "Immunizations" policy revised 03/05/24 documented upon admission determination of vaccination status will be determined by the Licensed Nurse (LN) who would ask the resident and or responsible party

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175386	A. BUILDING _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCHOWALTER VILLA	200 W CEDAR HESSTON, KS 67062

(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 883	Continued From page 43 or legal guardian about receiving the vaccination. If the vaccination status remains unknown, the nurse would contact the primary care physician for documentation of vaccination status. A consent form will be signed by the resident or responsible party for those who have never received any pneumococcal conjugate vaccine, CDC recommends PCV15 and PCV20 for adults 65 years or older and If PCV15 was used this would be followed by a dose of PPSV23. The facility failed to discuss and offer the PCV20 or obtain informed declinations for R31. This placed the resident at increased risk for complications related to pneumonia.	F 883		