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	175561	A. BUILDING _____ B. WING _____	03/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT ST MARY	3700 E LINCOLN ST WICHITA, KS 67218

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Recertification Survey and complaint survey regarding allegations in KS00191062. The 2567 was sent electronically on 04/14/25.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and	F 656		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 04/14/2025

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

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desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 22 residents with 15 residents sampled. Based on interviews and record review, the facility failed to complete a thorough baseline care plan for Resident (R) 17 regarding the use of a non-invasive ventilator (a mechanical ventilation technique that delivers oxygen through a face mask without the use of endotracheal (in the throat) intubation). This placed the resident at risk for respiratory complications due to uncommunicated care needs..

Findings included:

- A review of R17's electronic medical record (EMR) revealed a diagnosis of chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing).

The "Admission Minimum Data Set" (MDS),

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F 656	Continued From page 2 dated 01/20/25, documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. She utilized a non-invasive mechanical ventilator. The "Functional Abilities Care Area Assessment" (CAA), dated 01/20/25, documented the resident required fluctuating levels of staff assistance due to her respiratory function. R17's "Care Plan," revised 03/09/25, lacked staff instruction regarding the non-invasive ventilator. A review of the resident's EMR lacked a physician's order for the use of the non-invasive ventilator. On 03/31/25 at 07:07 AM, Administrative Nurse D stated the resident required a non-invasive ventilator since admission and cared for the device herself. Administrative Nurse D stated it was the expectation for a non-invasive ventilator to be included in the resident's care plan and confirmed it was not. The facility policy for "Baseline Care Plans", revised 11/21/24, included: The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective care of the resident.	F 656		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such	F 695		

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F 695	Continued From page 3	F 695		

care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 22 residents with 15 residents sampled, including one resident reviewed for respiratory care. Based on observation, record review, and interview, the facility failed to obtain a physician's order for the use of a non-invasive ventilator (a mechanical ventilation technique that delivers oxygen through a face mask without the use of endotracheal (in the throat) intubation) for Resident (R) 17. This placed R17 at risk for respiratory complications.

Findings included:

- R17's electronic medical record (EMR) revealed a diagnosis of chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing).

The "Admission Minimum Data Set" (MDS), dated 01/20/25, documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. She utilized a non-invasive mechanical ventilator.

The "Functional Abilities Care Area Assessment" (CAA) dated 01/20/25 documented the resident required fluctuating levels of staff assistance due to her respiratory function.

R17's "Care Plan," revised 03/09/25, lacked staff instruction regarding the non-invasive ventilator.

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F 695	Continued From page 4 R17's EMR lacked a physician's order for the use of the non-invasive ventilator. On 03/26/25 at 11:35 AM, R17 stated she has had a non-invasive ventilator since admission into the facility. On 03/27/25 at 12:41 PM, Licensed Nurse (LN) G confirmed the facility lacked a physician's order for the non-invasive ventilator. On 03/31/25 at 07:07 AM, Administrative Nurse D confirmed the facility lacked a physician's order for the non-invasive ventilator and stated it was the expectation for the facility to have an order. The facility policy for "Noninvasive Ventilator" implemented 12/01/24, included, the facility will obtain an order for the use of the noninvasive ventilator and settings from the resident's physician. The facility will document the use of the machine, the resident's tolerance, any skin, respiratory or other changes, and the response. The facility shall follow the manufacturer's instructions for the frequency of cleaning the device.	F 695		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F 697		

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F 697	Continued From page 5	F 697		

The facility reported a census of 22 residents with 15 residents sampled, including two residents reviewed for pain. Based on interview and record review, the facility failed to offer non-pharmaceutical interventions for pain for Resident (R)18, who had chronic pain (pain that lasts longer than three months). This placed R18 at risk for untreated pain.

Findings included:

- A review of R18's electronic medical record (EMR) revealed a diagnosis of chronic pain.

The "Significant Change Minimum Data Set" (MDS), dated 03/13/25, documented the resident had a Brief Interview for Mental Status (BIMS) score of five, indicating severe cognitive impairment. She received scheduled and as-needed (PRN) pain medications and had no non-pharmacological interventions for pain.

The "Pain Care Area Assessment" (CAA), dated 11/19/24, documented the resident had chronic pain and required PRN pain medication.

The "Quarterly MDS," dated 02/19/25, documented the resident had a BIMS score of five, indicating severe cognitive impairment. She received scheduled and PRN pain medications and had no non-pharmacological interventions for pain.

R18's "Care Plan," revised 03/11/25, lacked non-pharmacological pain interventions.

R18's EMR included the following physician orders:
Tramadol (an opioid pain medication), 50

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milligrams (mg), by mouth (PO), every (Q) four hours, as needed (PRN), for pain, ordered 11/17/23.

A review of the resident's "Medication Administration Record" (MAR) for March, revealed the resident received the PRN order of Tramadol 13 times, from 03/04/25 through 03/25/25, for pain rated three to nine on the one to 10 pain scale (a 10-point system to assess resident's pain level with 10 being the worse pain imaginable).

On 03/27/25 at 08:57 AM, Certified Nurse Aide (CNA) N stated the resident had pain medication for when she had pain. CNA N stated she was unsure of non-pharmacological interventions to help the resident with pain.

On 03/31/25 at 01:37 PM, Certified Medication Aide (CMA) R stated the only pain intervention the resident had was her pain medication.

On 03/31/25 at 09:17 AM, Administrative Nurse D confirmed the resident's care plan lacked non-pharmacological pain interventions. Administrative Nurse D confirmed the resident had quite a bit of pain and received PRN pain medication on an almost daily basis.

The facility policy for "Pain Management", revised 10/07/24, included: The facility must ensure pain management is provided to residents who require such services, consistent with professional standards of practice and the residents' goals and preferences. The facility must include non-pharmacological pain management interventions.

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F 730	Continued From page 7	F 730		
F 730 SS=F	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: The facility reported a census of 22 residents. Based on interviews and record review, the facility failed to complete an annual performance review at least once every 12 months for Certified Nurse Aide (CNA) M and Certified Medication Aides (CMA) S and CMA T. This placed the residents at risk for decreased quality of care. Findings included: - A review of five employee personnel files, employed by the facility for greater than one year, revealed the following concerns: CNA M, hired on 10/11/23, lacked an annual performance review in her personnel file. CMA S, hired on 12/21/23, lacked an annual performance review in his personnel file. CMA T hired on 1/18/23, lacked an annual performance review in her personnel file. On 03/27/25 at 11:03 AM, Administrative Nurse D stated CNA evaluations were to be done annually. Administrative Nurse D confirmed the three staff members (listed above) lacked an annual evaluation. The facility policy for "Evaluation Process,"	F 730		

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F 730	Continued From page 8 revised 01/02/25, included the Center shall review the work performance of employees with a formal written evaluation annually.	F 730		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention	F 732		

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F 732	Continued From page 9 requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: The facility reported a census of 22 residents. Based on record review and interviews, the facility failed to display accurate, publicly accessible, and identifiable staffing information on a daily basis for the 22 residents who reside in the facility. Findings included: - A review of the facility's "Daily Staffing Sheets" from 02/01/25 through 03/25/25, revealed the actual hours worked were not completed on the daily staffing sheets. On 03/27/25 at 11:03 AM, Administrative Nurse D confirmed the actual hours worked were not completed on the daily staffing sheets. The facility policy for "Daily Staff Posting", revised 10/07/24, included: The facility will post specific information regarding nurse staffing including the total number of staff and the actual hours worked per shift.	F 732		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:	F 758		

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F 758	Continued From page 10 (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §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	F 758		

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prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 22 residents with 15 residents selected for review. Based on observation, interview, and record review, the facility failed to ensure Resident (R) 12 was free from unnecessary medications when staff failed to assess R12 for signs of tardive dyskinesia (TD-an abnormal condition characterized by involuntary repetitive movements of the muscles of the face, limbs, and trunk) at least every six months per the standard of care. This placed the resident at risk for adverse effects of antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication.

Findings included:

- R12s Electronic Health Record (EHR) revealed a diagnosis of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and dementia (progressive mental disorder characterized by failing memory, confusion) with other behavioral disturbances.

The 02/11/25 "Minimum Data Set" (MDS) documented a Brief Interview for Mental Status (BIMS) of 6, indicating severe cognitive impairment. Total severity score of 0, indicating no depression. Physical behaviors towards others were documented on one to three days out of the seven day look back period. R12 took an antipsychotic and an antidepressant (a class of

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medications used to treat mood disorders) medication.

The 02/11/25 " Behavioral Symptoms Care Area Assessment" (CAA) documented R12 strikes out at others at times.

The 02/11/25 "Psychotropic Drug Use" CAA documented that R12 took Seroquel (an antipsychotic medication) twice a day for unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.

The 03/26/25 "Care Plan" documented the resident took Seroquel two times a day. An intervention dated 10/11/24 revealed an AIMS assessment was to be completed quarterly and as needed.

The "Physician Orders" documented an order for Seroquel 300 milligrams (mg) to be taken by mouth at bedtime and 50 mg to be taken by mouth in the morning for dementia with psychotic disturbances.

The 01/30/24 "Abnormal Involuntary Movement Scale" (AIMS) documented a score of one.
The 06/22/24 AIMS documented a score of zero.
The facility lacked an AIMS assessment or evidence of assessment for TD, from 06/22/24 to 02/07/25.
The 02/07/25 AIMS documented a score of zero.

During an observation on 03/31/25 at 08:00 AM, R12 was sitting in her wheelchair laying over the table and sleeping. The Certified Medication Aide (CMA) woke her up to give her a health shake, which R12 did not drink it. It sat on the table in

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front of her.

During an interview on 03/31/25 at 12:28 PM, Licensed Nurse (LN) G stated the registered nurse on duty completed the AIMS assessment quarterly for every resident who was on an antipsychotic medication.

During an interview on 03/31/25 at 01:26 PM, Administrative Nurse D stated she expected the charge nurse to complete AIMS assessments quarterly with the MDS schedule for any resident who is taking an antipsychotic medication.

The facility's policy "Use of Psychotropic Medication (s)" dated 02/05/25 documented residents who received antipsychotic medications, an "AIMS" assessment will be completed on admission, quarterly, with any significant change in condition, or change in medications.

The "Abnormal Involuntary Movement (AIMS) Scale Assessment" dated 02/05/25 documented that the AIMS assessment with be completed for residents taking any antipsychotic medications.