STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087167	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE COTTAGE- TYLER	968 N TYLER ROAD WICHITA, KS 67212

(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) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey with attached complaint numbers 191345 and 189867 for the above named facility conducted on 03/31/25 and 04/01/25.	S 000		
S5171 SS=D	26-42-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: K.A.R. 26-42-204 (i) The facility reported a census of 5 "Residents'" (R)'s. The sample included 3 R's and one closed record review. Based on interview and record review, the Operator failed to ensure the "Licensed Nurse" (LN) provided healthcare services to R4 within acceptable standards of practice, when the LN "borrowed" the prescription drug Haldol from one resident to administer to R4. Findings included: - Record review for R4 revealed an admission date of 07/24/24 with diagnoses of other symptoms and signs involving cognitive functions following cerebral infarction, vascular dementia, unspecified severity with agitation, delirium due to know physiological condition, visual hallucinations, chronic obstructive pulmonary	S5171		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S5171	Continued From page 1	S5171		

disease with heart failure, chronic atrial fibrillation, obstructive sleep apnea, type two diabetes without complications, major depressive disorder, and long term use of anticoagulants.

Review of R4's "Functional Capacity Screen" (FCS) dated 07/24/24 revealed R4 required physical assistance with bathing, dressing, toileting, transferring, walking/mobility, and he was independent with eating. R4 lacked the ability to manage his own medications/medical treatments and was incontinent. R4 was marked with impaired short-term memory, impaired long-term memory, impaired memory/recall, and impaired decision making. R4 was able to make himself understood and he understood others. R4 was marked at risk for falls, having impaired vision, and impaired decision making. R4 used a walker, and a wheelchair as needed.

Review of R4's signed "Negotiated Service Agreement" (NSA) dated 07/24/24 identified the facility would provide health care services for bathing, dressing, toileting, transferring, and walking with the assistive device of a gait belt, walker, or cane, and one staff member as tolerated. Facility staff would administer and order R4's medications, and the local hospice agency would manage medical treatments. Facility staff would provide frequent reminders and assist R4 in making safe and logical decisions. Facility staff were instructed to redirect R4 when he was having socially inappropriate behaviors.

Review of R4's "Health Service Plan" (HSP) dated 07/24/24 instructed facility staff to assist with toileting, and mobility, dressing and manage

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S5171	Continued From page 2	S5171		

his medications.

Review of R4's electronic "Medical Record" under the "Observation History" tab revealed the following entries:

On 07/24/25 at 07:15 PM a nurse note R4 admitted to the facility and "home medications received". The "Durable Power of Attorney" (DPOA) reported to the facility R4 had an adverse reaction to the prescription drug Ativan and was replaced by an order for "Haldol". The DPOA reported they had not used the Haldol yet due to fear of an adverse reaction.

On 07/25/24 at 02:42 AM a "Certified Nurse Aide" (CNA) note revealed R4 had an unwitnessed fall.

On 07/26/25 at 02:15 PM a nurse note revealed the local hospice nurse reviewed the medications with the LN, and the "DRT" (Daughter) was present for the visit and notified of medications not received on admission; Emergency kit medications, scopolamine patch and an inhaler.

Notes entered on the following dates indicated R4 was experiencing confusion and unsteadiness; 07/26/24, 07/27/24, and 07/28/24.

On 07/28/24 at 11:38 PM a CNA entry revealed R4 had a fall.

On 07/29/24 at 06:30 a nurse note revealed staff reporting R4 was having visual and auditory hallucinations, increased confusion, and restlessness. Urinalysis results reviewed and antibiotic treatment started for a urinary tract

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infection, and the family delivered the following medications which were requested on 07/26/24; the emergency kit and Haldol to be utilized instead of Ativan due to adverse reaction per the discussion with DPOA, R4 family member and hospice nurse case manager.

On 07/30/24 at 06:30 PM a CNA entry revealed R4 was restless, medications were administered to help calm him down.

On 07/30/24 at 08:00 PM a nurse note revealed R4 was continuing with increased confusion and restlessness. The order for PRN Haldol was administered with minimal and delayed effective results. R4 was one on one with staff for safety. Staff were unsuccessful with attempting to redirect R4. R4's DPOA came for a visit and the "Certified Medication Aide" (CMA) reported to her that R4 received a dose of the as needed Haldol for restlessness. The DPOA replied she did not want this medication given as "made him crazy at home". The LN educated the DPOA that the reported medication with an adverse reaction was the Ativan, and the family reported they had not used the Haldol at home for fear of adverse reaction.

On 07/31/24 at 07:15 PM a nurse note revealed R4 had decreased confusion and restlessness noted. No as needed medications were administered.

On 08/01/24 at 06:49 PM a noted entered revealed R4 was "quite confused".

On 08/02/24 at 12:15 AM a CNA entry reveled R4 had a "rough night, very confused and

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S5171	Continued From page 4	S5171		

agitated. R4 was wanting to call the police to leave the facility".

On 08/02/24 at 03:30 PM a nurse note revealed the LN found a note on the medication cart dated 07/31 signed by the DPOA which stated she did not wat R4 to receive any further "doses of Haldol". The LN reached out to the hospice provider to assist with DPOA education on the hospice order for Haldol.

On 08/03/24 at 06:36 PM a note entered revealed R4 was confused and accusing his wife of cheating on him.

On 08/05/24 at 11:00 AM a nurse note revealed R4 was agitated and "combative", with failed staff attempts at redirection. Hospice nurse infacility for routine visit and wrote a new order for Haldol to "QID" (four times a day) as needed. The hospice nurse updated R4's DPOA of the new order.

On 08/14/24 at 09:45 AM resident discharged from the facility to another facility of the DPOA's choosing.

R4 was in the facility for 22 days.

Record review of the facility provided document titled "Mood Diary" revealed R4 was marked as angry/agitated, anxious/worried, or disillusioned/confused on the following days:

07/28/24
07/29/24
07/30/24
07/31/24

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S5171	Continued From page 5 08/01/24 08/02/24 08/03/24 08/04/24 08/06/24 08/07/24 08/08/24 08/09/24 08/10/24 08/12/24 08/13/24 Review of R4's "Medication Administration Record" dated 07/24 revealed R4 was administered Haldol 2 milligrams per milliliter, give 0.5 milliliter (1 milligram) every day as needed for hallucinations, agitation, or restlessness twice on 07/29/24. Review of R4's Signed provider orders revealed the following orders: On 07/24/24 Continue home medications per medication list provided by hospice. On 07/29/24 May give 1 milligram Haldol tablet now "liquid Haldol not available - awaiting delivery from family" On 07/29/24 Increase as needed Haldol frequency to "BID" (Twice daily) as needed. Interview on 04/01/25 at approximately 10:30 AM with Operator A and LN B confirmed LN B did not have the prescribed Haldol 2 milligrams per 1 milliliter in the home when it was needed. LN B stated they had requested the family bring R4's	S5171		

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S5171	Continued From page 6 medications from home. LN B confirmed she "borrowed" a 1 milligram tablet from another resident and further confirmed it was a one milligram tablet. LN B stated the family brought the requested later in the day on 7/29/24, and that only one tablet was borrowed from the other resident. The Operator failed to ensure the LN provided healthcare services to R4 within acceptable standards of practice, when the LN "borrowed" the prescription drug Haldol from one resident to administer to R4.	S5171		
S5301 SS=D	26-42-205 (d) (3) Facility Administration of Medications (d) (3) A licensed nurse or medication aide shall perform the following: (A) Administer only the medication that the licensed nurse or medication aide has personally prepared; (B) identify the resident before medication is administered; (C) remain with the resident until the medication is ingested or applied; and (D) document the administration of each resident ' s medication in the resident ' s medication administration record immediately before or following completion of the task. If the medication administration record identifies only time intervals or events for the administration of medication, the licensed nurse or medication aide shall document the actual clock time the medication is administered. This REQUIREMENT is not met as evidenced	S5301		

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S5301	Continued From page 7 by: K.A.R. 26-42-205 (d) (3) (D) The facility reported a census of 5 "Residents'" (R)'s. The sample included 3 R's and one closed record review. Based on interview and record review, the Operator failed to ensure the documentation of the medication administration immediately before or following completion of the task for R4 when he received Haldol as needed. Findings included: - Record review for R4 revealed an admission date of 07/24/24 with diagnoses of other symptoms and signs involving cognitive functions following cerebral infarction, vascular dementia, unspecified severity with agitation, delirium due to know physiological condition, visual hallucinations, chronic obstructive pulmonary disease with heart failure, chronic atrial fibrillation, obstructive sleep apnea, type two diabetes without complications, major depressive disorder, and long term use of anticoagulants. Review of R4's "Functional Capacity Screen" (FCS) dated 07/24/24 revealed R4 required physical assistance with bathing, dressing, toileting, transferring, walking/mobility, and he was independent with eating. R4 lacked the ability to manage his own medications/medical treatments and was incontinent. R4 was marked with impaired short-term memory, impaired long-term memory, impaired memory/recall, and impaired decision making. R4 was able to make himself understood and he understood others. R4 was marked at risk for falls, having impaired	S5301		

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S5301	Continued From page 8	S5301		

vision, and impaired decision making. R4 used a walker, and a wheelchair as needed.

Review of R4's signed "Negotiated Service Agreement" (NSA) dated 07/24/24 identified the facility would provide health care services for bathing, dressing, toileting, transferring, and walking with the assistive device of a gait belt, walker, or cane, and one staff member as tolerated. Facility staff would administer and order R4's medications, and the local hospice agency would manage medical treatments. Facility staff would provide frequent reminders and assist R4 in making safe and logical decisions. Facility staff were instructed to redirect R4 when he was having socially inappropriate behaviors.

Review of R4's "Health Service Plan" (HSP) dated 07/24/24 instructed facility staff to assist with toileting, and mobility, dressing and manage his medications.

Review of R4's electronic "Medical Record" under the "Observation History" tab revealed the following entries:

On 07/24/25 at 07:15 PM a nurse note R4 admitted to the facility and "home medications received". The "Durable Power of Attorney" (DPOA) reported to the facility R4 had an adverse reaction to the prescription drug Ativan and was replaced by an order for "Haldol". The DPOA reported they had not used the Haldol yet due to fear of an adverse reaction.

On 07/25/24 at 02:42 AM a "Certified Nurse Aide" (CNA) note revealed R4 had an

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S5301	Continued From page 9 unwitnessed fall. On 07/26/25 at 02:15 PM a nurse note revealed the local hospice nurse reviewed the medications with the LN, and the "DRT" (Daughter) was present for the visit and notified of medications not received on admission; Emergency kit medications, scopolamine patch and an inhaler. Notes entered on the following dates indicated R4 was experiencing confusion and unsteadiness; 07/26/24, 07/27/24, and 07/28/24. On 07/28/24 at 11:38 PM a CNA entry revealed R4 had a fall. On 07/29/24 at 06:30 a nurse note revealed staff reporting R4 was having visual and auditory hallucinations, increased confusion, and restlessness. Urinalysis results reviewed and antibiotic treatment started for a urinary tract infection, and the family delivered the following medications which were requested on 07/26/24; the emergency kit and Haldol to be utilized instead of Ativan due to adverse reaction per the discussion with DPOA, R4 family member and hospice nurse case manager. On 07/30/24 at 06:30 PM a CNA entry revealed R4 was restless, medications were administered to help calm him down. On 07/30/24 at 08:00 PM a nurse note revealed R4 was continuing with increased confusion and restlessness. The order for PRN Haldol was administered with minimal and delayed effective results. R4 was one on one with staff for safety. Staff were unsuccessful with attempting to	S5301		

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S5301	Continued From page 10	S5301		

redirect R4. R4's DPOA came for a visit and the "Certified Medication Aide" (CMA) reported to her that R4 received a dose of the as needed Haldol for restlessness. The DPOA replied she did not want this medication given as "made him crazy at home". The LN educated the DPOA that the reported medication with an adverse reaction was the Ativan, and the family reported they had not used the Haldol at home for fear of adverse reaction.

On 07/31/24 at 07:15 PM a nurse note revealed R4 had decreased confusion and restlessness noted. No as needed medications were administered.

On 08/01/24 at 06:49 PM a noted entered revealed R4 was "quite confused".

On 08/02/24 at 12:15 AM a CNA entry reveled R4 had a "rough night, very confused and agitated. R4 was wanting to call the police to leave the facility".

On 08/02/24 at 03:30 PM a nurse note revealed the LN found a note on the medication cart dated 07/31 signed by the DPOA which stated she did not wat R4 to receive any further "doses of Haldol". The LN reached out to the hospice provider to assist with DPOA education on the hospice order for Haldol.

On 08/03/24 at 06:36 PM a note entered revealed R4 was confused and accusing his wife of cheating on him.

On 08/05/24 at 11:00 AM a nurse note revealed R4 was agitated and "combative", with failed staff

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S5301	Continued From page 11	S5301		

attempts at redirection. Hospice nurse infacility for routine visit and wrote a new order for Haldol to "QID" (four times a day) as needed. The hospice nurse updated R4's DPOA of the new order.

On 08/08/24 at 10:34 PM a CMA note revealed R4 stated he was restlessness and R4 was informed he had the order for Haldol. The CMA called the on call nurse and the PRN Haldol was administered.

On 08/14/24 at 09:45 AM resident discharged from the facility to another facility of the DPOA's choosing.

R4 was in the facility for 22 days.

Record review of the facility provided document titled "Mood Diary" revealed R4 was marked as angry/agitated, anxious/worried, or disillusioned/confused on the following days:

07/28/24
07/29/24
07/30/24
07/31/24
08/01/24
08/02/24
08/03/24
08/04/24
08/06/24
08/07/24
08/08/24
08/09/24
08/10/24
08/12/24
08/13/24

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S5301	Continued From page 12 Review of R4's "Medication Administration Record" (MAR) dated 07/24 revealed R4 was administered Haldol 2 milligrams per milliliter, give 0.5 milliliter (1 milligram) every day as needed for hallucinations, agitation, or restlessness on the following days: 07/29/24 administered twice. 07/30/24 administered twice. 08/02/24 administered once. 08/07/24 administered twice Review of the MAR under the section titled "PRN" (as needed) Medications Log revealed R4 received Haldol on 07/29/24 08/02/24 08/03/24 08/07/24 The MAR lacked the documentation of the administration by the CMA of Haldol to R4 on 08/03/24, 08/05/24, and 08/08/24. Review of R4's Signed provider orders revealed the following orders: On 07/24/24 Continue home medications per medication list provided by hospice. On 07/29/24 May give 1 milligram Haldol tablet now "liquid Haldol not available - awaiting delivery from family" On 07/29/24 Increase as needed Haldol frequency to "BID" (Twice daily) as needed.	S5301		

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S5301	Continued From page 13 Record review of the facility provided document titled "Plan of Care" from the local hospice agency and dated 05/24/24 revealed an order which was started on 02/06/24 for Haloperidol Lactate Oral Concentrate 2 milligrams/milliliter. Dose 0.5 milliliter daily as needed for hallucinations, restlessness and agitation. Review of the facility provided document titled "Comprehensive Medication Assessment" from the local Hospice pharmacy revealed the following; Haloperidol concentrate 2 milligrams/milliliter; give 0.5 milliliter by mouth sublingual every day as needed for hallucinations, restlessness or agitation. "Effectiveness of Therapy; Use the lowest effective dose. Doses less than 4milligram /day are less likely to cause extrapyramidal symptoms. Avoid Haloperidol if the patient has Parkinson disease or Lew Body Dementia. Interview on 04/01/25 with Registered Nurse C, Operator A and LN B confirmed the MAR for R4 lacked documentation of the administration of the as needed Haldol. The Operator failed to ensure the documentation of the medication administration immediately before or following completion of the task for R4 when he received Haldol as needed	S5301		