STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175508	A. BUILDING _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS NURSING & REHABILITATIVE CENTER	302 E IOWA STREET HIAWATHA, KS 66434

(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 Recertification Survey and complaint survey regarding allegations in KS00194238 and KS00194077. The 2567 was electronically sent on 4/10/25	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of	F 623		

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

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F 623	Continued From page 1	F 623		

this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402,

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F 623	Continued From page 2 codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by: The facility had a census of 44 residents. The sample included 15 residents. Based on observation, interview, and record review, the facility failed to notify the State Long Term Care Ombudsman (LTCO), Resident (R)9's and R15's facility-initiated discharge to the hospital. This placed the residents at risk for impaired rights. Findings included: -R9's Electronic Health Record (EHR) revealed	F 623		

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diagnoses of included healing fracture neck of the left femur (thigh bone,) dementia (a progressive mental disorder characterized by failing memory and confusion) osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk,) and muscle weakness.

R9's "Quarterly Minimum Data Set" (MDS), dated 03/06/25, recorded the resident had a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS documented R9 required extensive assistance of two staff with bed mobility and transfers. The MDS further documented the resident had no falls since reentry on 01/09/25.

The "Activities of Daily Living Care Area Assessment" (CAA), dated 01/16/25, documented the resident required one on one assistance with transfers due to recent left hip fracture repair. The CAA documented the resident was dependent on staff for all weight bearing Activities of Daily Living (ADLs) and for dressing and personal cares.

The "Care Plan," dated 01/29/25, documented the resident was a high fall risk due to history of a fall with a fracture, confined to her chair, required assistance with incontinence, and was not able to stand without physical help. The care plan documented staff placed a sign on the wall in her room to remind her to call for assistance and staff would constantly remind her to call for help. The care plan documented staff would assist the resident with ambulation and transfers and would keep her environment free of clutter.

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F 623	Continued From page 4 A "Nurse's Note" on 01/02/25 at 02:52 PM, documented the resident hollered for help and upon entering the room the nurse observed R9 on her left side, in a semi sitting position,-up against the end table and in between the recliner and the bathroom entry. Nurse Aide N placed a pillow behind the resident's head and removed her shoes at the resident's request. The resident complained of pain in the position she was in. The nurse and aide repositioned the resident so her back was resting against the recliner. Observation revealed her walker and wheelchair were not in reach or in use at the time of the fall. The resident stated she was trying to get a calendar that had fallen on the floor, and she fell. The resident stated she hit her head and her leg hurt. The resident stated she wanted to go to the hospital to have her leg checked out. Administrative Nurse D. documented the resident had slight shortening of the left leg with rotation observed. The resident was transferred to the hospital at 02:15 PM. On 01/09/25 at 05:07 PM, "Nurse's Notes "documented the resident returned from the hospital at 04:30 PM per facility van and accompanied by staff. The notes documented the resident had been hospitalized for closed left hip fracture with multiple left rib fractures. The resident had a surgery Open Reduction and Internal Fixation (ORIF) nailing of the left hip while hospitalized. R9's clinical record lacked documentation staff notified the LTCO of the resident's discharge from the facility.	F 623		

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F 623	Continued From page 5	F 623		

On 03/25/25 at 02:45 PM, Administrative Staff A stated she would send the discharges to the Ombudsman at the first of the month from the prior month discharges. Administrative Staff A reviewed the list of residents she had provided to the Ombudsman's office on 02/03/25 and verified R9. Administrative Staff A verifed R9 went to the hospital on 01/02/25 and she would ensure the notifed the LTCO.

The facility's, undated, "Transfer or Discharge, Facility -Initiated," stated the under the following circumstances, the notice is given as soon as it is practicable but before the transfer or discharge:
a. The health and/or safety of the individuals in the facility would be endangered due to the clinical or behavioral status of the resident.
b. The resident's health improves sufficiently to allow a more immediate transfer or discharge.
c. An immediate transfer or discharge is required by the resident's urgent medical needs, or
d. A resident has not resided in the facility for 30 days.
A notice of transfer is provided to the resident and representative as soon as practicable before the transfer and to the long-term care (LTC) Ombudsman when practicable (in a monthly list of residents that include all notice content requirements.)

- R15's Electronic Medical Record (EMR) documented R15 had a diagnoses of chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing) and heart failure.

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R15's "Modification of Quarterly Minimum Data Set" (MDS), 03/12/25, documented R15 had a Brief Interview of Mental Status (BIMS) score of 12, which indicated moderate cognitive impairment.

R15's "Care Plan," revised 03/12/25, documented R15 had shortness of breath (SOB) retaining to hypoxia, and instructed staff to elevate the head of R15's bed 45 degrees as R15 would allow. The plan instructed staff to encourage R15 to clear own secretions with effective coughing, if R15 unable to do suction as needed (PRN).

The "Progress Note," dated 12/1/2024 at 09:32 PM, documented R15 was admitted to the hospital.

The "Progress note," dated 02/5/2025 at 06:59 PM, documented R15 was admitted to the hospital.

Review of R15's clinical record lacked evidence the Office of the Long-Term Care Ombudsman (LTCO-a public official who works to resolve resident issues in nursing facilities) was notified of R15's discharge on the above dates.

03/25/25 at 03:03 PM, R15 sat in a chair in the dining room at an activity, no signs or symptoms of shortness of air.

03/27/25 at 10:00 AM, Administrative Staff A stated she was responsible for notifying the LTCO when residents were transferred to the hospital. Administrative Staff A verified the ombudsman had not been notified when the resident went to hospital on 12/01/24 and 02/05/25 and stated she

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F 623	Continued From page 7 must have printed the wrong form. The facility's "Transfer or Discharge, Facility Imitated Policy," undated, documented when residents who are sent emergently to an acute care setting, these scenarios are considered facility initiated transfers. notice of transfer are provided to the resident or representative and LTCO when practicable(in a monthly list of residents that included all notice content requirements."	F 623		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: The facility had a census of 44 residents. The sample included 15 residents with one reviewed for pressure ulcers. Based on observation, record review, and interview, the facility failed to initiate effective interventions to prevent the development of a left heel, facility acquired, unstageable pressure ulcer (depth of the wound is unknown due to the wound bed being covered by a thick	F 686		

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layer of other tissue and pus,) for Resident (R) 9.

Findings included:

- R9 's diagnoses included healing fracture neck of the left femur (thigh bone,) dementia (a progressive mental disorder characterized by failing memory and confusion) osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk,) and muscle weakness.

R9's "Quarterly Minimum Data Set" (MDS), dated 03/06/25, recorded the resident had a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS documented required extensive assistance of two staff with bed mobility and transfers. The MDS further documented the resident had one unstageable pressure ulcer that was not present on admission.

The "Pressure Ulcer Care Area Assessment" (CAA), dated 01/16/25, documented the resident was a moderate risk for pressure ulcers due to her skin is often moist, being chairfast, mobility limitations and problem with friction and shearing due to moderate to maximum assistance. The CAA documented the resident required one on one assistance with transfers due to recent left hip fracture repair. The CAA documented the resident was dependent on staff for all weight bearing Activities of Daily Living (ADLs) and for dressing and personal cares.

The "Braden Scale Assessment" for predicting pressure ulcer risk, dated 12/26/24 documented a

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score of 16.0 indicating the resident was at risk.

The "Pressure Ulcer Care Plan," dated 01/09/25, documented the resident was at moderate risk for pressure ulcers due to skin is often moist, being chair fast, mobility limitations and problems with frictions and shearing due to moderate to maximum assistance with movement. The care plan directed the staff to complete a weekly skin assessment and report any skin concerns to the wound nurse and physician. The care plan directed the staff to provide a pressure redistribution mattress in the bed and a pressure relief cushion in her recliner. Interventions would be adjusted according to R9's needs.

The "Physician Order," dated 01/09/25 directed the staff to apply a pressure redistribution mattress to bed, and a pressure relieving cushion in her recliner and wheelchair.

The 02/15/25 at 06:53 AM, "Nurse's Notes", documented the aide reported a new skin impairment on the left heel. The nurse assessment documented the area measured 8.0 centimeter (cm) by 5.0 cm across a boney prominence of the heel. The staff were to add heel protector boots while the resident was in bed and recheck history of interventions. The staff are presently off-loading the heels at the time of impairment discovery, and staff would monitor the left heel area daily for eschar changes and notify the nurse and primary care physician if any changes were noted.

The "Physician Order," dated 02/16/25, documented to monitor the left heel area daily, do not apply a dressing to the area. The staff would

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F 686	Continued From page 10	F 686		

notify the wound nurse and the primary care physician if any changes occur, or sign and symptoms of infection are present.

The "Weekly Pressure Injury Skin Report," dated 02/16/25, documented R9 had an area on her left heel, measuring 5.0 centimeter (cm) by 8.0 cm, no tunneling, with thick eschar (dead tissue), hard leathery black exudate (a fluid that leaks out of body vessels and tissues.) The report documented the suspected cause was from R9's recliner. The staff have added task of placing a heel protection on the left heel while in recliner.

The 02/19/25 at 12:58 PM, nurse's notes, documented the resident had one wound, a patch of eschar that covered the entire heel and pressure interventions started for management include wearing protective heel and foot cushions while the resident was in the recliner. Heel protectors have been added to the care plan off-loading heels were in place at the time of the wound occurrence, and heel protectors have been added to the care plan, to be on the left heel while in the recliner as this is the suspected cause of the pressure location. R9 has been noted to draw up her left leg and place her heel in the diversion of the footrest of the chair matching roughly to the eschar location.

The "Weekly Pressure Injury Skin Report," dated 03/08/25, documented R9's area on left heel, measured 5.0 cm by 8.0 cm, no tunneling, unstageable, with eschar of the left heel.

The "Weekly Pressure Injury Report," dated 03/12/25, documented R9 had a left heel pressure ulcer, measuring 4.1 cm by 4.1 cm, no tunneling, eschar was noted to have slight peeling

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at the distal edges, and a ring of it came off during the week and the remainder is well adhered. The surrounding tissue is pink with some scar tissue from the healing area.

The "Weekly Pressure Injury Report," dated 03/22/25, documented R22 had a left heel pressure ulcer, measuring 3.5 cm by 3.7 cm, no tunneling, unstageable, with eschar, and hard leathery black exudate. The report documented more eschar flaked off during assessment and the eschar remained firmly adhered. The evaluation documented the area was improving.

On 03/24/25 at 12:00 PM, observation revealed R9 sat in her wheelchair at the dining room table, awaiting staff to deliver her lunch. Continued observation revealed the resident had a pressure relieving boot on her left foot/heel and the foot has slipped between the two metal footrest pedals.

On 03/25/25 at 07:45AM, observation revealed R9 sat in recliner in her room with pressure relieving boot on her left foot/heel. Continued observation revealed LN H removed the resident pressure relieving boot and sock and revealed the resident's left heel with black eschar covering the heel no drainage and the eschar had separated from the skin. LN H placed the resident's sock and pressure relieving boot on her left heel/foot.

On 03/25/25 at 08:30 AM, Administrative Nurse D verified the resident developed the unstageable pressure ulcer on her left heel 02/15/25. Administrative Nurse D verified the resident did not have pressure relieving boot upon admission

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F 686	Continued From page 12 to the facility post left hip fracture 01/02/25. Administrative Nurse D verified the resident was at risk for skin impairment and the staff off loaded her feet when in bed but stated LN I felt the resident rested her left heel on the footrest of the recliner and this is how the area developed. The "The Wound Assessment, Prevention and Treatment, " policy undated, documented a resident who enters the facility without pressure ulcers would not develop them unless the individual's clinical condition demonstrates that they were unavoidable. In addition, if a resident has a wound, he/she would receive necessary treatment and services to promote healing, prevent infection, and prevent new wounds from developing. On admission a comprehensive assessment that includes skin condition and other casual factors that place a resident at risk for developing pressure ulcers and/or delayed healing and the nature of the pressure to which the resident is subject to. The assessment should identify which risk factors can be removed or modified. The assessment also helps in identifying the resident with multi-system failures or an end-of-life condition or who is refusing and treatment and the basis for the refusal and the identification and evaluation of potential alternatives. All residents with a pressure ulcer and all residents identified "at risk" for skin breakdown would have the problem identified on the Plan of Care with appropriate preventative approaches identified.	F 686		
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	F 756		

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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 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 had a census of 44 residents. The sample included 15 residents, of which five were

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reviewed for medication use. Based on observation, record review, and interview, the facility failed to ensure the Consultant Pharmacist (CP) identify and report Resident (R) 39's antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication had an approved indication for use. This placed the residents at risk for inappropriate use of medication.

Findings included:

- The Electronic Medical Record (EMR) for R39 documented diagnoses of dementia (a progressive mental deterioration characterized by confusion and memory failure) without behavioral disturbance, vitamin D deficiency, and hypothyroidism (a condition characterized by decreased activity of the thyroid gland).

The "Admission Minimum Data Set" (MDS), dated 12/26/24, documented severely impaired cognition. R39 required set-up assistance from staff for eating, oral hygiene, and partial assistance with dressing. R39 had physical and verbal behaviors toward others, wandered four to six days, and rejected care one to three days. R39 received antipsychotic medication (a class of medications used to treat major mental conditions that cause a break from reality) daily.

The "Psychotropic Drug Use Care Area Assessment" (CAA), dated 12/26/24, documented R39 received risperidone (antipsychotic medication) on schedule for her anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) and agitation (feeling of aggravation or restlessness brought on by a

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provocation or a medical condition).

The "Care Plan," dated 01/13/25, directed staff to administer medications as directed, document any side effects, and monitor her behaviors. The care plan directed staff to complete the Abnormal Involuntary Movement Scale (AIMS rating scale that was designed to measure involuntary movements know as tardive dyskinesia).

The "Physician's Order," dated 12/21/24, directed staff to administer risperidone, 0.25 milligrams (mg), by mouth, in the afternoon, for anxiousness (experiencing worry, unease, or nervousness), until 12/27/24. This medication was discontinued on 12/23/24.

The "Physician's Order," dated 12/23/24, directed staff to administer risperidone, 0.5 mg, by mouth, twice a day, for agitation. This medication was discontinued on 01/16/25.

The "Physician's Order," dated 01/16/25, directed staff to administer risperidone, 0.25mg, by mouth, twice a day, for psychosis (any major mental disorder characterized by a gross impairment perception). This medication was discontinued on 01/29/25.

The "Physician's Order," dated 01/29/25, directed staff to administer risperidone, 0.5 mg, by mouth, twice a day, for dementia without behavioral disturbance.

In the review of the EMR and Consultant Pharmacist monthly review from 12/2024 to 03/2025, lacked documentation regarding the approved indication or risk versus benefit for the continued use of the risperidone medication for

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dementia.

On 03/25/25 at 09:23 AM, R39 ambulated down to the doors to leave the Memory Care Unit, and knocked on the door over and over, stating "hey lady, hey lady!"

On 03/25/25 at 09:40 AM, Certified Medication Aide (CMA) R stated R39 spent a lot of time at the doors going out of the Memory Care Unit, exit seeking. Staff redirect her by offering food or conversation.

On 03/25/25 at 02:31 PM, Licensed Nurse (LN) G stated R39 was often more active and exit-seeking during the evening and not during the day. When R39 was anxious. staff take her to her room and show her the paintings she painted that hung in her room or show her the book she had with her paintings in it. LN G stated R39's husband visited daily and often took her out for coffee or ice cream and spent a lot of time with her. LNG stated R39's behaviors have been more under control with the risperidone medication.

On 03/25/25 at 03:31 PM, Administrative Nurse D stated she was unaware of the diagnosis of dementia for risperidone and stated she did not have a risk versus benefit or any type of indication for the use of the medication. Administrative Nurse D stated, the Consultant Pharmacist had not reported any irregularities related to the medication to her.

The facility's "Pharmacy Services" policy, undated, documented the facility ensures that pharmaceutical services, are provided to meet the needs of each resident, are consistent with state and federal requirements, and reflect

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F 756	Continued From page 17 current standards of practice. The facility failed to ensure that the CP identified and reported R39's antipsychotic medication had an approved indication for use. This placed the resident at risk for receiving inappropriate psychotropic medication.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order	F 758		

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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.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 44 residents. The sample included 15 residents, of which five were reviewed for medication use. Based on observation, record review, and interview, the facility failed to ensure the Consultant Pharmacist (CP) identify and report Resident (R) 39's antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication had an approved indication for This placed the residents at risk for inappropriate use of medication.

Findings included:

- The Electronic Medical Record (EMR) for R39 documented diagnoses of dementia (a progressive mental deterioration characterized by confusion and memory failure) without behavioral disturbance, vitamin D deficiency, and

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hypothyroidism (a condition characterized by decreased activity of the thyroid gland).

The "Admission Minimum Data Set" (MDS), dated 12/26/24, documented severely impaired cognition. R39 required set-up assistance from staff for eating, oral hygiene, and partial assistance with dressing. R39 had physical and verbal behaviors toward others, wandered four to six days, and rejected care one to three days. R39 received antipsychotic medication (a class of medications used to treat major mental conditions that cause a break from reality) daily.

The "Psychotropic Drug Use Care Area Assessment" (CAA), dated 12/26/24, documented R39 received risperidone (antipsychotic medication) on schedule for her anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) and agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition).

The "Care Plan," dated 01/13/25, directed staff to administer medications as directed, document any side effects, and monitor her behaviors. The care plan directed staff to complete the Abnormal Involuntary Movement Scale (AIMS rating scale that was designed to measure involuntary movements know as tardive dyskinesia).

The "Physician's Order," dated 12/21/24, directed staff to administer risperidone, 0.25 milligrams (mg), by mouth, in the afternoon, for anxiousness (experiencing worry, unease, or nervousness), until 12/27/24. This medication was discontinued on 12/23/24.

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The "Physician's Order," dated 12/23/24, directed staff to administer risperidone, 0.5 mg, by mouth, twice a day, for agitation. This medication was discontinued on 01/16/25.

The "Physician's Order," dated 01/16/25, directed staff to administer risperidone, 0.25mg, by mouth, twice a day, for psychosis (any major mental disorder characterized by a gross impairment perception). This medication was discontinued on 01/29/25.

The "Physician's Order," dated 01/29/25, directed staff to administer risperidone, 0.5 mg, by mouth, twice a day, for dementia without behavioral disturbance.

In the review of the EMR and Consultant Pharmacist monthly review from 12/2024 to 03/2025, lacked documentation regarding the approved indication or risk versus benefit for the continued use of the risperidone medication for dementia.

On 03/25/25 at 09:23 AM, R39 ambulated down to the doors to leave the Memory Care Unit and knocked on the door over and over, stating, "hey lady! hey lady!"

On 03/25/25 at 09:40 AM, Certified Medication Aide (CMA) R stated R39 spent a lot of time at the doors going out of the Memory Care Unit, exit seeking. The staff redirect her by offering food or conversation.

On 03/25/25 at 02:31 PM, Licensed Nurse (LN) G stated R39 was often more active and exit-seeking during the evening and not during the day. Wen R39 was anxious. staff take her to

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F 758	Continued From page 21 her room and shows her the paintings she painted that hung in her room or show her the book she had with her paintings in it. LN G stated R39's husband visited daily and often took her out for coffee or ice cream and spent a lot of time with her. LNG stated R39's behaviors have been more under control with the risperidone medication. On 03/25/25 at 03:31 PM, Administrative Nurse D stated she was unaware of the diagnosis of dementia for risperidone and stated she did not have a risk versus benefit or any type of indication for the use of the medication. Administrative Nurse D stated, the Consultant Pharmacist had not reported any irregularities related to the medication to her. The facility's "Psychotropic Medication Use" policy, dated 07/22, documented that residents would not receive medications that are not clinically indicated to treat a specific condition. Consideration of the use of any psychotropic medication is based on a comprehensive review of the resident. This includes evaluation of the resident's signs and symptoms to identifying causes. The facility failed to ensure that the CP identified and reported R39's antipsychotic medication had an approved indication for use. This placed the resident at risk for receiving inappropriate psychotropic medication.	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be	F 761		

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labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

§483.45(h) Storage of Drugs and Biologicals

§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 31 residents. Based on observation, interview, and record review, the facility failed to label Resident (R) 12 and R31s' insulin (a hormone that lowers the level of glucose in the blood) flex pens when started in use and when expired. This deficient practice placed the affected residents at risk for ineffective medications.

Findings included:

- On 03/24/25 at 09:10 AM, observation of the

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facility's 100 and 200 hall treatment cart revealed the following:

R12's Lantus (long-acting insulin) two flex pens were not labeled with an open or expired date.

R31's Humalog (fast-acting insulin) flex pen was labeled with an open date of 02/26/25 and expired date of 03/19/25. (Date of observation 03/24/25 - 5 days past expiration)

On 03/24/25 at 09:15 AM, Administrative Nurse D verified the nurses should label and date the insulin flex pens with the date opened and the expiration date and should discard the expired insulin pens.

Medlineplus.gov directs open, unrefrigerated Lantus and Humalog can be used within 28 days; after that time, they must be discarded.

The facility's "Storage of Medication" policy, undated, documented the facility would assure proper storage and safe storage of medications requiring refrigeration and to prevent the potential alteration of medication by exposure to improper temperatures. The facility would provide safe and effective storage of all drugs and biologicals in a locked storage area with limited access by authorized personnel. The facility would ensure that all drugs and biologicals used would be labeled in accordance with professional standards, including expiration dates (when applicable) and with appropriate accessary and precautionary instructions (such as shake well, take with meals, do not crush, special storage

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F 761	Continued From page 24 instructions.) Staff should observe proper storage and labeling requirements for all medications and vaccines during the performance of their daily tasks and should demonstrate safety in regard to the medication's integrity, such duties should include but not limited to: Remove any expired medications from active stock and discard medications according to facility policy. The facility failed to date the insulin flex pens when opened and the expiration date placing the residents at risk for ineffective medication	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: The facility had a census of 44 residents. The	F 812		

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F 812	Continued From page 25	F 812		

facility had one kitchen. Based on observation, interview, and record review the facility failed to prepare, store, distribute, and serve food under sanitary conditions for the 44 residents in the facility, who receive their meals from the kitchen. This deficient practice placed the residents of the facility at risk for food borne illness.

Findings included:

- On 03/24/25 at 8:20 AM, during initial kitchen tour, observation revealed the following:

Two 24 inch by 24 inch, air vent located above the cooking stove area covered with brownish grease/sticky substance and gray fuzzy substance blowing directly on the food preparation and stove cooking area.

Four overhead florescent light fixtures had the covers missing and located over the food preperation area.

One 36 inch by 24 inch return air grill covered with brownish gray fuzzy substance that covered the metal grill.

Six round light bulbs with wire cages around the bulbs, located in the exhaust hood above the stove top with brownish gray fuzzy substance affixed to the wire cages. Continued observation revealed two fire suppression spigots with brownish gray fuzzy substance that covered the hose and spigot area.

On 03/24/25 at 9:00 AM, Dietary staff BB verified the dirty register grill, the dirty light bulbs and fire suppression spigots in the exhaust hood, and the overhead florescent light -the bulbs were not

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F 812	Continued From page 26 encapsulated with a plastic covering and lacked a cover for the light fixtures. Dietary Staff BB stated maintenance staff cleaned the grills and replaced the light bulbs and fixtures On 03/24/24 at 11:00 AM, Maintenance Staff U verified the dirty register grill, the dirty light bulbs and fire suppression spigots in the exhaust hood, and the overhead florescent light - and verified the bulbs were not encapsulated with a plastic covering and lacked a cover for the light fixtures. Maintenance Staff U stated the light fixtures had been missing the covers since he started at the facility about one year ago and stated the air grill and registers were cleaned about one month ago. The facility's "Cleaning and Disinfection of Environment" policy, dated October 2018, documented environmental surfaces would be cleaned and disinfected according to current Center for Disease Control (CDC) recommendations for disinfection of healthcare facilities. Housekeeping surfaces would be cleaned on a regular basis, when spills occur, and when the surfaces become visibly soiled.	F 812		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: The facility had a census of 44 residents. Based on observation, record review and interview the facility failed to provide a safe, sanitary environment for Resident (R) 15 when staff failed	F 921		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175508	A. BUILDING _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS NURSING & REHABILITATIVE CENTER	302 E IOWA STREET HIAWATHA, KS 66434

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F 921	Continued From page 27	F 921		

to clean his carpet and recliner.

Findings included:

03/24/25 at 10:00 AM, R15's room had a black stain in the carpet in front of a recliner, approximately 18 inches (in) long by eight in wide. The recliner had a red stain on the left arm , approximately six in. by three in wide. The left arm cover had a yellow stain , approximately two in by two in. The room and the recliner had a urine odor.

03/25/25 at 11:47 AM Housekeeping Supervisor (HS) V verified there was a urine odor in R15 room. HS V stated the urine smell was in the carpet and the recliner. HS v verified the stains in the carpet and on the recliner and stated she had cleaned the carpet several times and could not get the urine odor out, it was probably in the carpet pad also.

03/25/25 11:59 AM Administrative Staff A stated she was aware of the urine smell in the resident's room and recliner. The stain in front of the recliner is from when the resident was able to do crafts, he spilled paint. Administrative Staff A stated the faciity had a plan to start replacing carpeted rooms with vinyl flooring. Administrative Staff A stated she knew the recliner had an urine odor.

The facility's "Cleaning and Disinfection of Environmental Surfaces Policy," revised August 2019, documented environmental surfaces would be cleaned and disinfected according to current Centers for Disease Control and Prevention (CDC) recommendations for disinfection of healthcare facilities and the Occupational Safety

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F 921	Continued From page 28 and Health Administration (OSHA) bloodborne pathogen standard.	F 921		