STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175380	A. BUILDING _____ B. WING _____	08/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CEDARS	1021 CEDARS DRIVE MCPHERSON, KS 67460

(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. The 2567 was sent electronically on 09/02/22.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: The facility had a census of 51 residents. The sample included 13 residents with one reviewed for abuse. Based on observation, record review, and interview, the facility failed to prevent an incident of abuse and/or retaliation for Resident (R)23, when agency Licensed Nurse (LN) G refused to give R23 his evening medications then took the residents cell phone out of his hand, threw it in the recliner, refused to let the resident to call the police and then transferred R23 using a lift whereas R23 sustained a skin tear during the transfer. This deficient practice placed R23 at risk for physical injury and impaired psychosocial	F 600		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 09/02/2022

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
	175380	A. BUILDING _____ B. WING _____	08/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CEDARS	1021 CEDARS DRIVE MCPHERSON, KS 67460

(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 600	Continued From page 1	F 600		

wellbeing.

Findings included:

- R23's "Physician Order sheet," dated 08/16/22 documented diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), chronic obstructive pulmonary disease (COPD-progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), dry eye syndrome, facial dermatitis (a condition of the skin in which the skin becomes red swollen, and sore, sometimes with small blisters, resulting from direct irritation of the skin by an external agent or allergic reaction to it) and chronic pain.

The "Quarterly Minimum Data Set" (MDS), dated 07/05/22, documented the resident had intact cognition, with a Brief Interview for Mental Status (BIMS) score of 15. The resident required extensive staff assistance with bed mobility, transfers, personal hygiene, and toileting. The resident received dialysis (the process of removing excess water, solutes, and toxins from the blood in people who can no longer perform these functions naturally) treatment.

The "Activities of Daily Living (ADLs) Care Plan," dated 07/20/22, directed staff to assist R23 with all ADLs and self-cares. The care plan documented the resident used an electric scooter for mobility and a sit to stand lift for transfers with assistance of one staff.

The "Psychosocial Wellbeing Care Plan," dated 07/20/22, directed staff to provide emotional

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175380	A. BUILDING _____ B. WING _____	08/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CEDARS	1021 CEDARS DRIVE MCPHERSON, KS 67460

(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 600	Continued From page 2	F 600		

support and validate R23's concerns and feelings. The care plan documented the social worker and chaplain were available as needed.

The "Nurse Note," date 07/03/22 at 11:26 AM, recorded the resident complained of discomfort to his left shin where a small skin tear was obtained on 07/02/22 evening shift. LN H documented the skin tear was bandaged and clean.

The Nurse's notes lacked any further documentation of the incident.

The facility completed an "Investigation" on 07/03/22 regarding an incident on 07/02/22. Information obtained revealed on 07/02/22 R23 stated LN G refused to give him his evening medications. R23 became very upset and stated that he was going to call the police. R23 stated LN G took R23's cell phone from him and threw it in the chair so he could not call the police. R23 reported he received a skin tear when LN G was rough with him when she put him to bed afterwards. On 07/03/22 LN H was instructed to complete a head to toe assessment regarding R23's allegations and noted the resident had a skin tear to his left shin. LN H cleansed the area and placed a bandage to the open skin tear. The investigation documented Administrative Staff A, the primary care physician, and R23's Durable Power of Attorney (DPOA) were notified of the incident. The investigation documented LN H was not allowed to return to the facility.

The 07/04/22 at 09:38 AM, "Witness Statement" documented LN G stated R23 asked for his evening medication several times and stated he had not received his medications. LN G stated she looked at the electronic medical record and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175380	A. BUILDING _____ B. WING _____	08/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CEDARS	1021 CEDARS DRIVE MCPHERSON, KS 67460

(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 600	Continued From page 3	F 600		

R23's medications were signed off by another agency employee, Certified Medication Aide (CMA) R. LN G explained to the resident he had already received his medications and she would not be able to administer them again. LN G stated R23 said if he did not get his medications he would call the police, LN G stated she would not be able to do anything for him and she would not give him the medications he had already received. LN H stated she asked the resident if he needed anything else and went to move his bedside table. R23's cell phone fell to the ground and the back part of the screen protector fell off, LN G put it back on and placed the cell phone on his bedside table. LN G stated later that night, towards the end of the shift, it was shared with her that R23's eye drops and inhaler were kept at the resident's bedside in a locked box and the agency CMA was not aware there were additional medications in a locked box in the resident's room. LN G then administered the resident's remaining medications and apologized to R23 for not understanding that there were additional medications. LN G stated she assisted the resident to bed with a sit to stand lift and was not aware he sustained a skin tear during the transfer.

On 8/23/22 at 10:45 AM R23 stated the incident on 07/02/22 with LN G caused him distress and he felt threatened when LN G denied him the cell phone to call the police to resolve the issue.

On 08/25/22 at 02:30 PM, Administrative Staff A stated on 07/03/22 she became aware of R23's allegation of not receiving some of his evening medications and the incident that took place. Administrative Staff A terminated agency LN G from working at the facility after she completed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175380	A. BUILDING _____ B. WING _____	08/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CEDARS	1021 CEDARS DRIVE MCPHERSON, KS 67460

(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 600	Continued From page 4 the investigation. The facility's "Abuse, Neglect, and Exploitation" policy, undated, recorded the facility would protect the residents from any physical and mental mistreatment, involuntary seclusion and misappropriation of resident property through the action of the staff, other residents, family members and other visitors. The facility failed to protect R23 from abuse and/or retaliation when LN G refused to provide the resident his evening medications, took his cell phone away, denied him access to call police for help, and transferred him roughly. This deficient practice placed the resident at risk for pain and suffering.	F 600		
F 675 SS=D	Quality of Life CFR(s): 483.24 § 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: The facility reported a census of 51 residents. The sample included 13 residents with one reviewed for quality of life. Based on observation, record review, and interview, the facility failed to ensure all staff honored and responded to Resident (R)23's preferences, requests and	F 675		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175380	A. BUILDING _____ B. WING _____	08/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CEDARS	1021 CEDARS DRIVE MCPHERSON, KS 67460

(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 675	Continued From page 5	F 675		

choices to ensure R23's quality of life. This deficient practice placed R23 at risk for decreased psychosocial wellbeing and impaired dignity and autonomy.

Findings Included:

- R23's "Physician Order sheet," dated 08/16/22 documented diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), chronic obstructive pulmonary disease (COPD-progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), dry eye syndrome, facial dermatitis (a condition of the skin in which the skin becomes red swollen, and sore, sometimes with small blisters, resulting from direct irritation of the skin by an external agent or allergic reaction to it) and chronic pain.

The "Quarterly Minimum Data Set" (MDS), dated 07/05/22, documented the resident had intact cognition, with a Brief Interview for Mental Status (BIMS) score of 15. The resident required extensive staff assistance with bed mobility, transfers, personal hygiene, and toileting. The resident received dialysis (the process of removing excess water, solutes, and toxins from the blood in people who can no longer perform these functions naturally) treatment.

The "Activities of Daily Living (ADLs) Care Plan," dated 07/20/22, directed staff to assist R23 with all ADLs and self-cares. The care plan documented the resident used an electric scooter for mobility and a sit to stand lift for transfers with assistance of one staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175380	A. BUILDING _____ B. WING _____	08/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CEDARS	1021 CEDARS DRIVE MCPHERSON, KS 67460

(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 675	Continued From page 6	F 675		

The "Psychosocial Wellbeing Care Plan," dated 07/20/22, directed staff to provide emotional support and validate R23's concerns and feelings. The care plan documented the social worker and chaplain were available as needed.

The facility completed an "Investigation" on 07/03/22 regarding an incident on 07/02/22. Information obtained revealed on 07/02/22 R23 stated agency Licensed Nurse G refused to give him his evening medications. R23 got very upset and stated that he was going to call the police. R23 stated LN G took his cell phone from him and threw it in the chair so he could not call the police. The investigation documented Administrative Staff A, the primary care physician, and R23's Durable Power of Attorney (DPOA) were notified of the incident. The investigation documented LN H was not allowed to return to the facility.

The 07/04/22 at 09:38 AM, a "Witness Statement" documented LN G stated R23 asked for his evening medication several times and stated he had not received his medications. LN G stated she had looked at the electronic medical record and R23's medications were signed off by another agency employee, Certified Medication Aide (CMA) R. LN G explained to the resident he had received his medications and she would not be able to administer them again. LN G stated R23 said if he did not get his medications he would call the police, LN G stated she would not be able to do anything for him and she would not give him the medications he had already received .LN H stated she asked the resident if he needed anything else and went to move his bedside table. R23's cell phone fell to the ground and the back part of the screen protector fell off , LN G put it

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175380	A. BUILDING _____ B. WING _____	08/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CEDARS	1021 CEDARS DRIVE MCPHERSON, KS 67460

(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 675	Continued From page 7	F 675		

back on and placed the cell phone on his bedside table. LN G stated later that night, towards the end of the shift, it was shared with her R23's eye drops and inhaler, were kept at the resident's bedside in a locked box and the other agency personnel was not aware there were additional medications in a locked box in the resident's room. LN G then administered the resident's remaining medications and apologized to R23 for not understanding that there were additional medications..

On 8/23/22 at 10:45 AM, R23 stated on the 07/02/22 evening shift he did not get all of his medications and had explained to agency LN G the medication aide had not given him his eye drops, inhaler, or face cream. R23 stated he asked for the medication's multiple times throughout the evening and the nurses denied him the medication, stated he had received it, and the medication aide had signed off he received it. The resident stated he told the nurse if he did not get it he would call the police and stated LN G took the cell phone out of his hand and threw it in a bedside chair and he was unable to reach the phone. R23 stated this incident cause him distress and he felt threatened when they denied him the cell phone to call the police to resolve the issue. R23 stated he had never felt threatened or fearful in the three years he lived at the facility, and stated the involved staff were agency, not the regular staff.

On 08/25/22 at 02:30 PM, Administrative Staff A stated on 07/03/22 she became aware of R23's allegation of not receiving some of his evening medications and the incident that took place. Administrative Staff A terminated agency LN G from working at the facility after she completed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175380	A. BUILDING _____ B. WING _____	08/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CEDARS	1021 CEDARS DRIVE MCPHERSON, KS 67460

(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 675	Continued From page 8 the investigation. The facility's "Resident Right's" policy, dated 7/19, documented the resident would be treated with respect, dignity and consideration, and would be free from discrimination, coercion or reprisals in the exercise of resident rights. The policy documented the resident would receive services for the resident's special needs and responses to requests and receive adequate health care and appropriate support services. The facility failed to ensure all staff honored R23's preferences, requests and choices to support and maintain R23's quality of life when LN G refused to follow up on R23's requests. This deficient practice placed R23 at risk for decreased psychosocial wellbeing, and impaired dignity and autonomy.	F 675		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents'	F 726		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175380	A. BUILDING _____ B. WING _____	08/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CEDARS	1021 CEDARS DRIVE MCPHERSON, KS 67460

(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 726	Continued From page 9	F 726		

needs, as identified through resident assessments, and described in the plan of care.

§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.

§483.35(c) Proficiency of nurse aides.
The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 51 residents. The sample included 13 residents. Based on observation, interview, and record review, the facility failed to ensure staff possessed the appropriate skills and competencies when staff failed to complete post-fall neurological assessments for one of three residents reviewed for accidents, Resident (R) 9. This placed R9 at increased risk for unrecognized fall related injury and delayed treatment.

Findings included:

-The "Medical Diagnosis" section within R9's Electronic Medical Record (EMR) included diagnoses of transient cerebral ischemic attack (TIA-episode of cerebrovascular insufficiency), epilepsy (brain disorder characterized by repeated seizures), dementia (progressive mental disorder characterized by failing memory, confusion) without behavioral disturbance, fall trip with strike against object and depressive disorder (abnormal emotional state characterized by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175380	A. BUILDING _____ B. WING _____	08/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CEDARS	1021 CEDARS DRIVE MCPHERSON, KS 67460

(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 726	Continued From page 10	F 726		

exaggerated feelings of sadness, worthlessness, emptiness and hopelessness).

The "Quarterly Minimum Data Set" (MDS), dated 06/02/22, documented R9 had severe cognitive impairment, required limited assistance of one staff for activities of daily living, was not steady, but able to stabilize without staff assistance with balance and transitions. The MDS further documented R9 had no falls since prior assessment.

The "Care Plan", dated 06/07/22, documented R9 had actual falls related to hypertension (elevated blood pressure), dementia and seizures. The "Care Plan" directed staff to assist the resident to get ready for bed right after supper meal, cluster cares so R9 did not have to turn around and she could focus on ambulation, keep walker close, and staff were to assist with ambulation.

The "Physician Order Sheet" (POS), dated 08/01/22, documented R9 routinely took Plavix (medication used to prevent blood clots), aspirin, and Keppra (used to treat seizures).

The "Interdisciplinary (ID) Note", dated 07/19/22 at 06:18 PM, documented at 05:30 PM R9 was on her buttocks in front of her closet. The note further documented R9 lost her balance attempting to get into pajamas for the evening. The physician was notified via fax of the unwitnessed fall.

A "Neurological Assessment Tool" initiated on 07/19/22 at 05:30 PM directed staff to complete a neurological check every 15 minutes for one hour, every 30 minutes for one hour, then every two hours for six hours, every four hours for eight

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175380	A. BUILDING _____ B. WING _____	08/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CEDARS	1021 CEDARS DRIVE MCPHERSON, KS 67460

(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 726	Continued From page 11	F 726		

hours, and then every eight hours for 56 hours.

The "ID Note" dated 07/20/22 at 05:13 AM, documented R9 had been sleeping all night. The (agency) nurse did not obtain vital signs (neurological checks) at 11:30 PM (07/19/22), 01:30 AM (07/20/22) and 05:30 AM (07/20/22). The note recorded the agency nurse did not obtain the vital sign measurements because she was told not to disturb the residents while they slept.

On 08/29/22 at 10:10 AM, Licensed Nurse (LN) I stated the facility's policy directed staff to perform neurological checks for resident's who had an unwitnessed fall. LN I stated staff should have woke R9 for vital sign and neurological checks. LN I also verified R9 took blood thinning medications: Plavix and aspirin.

On 08/29/22 at 11:00 AM, Administrative Nurse D stated she expected nursing staff to make at least one attempt to check the resident's neurological status and document information related to not completing the assessment.

The facility's "Fall Management" policy, dated 07/2022, documented the charge nurse will initiate the Fall Incident-Immediate Care Plan which will identify immediate care plan changes and include neuro checks when indicated per protocol. The policy further documented to continue follow up assessment, monitoring, documentation for actual and/or potential complication or harm and care plan effectiveness.

The facility failed to complete neurological assessments for R9 who received blood thinners and had an unwitnessed fall which placed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175380	A. BUILDING _____ B. WING _____	08/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CEDARS	1021 CEDARS DRIVE MCPHERSON, KS 67460

(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 726	Continued From page 12 resident at risk for unrecognized injury and delayed treatment.	F 726		
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 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	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175380	A. BUILDING _____ B. WING _____	08/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CEDARS	1021 CEDARS DRIVE MCPHERSON, KS 67460

(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		

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 51 residents. The sample included 13 residents with five reviewed for unnecessary drugs. Based on observation, interview, and record review the facility failed to follow up on the consultant pharmacist recommendations to ensure the facility obtained a risk versus benefit statement annually for the continued use of Seroquel (antipsychotic drug) for R42 and an appropriate diagnosis for the use of Seroquel for R16. This deficient practice placed R16 and R42 at risk for unnecessary drugs.

Findings included:

- R42's "Physician Order Sheet" (POS), dated 08/04/22, documented diagnoses of anxiety disorder (disorder characterized by feelings of worry, anxiety) and dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life).

The "Annual Minimum Data Set" (MDS), dated 08/01/22, documented a Brief Interview for Mental Status (BIMS) score of six, indicating severe cognitive impairment. R42 required supervision for eating and one to two staff assistance for all other activities of daily living. The MDS documented R42 had no pain, one non-injury fall, one minor injury fall, and received antipsychotic (class of medicines used to treat psychosis and other mental and emotional conditions), antidepressant (prescription

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175380	A. BUILDING _____ B. WING _____	08/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CEDARS	1021 CEDARS DRIVE MCPHERSON, KS 67460

(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		

medicines to treat depression), and anticoagulant (chemical used to prevent and treat blood clots in blood vessels and the heart) medications seven days of the lookback period.

The "Psychotropic Drug Use Care Area Assessment" (CAA), dated 08/01/22, documented the CAA triggered secondary to use of psychotropic (medication which alters mood or thoughts) medication to manage psychiatric condition and contributing factors included diagnoses of dementia and acute psychosis (mental disorder characterized by a disconnection from reality) episode.

The "Medication Care Plan," 06/23/22, documented R42 had potential for drug related complications associated with use of psychotropic medications and directed staff to monitor for target behaviors and document per facility protocol. Observe, document, report to the physician as needed, signs of drug related complications. Consult with pharmacist and physician to consider dosage reduction when clinically appropriate.

The "Consultant Pharmacist Reviews" reviewed for the past year documented on 11/11/21 and 12/08/21 recommendations noted the need for a review of Seroquel use. The physician did not respond to the 11/11/21 recommendation.

The "Pharmacist Consultant Note," dated 12/08/21, documented he resent a note to R42's physician (second attempt) on 12/08/21 requesting he assess R42 for possible gradual dose reduction (GDR) to Seroquel and/or Trazodone (antidepressant). The physician response, dated 12/08/21, ordered a GDR of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175380	A. BUILDING _____ B. WING _____	08/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CEDARS	1021 CEDARS DRIVE MCPHERSON, KS 67460

(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		

Trazodone. The physician did not respond to the recommendation for a GDR for Seroquel and did not write a risk versus benefit statement for continuing it.

The "Physician Order," dated 08/23/22, directed staff to administer Seroquel 50 milligrams (mg) at bedtime, for psychosis.

Review of the medical record revealed R42 had received Seroquel since 03/24/21(17 months) and lacked evidence of an attempted GDR or risk versus benefit statement.

The "Psychiatric Visit Note," dated 04/30/22, documented R42 was cooperative, had no agitation, disorganized thought, delusions, no hallucinations or paranoia and not reported to have any recent target symptoms. The psychiatrist documented a diagnosis of dementia with behavioral problem.

The "Psychiatric Visit Note," dated 08/20/22, documented during a follow up psychiatry visit R42 was cooperative, no agitation, delusions, possible hallucinations, no paranoia. The psychiatrist documented a diagnosis of dementia with behavioral problem and directed staff to continue to provide care with physical activity, offer toileting, hygiene, snacks may be helpful for wandering or restlessness, and to contact psychiatry if hallucinations become distressing.

On 08/24/22 at 07:45 AM, observation revealed R42 sat in a chair in the dining room and Certified Nurse Aide (CMA) R assisted her to walk to her room. R42 walked with small steady steps and cooperated well. CMA R offered toileting assistance, R42 declined, and CMA R assisted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175380	A. BUILDING _____ B. WING _____	08/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CEDARS	1021 CEDARS DRIVE MCPHERSON, KS 67460

(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		

her to bed.

On 08/25/22 at 03:20 PM, CMA S stated R42 wandered some days, especially when agitated or needed to use the bathroom. CMA S stated R42 had not attempted to open doors for the past three weeks, as she tried to open doors a year ago. She stated R42 used to hallucinate or have delusional thoughts but slept a lot now.

On 08/29/22 at 03:08 PM, Administrative Nurse D verified the physician had not initiated a gradual dose reduction (GDR) or written a risk versus benefit statement for the continued use of Seroquel during the 17 months the resident received the antipsychotic. She stated the consultant pharmacist had attempted twice to obtain a GDR or risk versus benefit statement from the physician.

The facility's "Pharmacy Services Policy and Procedure," dated 08/2018, documented Resident-specific recommendations are documented in the resident's active medical record. Attending providers are required to 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 provider should document the rationale and placed in the resident's medical record. The director of nursing, or designated individual, will track physician responses. If the attending provider fails to respond to an irregularity within fourteen (14) business days of the initial requested review, the attending provider will be contacted by the director of nursing or designated facility agent to obtain a response and the attempted contact will be documented in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175380	A. BUILDING _____ B. WING _____	08/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CEDARS	1021 CEDARS DRIVE MCPHERSON, KS 67460

(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	F 756		

resident's medical record. If no response is received from the attending provider within twenty-one (21) business days of the initial requested review, the facility's medical director will be contacted by the director of nursing or designated facility agent for requested responses/recommendations and the attempted contact will be documented in the resident's medical record.

The facility failed to follow up on the consultant pharmacist's recommendation to attempt GDR of R42's Seroquel or obtain a statement from the physician weighing the risk versus benefit for the continued use of Seroquel, placing R42 at risk for adverse effects from the antipsychotic drug.

- R16's "Physician Order Sheet" (POS), dated 08/25/22, documented diagnoses of dementia (group of symptoms that affects memory, thinking and interferes with daily life) with behavioral disturbance, anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear,) Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), and major depressive disorder (major mood disorder.)

The "Quarterly Minimum Data Set" (MDS), dated 06/23/22, documented the resident had severely impaired cognition. The MDS documented R16 had disorganized thinking, was easily annoyed, and had behaviors which fluctuated. R16 required extensive assistance with all activities of daily Living (ADLs). The MDS documented the resident received antipsychotic and antidepressant medication six days of the look back period.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175380	A. BUILDING _____ B. WING _____	08/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CEDARS	1021 CEDARS DRIVE MCPHERSON, KS 67460

(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 18	F 756		

The "Psychotropic Care Area Assessment" (CAA), dated 08/22/22, documented to proceed to the care plan with management of psychotropic (medications which alter mood or thought) medication during therapeutic use.

The "Cognitive/Dementia" CAA, dated 08/22/22, documented to proceed to the care plan, no additional information provided.

The "Medication Care Plan," dated 07/15/22, documented R16 had the potential for drug related complications associated with the use of psychotropic medication. The care plan directed staff to monitor the resident for targeted behaviors/symptoms such as physically abuse, drug related complications, and document per facility protocol. The care plan documented the resident took Seroquel (antipsychotic) and the resident's family has been educated on the risk versus benefits of the resident receiving antipsychotic medications for treatment of his dementia related. The care plan directed the staff to consult the pharmacy and the medical director to consider dosage reduction when clinically appropriate.

The "Consultant Pharmacist Review," dated 06/14/22, documented an inappropriate diagnosis for the use of Seroquel and requested a risk versus benefit statement.

The "Nurse's Notes," date 06/21/22, at 02:45 PM, documented Administrative Nurse D contacted the primary care physician to discuss psychotropic regimen regarding Seroquel was not an approved treatment for residents with dementia related psychosis. The primary care physician stated she was frustrated by this

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175380	A. BUILDING _____ B. WING _____	08/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CEDARS	1021 CEDARS DRIVE MCPHERSON, KS 67460

(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 19	F 756		

guidance and stated she cannot diagnosis a resident with an illness that he did not have. The primary care physician stated "the only other option is to send the resident to a behavioral health unit where the resident will potentially be inappropriately diagnosed and given antipsychotic medication anyway."

The facility was unable to provide documentation this situation was referred to the facility Medical Director for physician consult and review.

The "Physician's Order," dated 06/30/22, directed the staff to administer Seroquel 50 milligrams (mg), daily for a diagnosis of dementia with behavioral disturbance.

The "Physician's Order," dated 07/07/22, directed staff to administer Seroquel 25 mg, daily for a diagnosis of dementia with behavioral disturbance.

On 08/24/22 at 11:25 AM, observation revealed R16 sat at the dining room table, in a wheelchair. Certified Medication Aid (CMA) S crushed the resident's Seroquel 25 mg tablet and mixed it in pudding, then administered the spoonful to the resident at the dining room table.

On 08/29/22 at 01:00 PM, Administrative Nurse D verified the diagnosis of dementia for the use of Seroquel was inappropriate. Administrative Nurse D verified the facility had been in contact with R16's primary care physician who refused to change the diagnosis for the use of the medication stating it was for "dementia with behavioral disturbance."

The facility's "Antipsychotic Medication Use,"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175380	A. BUILDING _____ B. WING _____	08/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CEDARS	1021 CEDARS DRIVE MCPHERSON, KS 67460

(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 20	F 756		

policy, dated 06/19, documented residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. All physician orders for antipsychotic medications will be clear and accurate and will include an appropriate diagnosis, condition or indication for use; and the consultant pharmacist will review the appropriateness of all medication orders for medications to be administered by clinical staff. An Informed Consent Agreement would be initiated and reviewed with the resident/resident representative. The ordering physician will outline the risks and the benefits of administration of the medication. The dispensing pharmacy or consultant pharmacist will be instructed by the facility to complete a drug regimen review related to possible behavioral symptoms as an adverse side effect of another drug or a drug-to- drug interaction side effect, appropriate indication for antipsychotic drug, and the pharmacist discusses the medication order with the facility's DON/Administrator/Nurse Manager.

The facility's "Pharmacy Review" policy, dated 08/18, stated the pharmacist would review resident medications at least monthly and recommend changes to the physician and facility. The pharmacist shall document in the medical records the drug regimen review has been performed and including review of unnecessary medication. Attending providers are required to document in the medical records this has been reviewed and what, if any action has been taken to address the concern. If no change, the attending provider should document the rationale which would be placed in the resident's medical record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175380	A. BUILDING _____ B. WING _____	08/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CEDARS	1021 CEDARS DRIVE MCPHERSON, KS 67460

(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 21 The facility failed to act upon the Consultant Pharmacist's report regarding an inappropriate diagnosis for the use of Seroquel which included involving the Medical Director as needed, placing the resident at risk for inappropriate use of an antipsychotic 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 unless that medication is necessary to treat a	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175380	A. BUILDING _____ B. WING _____	08/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CEDARS	1021 CEDARS DRIVE MCPHERSON, KS 67460

(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		

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 51 residents. The sample included 13 residents with five reviewed for unnecessary drugs. Based on observation, interview, and record review the facility failed to ensure two sampled Residents (R) did not receive unnecessary psychotropic medications (class of medications which alter mood or thought) when they failed to obtain a risk versus benefit statement for the continued use of Seroquel (antipsychotic drug) for R42 and an appropriate diagnosis for the continued use of Seroquel for R16. This deficient practice placed R16 and R42 at risk to receive unnecessary psychotropic drugs.

Findings included:

- R42's "Physician Order Sheet" (POS), dated 08/04/22, documented diagnoses of anxiety disorder (disorder characterized by feelings of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175380	A. BUILDING _____ B. WING _____	08/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CEDARS	1021 CEDARS DRIVE MCPHERSON, KS 67460

(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		

worry, anxiety) and dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life).

The "Annual Minimum Data Set" (MDS), dated 08/01/22, documented a Brief Interview for Mental Status (BIMS) score of six, indicating severe cognitive impairment. R42 required supervision for eating and one to two staff assistance for all other activities of daily living. The MDS documented R42 had no pain, one non-injury fall, one minor injury fall, and received antipsychotic (class of medicines used to treat psychosis and other mental and emotional conditions), antidepressant (prescription medicines to treat depression), and anticoagulant (chemical used to prevent and treat blood clots in blood vessels and the heart) medications seven days of the lookback period.

The "Psychotropic Drug Use Care Area Assessment" (CAA), dated 08/01/22, documented the CAA triggered secondary to use of psychotropic (medication which alters mood or thoughts) medication to manage psychiatric condition and contributing factors included diagnoses of dementia and acute psychosis (mental disorder characterized by a disconnection from reality) episode.

The "Behavior Care Plan," dated 06/23/22, documented R42 had impaired decision making related to dementia. Social worker available as needed. Observe for any changes in resident's psychosocial/mood state and report changes to resident's nurse or facility social worker as needed. Intervene as necessary to ensure safety of resident and others, divert attention from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175380	A. BUILDING _____ B. WING _____	08/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CEDARS	1021 CEDARS DRIVE MCPHERSON, KS 67460

(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		

stimulus. Talk with the resident in a calm voice when behavior is disruptive and redirect. Leave and reapproach when resident has calmed down. Document any observed behaviors and notify the physician. Wandering or pacing will be managed to allow freedom but support safety. The care plan documented R42 had a history of demonstrating physically violent behaviors towards others related to dementia with behavioral disturbance. R42 sometimes believed that she was in her 20's and that she had young children. Do not attempt to re-orient R42 by proving otherwise, as this has been known to potentially increase her agitation and anxiety.

The "Medication Care Plan," 06/23/22, documented R42 had potential for drug related complications associated with use of psychotropic medications and directed staff to monitor for target behaviors and document per facility protocol. Observe, document, report to the physician as needed, signs of drug related complications. Consult with pharmacist and physician to consider dosage reduction when clinically appropriate.

The "Pharmacist Consultant Note," dated 12/08/21, documented he resent a note to R42's physician (second attempt) on 12/08/21 requesting he assess R42 for possible gradual dose reduction (GDR) to Seroquel and/or Trazodone (antidepressant). The Physician Response, dated 12/08/21, ordered a GDR of Trazodone. The physician did not respond to the recommendation for a GDR for Seroquel and did not write a risk versus benefit statement for continuing it.

The "Physician Order," dated 08/23/22, directed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175380	A. BUILDING _____ B. WING _____	08/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CEDARS	1021 CEDARS DRIVE MCPHERSON, KS 67460

(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		

staff to administer Seroquel 50 milligrams (mg) at bedtime, for psychosis.

Review of the medical record revealed R42 had received Seroquel since 03/24/21(17 months) and lacked evidence of an attempted GDR.

The "Psychiatric Visit Note," dated 04/30/22, documented R42 was cooperative, had no agitation, disorganized thought, delusions, no hallucinations or paranoia and not reported to have any recent target symptoms. The psychiatrist documented a diagnosis of dementia with behavioral problem.

The "Psychiatric Visit Note," dated 08/20/22, documented during a follow up psychiatry visit R42 was cooperative, no agitation, delusions, possible hallucinations, no paranoia. The psychiatrist documented a diagnosis of dementia with behavioral problem and directed staff to continue to provide care with physical activity, offer toileting, hygiene, snacks may be helpful for wandering or restlessness, and to contact psychiatry if hallucinations become distressing.

On 08/24/22 at 07:45 AM, observation revealed R42 sat in a chair in the dining room and Certified Nurse Aide (CMA) R assisted her to walk to her room. R42 walked with small steady steps and cooperated well. CMA R offered toileting assistance, R42 declined, and CMA R assisted her to bed.

On 08/25/22 at 03:20 PM, CMA S stated R42 wandered some days, especially when agitated or needed to use the bathroom. CMA S stated R42 had not attempted to open doors for the past three weeks, as she tried to open doors a year

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175380	A. BUILDING _____ B. WING _____	08/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CEDARS	1021 CEDARS DRIVE MCPHERSON, KS 67460

(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		

ago. She stated R42 used to hallucinate or have delusional thoughts, but slept a lot now.

On 08/29/22 at 03:08 PM, Administrative Nurse D verified the physician had not initiated a gradual dose reduction (GDR) or written a risk versus benefit statement for the continued use of Seroquel during the 17 months the resident received the antipsychotic.

The facility's "Antipsychotic Medications" policy dated 06/2019, documented any resident who uses an antipsychotic drug receives a gradual dose reduction and behavioral interventions, unless clinically contraindicated, in an effort 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. The policy stated each resident who has an order for an antipsychotic drug will be assessed and periodically reassessed during their residency to determine the effectiveness of the medication.

The facility failed to ensure a GDR of R42's Seroquel or a statement from the physician weighing the risk versus benefit for the continued use of Seroquel, placing R42 at risk for adverse effects from the antipsychotic drug.

Surveyor: Ravenkamp, Pat

- R16's "Physician Order Sheet" (POS), dated 08/25/22, documented diagnoses of dementia (group of symptoms that affects memory, thinking and interferes with daily life) with behavioral disturbance, anxiety (mental or emotional

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175380	A. BUILDING _____ B. WING _____	08/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CEDARS	1021 CEDARS DRIVE MCPHERSON, KS 67460

(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		

reaction characterized by apprehension, uncertainty and irrational fear,) Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), and major depressive disorder (major mood disorder.)

The "Quarterly Minimum Data Set" (MDS), dated 06/23/22, documented the resident had severely impaired cognition. The MDS documented R16 had disorganized thinking, was easily annoyed, and behaviors which fluctuated. R16 required extensive assistance with all activities of daily Living (ADLs). The MDS documented the resident received antipsychotic (class of medicines used to treat psychosis and other mental and emotional conditions), and antidepressant (prescription medicines to treat depression) medication six days of the look back period.

The "Psychotropic Care Area Assessment" (CAA), dated 08/22/22, documented to proceed to the care plan with management of psychotropic medication during therapeutic use.

The "Cognitive/Dementia" CAA, dated 08/22/22, documented to proceed to the care plan, no additional information provided.

The "Medication Care Plan," dated 07/15/22, documented R16 had the potential for drug related complications associated with the use of psychotropic medication. The care plan directed staff to monitor the resident for targeted behaviors/symptoms such as physically abuse, drug related complications, and document per facility protocol. The care plan documented the resident took Seroquel and the resident's family has been educated on the risk versus benefits of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175380	A. BUILDING _____ B. WING _____	08/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CEDARS	1021 CEDARS DRIVE MCPHERSON, KS 67460

(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		

the resident receiving antipsychotic medications for treatment of his dementia related. The care plan directed the staff to consult the pharmacy and the medical director to consider dosage reduction when clinically appropriate.

The "Physician's Order," dated 06/30/22, directed the staff to administer Seroquel 50 milligrams (mg), daily for a diagnosis of dementia with behavioral disturbance.

The "Physician's Order," dated 07/07/22, directed staff to administer Seroquel 25 mg, daily for a diagnosis of dementia with behavioral disturbance.

The "Consultant Pharmacist Review," dated 06/14/22, documented an inappropriate diagnosis for the use of Seroquel and requested a risk versus benefit statement.

The "Nurse's Notes," date 06/21/22, at 02:45 PM, documented Administrative Nurse D contacted the primary care physician to discuss psychotropic regimen regarding Seroquel was not an approved treatment for residents with dementia related psychosis. The primary care physician stated she was frustrated by this guidance and stated she cannot diagnosis a resident with an illness that he does not have. The primary care physician stated "the only other option is to send the resident to a behavioral health unit where the resident will potentially be inappropriately diagnosed and given antipsychotic medication anyway."

The facility was unable to provide documentation this situation was referred to the facility Medical Director for physician consult and review.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175380	A. BUILDING _____ B. WING _____	08/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CEDARS	1021 CEDARS DRIVE MCPHERSON, KS 67460

(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		

On 08/24/22 at 11:25 AM, observation revealed R16 sat at the dining room table, in a wheelchair. Certified Medication Aid (CMA) S crushed the resident's Seroquel 25 mg tablet and mixed it in pudding, then administered the spoonful to the resident at the dining room table.

On 08/29/22 at 01:00 PM, Administrative Nurse D verified the diagnosis of dementia for the use of Seroquel was inappropriate. Administrative Nurse D verified the facility had been in contact with R16's primary care physician who refused to change the diagnosis for the use of the medication stating it was for "dementia with behavioral disturbance."

The facility's "Antipsychotic Medication Use," policy, dated 06/19, documented residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. All physician orders for antipsychotic medications will be clear and accurate and will include an appropriate diagnosis, condition or indication for use; and the consultant pharmacist will review the appropriateness of all medication orders for medications to be administered by clinical staff. An Informed Consent Agreement would be initiated and reviewed with the resident/resident representative. The ordering physician will outline the risks and the benefits of administration of the medication. The dispensing pharmacy or consultant pharmacist will be instructed by the facility to complete a drug regimen review related to possible behavioral symptoms as an adverse side effect of another drug or a drug-to- drug interaction side effect, appropriate indication for antipsychotic drug, and the pharmacist discusses

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175380	A. BUILDING _____ B. WING _____	08/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CEDARS	1021 CEDARS DRIVE MCPHERSON, KS 67460

(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 the medication order with the facility's DON/Administrator/Nurse Manager The facility failed to ensure R16 did not receive antipsychotic medication without an appropriate diagnosis or clinical justification for its use, placing R16 at risk for adverse side effects related to the use of Seroquel.	F 758		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: The facility had a census of 51 residents. The sample included 13 residents. Based on observation, record review, and interview the facility failed to ensure one of seven residents reviewed during medication administration pass remained free of medication errors. This deficient practice placed Resident (R) 23 at risk for adverse reaction from the medication. Findings included: - R23's "Physician Order sheet," dated 08/16/22 documented diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), chronic obstructive pulmonary disease (COPD-progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), dry eye syndrome, facial dermatitis (a condition of the skin in which the skin becomes red swollen, and sore, sometimes with small blisters, resulting	F 760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175380	A. BUILDING _____ B. WING _____	08/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CEDARS	1021 CEDARS DRIVE MCPHERSON, KS 67460

(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 760	Continued From page 31	F 760		

from direct irritation of the skin by an external agent or allergic reaction to it,) chronic kidney disease Stage 4 (kidneys are severely damaged and are not working to clear filter waste from your blood) and chronic pain.

R23's "Physician Order," dated 01/29/22 instructed staff to administer Renvela (medication used to control phosphorus levels for resident's who received dialysis [the process of removing excess water, solutes, and toxins from the blood in people who can no longer perform these functions naturally]), 0.8 grams (g) oral powder one packet, three times a day with meals.

On 08/23/22 at 04:20 PM, observation revealed License Nurse (LN) H administered Renvela 2.4 g, hydroxyzine (antihistamine) 500 milligrams (mg,) and carvedilol (medication for high blood pressure and heart failure) 12.5 mg tablet (crushed) in jelly. R23 ingested all of the medication.

On 08/23/22 at 04:25 PM, LN H stated staff crushed R23's medications, and mixed the medications with the powder medication [Renvela]. LN H said R23 liked the medications mixed with jelly.

On 08/29/22 at 09:30 AM, Administrative Nurse D verified the physician ordered Renvela 0.8 grams three times a day. Administrative Nurse D confirmed the pharmacy sent out Renvela 2.4 mg packets on 06/03/22 and the nurses had administered the incorrect dose for 12 weeks. Administrative Nurse D said the nurse was expected to check the five rights for medication administration (the right patient, the right drug, the right dose, the right route, and the right time)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175380	A. BUILDING _____ B. WING _____	08/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CEDARS	1021 CEDARS DRIVE MCPHERSON, KS 67460

(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 760	Continued From page 32 and the nurses failed to do that. The facility's "Medication Administration" policy, dated 05/21, documented staff would dispense medication according to the residents "Medication Administration Record" (MAR), read the medication label, dispense it into a cup, and read the medication label again when it was placed back in the medication cart. The facility failed to prevent a significant medication error when staff administered the incorrect dose of medication to R23. This placed the resident at risk for adverse reaction from the medication.	F 760		