STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175244	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Memorial Hospital Ltcu (Village Manor)	705 N Brady Street Abilene, KS 67410

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360 The facility had a census of 65 residents. The sample included 17 residents. Based on observation, record review, and interview, the facility failed to notify the physician of changes in status or condition for Resident (R) 168, who made statements of self-harm. This placed the resident at risk of delayed treatment due to a delay in physician involvement. Findings included: - The Electronic Medical Record (EMR) for R168 documented diagnoses of dementia without behavioral disturbance (a progressive mental disorder characterized by failing memory and confusion), bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), traumatic brain injury (TBI-an injury to the brain caused by external forces), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and as of 08/26/24, suicidal ideation (the thought process of having ideas of not wanting to live). The Admission Minimum Data Set (MDS), dated [DATE], documented R168 had severely impaired cognition and required partial assistance with toileting, dressing, personal hygiene, and was independent with eating, mobility, transfers, and ambulation. The assessment documented R168 had trouble concentrating for four to six days, had no behaviors, and received an antipsychotic (a class of medication used to treat major mental conditions that cause a break from reality) and antianxiety (a class of medications that calm and relax people) medication. R168's Baseline Care Plan, dated 08/20/24, documented R168 was oriented to person, and was able to make his needs known. R168 was independent with grooming, dressing, shaving, and eating. The update dated 08/24/24 documented R168 received lorazepam (an antianxiety medication), 0.5 milligrams (mg), by mouth, three times per day as needed for agitation. R168's Care Plan, dated 09/10/24, documented R168 had a potential for mood swings due to depression, bipolar disorder, and statements of wanting to die. The care plan directed staff to administer medications as ordered, monitor for adverse side effects, and notify the physician if behavior interferes with the functioning of his activities of daily living and safety to himself or others. The plan directed staff to involve him in activities daily, notify the physician immediately if any suicidal ideation, self-harm threats, behaviors of threat of harm to others, and to see behavioral health physician and social services as needed. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175244	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Memorial Hospital Ltcu (Village Manor)	705 N Brady Street Abilene, KS 67410

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Physician's Order, dated 08/20/24, directed staff to administer mirtazapine (an antidepressant medication), 15 mg, by mouth, daily for depression and risperidone (an antipsychotic medication), 0.5 mg, at bedtime for bipolar. The Physician's Order, dated 09/10/24, directed staff to administer lurasidone hydrochloride (an antipsychotic medication), 40 mg, by mouth, for dementia without behavioral disturbance and directed staff to discontinue the risperidone medication. The Nurse's Note, dated 08/20/24 documented R168 was wandering the halls, asking staff repeatedly when he could leave, and calling his family several times. The Nurse's Note dated 08/21/25 at 09:45 PM, documented R168 was anxious all shift, wandered the halls, called his family several times, and asked staff when he could leave. The Physician's Order, dated 08/22/24, directed staff to administer Valium, (an antianxiety medication), 2 mg, by mouth, twice per day for mood. This medication was discontinued on 09/05//24. The Nurse's Note, dated 08/25/24 at 06:13 AM, documented R168 had suicidal ideation from 04:30 AM to 05:45 AM. R168 stated he wanted to be dead and made a shot to the head gesture. He stated he was going to fail everyone and thought he might as well be dead. The note further documented R168 paced the hallways and mumbled aggressive things. R168 was placed on 15-minute checks and staff were directed to keep him occupied. Staff continued to monitor him throughout the shift. The note lacked evidence the physician was notified. The Nurse's Note, dated 08/27/24 at 03:24 PM, documented that staff notified the physician regarding R168's suicidal ideation from 08/25/24 and requested a behavioral health visit. The note directed staff to administer lorazepam, 0.5 mg, by mouth three times per day and to administer lorazepam, 0.5 mg. by mouth three times per day, as needed, for agitation. The Nurse's Note, dated 09/02/24 at 10:51 AM, documented that R168 made comments about wanting to hurt himself and stated he was tired of not being able to do anything anymore. R168 stated it was a daily chore to keep living and wanted to blow out his brain. R168 stated he did not understand why his family didn't want to take care of him and felt they did not want him around anymore. The note documented staff explained to him that he was loved by his family and was at the facility for extra help. Staff asked R168 if he wanted to go outside for fresh air. Staff took R168 outside and walked with him for 10-15 minutes before he asked to go back inside. The staff checked on him frequently to make sure he was ok, and the nurse told him that if he started to feel that way again, she would come back and talk with him. Staff checked on the resident every hour for safety precautions and monitored for any changes or repeated suicidal thoughts. R168's EMR lacked documentation the physician was notified and any further documentation regarding R168's suicidal ideation. The Nurse's Note, dated 09/07/24 at 11:15 AM, documented R168 paced, was agitated, and was seen by the behavioral health physician. The note further documented R168 was given an as-needed lorazepam. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175244	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Memorial Hospital Ltcu (Village Manor)	705 N Brady Street Abilene, KS 67410

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Nurse's Note, dated 09/07/24 at 02:00 PM, documented R168's family called and stated he was agitated and requested he be administered as-needed medication. R168 paced, was upset and agitated, and staff took him outside for a walk. The Nurse's Note, dated 09/08/24 at 11:00 am, documented R168 paced, was agitated and wanted his glasses and jacket so he could leave. R168 stated That's not sharp enough for what I need, R168 stated he would deal with God when he got there. Staff placed R168 on 15-minute checks, administered as-needed lorazepam, and took R168 outside for a walk. Staff provided 1:1. R168 stated, This is not what I signed up for and was pleasant and cooperative after walking outside with staff. On 09/10/24 at 07:45 AM, observation revealed R168 in the dining room of the Special Care Unit. He had a sad affect. When asked how his day was going, R168 stated, Not very good. He stated he did not understand why he was living there and did not think it was God's plan for him. He stated he had been living there for a short time, but it seemed like a lot longer. R168 stated no one does anything for him to help him and he does not know what to do. Observation on 09/10/24 at 09:45 AM, Consultant GG visited with R168, and the resident was smiling and engaged in conversation. On 09/10/24 at 08:45 AM, Administrative Nurse D stated she saw the note about R168's verbalizations of self-harm the day after it happened and probably called the doctor but did not think to document it. Administrative Nurse D further stated the nursing staff would document if R168 had any statements of self-harm and verified the physician was not notified of R168's threat of self-harm. Administrative Nurse D said she expected staff to ensure R168 was monitored and safe. Administrative Nurse D further stated she talked with R168 and he did not remember making those statements. Administrative Nurse D said staff should contact the physician whenever a resident makes statements of self-harm. On 09/10/24 at 09:50 AM, Consultant GG stated he was not opposed to staff calling him if the resident discussed self-harm. The facility's Nurse Notification of Physician policy, undated, documented licensed nurses were responsible for reporting to the resident's physician any time they believed a resident had a clinical issue that required physician notification and or intervention. If the physician was an on-call physician, identify the resident's attending physician. In situations when immediate action was necessary due to a life-threatening condition, as warranted by the resident and/or resident's representative, the decision to be transported when the physician cannot be reached immediately, contact emergency medical services to request immediate transport to the hospital. Monitor and reassess the resident's status and response to interventions. The facility failed to notify the physician of R168's statements of self-harm. This placed the resident at risk for delayed treatment due to a delay in physician involvement.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175244	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Memorial Hospital Ltcu (Village Manor)	705 N Brady Street Abilene, KS 67410

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32358 The facility had a census of 65 residents. The sample included 17 residents with one reviewed for missing personal property. Based on observation, record review, and interview, the facility staff failed to log and promptly resolve Resident (R) 18's grievance when she reported to staff that she had missing clothing items. This placed the resident at risk for unresolved grievances and decreased quality of life. Findings included: - R18's Electronic Medical Record (EMR) documented that R18 had diagnoses of bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods) and major depressive disorder (a major mood disorder that causes persistent feelings of sadness). R18's Quarterly Minimum Data Set (MDS), dated [DATE], documented that R18 had a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R18 was independent with most activities of daily living (ADLs), R18's Care Plan, revised 07/03/24, documented R18 had mood swings and instructed staff to notify the nurse if behaviors interfered with functioning, involve R18 in daily activities, notify the physician immediately of any suicidal ideation, self-harming threats, behaviors, or threats of harm to others, and encourage R18 to verbalize feelings and provide validation and reassurance as needed. A review of the Resident Grievance/Complaint Log from 03/13/23 to 08/23/24 lacked documentation of R18's grievance regarding missing clothing items. R18's clinical record lacked documentation regarding R18's missing clothing. On 09/09/24 at 01:00 PM, observation revealed R18 ambulated down the hall. She wore pink leggings with the Nike emblem down the left side of her pants and a pink t-shirt. On 09/09/24 at 10:01 AM, during an interview with R18, she reported the following missing clothing items since February 2024: Green Nike leggings with glitter running down the left side around the Nike emblem. White men's T-shirt with festival design including fruits across the front. Mint green outfit Men's T-shirt with fish on the front. Black daisy jeggings with frayed hem and a drawstring waist. Brown Nike short outfit with a goat on the front of the shirt. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175244	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Memorial Hospital Ltcu (Village Manor)	705 N Brady Street Abilene, KS 67410

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nike bike shorts. Blue Nike gym shorts with roll-down waistband with Nike written across the waistband. Black valley lace (delicate fabric made of yarn or thread in an open weblike pattern) underwear. Nike [NAME] pink sleeve t-shirt with matching wind shorts. On 09/10/24 at 09:10 AM, Certified Nurse Aide (CNA) R stated R18 had reported that she had some missing clothing. CNA R said she notified the laundry supervisor and the social service designee (SSD). CNA R stated the facility had a new laundry staff and a lot of the residents' clothes were mixed up, so staff were looking for them. CNA R stated staff had found some of R18's missing clothes. On 09/11/24 at 10:15 AM, Licensed Nurse (LN) G stated R18 mentioned missing clothing. LN G said she reported to the SSD in an e-mail but did not fill out a form. On 09/10/24 at 08:35 AM, Social Services X stated R18 had mentioned the missing clothing, but she did not fill out a grievance or place it on the grievance log because she considered R18's issue a complaint and she did not place missing clothing on the log. Social Service X stated the facility had replaced some of the items, but others could be items R18 wanted the facility to buy for her. Social Services X stated R18's friend had also helped her cut down her clothing collection, and some were bagged and given away without telling staff. Social Services X stated she filled out the grievance form for the resident's issues based on the severity of the issue or if a resident stated they wanted a grievance form filled out. On 09/10/24 at 09:49 AM, Administrative Nurse D stated if a resident reported to staff that he/she was missing a clothing item, she expected staff to report to the SSD. Administrative Nurse D said she probably would start a grievance form. On 09/10/24 at 01:58 PM, Housekeeping Staff (HS) U stated R18 reported to her what clothing items were missing but she did not write them down. HS U stated if R18 went through her closet, she would probably find the missing items. The facility's Grievances/Complaints, Recording, and Investigating Policy, revised in March 2017, documented that all grievances and complaints filed with the facility would be investigated and corrective actions would be taken to resolve the grievances(s). Upon receiving a grievance and complaint report, SSD or designee would begin an investigation into the allegation. The SSD or designee would record and maintain all grievances and complaints on the Resident Grievance Complaint Log. The following information would be recorded and maintained in the log: The date the grievance, and complaint were received. The name and room number of the resident filing the grievance or complaint The name and relationship of the person filing the grievance, complaint on behalf of the resident The date the alleged incident took place (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175244	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Memorial Hospital Ltcu (Village Manor)	705 N Brady Street Abilene, KS 67410

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The name of the person investigating the incident The date the resident or interested party was informed of the findings and the disposition of grievance (for example resolved, dispute, etcetera (etc.). The facility failed to log and promptly resolve R18's grievance. This placed the resident at risk for unresolved grievances and decreased quality of life.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175244	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Memorial Hospital Ltcu (Village Manor)	705 N Brady Street Abilene, KS 67410

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360 The facility had a census of 65 residents. The sample included 17 residents with one reviewed for abuse. Based on observation, record review, and interview, the facility failed to identify an injury of unknown origin as potential abuse and report immediately to the administrator for Resident (R) 57, who had bilateral (both sides) upper arm bruises. This placed the resident at risk for further injury and unidentified abuse or mistreatment. Findings included: - The Electronic Medical Record (MR) documented R57 had diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), neurocognitive disorder with Lewy body (a progressive brain disorder that causes a gradual decline in thinking abilities and other functions), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and posttraumatic stress disorder (PTSD- a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress.) The Annual Minimum Data Set (MDS), dated [DATE], documented R57 had severely impaired cognition. R57 required partial assistance with dressing, supervision with dressing, showers, toileting, and personal hygiene; R57 was independent with mobility, transfers, and ambulation. The assessment documented R57 had no functional impairment and no skin issues. R57's Care Plan, dated 06/26/24, initiated on 08/08/23, directed staff to observe her skin during care and her showers and notify the nurse of any abnormal findings. The plan directed staff to provide skin assessments weekly based on the Braden scale (a tool used to assess a resident's risk of developing pressure ulcers, or skin breakdown). The Nurse's Note, dated 07/15/24 at 02:32 PM, documented that R57 received a shower and had bilateral upper arm bruises. The Facility Shower Sheet, dated 07/25/24, documented that R57 had bilateral deltoid (the large triangular muscle that lies over the shoulder joint and upper arm) bruises. R57's EMR lacked documentation further assessment was completed regarding the status of the bruises, or how the injuries were obtained. On 09/11/24 at 07:35 AM, observation revealed R57 sat at the dining table with her eyes closed. On 09/10/24 at 10:35 AM, Certified Nurse Aide (CNA) M stated she was unaware of any bruises found on R57's upper arms and said she would make sure she notified the nurse if the resident had any skin issues. CNA M further stated that R57 had not had any recent falls, was independent with transfers and ambulation, was severely cognitively impaired, and would not be able to tell staff what happened. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175244	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Memorial Hospital Ltcu (Village Manor)	705 N Brady Street Abilene, KS 67410

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/11/24 at 08:54 AM, Licensed Nurse (LN) G stated the CNA staff complete a skin assessment if there are any skin issues. LN G said R57 was cognitively impaired and was unable to say what happened so she would report any injuries of unknown origin to the administration for an investigation to be completed. On 09/11/24 at 09:00 AM, Administrative Nurse D stated she was unaware of the bilateral bruises on R57 and said that due to the bruises on both arms, she would be investigating immediately and re-educating staff on the importance of reporting to administration to rule out abuse. On 09/11/24 at 12:15 PM, Administrative Staff A stated he was unaware of the bruises on R57's bilateral upper arms and said it was important for staff to notify him and the Director of Nursing of any injuries of unknown origin so that they could investigate, and report as needed. The facility's Reporting Abuse to Facility Management policy, dated 03/17, documented it was the responsibility of the employees, facility consultants, attending physicians, family members, and visitors, to promptly report any incident or suspected incident of neglect or resident abuse, including injuries of unknown source, and theft or misappropriation of resident property to facility management. The facility failed to identify R57's injury of unknown origin as potential abuse and report it to administration staff immediately. This placed the resident at risk for further injury and unidentified abuse or mistreatment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175244	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Memorial Hospital Ltcu (Village Manor)	705 N Brady Street Abilene, KS 67410

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32358 The facility had a census of 65 residents. The sample included 17 residents with three reviewed for hospitalization . Based on record review and interview the facility failed to provide a written notice for a facility-initiated transfer for Resident (R) 42 or his representatives as soon as practicable when he was transferred to the hospital. The facility also failed to notify the Office of the Long-Term Care Ombudsman (LTCO-a public official who works to resolve resident issues in nursing facilities) of R42's discharge. This placed the resident at risk for impaired rights and uninformed care choices. Findings included: - R42's Electronic Medical Record (EMR) documented the resident had diagnoses of cirrhosis (chronic degenerative disease of the liver) of the liver, ascites (a condition characterized by an excessive buildup of fluid in the abdomen, or belly), and acute pancreatitis (inflammation of the pancreas). R42's Quarterly Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview of Mental Status (BIMS) of seven, which indicated severe cognitive impairment. The MDS documented R42 required partial to moderate staff assistance with toileting, showering, upper and lower body dressing, and toilet transfers. R42 required supervision or touching assistance with shower transfers and setup for personal hygiene. R42 was independent with eating, oral hygiene, putting on and taking off footwear, bed mobility, chair-to-bed, bed-to-chair, and sit-to-stand transfers, and ambulation. R42's Care Plan, revised 09/04/24, documented that R42 was at risk for dehydration (a condition in which you lose so much body fluid that your body can't function normally) related to his diuretics. He was at risk for weight gain and had increased abdominal girth (a measurement of the distance around the abdomen at a specific point, usually the belly button) related to cirrhosis of the liver (chronic degenerative disease of the liver). R42's Progress Note, dated 12/30/23 at 09:05, documented R42 was admitted to hospital for pancreatitis The Progress Note, dated 02/12/24 at 17:55, documented that R42 was admitted to the hospital for abdominal pain retaining to pancreatitis (a condition that causes inflammation of the pancreas (a gland that produces digestive enzymes and hormones). The Progress Note, dated 03/21/24 at 19:01, documented R42 res was admitted to the hospital on 03/20/24 for gastrointestinal (GI) bleed (when there is blood loss from any of the several organs included in your digestive system). The Progress Note, dated 05/3/24, documented R42 was admitted to the hospital for pancreatitis symptoms. R42's clinical record lacked evidence the resident or representative was provided a written notice when R42 was transferred to the hospital on the dates. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175244	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Memorial Hospital Ltcu (Village Manor)	705 N Brady Street Abilene, KS 67410

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/09/24 at 12:30 PM, observation revealed R42 sat in a chair at the dining room table with no signs or symptoms of pain. On 09/10/24 at 08:35 AM, Social Service X stated was unaware she was required to provide R42 or his representative with written notice when he was transferred to the hospital, or that she was to notify the LTCO when residents were discharged . On 09/11/24 at 10:30 AM, Administrative Nurse D Stated Social Service X or the Administrative Nurse business office manager was responsible for providing R42 or his representative with written notice of the transfer and notifying the LTCO when the resident was transferred to the hospital. The facility's Bed-Holds and Returns Policy, revised in March 2017, documented that before a transfer, written information would be given to the residents and the resident representatives that explains in detail the following: The rights and limitations of the resident regarding bed-holds. The reserve bed payment policy is indicated by the state plan (Medicaid residents). The facility per diem rate required to hold a bed (non-Medicaid residents), or to hold a bed beyond the state bed-hold period (Medicaid residents); and The details of the transfer (per the Notice of Transfer). The facility failed to provide R42 or his representative written notice regarding R42's transfers to the hospital as soon as practicable. The facility also failed to notify the LTCO when he was discharged . This placed the resident and/or her representative at risk of impaired rights and uninformed care choices.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175244	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Memorial Hospital Ltcu (Village Manor)	705 N Brady Street Abilene, KS 67410

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32358 The facility had a census of 65 residents. The sample included 17 residents. Based on observation, record review, and interview, the facility failed to provide Resident (R)42 or his representative with written information regarding the facility bed hold policy when R42 was transferred to the hospital. This placed R42 at risk for impaired ability to return and resume residence in the nursing facility. Findings included: - R42's Electronic Medical Record (EMR) documented the resident had diagnoses of cirrhosis (chronic degenerative disease of the liver) of the liver, ascites (a condition characterized by an excessive buildup of fluid in the abdomen, or belly), and acute pancreatitis (inflammation of the pancreas). R42's Quarterly Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview of Mental Status (BIMS) of seven, which indicated severe cognitive impairment. The MDS documented R42 required partial to moderate staff assistance with toileting, showering, upper and lower body dressing, and toilet transfers. R42 required supervision or touching assistance with shower transfers and setup for personal hygiene. R42 was independent with eating, oral hygiene, putting on and taking off footwear, bed mobility, chair-to-bed, bed-to-chair, and sit-to-stand transfers, and ambulation. R42's Care Plan, revised 09/04/24, documented that R42 was at risk for dehydration. He was at risk for weight gain and had increased abdominal girth related to cirrhosis of the liver. R42's Progress Notes, dated 12/30/23, 02/12/24, 03/21/24, and 05/03/24, documented the resident was transferred to the hospital. R42's clinical record lacked evidence the resident or representative was provided the bed hold policy when R42 was transferred to the hospital on the above dates. On 09/09/24 at 12:30 PM, observation revealed R42 sat in a chair at the dining room table with no signs or symptoms of pain. On 09/11/24 at 10:30 AM, Administrative Nurse D stated that Social Service X or the Administrative Nurse business office manager was responsible for providing the bed hold policy to residents on admission. Administrative Nurse D said she was unaware the bed hold policy was to be provided when residents were transferred to the hospital. On 09/10/24 at 08:35 AM, Social Service X stated she was unaware she was required to provide R42 or his representative with the bed hold policy when he was transferred to the hospital. Social Service X stated the facility provided the bed hold policy on admission, and if the resident received Medicaid the facility would automatically hold his bed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175244	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Memorial Hospital Ltcu (Village Manor)	705 N Brady Street Abilene, KS 67410

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Bed-Holds and Returns Policy, revised in March 2017, is documented before transfers and therapeutic leaves, residents or resident representatives would be informed in writing of the bed-hold and return policy. Before a transfer, written information would be given to the residents and the resident representatives that explains in detail: The rights and limitations of the resident regarding bed-holds. The reserve bed payment policy is indicated by the state plan (Medicaid residents). The facility per diem rate required to hold a bed (non-Medicaid residents), or to hold a bed beyond the state bed-hold period (Medicaid residents); and The details of the transfer (per the Notice of Transfer). The facility failed to provide R42 or his representative with the bed hold policy upon transfer to the hospital. This placed the resident at risk for impaired ability to return and resume residence in the nursing facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175244	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Memorial Hospital Ltcu (Village Manor)	705 N Brady Street Abilene, KS 67410

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37450 The facility had a census of 65 residents. The sample included 17 residents. Based on record review and interview the facility failed to complete a recapitulation (summary) post-discharge for Resident (R) 17, who had a self-initiated discharge from the facility. This placed the resident at risk of unidentified and unmet care needs. Findings included: - The Electronic Medical Record (EMR) documented R17 had diagnoses of infection and inflammatory reaction to an indwelling catheter (a tube inserted into the bladder to drain the urine into a collection bag), atherosclerotic (plaque build narrowing of blood flow) heart disease, chronic pain, dementia (a progressive mental disorder characterized by failing memory and confusion), muscle weakness, diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), reduced mobility, and mixed receptive-expressive language (trouble understanding language) disorder. R17's EMR documented R17's admitted [DATE] and discharge date of [DATE]. The Admission Minimum Data Set (MDS), dated [DATE], documented that R17 had severe cognitive impairment. R17 used a wheelchair and required substantial/maximal assistance with personal hygiene, and partial/moderate assistance with mobility. R17 had an indwelling urinary catheter and was always incontinent of bowel. The MDS further documented that R17 had moisture-associated skin damage (MASD-inflammation or skin erosion caused by prolonged exposure to a source of moisture such as urine, stool, sweat, wound drainage, saliva, or mucous), received pain medication and an antiplatelet (medication that prevents forming blood clots). R17 had speech, occupational, and physical therapy services, and wanted to be asked about returning to the community. R17's Care Plan, dated 05/14/24, documented discharge planning for R17 to his home with family members. The care plan directed staff to contact the family to assist in arranging home health and therapy follow-up as needed. The care plan further directed staff to provide referrals to be given for lifeline (provides help or support), meals on wheels, bathing aid, and assistance for transferring equipment as needed. The plan directed staff to ensure that continuity of care is maintained by giving a detailed summary of care needed when discharged . The Physician Order dated 06/17/24 directed staff to discharge R17. The Progress Note dated 06/17/24 at 10:00 AM documented the social worker spoke with R17's family, and the family assured the social worker they had everything they needed to provide care for the resident in their home before his hospital stay. The family reported having a lift and slide board and would pick up the resident for discharge. The Progress Note dated 06/17/24 at 06:13 PM, documented R17 was discharged from the facility. R17's clinical record lacked evidence of a recapitulation of R17's stay in the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175244	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Memorial Hospital Ltcu (Village Manor)	705 N Brady Street Abilene, KS 67410

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/11/27 at 07:42 AM, Administrative Nurse D reported she was not aware of the need for a recapitulation of R17's facility course of care in the facility following the resident's discharge. Upon request, the facility did not provide a policy for recapitulation for discharged residents. The facility failed to complete a recapitulation post-discharge for R17. This placed R17 at risk of unidentified and unmet care needs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175244	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Memorial Hospital Ltcu (Village Manor)	705 N Brady Street Abilene, KS 67410

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360 The facility had a census of 65 residents. The sample included 17 residents. Based on observation, record review, and interview, the facility failed to provide medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of one sampled resident, Resident (R) 168, who made statements of self-harm. This placed R168 at risk for further decline in his emotional and mental well-being. Findings included: - The Electronic Medical Record (EMR) for R168 documented diagnoses of dementia without behavioral disturbance (a progressive mental disorder characterized by failing memory and confusion), bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), traumatic brain injury (TBI-an injury to the brain caused by external forces), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and as of 08/26/24, suicidal ideation (the thought process of having ideas of not wanting to live). The Admission Minimum Data Set (MDS), dated [DATE], documented R168 had severely impaired cognition and required partial assistance with toileting, dressing, personal hygiene, and was independent with eating, mobility, transfers, and ambulation. The assessment documented R168 had trouble concentrating for four to six days, had no behaviors, and received an antipsychotic (a class of medication used to treat major mental conditions that cause a break from reality) and antianxiety (a class of medications that calm and relax people) medication. R168's Baseline Care Plan, dated 08/20/24, documented R168 was oriented to person, and was able to make his needs known. R168 was independent with grooming, dressing, shaving, and eating. The update dated 08/24/24 documented R168 received lorazepam (an antianxiety medication), 0.5 milligrams (mg), by mouth, three times per day as needed for agitation. R168's Care Plan, dated 09/10/24, documented R168 had a potential for mood swings due to depression, bipolar disorder, and statements of wanting to die. The care plan directed staff to administer medications as ordered, monitor for adverse side effects, and notify the physician if behavior interferes with his activities of daily living and safety to himself or others. The plan directed staff to involve him in activities daily, notify the physician immediately if any suicidal ideation, self-harm threats, behaviors of threat of harm to others, and to see behavioral health physician and social services as needed. The Physician's Order, dated 08/20/24, directed staff to administer mirtazapine (an antidepressant medication), 15 mg, by mouth, daily for depression and risperidone (an antipsychotic medication), 0.5 mg, at bedtime for bipolar. The Physician's Order, dated 09/10/24, directed staff to administer lurasidone hydrochloride (an antipsychotic medication), 40 mg, by mouth, for dementia without behavioral disturbance and directed staff to discontinue the risperidone medication. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175244	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Memorial Hospital Ltcu (Village Manor)	705 N Brady Street Abilene, KS 67410

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Nurse's Note, dated 08/20/24 documented R168 wandering the halls, asking staff repeatedly when he could leave, and calling his family several times. The Nurse's Note dated 08/21/25 at 09:45 PM, documented R168 was anxious all shift, wandered the halls, called his family several times, and asked staff when he could leave. The Physician's Order, dated 08/22/24, directed staff to administer Valium, (an antianxiety medication), 2 mg, by mouth, twice per day for mood. This medication was discontinued on 09/05//24. The Nurse's Note, dated 08/25/24 at 06:13 AM, documented R168 had suicidal ideation from 04:30 AM to 05:45 AM. R168 stated he wanted to be dead and made a shot to the head gesture. He stated he was going to fail everyone and thought he might as well be dead. The note further documented R168 paced the hallways and mumbled aggressive things. R168 was placed on 15-minute checks and staff were directed to keep him occupied. Staff continued to monitor him throughout the shift. The note lacked evidence the physician was notified. The Nurse's Note, dated 08/27/24 at 03:24 PM, documented that staff notified the physician regarding R168's suicidal ideation from 08/25/24 and requested a behavioral health visit. The note directed staff to administer lorazepam, 0.5 mg, by mouth three times per day and to administer lorazepam, 0.5 mg. by mouth three times per day, as needed, for agitation. The Nurse's Note, dated 09/02/24 at 10:51 AM, documented that R168 made comments about wanting to hurt himself and stated he was tired of not being able to do anything anymore. R168 stated it was a daily chore to keep living and wanted to blow out his brain. R168 stated he did not understand why his family didn't want to take care of him and felt they did not want him around anymore. The note documented staff explained to him that he was loved by his family and was at the facility for extra help. Staff asked R168 if he wanted to go outside for fresh air. Staff took R168 outside and walked with him for 10-15 minutes before he asked to go back inside. The staff checked on him frequently to make sure he was ok, and the nurse told him that if he started to feel that way again, she would come back and talk with him. Staff checked on the resident every hour for safety precautions and monitored for any changes or repeated suicidal thoughts. R168's EMR lacked documentation the physician was notified of any further documentation regarding R168's suicidal ideation. The Nurse's Note, dated 09/07/24 at 11:15 AM, documented R168 paced, was agitated, and was seen by the behavioral health physician. The note further documented R168 was given an as-needed lorazepam. The Nurse's Note, dated 09/07/24 at 02:00 PM, documented R168's family called and stated he was agitated and requested he be administered as-needed medication. R168 paced, was upset and agitated, and staff took him outside for a walk. The Nurse's Note, dated 09/08/24 at 11:00 am, documented R168 paced, was agitated and wanted his glasses and jacket so he could leave. R168 stated That's not sharp enough for what I need, R168 stated he would deal with God when he got there. Staff placed R168 on 15-minute checks, administered as-needed lorazepam, and took R168 outside for a walk. Staff provided 1:1. R168 stated, This is not what I signed up for and was pleasant and cooperative after walking outside with staff. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175244	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Memorial Hospital Ltcu (Village Manor)	705 N Brady Street Abilene, KS 67410

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R168's clinical record lacked evidence of a social work follow-up to address R168's suicidal verbalizations, feelings of sadness, and potential spiritual crisis. On 09/10/24 at 07:45 AM, observation revealed R168 in the dining room of the Special Care Unit. He had a sad affect. When asked how his day was going, R168 stated, Not very good. He stated he did not understand why he was living there and did not think it was God's plan for him. He stated he had been living there for a short time, but it seemed like a lot longer. R168 stated no one does anything for him to help him and he does not know what to do. Observation on 09/10/24 at 09:45 AM, Consultant GG visited with R168, and the resident was smiling and engaged in conversation. On 09/10/24 at 08:27 AM, Social Service X stated she had talked with R168's previous caregiver and was told that he had made statements like that before but never acted upon them. Social Service X verified she had not discussed with R168 his suicidal ideation because she did not want to bring it up. Social Service X further stated she does spend time with him quite often but did not document her visits, She said she has taken him outside to talk. Social Service X stated she has been in contact with the behavioral health physician and R168 had been seen once since admission and would be seen on Tuesdays and Thursdays. On 09/10/24 at 08:45 AM, Administrative Nurse D stated she saw the note about R168's verbalizations of self-harm the day after it happened and probably called the doctor but did not think to document it. Administrative Nurse D further stated the nursing staff would document if R168 had any statements of self-harm and verified the physician was not notified of R168's threat of self-harm. Administrative Nurse D said she expected staff to ensure R168 was monitored and safe. Administrative Nurse D further stated she talked with R168 and he did not remember making those statements. Administrative Nurse D said staff should contact the physician whenever a resident makes statements of self-harm. On 09/10/24 at 09:50 AM, Consultant GG stated he officially saw R168 in the facility twice but knew him out in the community and had known him for a long time. Consultant GG stated R168 had a history of alcohol and drug addiction, had mood fluctuations, and could be impulsive but Consultant GG did not feel R168 would harm himself. Consultant GG further stated he was not opposed to staff calling him if the resident discussed self-harm. Consultant GG stated he expected social services to follow and document how R168 was adjusting to the facility as well as statements of self-harm. On 09/10/24 at 10:38 AM, Certified Nurse Aide (CNA) M stated R168 paced back and forth and did not understand why he was in the facility. CNA M stated she often talked with R168 to try to help him adjust and make sure he was feeling ok but had not been there when he had threats of self-harm. CNA M stated she would notify the nurse if she did. CNA M further stated she has had training for residents with dementia and behaviors, and stated the psychiatrist comes to talk with R168 but she was not sure how often. CNA M stated she had not seen Social Service X visit with the resident but said it could have happened when she was not working. On 09/11/24 at 08:54 AM, Licensed Nurse (LN) G stated staff should redirect R168 talk with him if he is having threats of self-harm, and notify the physician. LN G stated if R168 threatened or had intent to self-harm she would call 911. LN G said staff monitored R168 and documented on a tracking form every 15 minutes, 30 minutes, or hourly depending upon on situation just like all residents in the Special Care Unit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175244	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Memorial Hospital Ltcu (Village Manor)	705 N Brady Street Abilene, KS 67410

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Behavioral Health Services, policy, undated, documented the facility would have sufficient staff that provided direct services to residents with the appropriate competencies and skill set 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 the resident assessments and individual plan of care. The resident would be monitored for suicidal issues. If any indicated the Director of Nursing would be notified immediately and safety protocols would be implemented. The facility must provide medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The facility failed to provide medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for R168. This placed R168 at risk for further decline in his emotional and mental well-being.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175244	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Memorial Hospital Ltcu (Village Manor)	705 N Brady Street Abilene, KS 67410

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37450 The facility had a census of 65 residents. The sample included 17 residents. Based on observation, record review, and interview, the facility failed to ensure an appropriate indication of use or a documented physician rationale which included the multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the continued use of an antipsychotic (class of medications used to treat mental disorder characterized by a gross impairment in reality testing) for Resident (R) 43. This placed the resident at risk for unnecessary psychotropic (alters mood or thought) medication and related complications. Finding included: - R43's Electronic Medical Record (EMR) documented diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), history of urinary tract infection (UTI-an infection in any part of the urinary system), pain, hypertension (HTN-elevated blood pressure), weakness, and a need for assistance with personal care. The Quarterly Minimum Data Set (MDS), dated [DATE], documented that R43 had moderately impaired cognition, evidence of an acute change in mental status, no symptoms of psychosis (any major mental disorder characterized by a gross impairment in reality perception), and exhibited no behaviors. R43 required set-up assistance with oral and personal hygiene, partial/moderate assistance with toileting hygiene, dressing, and mobility. The MDS further documented that R43 had a diagnosis of depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and received an antipsychotic, antidepressant (a class of medications used to treat mood disorders), diuretic (a medication to promote the formation and excretion of urine), antiplatelet (medication that prevents forming blood clots), and hypoglycemic (class of medications used to lower blood sugar levels). R43's Care Plan, dated 08/24/24, documented that R43 was at risk for increased depression due to diagnosis. The care plan directed staff to notify the physician if behaviors interfered with functioning, encourage the resident to verbalize feelings, provide reassurance as needed, redirect the resident when feeling depressed or upset, involve the resident in activities daily, and obtain a psychiatric consult as indicated. The plan lacked interventions related to the use of antipsychotics, behavioral interventions, and drug information including side effects and warnings. The Physician Visit Note, dated 04/18/24, documented that R43 had decreased confusion and possible hallucinations (sensing things while awake that appear to be real, but the mind created) in the evenings. The note documented the physician would check a urine analysis (lab analysis of urine) and treat it if indicated. The physician discussed if the urine test was normal and if the confusion of R43 seeing her husband was distressing enough for the resident, the physician would start medication to help treat symptoms. The Physician Order dated 04/22/24 directed staff to discontinue R43's Trazodone (an antidepressant) and start Zyprexa (an antipsychotic) 2.5 milligrams (mg) daily for hallucinations. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175244	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Memorial Hospital Ltcu (Village Manor)	705 N Brady Street Abilene, KS 67410

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/24/24, the Consultant Pharmacist Review recorded that the use of an antipsychotic for diagnosis other than schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), Huntington's (a rare abnormal hereditary condition characterized by progressive mental deterioration, a disabling central nervous system movement disorder), or Tourette's (condition of the nervous syndrome causing uncontrollable repetitive movements or unwanted sounds)is discouraged and leads to a reduced star rating and fines for the facility. Antipsychotics for the behavior of dementia show a 35% increase in mortality and a 50% increase in hospitalization . Scheduled pain medication may help with behaviors. Periodic review is needed due to the Box Warning for sudden death and the risk of elevated lipid (fat), glucose, EPS (movement disorders as a result of taking certain medications), seizures, stroke, pneumonia, falls, and leg or lung blood clots. For behaviors of dementia (a progressive mental disorder characterized by failing memory and confusion), results may be no better than a placebo (a substance that has no therapeutic effect). Guidelines advise limiting antipsychotic use to residents who present a danger to themselves or others or show persistent inconsolable distress. The physician's response to the Consultant Pharmacist Review documented that R43 still hallucinated, but they were not distressing with the medication. R43's EMR lacked documentation of any history of, or ongoing, hallucinations or behaviors. On 09/10/24 at 07:44 AM., observation revealed R43 sat in the dining room, dressed and groomed appropriately for the day. She ate breakfast with other female residents. She fed herself and took her medications without difficulty. On 09/10/24 at 09:24 AM, Certified Medication Aide (CMA) R reported that R43 had not exhibited behaviors, nor had there been reports from other staff of R43 experiencing hallucinations or behaviors. On 09/11/24 at 10:21 AM, Licensed Nurse (LN) H reported when R43 was first admitted to the facility she seemed depressed and self-isolated, adjusting to placement. R43 received therapy services, gained functional abilities, and started coming out to the dining room for meals. LN H stated that R43 had not reported hallucinations to her nor exhibited behaviors and she thought R43 was adjusting well at this time. On 09/11/24 at 12:22 PM, Administrative Nurse D reported that nurses are to monitor and document behaviors in the EMR. Administrative Nurse D verified she could not find documentation in the medical record of hallucinations by staff. Administrative Nurse D verified the care plan lacked R43's use of an antipsychotic and medication information. The updated facility's Psychotropic's and PRN Orders policy documented 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 their clinical record with a supporting diagnosis. Every resident on psychotropic medication will have a care plan, interventions, diagnosis, medication list, black box warning, and family/resident consent form that will be done annually or with changes. Behavioral and sleep monitoring will be done every shift on EMR. The facility failed to ensure an appropriate CMS approved indication or the required physician documentation for continued use of R43's antipsychotic. This placed the resident at risk for unnecessary psychotropic medications and adverse side effects.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175244	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Memorial Hospital Ltcu (Village Manor)	705 N Brady Street Abilene, KS 67410

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32358 The facility had a census of 65 residents. The sample included 17 residents. Based on observation, record review, and interview, the facility failed to store and label biologicals, including insulin (a hormone that lowers the level of glucose in the blood) as required when staff failed to place an open date on Resident (R) 22's Admelog Solostar (fast-acting insulin) and Tresiba (long-acting insulin) insulin pen (a device used to inject insulin). This placed the resident at risk of receiving an expired and ineffective dose of insulin. Findings included: - On [DATE] at 11:35 AM, observation of the 500-hall medication cart revealed R22's Admelog and Tresiba flex pens without an open date or discard date. On [DATE] at 11:35 AM, Licensed Nurse (LN) H verified the above finding. LN H stated the insulin should be labeled with an open date. LN H took the insulin pens from the cart and stated he would take them to the director of nursing. On [DATE] at 07:50 AM, Administrative Nurse D stated she expected staff to label open insulin pens with the date opened whenever staff get a new pen for R22. Medlineplus.gov documented all unrefrigerated, open pens of Admelog and Tresiba insulin can be used within 28 days, but after that time they must be discarded. Upon request, the facility did not provide an insulin storage policy. The facility failed to place open and/or discard dates on R22's Admelog and Tresiba flex pen. This placed the resident at risk of receiving an expired or ineffective dose of insulin.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175244	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Memorial Hospital Ltcu (Village Manor)	705 N Brady Street Abilene, KS 67410

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 32360 The facility had a census of 65 residents. Based on record review and interview, the facility failed to submit complete and accurate staffing information through the Payroll Based Journal (PBJ) as required. This deficient practice placed the residents at risk for unidentified and ongoing inadequate nurse staffing. Findings included: - The PBJ report provided by the Centers for Medicare & Medicaid Services (CMS) for Fiscal Year (YR) 2024 Quarters 1, 2, and 3 indicated the facility did not have licensed nurse coverage 24 hours a day, seven days a week on multiple days, (Quarter 1: 18 dates, Quarter 2: 19 dates, Quarter 3: 13 dates). A review of the facility's licensed nurse data or the dates listed on the PBJ revealed a licensed nurse was on duty for 24 hours a day seven days a week. On 09/11/24 at 08:54 AM, observation revealed a licensed nurse on duty in the facility. On 09/11/24 at 12:00 PM, Administrative Staff A stated the schedule was input into the computer. Administrative Staff A stated he submitted the PBJ and he thought that since he did not receive an error report, all was correct. Administrative Staff A further stated he looked at the information provided to CMS and noted that some of the licensed nurse hours were not input into the computer. He stated he would make sure he checks it prior to sending it to CMS. A policy for Payroll Based Journaling was not provided by the facility. The facility failed to submit accurate PBJ data which placed the residents at risk for unidentified and ongoing inadequate staffing.