STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175302	A. BUILDING _____ B. WING _____	C 05/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWTON PRESBYTERIAN MANOR	1200 E 7TH STREET NEWTON, KS 67114

(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 complaint #KS00171648 and KS00171834. This 2567 was electronically sent to the facility on 5/26/22.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility reported a census of 55 residents and identified 25 residents as elopement risks. The sample included four residents reviewed for accidents/elopement (exit of facility without staff knowledge). Based on observation, record review, and interview, the facility failed to ensure two of the four sampled residents remained safe including Resident (R) 2 for staff failure to secure an oxygen tank during the resident's shower. When Certified Medication Aide (CMA) R removed the oxygen tank from the secured back of the resident's wheelchair and set it unsecured on the floor, she knocked the oxygen tank over onto the resident's left foot, causing a fracture of the left great toe. The facility also failed to provide adequate supervision for R1, who was a fall and elopement risk, when Licensed Nurse (LN) G left the resident alone outside the facility in an unsecured area.	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 05/26/2022

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.

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Findings included:

- R2's "Physician Order Sheet" (POS), dated 02/09/22, documented the resident with a diagnosis of chronic obstructive pulmonary disease (COPD, a type of lung disease marked by permanent damage to tissues in the lungs, making it hard to breathe).

The "Comprehensive Minimum Data Set" (MDS), dated 02/21/22, documented the resident with a Brief Interview for Mental Status (BIMS) score of 14, or intact cognition. The resident required extensive assistance of two staff members for transfer and bathing. The resident also used oxygen during the lookback period.

The "Activities of Daily Living Care Area Assessment" (CAA), dated 02/27/22, documented the resident with a diagnosis of COPD which caused her to experience shortness of air during exertion and she received continuous oxygen via nasal cannula. She required limited assistance from staff with bathing.

The "Care Plan" updated 05/19/22, documented the resident with a self-care deficit related to progressive weakness and jerking movements. The staff were to provide appropriate assistance with activities of daily living (ADLs) to ensure all needs and cares were met over the next 90 days. The staff assisted the resident with bathing and the resident received oxygen therapy. The oxygen tank should always be kept in a bag or rolling tank canister.

A "Licensed Practical Nurse" (LPN) note, dated

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05/18/22 at 08:46 AM, by Licensed Nurse (LN) K revealed R2 reported an oxygen tank fell on her left great toe after her shower in the spa room. There was a dark purple bruise on R2's entire toe. A "U" shaped blood blister noted on the left side of the toe. Staff to monitor daily until resolved.

A "Registered Nurse" (RN) note, dated 05/19/22 at 08:15 AM, by LN I revealed an x-ray report dated 05/18/22 of R2's left great toe which documented the resident received a comminuted (bone that is broken in at least two places) fracture of the distal phalanx (tubular bone of the toe) of the first toe with minimal displacement. Staff notified consultant Staff GG of the x-ray results. Consultant Staff GG was in the facility on 05/18/22, assessed R2's toe, and advised staff to continue to provide symptom management for R2's fracture with no orthopedic referral.

An "LPN note," dated 05/24/22 at 09:46 AM, by LN H revealed a late entry from 05/18/22. At approximately 08:46 AM, a CMA reported to LN H that the resident stated an oxygen tank fell on her left great toe in the spa room after her shower. LN H assessed R2's toe and noted a small "u" shaped blood blister to the inside of the toe. The entire toe was reddish purple in color with no swelling at that time.

Observation on 05/25/22 at 10:08 AM, revealed the resident lying on her bed asleep with no signs of pain or distress. She had a bandage on her left foot which remained wrapped and elevated on a pillow.

Interview on 05/24/22 at 01:58 PM, CMA R revealed the morning of 05/18/22, she assisted

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the resident in the spa room to get ready for a shower. There was an oxygen tank in a bag on the back of the resident's wheelchair. CMA R removed the tank from the bag and set it on the floor, unsecured, next to the resident, who was sitting in the shower chair. When CMA R moved R2 in the shower chair towards the shower, the oxygen tank fell over and onto R2's foot. R2 told CMA R that the tank fell on her toe. CMA R assisted the resident to finish her shower and after it was over, she looked at her foot. The resident was unable to tell her which toe the tank hit. CMA R found no injury, so she helped the resident finish getting ready and back to her room. CMA R did not report the incident immediately to the charge nurse.

Interview on 05/25/22 at 09:27 AM, LN H revealed a couple of hours after R2's shower, Certified Nurse Aide (CNA) M reported R2 told her that an oxygen tank fell on her toe during her shower. CMA R provided the shower, but failed to immediately report the incident to LN H. LN H assessed the resident's toe and noted it to be reddish in color with no swelling. There was a blood blister between the first and 2nd toes of R2's left foot. LN H provided pain medication to the resident and thought no more about it until the resident complained of elevated pain in her foot later that day. LN H contacted the physician for an order for stronger pain medication which she received and administered to the resident. She reported the incident to the next shift. The next day LN H found out the physician ordered an x-ray which showed a toe fracture. CMA R should have reported the incident to her when it happened, and the oxygen should have been placed in a caddy to secure it in an upright position.

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The facility policy for "Oxygen Therapy," revised 10/08/21, documented" ...Oxygen Tanks ...1. To use oxygen tanks ...a. Store all O2 cylinders in an upright position in a storage device/wheeled tank cart ...3. Place delivery device comfortably on resident ..."

The facility failed to ensure R2's oxygen tank remained secured. During a shower, the tank fell over onto the resident's foot and she experienced a fractured toe from the accident.

- R1's "Physician Order Sheet" (POS), dated 03/30/22, documented the resident with a diagnosis of dementia with behavioral disturbance (a chronic or persistent disorder of the mental processes caused by brain disease marked by memory disorders, personality changes, and impaired reasoning).

The "Comprehensive Minimum Data Set" (MDS), dated 04/05/22, documented the resident with a Brief Interview for Mental Status (BIMS) score of 9 or moderately impaired cognition. The resident required extensive assistance of two staff members for transfer and walking. He used a walker and a wheelchair for mobility.

The "Cognitive Loss/Dementia Care Area Assessment" (CAA), dated 04/08/22, documented the resident was at risk for continued cognitive loss due to the diagnosis of dementia and had short term memory deficits.

The "Activities of Daily Living CAA," dated 04/08/22, documented the resident required limited to extensive assistance with activities of

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daily living (ADLs). The staff reported that he can be "sneaky" and would sometimes take himself (with his walker) to the bathroom from his bed in his room. He often walked with staff with his walker but used a wheelchair for longer distances when he was tired.

The "Care Plan," updated 05/16/22, advised the staff that the resident had a safety alarm bracelet on his left ankle due to exit seeking behaviors and used a walker for ambulation. R1 was at risk for elopement related to his wander risk assessment. His frequency for wandering was rare, but he did get confused and turned around at times in the unit.

An "Elopement Risk Screen," dated 03/05/22, documented the resident with a score of 12 or at risk for elopement. The resident wore a safety alarm bracelet and resided in a secured unit.

A "Licensed Practical Nurse" (LPN) note, dated 05/05/22 at 09:26 PM, by Licensed Nurse (LN) J revealed the resident had been exit seeking all evening. R1 became agitated and cursed at staff because they would not open the door. Attempts at redirection were unsuccessful. R1 sat in a chair in the dining room and watched the door to see if it would open. A sign was put on the outside of the entrance door directing staff to use a different door to get into the unit. The resident finally got up and went to bed.

A "Registered Nurse" (RN) note, dated 05/08/22 at 01:41 PM, LN I, revealed the resident was exit seeking at approximately 12:45 PM. LN I administered as needed (PRN) anti-anxiety medication and the resident was resting in the recliner in the living room of the unit.

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Review of the facility's video footage, dated 05/08/22, with Administrative Staff A, revealed at approximately 04:14 PM, Certified Medication Aide (CMA) S and the resident approached the front entrance of the facility and CMA S punched the code on the door to open it and the resident went outside. CMA S stayed in the foyer and visited with Certified Nurse Aide (CNA) N. The CMA had her back turned to the entrance door. R1 walked down the sidewalk towards the parking lot turned around and walked back and sat down on a bench within a few feet of the entrance door. It was 04:16 PM. At that time, CMA S left and LN G went outside and sat down to visit with the resident. LN G sat with the resident until approximately 04:26 PM when she got up and went back into the facility. The resident sat on the bench alone until approximately 04:29 PM when he stood up and went to the entrance door to get back into the facility. The door would not open. Visitors approached the door and went to get assistance to let the resident back into the facility. The resident was let back in without incident.

Interview, on 05/16/22 at 12:01 PM, Administrative Nurse D stated residents who wore safety alarm bracelets required staff supervision when outside the facility and should not be left alone. The staff involved knew the resident wore a safety alarm bracelet and was an elopement risk. The staff should have remained outdoors with him to ensure his safety.

Interview, on 05/24/22 at 12:42 PM, Consultant Staff HH stated all agency staff are required to have an orientation checklist completed starting with their first shift in the facility. The checklist

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covered elopement and residents who were elopement risks. All staff should be aware of residents who are elopement risks in the facility.

The facility's policy "Hazardous Wandering and Elopement (Unwitnessed Exit)," updated 05/09/22, documented ...Policy ...the community will exercise reasonable care to prevent injuries and ensure a secure environment for residents ...Procedure ...3. Staff, especially primary caregivers, will be notified of residents who are likely to attempt to leave or to get lost within the community. Staff will be instructed on the use of effective interventions to prevent unwitnessed/exits ...

The facility failed to ensure adequate supervision continued for R1, who was a fall and elopement risk, when a staff member left the resident alone outside the facility in an unsecured area.