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F 000	INITIAL COMMENTS The following citations represent the findings of complaint #KS00166957, KS00167603, and KS00167822. Complaint survey investigations for #16957, #167603, and #167822 was conducted by the Kansas Department for Aging and Disability Services (KDADS), on behalf of the Centers for Medicare and Medicaid Services (CMS) on 02/09-10/2022 and 02/15-16/2022. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. This 2567 was electronically sent to the facility on 02/18/2022.	F 000		
F 604 SS=J	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 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.	F 604		

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

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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F 604	Continued From page 1 §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: The facility reported a census of 48 residents with one resident reviewed for physical restraints. Based on record review and interview, the facility failed to ensure that Resident (R) 1 remained free from physical restraints on 11/03/21, when the resident had escalating behaviors in the memory care unit during medication administration. Licensed Nurse (LN) G failed to appropriately respond to the agitated state of R1, which resulted in a physical altercation. LN G called for help from additional staff and the response from multiple staff members caused a higher escalation in the resident's behaviors which resulted in five staff members holding the resident down on the floor. Administrative Nurse D attempted medication administration with a spoon as the resident was being restrained on the floor by LN G and other staff members. The resident yelled and screamed "NO!" and shook her head back and forth. This placed R1 at risk for serious physical injury and the physical restraining of R1 by five staff members placed the resident at risk for psychosocial and physical harm. This deficient practice placed the resident in immediate jeopardy.	F 604	Past noncompliance: no plan of correction required.	

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Findings included:

- R1's signed "Physician Orders" (PO), dated 10/17/21, documented the resident with diagnoses of Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement, chiefly affecting middle-aged and elderly people), dementia (chronic disorder of the mental processes caused by brain disease or injury marked by memory disorders, personality changes and impaired reasoning), and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities).

The "Comprehensive Minimum Data Set" (MDS), dated 09/30/21, documented the resident with a Brief Interview for Mental Status (BIMS) score of four, indicating severely impaired cognition and fluctuating disorganized thinking. R1 had physical and verbal behavioral symptoms which were directed at others one to three days during the seven-day lookback period. She rejected care from the staff one to three days and wandered daily. The resident did not use a mobility device and required setup assistance of two staff members for transfers and walking.

The "Cognitive Loss/Dementia Care Area Assessment" (CAA), dated 10/05/21, documented R1 with a BIMS score of four indicating severe cognitive impairment. The resident had physical and verbal aggression towards the staff during the assessment period. The resident resided in the memory care unit due to her diagnosis of dementia.

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The "Behavioral Symptoms CAA," dated 10/05/21, documented R1 rejected care from the staff and wandered the unit.

The "Psychosocial Well-being CAA," dated 10/05/21, documented the resident was upset at the time of admission and lashed out at the staff with both physical and verbal aggression. Since admission, R1 settled down and interacted with the staff and other residents in an appropriate manner.

The "Care Plan," revised 11/03/21, advised the staff that the resident had an activities of daily living (ADL) self-care deficit due to dementia and Parkinson's disease. The resident required set-up assistance with ADLs such as toileting, transferring, and ambulation. The resident required prompting by the staff to complete her ADLs. On 11/03/21, the care plan advised the staff not to touch R1 without her permission.

A "Registered Nurse's Note," dated 11/03/21 by LN G, revealed she was in R1's room packing up her belongings. Certified Medication Aide (CMA) R came down the hall with the resident stating that the resident had her medications in her hand. LN G stated "well hello there, shall we get dressed? Let's take your medications first." R1 threw the pills on the hallway floor and started stepping on them. R1 went right up to LN G and stated, "you need to get out of here." LN G started picking up the pills and R1 attempted to kick at her and was swinging to hit her. LN G stated, "let's not do that." The resident started kicking and hitting. Additional staff were summoned to assist LN G. R1 was kicking, attempting to bite, cussing, and name calling. R1 received medication from LN G but spit it out and

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continued to try to hit and kick at staff.

A "Witness Statement," dated 11/03/21, by LN G revealed she got called to the memory care unit because R1 was having behaviors. The resident was being aggressive with staff at the medication cart. LN G redirected the resident and took her back to the dining room to eat. The resident sat down and started eating breakfast. LN G went to the resident's room to pack her things to leave the facility. CMA R radioed LN G and stated the resident had her meds but wouldn't take them. LN G left R1's room and went to the resident and told her to take her medication and then they would get her ready to leave the facility. The resident threw the pills on the floor in the hallway and started stepping on them. LN G told her not to do that and the resident started swinging at her. LN G said "No!" to the resident and raised the resident's hands and wrists up away from her. R1 was also trying to kick and bite at LN G. They ended up on the floor in the hallway. They had a hold of each other's wrists and arms. R1 continued to attempt to kick and bite at LN G while they were lying on the floor. LN G hollered for help. Two CMAs, one CNA, and the maintenance man came to assist and were able to get the resident to let go of her wrists. Administrative Nurse D finally arrived and asked if the resident only had Ativan (antianxiety agent). CMA R got the medication and it was given to R1 by Administrative Nurse D. R1 spit the medication out of her mouth and into the face of CNA M. All staff remained calm and the resident was told that they wanted her to stop biting, kicking, and hitting. The resident wanted up off the floor. LN G told her they would let her get up if she stopped hitting, biting, and kicking the staff. LN G removed herself from the resident and went to

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get another dose of Ativan. When she returned, R1 was up off the floor and talking to Social Services Staff (SS) X and Activity Staff Z at the end of the hall.

A "Witness Statement," dated 11/04/21, by Certified Nurse Aide (CNA) M, revealed R1 was in a bad mood and calling staff vulgar names. She saw the resident walk down the hallway to the dining room. The next thing CNA M knew, she heard people hollering for help down the hall. LN G asked CNA M to hold the resident's arm so they could give her a pill, so she did. The resident spit the pill into her face. Afterwards, they let R1 up off the floor to walk down the hall and CNA M went back to the dining room.

A "Witness Statement," dated 11/04/21, by Administrative Nurse D, revealed staff reported to her that R1 was being combative. When she arrived, the resident was on the floor with CMA R, CNA N, LN G, and Maintenance Staff U. They were holding the resident's arms and legs as they were lying on the floor. R1 hollered out that she wanted out of there and was going to call the police. LN G reported to Administrative Nurse D that R1 was having combative behaviors and physically attempting to harm staff. Administrative Nurse D attempted to talk to the resident through "reassurance and bargaining" but R1 continued to be verbally aggressive and threatening physical harm to the staff. Administrative Nurse D offered to give the resident medication and the resident agreed but bit the spoon and spit it out. SS X and Activity Staff Z arrived on the scene and asked the staff to let R1 go and leave her be. They let her go. Administrative Nurse D explained the situation to SS X and Activity Staff Z and suggested the resident be redirected to her room

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if possible. SS X and Activity Staff Z walked away with the resident towards the end of hall and Administrative Nurse D asked if they were ok with R1. They responded yes and Administrative Nurse D left the unit.

A "Witness Statement," dated 11/03/21, by Activity Staff Z, revealed that it was reported to her by SS X, that staff had R1 restrained in the memory care unit on the floor. Transportation Staff GG asked Maintenance Staff U to help restrain the resident and they needed clarification if that was appropriate. Activity Staff Z went to the unit to find six staff (five restraining R1) and the resident on her back on the floor. R1 was yelling, screaming, and trying to get up. Activity Staff Z observed Administrative Nurse D trying to put medication in R1's mouth while she was being held down to the floor by the five staff members. R1 was hollering "No! Call the police!" She moved her head side to side trying to avoid Administrative Nurse D putting medication in her mouth. The resident was on the floor with CMA R, CNA N, LN G, and Maintenance Staff U. Activity Staff Z told everyone to "let her go, release her, let her go." The staff were hesitant. CMA R let go of R1's legs and the staff helped R1 get up. SS X talked with Administrative Nurse D and she left upset. Activity Staff Z wasn't sure what was said between the two staff members. Activity Staff Z got R1's attention. R1 swung at her head and missed. She asked the resident to look at her and asked if she would walk down the hall with her. R1 stated she wanted to go home. Activity Staff Z and SS X talked with her and calmed her down, offering emotional support. LN G came to them with something in a syringe. SS X told LN G that R1 didn't need the medication, the resident was calm now. LN G turned and left. They took the

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resident to her room to help her get ready to leave the facility. They helped get all her things together and visited with R1. The resident was calm and in a good mood at the time she left the facility.

A "Witness Statement," dated 11/03/21, by SS X, revealed she was contacted by Activity Staff AA at 08:23 AM that there was an incident taking place with R1 in the memory care unit. Transportation Staff GG was running to get Maintenance Staff U to help restrain R1. SS X educated Activity Staff AA that the facility was not authorized to provide any physical restraints to residents and stated that she would go to the memory care unit as soon as possible. SS X reported the situation to Activity Staff Z and both walked to the memory care unit. Upon entering, they observed R1 lying on her back on the floor in the middle of the residential hallway with six staff members standing over her, five of which were physically holding R1 to the ground. The resident was screaming and yelling and trying to get up. SS X also observed Administrative Nurse D trying to put medication in the resident's mouth as R1 was being held down to the floor by the five staff members. The resident repeatedly yelled "no" and tried to move her head side to side and back and forth to avoid the medication that Administrative Nurse D continued to attempt to put in her mouth. They approached the staff members and advised them to leave the area and that SS X and Activity Staff Z would handle the situation. Staff allowed the resident to get up and SS X and Activity Staff Z walked with R1 down to the end of the hallway. LN G approached with medication to give to the resident which SS X told her they did not need. LN G left. They helped the resident get ready to leave the facility without

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incident and the resident was fine before getting in the van for transport. SS X notified Administrative Staff A at 09:10 AM that the incident was likely a state reportable occurrence.

Interview, on 02/10/22 at 02:30 PM, Administrative Staff A revealed it was reported to her by SS X the day it happened. The investigation revealed there were five people holding R1 down and Administrative Nurse D attempting to give the resident medication. The resident became agitated and Administrative Staff A thought the staff panicked because they weren't sure what to do. LN G and R1 were on the floor and R1 was kicking and hitting at her. LN G hollered for help and the staff came out of the woodwork. LN G held the resident down while Administrative Nurse D was trying to give the medication. It should not have taken five people to hold R1 down. They should have backed off. The staff showing up only escalated the resident's agitation and the situation. The staff reported to Administrative Nurse D more than once what was happening with R1 and asked her to come and help. At first Administrative Staff D was not going to do anything about it, but finally decided to go to the unit. Due to the fact that she didn't want to "handle the situation" and trying to force the medication into the resident's mouth when R1 was refusing, it was determined that Administrative Nurse D's position here at the facility be terminated. LN G received dementia education, verbal counseling, and allowed to continue her duties here at the facility. The other staff were also provided education about dementia and handling escalating behaviors. Maintenance Staff U should not have been involved in that situation. LN G no longer worked for the facility.

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Interview on 02/11/22 at 4:18 PM with SS X revealed during the incident she assisted in asking all the staff members to leave the immediate area around R1 and assisted in de-escalating the resident's behaviors after everyone left. Activity Staff Z and SS X worked together during the incident. They calmed the resident down and assisted R1 to pack and leave the facility to admit to a geriatric psych unit. All memory care staff received training on managing escalating behaviors. The facility was not authorized to physically restrain the residents.

Interview on 02/14/22 at 09:45 AM with Activity Staff Z revealed during the incident she told the staff to let go of R1 and leave the area. SS X helped her to de-escalate the situation and R1's behaviors towards the staff. Afterwards, they were able to get R1 to the end of the hallway, talk with her, and calm her down. They all went to R1's room to gather her belongings and prepare to leave the facility. There were prior arrangements for R1 to admit to a geriatric psych unit that morning. They assisted the resident into the van and transported her to the unit. Staff Z stated the facility was not authorized to physically restrain residents.

The facility policy, "Restraint Use," reviewed 10/11/21, documented ...Residents will attain and maintain his/her highest practicable well-being in an environment that prohibits the use of restraints ...Emergency Use ...2. If a resident's unanticipated violent behavior or aggressive behavior places him/her or others in imminent danger, the resident does not have the right to refuse the use of restraints ...the use of restraints is a measure of last resort ...

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The facility failed to ensure that Resident (R) 1 remained free from physical restraint on 11/03/21, when the resident had escalating behaviors in the memory care unit during medication administration. Licensed Nurse (LN) G failed to appropriately respond to the agitated state of R1, which resulted in a physical altercation. LN G called for help from additional staff and the response from multiple staff members caused a higher escalation in the resident's behaviors which resulted in five staff members holding the resident down on the floor. Administrative Nurse D attempted medication administration with a spoon as the resident was being restrained on the floor by LN G and other staff members. The resident yelled and screamed "NO!" and shook her head back and forth. This placed R1 at risk for serious physical injury and the physical restraining of R1 by five staff members placed the resident at risk for psychosocial and physical harm. This deficient practice placed the resident in immediate jeopardy.

This deficiency was cited as past non-compliance as the facility completed the following as of 11/30/21:

1. At 08:00 AM on 11/04/21, Administrative Staff A began investigation interviews with facility staff involved in the incident. Along with the interviews, dementia and behavior care education was provided verbally to the staff.

2. At 06:46 PM on 11/30/21, the final facility staff member completed mandatory education as follows:

a.) "Caring for the Person with Dementia:

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F 604	Continued From page 11 Behaviors and Communication" b.) "Recognizing, Reporting, and Preventing Abuse"	F 604		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: The facility reported a census of 48 residents with three residents reviewed for pressure ulcers. Based on interview and record review, the facility failed to provide necessary treatment and services to promote healing for one of the three sampled residents, Resident (R) 3, who had a pressure ulcer of the right hip, when Licensed Nurse (LN) H failed to follow physician orders to order a wound vac for treatment of the resident's right hip. Findings included: - The "Physician Orders" (PO), dated 02/01/22, for R3, revealed diagnoses of pressure ulcer of	F 686		

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the right hip, stage four, chronic peripheral venous insufficiency (improper functioning of the vein valves in the leg, causing swelling and skin changes), and edema (build-up of fluid in the body's tissues).

The "Admission Minimum Data Set" (MDS), dated 11/11/21, documented the resident with a Brief Interview for Mental Status (BIMS) score of five, indicating severely impaired cognition. He required extensive assistance of two staff members for bed mobility and transfer. The resident was determined to be at risk for pressure ulcers and a pressure reducing device was provided for his chair and bed. The resident also received pressure ulcer care from the facility for one unhealed unstageable pressure ulcer.

The "Activities of Daily Living (ADL) Care Area Assessment" (CAA), dated 11/17/21, documented the resident admitted to the facility following hospitalization after a fall at home that resulted in a left femur fracture. He required extensive assistance for bed mobility, transfers, and toileting.

The "Pressure Ulcer/Injury CAA", dated 11/17/21, documented the resident had a current pressure ulcer and was at risk for developing pressure ulcers. He was noted to have an unstageable pressure ulcer to his right hip on admission and treatment was currently being provided.

The "Baseline Care Plan," dated 11/04/21, documented the resident had a pressure ulcer to his right hip on admission.

The "Care Plan," updated 12/03/21, documented the resident with actual impaired skin integrity. He

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 02/16/2022

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 686	Continued From page 13	F 686		

had a wound vac to his right hip to increase wound healing.

A "Nurse's Note," dated 11/24/21 at 09:02 AM, by Licensed Nurse (LN) H, revealed the resident returned from the wound center with the following orders ...Problem location: Ulcer: Right hip - Measures 1.5 centimeters (cm) x 1.5 cm x 1.7 cm: 1) Remove old dressing. 2) Cleanse with Wound Cleanser. 3) Use Prisma/Hydrofera Blue Rope as the primary dressing. 4) Use Calmoseptine and Mepilex Border as the secondary dressing. 5) This order was to be carried out two times per week for one month ...10) Nursing Home: Please order a Negative Pressure Wound Treatment (NPWT- [wound vac]) for the patient. If approved by insurance, it will be placed to the right hip ulcer and set to 125 millimeters of mercury (mmHg) continuous suction and change two times per week and as needed (PRN). Please notify the wound care clinic when and if the NPWT is approved and delivered to the nursing home. Until NPWT applied, please continue to apply above dressings to the right hip ulcer.

Review of R3's "Treatment Record for 12/2021" revealed Administrative Nurse E placed the NPWT on 12/03/21, 9 days after the physician ordered the NPWT.

The facility's investigation, dated 12/03/21, revealed the resident's family contacted the facility and inquired as to why the resident did not have the NPWT yet. Administrative Nurse E reviewed the resident's wound orders and found that the nurse who received the order had not ordered the NPWT on 11/23/21, the day the facility received the order. Administrative Nurse E

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immediately ordered the NPWT on 12/03/21 and notified the wound clinic and the physician.

Interview, on 02/10/22 at 11:37 AM, with Administrative Nurse E revealed after the resident returned from the wound clinic on 11/23/21, new orders were put in for wound care. The charge nurse, LN H, put the orders in for the wound care, but missed the NPWT order. Administrative Nurse E stated she caught the mistake over a week later and immediately put the order in the system, notified the physician, and then notified the wound care center. The resident had wound treatment orders in place for nursing to provide to the resident while the facility waited for the delivery of NPWT to the facility. Administrative Nurse E notified LN H of the missed order and provided education.

Interview, on 02/16/22 at 12:15 PM, with LN H revealed she missed the order and should have put it in right away with the rest of the physician orders for wound care.

The facility policy "Skin Integrity: Pressure Ulcer/Injury Prevention, Nursing Intervention and Wound Treatment," revised 10/12/21, documented ...Guidelines for Health Care Center ...Purpose ...Initiate and implement wound treatment orders when pressure ulcer/injury(s) and/or wound(s) are present or acquired ...

The facility failed to follow the physician order for application of a Negative Pressure Wound Treatment to promote the healing of R3's pressure ulcer of the right hip for 9 days.