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 _____	08/25/2022

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 deficiencies represent the findings of a health resurvey and investigation of complaints #173414, #173432, #173458, #173552, #173813, #171880, #171793,#172382,#172648, #173031, and #173615. This 2567 was electronically sent to the facility on 08/30/2022.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the	F 657		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 08/30/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175302	A. BUILDING _____ B. WING _____	08/25/2022

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 657	Continued From page 1	F 657		

comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 55 residents with 22 selected for review. Based on observation, interview and record review, the facility failed to review and revise the plan of care for one resident (R)2's with a pressure ulcer.

Findings included:

- Review of resident (R)2's "Physician's Order Sheet," undated, revealed diagnoses included pneumonia (inflammation of the lungs), unspecified dementia (progressive mental disorder characterized by failing memory, confusion), restlessness with agitation, and localized edema (swelling).

The "Admission MDS," dated 03/27/22, assessed the resident with moderate cognitive impairment, required extensive assistance of two persons with bed mobility, transfer, and ambulation. The resident had no impairment in range of motion in the upper or lower extremities, with no current pressure ulcers and was at risk for pressure ulcers development with no interventions in place.

The "Significant Change Minimum Data Set" (MDS), dated 05/16/22, assessed the resident with severe cognitive impairment, required extensive assistance of two persons with bed mobility, transfer, and ambulation. The resident had no impairment in range of motion in the upper or lower extremities. The resident was assessed as at risk for pressure ulcer development and had no unhealed pressure ulcers. The resident had a pressure reducing

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 _____	08/25/2022

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 657	Continued From page 2	F 657		

devise on her bed.

The "Pressure Ulcer Care Area Assessment" (CAA), dated 05/16/22, assessed the resident at risk for pressure ulcer and other related skin complications due to decreased mobility incontinence, self-care limitations and dementia. The resident had no current pressure related skin alterations. A Braden score (an assessment for pressure ulcer risk) of 18 indicated a risk for skin integrity concerns.

The "Quarterly MDS," dated 08/16/22, assessed the resident with severe cognitive impairment. The resident required extensive assistance of two staff for bed mobility, transfer and ambulation. The resident was at risk for developing pressure ulcers and had one unstageable pressure ulcer. The resident had a pressure reducing device for her bed and pressure ulcer care and application of dressings to her feet.

The "Care Plan," reviewed 07/11/22, instructed staff the resident was at risk for pressure ulcers and not able to make major position changes independently. The resident required extensive assistance with transfers and bed mobility. Staff to encourage adequate intake at meals and offer snacks. The resident took a diuretic (medication to remove excess fluid) for hypertension (high blood pressure). This care plan lacked interventions for the blood blister and subsequent pressure ulcer/wound on her left foot.

A "Wound Treatment Order" dated 06/08/22, revealed the resident had an ulcer (described as "other") on her left heel with measurements of 1.25 centimeters (cm) by 1 cm, by 0.25 in depth. The wound had no drainage. Staff requested

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 _____	08/25/2022

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 657	Continued From page 3	F 657		

wound cleanser with an autolytic (an agent that breaks down damaged tissue) agent for debridement (removal of damaged tissue) and to change the dressing every 3-5 days. The physician signed the request, and the treatment began on 06/11/22, per review of the June 2022 treatment administration record (TAR).

A "Physician's Order," dated 07/03/22, instructed staff to keep pressure off the left heel and float it with a pillow three times a day, per the July 2022 TAR.

An e-mail, dated 08/19/22, Licensed Nursing staff (LN) H, described the resident's left foot ulcer as 0.5 by 0.5 by 0.3 with 0.4 cm tunneling, and requested an order to apply calcium alginate (a type of material that minimize infection and form a moist gel) to the wound bed. Per the August 2022 TAR this treatment started 08/20/22.

A "Nursing "Progress Note," dated 03/21/22, assessed the resident with 2-3 plus pitting edema in her lower extremities. Staff identified a scabbed area to her left elbow and pink discoloration to her coccyx region.

A "Nursing Progress Note," dated 04/14/22, indicated the resident had intermittent confusion and forgetfulness but was alert and oriented and worked with therapy. The resident had bilateral dependent edema and had lymphedema wraps applied by therapy to her bilateral lower legs.

A "Nursing Progress Note," dated 05/05/22, indicated the resident was admitted to hospice care.

The Braden scores for pressure ulcer

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 _____	08/25/2022

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 657	Continued From page 4	F 657		

development documented as follows:

On 03/24/22, score of 17 (19-23 no risk, 15-18 mild risk, 13-14 moderate risk, 10-12 high risk, 6-9 very high risk).
On 04/07/22, score of 16 mild risk.
On 06/23/22, score of 18 mild risk.

The "Skin Evaluation Record General Skin Check" dated 05/11/22 at 07:20 AM, indicated the resident had no new issues.

The "Skin Evaluation Record General Skin Check," dated 05/11/22 at 09:19 AM, indicated the resident had a blood blister on her left heel, approximately 2 centimeters (CM) by 1 centimeter with undefined edges and without pain.

Review of the May 2022, treatment administration record, lacked documentation of daily monitoring of the blood blister. The medical record lacked documentation of daily monitoring or resolution of this blood blister.

The "Skin Evaluation Record General Skin Check," dated 05/18/22 at 06:54 AM, revealed the resident had no existing issues.

The "Skin Evaluation Record General Skin Check," dated 05/25/22 at 02:21 PM, indicated the resident had no existing issues.

The "Skin Evaluation Record General Skin Check," dated 06/01/22 at 08:57 AM, indicated the resident had no new issues.

The "Skin Evaluation Record Left Heel" dated 06/18/22, indicated the resident had a partial

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 _____	08/25/2022

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 657	Continued From page 5	F 657		

thickness wound on her left heel, measuring 1.5 cm by 1.5 cm with a depth of 0.1 cm with origin date of 06/11/22. Staff cleansed the wound with wound spray and applied a foam dressing.

The "Skin Evaluation Record General Skin Check," dated 06/22/22 indicated no new issues.

The "Skin Evaluation Record Left Heel" dated 06/28/22, indicated the resident had a partial thickness wound to her left heel measured 0.9 by 0.8 by 0.1 cm with irregular edges with dry yellow scab in place surrounded by new epithelial tissue. Staff cleansed the wound with wound spray and applied a foam dressing.

The "Skin Evaluation Record Left Heel," dated 07/03/22, indicated the resident had a small circular lesion, painful to touch, with 60% clean non-granulating tissue, and 40 % slough with an increase in the wound from the prior week with measurements of 1.5 cm by 1 cm by 0.2 cm with scant serous (yellow clear fluid) drainage. Staff cleansed the wound with wound spray, applied a foam dressing and floated the heel.

The "Skin Evaluation Record Left Heel," dated 07/11/22, reveals a circular lesion with 100% slough. A soft debridement used but painful to fully remove the slough layer. The area measured 0.8 by 0.6 by 0.1 cm. Staff cleansed the wound with wound spray, applied a foam dressing and floated the heel.

The "Skin Evaluation Record Left Heel," dated 07/16/22, revealed a circular lesion with 100% slough with measurements of 0.7 by 0.6 by 0.1 cm. Staff debrided the wound and revealed granulating tissue with pink epithelial tissue

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 _____	08/25/2022

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 657	Continued From page 6	F 657		

surrounding the wound. Staff cleansed the wound with wound spray, applied a foam dressing and floated the heel.

The "Skin Evaluation Record Left Heel," dated 07/29/22, revealed 100% slough with measurement of 0.7 by 0.6 by 0.1 cm. Staff debrided the wound, and revealed granulating tissue and pink epithelial tissue surrounding the wound edge. Staff cleansed the wound with wound spray, applied a foam dressing and floated the heel.

The "Skin Evaluation Record Left Heel," dated 08/05/22, revealed the wound measurement of 0.5 by 0.7 by 0.2 with macerated wound edge and pink tissue surrounding the wound. Staff cleansed the wound with wound spray, applied a foam dressing and floated the heel.

The "Skin Evaluation Record Left Heel," dated 08/09/22, revealed the 0.7 by 0/9 by 0.2 cm with macerated surrounding tissue and a pink tissue surrounding the wound.

The "Skin Evaluation Record Left Heel," dated 08/18/22, revealed the wound measured 0.5 by 0.5 by 0.3 cm with undermining of 0.4 cm at 2:00 o'clock, macerated wound edge and pink tissue surrounding the wound. Staff cleansed the wound with wound spray, applied a foam dressing and floated the heel.

The "Skin Evaluation Record Left Heel," dated 08/24/22, revealed staff applied calcium alginate to the wound bed and covered it with a foam dressing. The wound had a scant amount of purulent drainage on the dressing with slough noted to the wound bed. Staff measured the

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 _____	08/25/2022

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 657	Continued From page 7	F 657		

wound as 0.2 by 0.3 cm with no depth and discoloration noted in the surrounding skin.

Observation, on 08/23/22 at 09:15 AM, revealed the resident seated in her recliner with footrest elevated. The resident had her shoes on, and her feet were hanging off the end of the footrest beginning at her lower ankle area and continued in this manner until 10:00 AM.

Observation on 08/23/22 at 10:00 AM, with Licensed Nurse (LN) G, revealed she did notice a blood blister in the area in May, but it did not currently require treatment and the staff performs weekly skin assessments. LN G stated she did not know how this ulcer developed, but since she was on hospice services, wound care was not consulted. LN G stated nursing staff check the dressing daily, and change the dressing as needed but at least every 3 days. LN G removed the resident's shoe and the dressing to her left heel was intact. LN G then replaced the resident's shoe after asking the resident if she wanted her shoe on. The resident sat in her recliner with the footrest in the elevated position and her heel positioned off the end of the footrest. LN G stated the resident preferred to keep her shoes on when in her recliner, but the heel was off the edge of the footrest for pressure relief.

Interview, on 08/23/22 at 02:45 PM, with Certified Nurse Aide (CNA) O, revealed the resident sits in her recliner with the footrest elevated but prefers to keep her shoes on. CNA O stated the resident ambulates with her walker with stand by assistance of staff.

Observation on 08/24/22 at 08:44 AM, with LN H, revealed she does wound care once a week and

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 _____	08/25/2022

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 657	Continued From page 8	F 657		

measures the area. At that time LN H removed the resident's shoe and sock and observed the wound on the left lateral heel area. LN H measured the wound as 0.2 cm by 0.3 cm with no depth. The wound was yellow brown in color. LN H stated the wound had tunneling last week but greatly improved. LN O did not know if staff float her heels but thought they did when she lay in bed LN H did not know if staff removed her shoes when she sat in the recliner. LN H stated the resident no longer received wraps for lymphedema (accumulation of fluid) but did not know when therapy stopped the wraps.

Interview, on 08/24/22 at 03:30 PM, with LN I, revealed the resident sits in her recliner with her shoes on per her preference. She stated staff float her heels at night in bed with pillows.

Interview, on 08/24/22 at 10:57 AM, with Administrative Nurse DD, confirmed the care plan lacked interventions for the resident's left foot pressure ulcer and would expect nursing staff to add interventions as needed to heal and prevent further decline.

Interview, on 08/24/22 at 04:30 PM, with Administrative Nurse D, revealed she would expect staff to update the care plan to include interventions for the blood blister and subsequent pressure ulcer on the resident's left foot. Administrative Nurse D stated she would expect nursing staff to identify risk factors and revise the care plan as indicated.

The facility policy "Skin Integrity: Pressure Ulcer/Injury Prevention, Nursing Intervention and Wound Treatment," revised 10/21/21, instructed staff to provide daily documentation of heel

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 _____	08/25/2022

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 657	Continued From page 9 pressure ulcer/injury. Risk factors should be reviewed along with possible causes and a determination made to what extents if any, the factors can be modified. Modifiable risk factors should be addressed in the plan of care. The facility failed to review and revise this resident's care plan for specific interventions and risk factors for her left heel pressure ulcer to heal and prevent further decline.	F 657		
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 55 residents with 22 selected for review which included two residents reviewed for pressure ulcers. Based on observation, interview and record review, the facility failed to ensure staff provided care and interventions to prevent pressure ulcers for one of two sampled at risk residents (R)2 in which staff identified a blood blister on her foot and subsequently developed an unstageable pressure	F 686		

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 _____	08/25/2022

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 686	Continued From page 10	F 686		

ulcer (coverage of a wound by slough and/or eschar) on the same area of the foot.

Findings included:

- Review of resident (R)2's "Physician's Order Sheet," undated, revealed diagnoses included pneumonia (inflammation of the lungs), unspecified dementia (progressive mental disorder characterized by failing memory, confusion), restlessness with agitation, and localized edema (swelling).

The "Admission MDS," dated 03/27/22, assessed the resident with moderate cognitive impairment, required extensive assistance of two persons with bed mobility, transfer, and ambulation. The resident had no impairment in range of motion in the upper or lower extremities, with no current pressure ulcers and was at risk for pressure ulcers development with no interventions in place.

The "Significant Change Minimum Data Set" (MDS), dated 05/16/22, assessed the resident with severe cognitive impairment, required extensive assistance of two persons with bed mobility, transfer, and ambulation. The resident had no impairment in range of motion in the upper or lower extremities. The resident was assessed as at risk for pressure ulcer development and had no unhealed pressure ulcers. The resident had a pressure reducing devise on her bed.

The "Pressure Ulcer Care Area Assessment" (CAA), dated 05/16/22, assessed the resident at risk for pressure ulcer and other related skin complications due to decreased mobility incontinence, self-care limitations and dementia.

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 _____	08/25/2022

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 686	Continued From page 11	F 686		

The resident had no current pressure related skin alterations. A Braden score (an assessment for pressure ulcer risk) of 18 indicated a risk for skin integrity concerns.

The "Quarterly MDS," dated 08/16/22, assessed the resident with severe cognitive impairment. The resident required extensive assistance of two staff for bed mobility, transfer and ambulation. The resident was at risk for developing pressure ulcers and had one unstageable pressure ulcer. The resident had a pressure reducing device for her bed and pressure ulcer care and application of dressings to her feet.

The "Care Plan," reviewed 07/11/22, instructed staff the resident was at risk for pressure ulcers and not able to make major position changes independently. The resident required extensive assistance with transfers and bed mobility. Staff to encourage adequate intake at meals and offer snacks. The resident took a diuretic (medication to remove excess fluid) for hypertension (high blood pressure).

A "Wound Treatment Order" dated 06/08/22, revealed the resident had an ulcer (described as "other") on her left heel with measurements of 1.25 centimeters (cm) by 1 cm, by 0.25 in depth. The wound had no drainage. Staff requested wound cleanser with an autolytic (an agent that breaks down damaged tissue) agent for debridement (removal of damaged tissue) and to change the dressing every 3-5 days. The physician signed the request, and the treatment began on 06/11/22, per review of the June 2022 treatment administration record (TAR).

A "Physician's Order," dated 07/03/22, instructed

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 _____	08/25/2022

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 686	Continued From page 12	F 686		

staff to keep pressure off the left heel and float it with a pillow three times a day, per the July 2022 TAR.

An e-mail, dated 08/19/22, Licensed Nursing staff (LN) H, described the resident's left foot ulcer as 0.5 by 0.5 by 0.3 with 0.4 cm tunneling, and requested an order to apply calcium alginate (a type of material that minimize infection and form a moist gel) to the wound bed. Per the August 2022 TAR this treatment started 08/20/22.

A "Nursing "Progress Note," dated 03/21/22, assessed the resident with 2-3 plus pitting edema in her lower extremities. Staff identified a scabbed area to her left elbow and pink discoloration to her coccyx region.

A "Nursing Progress Note," dated 04/14/22, indicated the resident had intermittent confusion and forgetfulness but was alert and oriented and worked with therapy. The resident had bilateral dependent edema and had lymphedema wraps applied by therapy to her bilateral lower legs.

A "Nursing Progress Note," dated 05/05/22, indicated the resident was admitted to hospice care.

The Braden scores for pressure ulcer development documented as follows:

On 03/24/22, score of 17 (19-23 no risk, 15-18 mild risk, 13-14 moderate risk, 10-12 high risk, 6-9 very high risk).
On 04/07/22, score of 16 mild risk.
On 06/23/22, score of 18 mild risk.

The "Skin Evaluation Record General Skin

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 _____	08/25/2022

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 686	Continued From page 13	F 686		

Check" dated 05/11/22 at 07:20 AM, indicated the resident had no new issues.

The "Skin Evaluation Record General Skin Check," dated 05/11/22 at 09:19 AM, indicated the resident had a blood blister on her left heel, approximately 2 centimeters (CM) by 1 centimeter with undefined edges and without pain.

Review of the May 2022, treatment administration record, lacked documentation of daily monitoring of the blood blister. The medical record lacked documentation of daily monitoring or resolution of this blood blister.

The "Skin Evaluation Record General Skin Check," dated 05/18/22 at 06:54 AM, revealed the resident had no existing issues.

The "Skin Evaluation Record General Skin Check," dated 05/25/22 at 02:21 PM, indicated the resident had no existing issues.

The "Skin Evaluation Record General Skin Check," dated 06/01/22 at 08:57 AM, indicated the resident had no new issues.

The "Skin Evaluation Record Left Heel" dated 06/18/22, indicated the resident had a partial thickness wound on her left heel, measuring 1.5 cm by 1.5 cm with a depth of 0.1 cm with origin date of 06/11/22. Staff cleansed the wound with wound spray and applied a foam dressing.

The "Skin Evaluation Record General Skin Check," dated 06/22/22 indicated no new issues.

The "Skin Evaluation Record Left Heel" dated

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 _____	08/25/2022

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 686	Continued From page 14	F 686		

06/28/22, indicated the resident had a partial thickness wound to her left heel measured 0.9 by 0.8 by 0.1 cm with irregular edges with dry yellow scab in place surrounded by new epithelial tissue. Staff cleansed the wound with wound spray and applied a foam dressing.

The "Skin Evaluation Record Left Heel," dated 07/03/22, indicated the resident had a small circular lesion, painful to touch, with 60% clean non-granulating tissue, and 40 % slough with an increase in the wound from the prior week with measurements of 1.5 cm by 1 cm by 0.2 cm with scant serous (yellow clear fluid) drainage. Staff cleansed the wound with wound spray, applied a foam dressing and floated the heel.

The "Skin Evaluation Record Left Heel," dated 07/11/22, reveals a circular lesion with 100% slough. A soft debridement used but painful to fully remove the slough layer. The area measured 0.8 by 0.6 by 0.1 cm. Staff cleansed the wound with wound spray, applied a foam dressing and floated the heel.

The "Skin Evaluation Record Left Heel," dated 07/16/22, revealed a circular lesion with 100% slough with measurements of 0.7 by 0.6 by 0.1 cm. Staff debrided the wound and revealed granulating tissue with pink epithelial tissue surrounding the wound. Staff cleansed the wound with wound spray, applied a foam dressing and floated the heel.

The "Skin Evaluation Record Left Heel," dated 07/29/22, revealed 100% slough with measurement of 0.7 by 0.6 by 0.1 cm. Staff debrided the wound, and revealed granulating tissue and pink epithelial tissue surrounding the

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 _____	08/25/2022

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 686	Continued From page 15	F 686		

wound edge. Staff cleansed the wound with wound spray, applied a foam dressing and floated the heel.

The "Skin Evaluation Record Left Heel," dated 08/05/22, revealed the wound measurement of 0.5 by 0.7 by 0.2 with macerated wound edge and pink tissue surrounding the wound. Staff cleansed the wound with wound spray, applied a foam dressing and floated the heel.

The "Skin Evaluation Record Left Heel," dated 08/09/22, revealed the 0.7 by 0/9 by 0.2 cm with macerated surrounding tissue and a pink tissue surrounding the wound.

The "Skin Evaluation Record Left Heel," dated 08/18/22, revealed the wound measured 0.5 by 0.5 by 0.3 cm with undermining of 0.4 cm at 2:00 o'clock, macerated wound edge and pink tissue surrounding the wound. Staff cleansed the wound with wound spray, applied a foam dressing and floated the heel.

The "Skin Evaluation Record Left Heel," dated 08/24/22, revealed staff applied calcium alginate to the wound bed and covered it with a foam dressing. The wound had a scant amount of purulent drainage on the dressing with slough noted to the wound bed. Staff measured the wound as 0.2 by 0.3 cm with no depth and discoloration noted in the surrounding skin.

Observation, on 08/23/22 at 09:15 AM, revealed the resident seated in her recliner with footrest elevated. The resident had her shoes on, and her feet were hanging off the end of the footrest beginning at her lower ankle area and continued in this manner until 10:00 AM.

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 _____	08/25/2022

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 686	Continued From page 16	F 686		

Observation on 08/23/22 at 10:00 AM, with Licensed Nurse (LN) G, revealed she did notice a blood blister in the area in May, but it did not currently require treatment and the staff performs weekly skin assessments. LN G stated she did not know how this ulcer developed, but since she was on hospice services, wound care was not consulted. LN G stated nursing staff check the dressing daily, and change the dressing as needed but at least every 3 days. LN G removed the resident's shoe and the dressing to her left heel was intact. LN G then replaced the resident's shoe after asking the resident if she wanted her shoe on. The resident sat in her recliner with the footrest in the elevated position and her heel positioned off the end of the footrest. LN G stated the resident preferred to keep her shoes on when in her recliner, but the heel was off the edge of the footrest for pressure relief.

Observation, on 08/23/22 at 11:30 AM, revealed staff ambulated with the resident and her walker to the dining room.

Interview, on 08/23/22 at 02:45 PM, with Certified Nurse Aide (CNA) O, revealed the resident sits in her recliner with the footrest elevated but prefers to keep her shoes on. CNA O stated the resident ambulates with her walker with stand by assistance of staff.

Observation on 08/24/22 at 08:44 AM, with LN H, revealed she does wound care once a week and measures the area. At that time LN H removed the resident's shoe and sock and observed the wound on the left lateral heel area. LN H measured the wound as 0.2 cm by 0.3 cm with no depth. The wound was yellow brown in color. LN

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 _____	08/25/2022

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 686	Continued From page 17	F 686		

H stated the wound had tunneling last week but greatly improved. LN O did not know if staff float her heels but thought they did when she lay in bed LN H did not know if staff removed her shoes when she sat in the recliner. LN H stated the resident no longer received wraps for lymphedema (accumulation of fluid) but did not know when therapy stopped the wraps.

Interview, on 08/24/22 at 03:30 PM, with LN I, revealed the resident sits in her recliner with her shoes on per her preference. She stated staff float her heels at night in bed with pillows.

Interview, on 08/24/22 at 04:30 PM, with Administrative Nurse D, revealed she would expect staff to follow the wound protocol and monitor the blood blister when identified on 05/11/22. Administrative Nurse D stated she would expect nursing staff to identify risk factors and revise the care plan as indicated.

The facility policy "Skin Integrity: Pressure Ulcer/Injury Prevention, Nursing Intervention and Wound Treatment," revised 10/21/21, instructed staff to provide daily documentation of heel pressure ulcer/injury. The licensed nurse will complete a skin evaluation and if new alterations are noted the licensed nurse will initiate treatment per guidelines and document as indicated. The support surface is on aspect of the comprehensive treatment plan. Utilizing a therapeutic support surface does not lessen the need to turn the resident, utilize clinically proven treatment regimes, provide nutritional support or routinely assess the wound. Staff instructed to use site specific support surfaces on the resident's extremities. Risk factors should be reviewed along with possible causes and a

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 _____	08/25/2022

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 686	Continued From page 18 determination made to what extents if any, the factors can be modified. Modifiable risk factors should be addressed in the plan of care. The facility failed to monitor daily for resolution of this resident's blood blister identified on 05/11/22, failed to identify causative factors of the development of the blister and failed to timely determine interventions for the prevention of pressure ulcer injury which resulted in an unstageable pressure injury to the resident's heel.	F 686		
F 689 SS=D	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 with 22 selected for review including six residents reviewed for accident hazards. Based on observation, interview, and record review, the facility failed to follow and implement care plan interventions following a fall for Resident (R)7 and failed to ensure the oxygen tubing for R14 was off the floor to reduce a tripping hazard. Findings included: - The "Physician Orders" for 08/22/22, for Resident (R)7 included diagnoses of dementia (progressive mental disorder characterized by	F 689		

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 _____	08/25/2022

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 689	Continued From page 19	F 689		

failing memory, confusion) and history of falling.

The "Quarterly Minimum Data Set" (MDS) dated 03/23/22 assessed R7 with a short-term and a long-term memory problem and moderately impaired decision making. He required extensive assistance of one staff for transfers and limited assistance of one for walking. His balance during transitions were not steady and required staff to support him, however he could balance himself when walking. R7 used a walker for mobility and had not had any falls since the prior assessment.

The "Significant Change MDS" dated 05/25/22 did not reveal any changes to his cognition, transfers, or walking. His balance during transitions and walking were not steady and required staff support. He continued to use a walker for mobility and since the last assessment he had one non-injury fall and had one fall with injury that was not a major injury (break in a bone, head injury).

The "Falls Care Area Assessment" dated 05/30/22 revealed R7's fall risk score was 18, indicating a high risk for falls, and he has had several falls due to his poor balance and unsteady gait.

The "Care Plan" dated 05/08/22 for R7 revealed he was at risk for falls due to his confusion, multiple medications, history of falls and general weakness. Interventions included for the staff to ensure his bed was in the position easiest for him to access/exit, assist with ambulation when he was feeling weak or having poor balance, and to remind him to use the walker as sometimes he forgot. R7 required a walker and limited to extensive assist of staff with walking. The care

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 _____	08/25/2022

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 689	Continued From page 20	F 689		

plan had these added interventions:
1. On 08/01/22, the staff were to keep his walker within his reach but not directly in front of him when he was in his room.
2. On 08/22/22, the staff were to increase visual checks to approximately every hour when he was in his room, and to maximize his independence and quality of life by adding an easy touch call light.

The "Interdisciplinary Notes " (ID) located in the electronic medical record (EMR) revealed R7 fell on 04/22/22, 04/29/22, 05/08/22, and 08/21/22.

The "ID note" located in the EMR, dated 08/22/22 at 12:41 AM, revealed the staff found R7 sitting on the floor in the middle of the room on 08/21/22 at 11:30 PM. R7 stated he was walking across the room and going back to bed. The fall resulted in an abrasion (scraping or rubbing away of a surface, such as skin, by friction) to the left buttocks 14.4 centimeters (cm) by 3.7 cm and an abrasion to the right side of his back measuring 17.1 cm by 1.4 cm. The intervention was to increase visual checks to approximately every hour when he was in his room.

The facility "Investigation Report" for the fall on 08/21/22 included additional interventions of an easy touch call light pad placed in R7's room on 08/22/22 and to keep his walker within reach but not directly in front of him when he was in his room.

On 08/23/22 01:34 PM, R7 was in his room sitting in the recliner and his walker was across the room at the foot of the bed out of his reach. The staff failed to ensure the walker was in reach while in his room as planned to prevent further

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 _____	08/25/2022

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 689	Continued From page 21	F 689		

falls.

On 08/23/22 at 02:55 PM, R7 continued to sit in his room in the recliner with the walker out of reach. The staff failed to ensure the walker was in reach while he was in his room.

On 08/24/22 at 08:51 AM, Certified Medication Aide (CMA) LL, who was providing direct care, stated R7 was a fall risk and there was a touch pad call light that the staff placed beside him. CMA LL stated when he was in his room the walker was to be in his reach in front of him and she had not been told what the new fall intervention was for his fall on 08/21/22. CMA LL stated there was not a place to look and see what the intervention was, the charge nurse would let her know.

On 08/24/22 at 08:58 AM, CMA T, who was providing direct care, stated R7 was a fall risk and was told on 08/22/22 that he fell but she did not know what the new intervention was put in place to prevent further falls. CMA T stated he did have a touch pad call light that was beside him and the staff check on him about every 15 minutes and the new intervention was probably in the "care plan book."

On 08/24/22 at 03:25 PM, observed R7 in his room sitting in his recliner and the touch pad call light was draped across the top of a folding tray table next to the recliner, rather than placed next to him.

On 08/24/22 at 03:29 PM, CNA MM stated when she comes in for her shift, report was done and that was when any new fall interventions were communicated. CNA MM stated typically a new

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 _____	08/25/2022

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 689	Continued From page 22	F 689		

intervention was not put in place after a fall unless it keeps happening then they would come up with a new intervention to prevent a fall from happening again. CNA MM was not sure if R7 was a fall risk as it was her second time working that unit and did not know if R7 had fell recently, however stated the touch pad call light should be placed on his chair. CNA MM was not aware of any other interventions other than lowering the bed to the floor.

On 08/24/22 at 03:47 PM, Licensed Nurse (LN) I stated when a resident falls the staff attempt to determine the cause of the fall, come up with a new intervention to prevent further falls, and document the intervention on the care plan and in the ID notes. The staff were made aware of the intervention by passing it on in report and the intervention was in the care plan. The care plan included an intervention on 08/22/22 for an easy touch call light and to keep the walker in his reach but not directly in front of him when in his room. LN I stated she would expect the staff to follow the care plan.

On 08/25/22 at 11:45 AM, Administrative Nurse D stated she expected the staff to communicate fall interventions during shift-to-shift report, place the intervention on the care plan which all staff had access to, and staff should follow the care plan interventions.

The facility policy "Falls" dated 10/11/21 included interventions after a fall should be documented on the care plan, however lacked direction how to communicate if a fall occurred and the post fall interventions to the staff.

The facility failed to follow the implemented

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 _____	08/25/2022

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 689	Continued From page 23	F 689		

interventions following R7's fall, failed to communicate the interventions to the staff, for R7 with a history of falls, to prevent further falls.

Review of resident (R)14's "Physician Order Sheet," undated, revealed diagnoses included cerebral infarction (stroke sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), Chronic Obstructive Pulmonary Disease (COPD progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), dementia (progressive mental disorder) characterized by failing memory, confusion, and rheumatoid arthritis (chronic inflammatory disease that affected joints and other organ systems).

The "Significant Change Minimum Data Set" (MDS), dated 06/14/22, assessed the resident with moderate cognitive impairment, required limited assistance of one person for bed mobility, transfer toilet use, dressing and personal hygiene. The resident required supervision with ambulation and had unsteady balance with stabilization with staff assistance. The resident had no impairment in the upper or lower extremities. The resident was not on a toileting plan and had occasionally urinary incontinence and frequent bowel incontinence.

The "Fall Care Area Assessment" (CAA,) dated 06/14/22, assessed the resident had impaired balance with contributing factors of weakness and physical performance limitations affecting balance and history of falls.

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 _____	08/25/2022

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 689	Continued From page 24	F 689		

The 'Urinary Incontinence CAA" dated 06/14/22, assessed the resident required assistance with toileting and had occasional urinary incontinence.

The "Care Plan," reviewed 08/18/22, instructed staff the resident sometimes moved too fast with a walker and staff were to remind her to slow down. Staff instructed to remind the resident to sit farther back in her chair and bed to help prevent falls. Staff instructed to offer to walk with the resident when she was having balance problems. Staff to remind the resident to check the wheels on her walker before she starts ambulating. Staff instructed to check on her often and offer to take her to the bathroom. Staff to provide the resident with the shortest length of oxygen tubing appropriate for her needs so she does not trip on it. Staff to make sure her walker is within her reach.

Review of the "Fall Investigation Report," dated 07/17/22 at 08:00 PM, revealed staff found the resident on the floor in her room and the resident stated she tripped over her oxygen tubing. The immediate intervention was to remind the resident to manage her oxygen tubing and to change her concentrator to her portable unit which was attached to her walker.

Observation, on 08/22/22 at 03:02 PM, revealed the resident in bed without her oxygen on. The resident's oxygen concentrator was "on" and the tubing was in a disorganized pile on the floor beside the oxygen concentrator which was positioned beside the resident's bed. The resident's portable oxygen concentrator was on her walker near her chair, with the tubing also on the floor.

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 _____	08/25/2022

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 689	Continued From page 25	F 689		

Interview, on 08/22/22 at 03:15 PM, with Certified Nurse Aide (CNA) P, revealed the resident will often put herself in bed and forget to wear the oxygen. CNA P stated the portable oxygen concentrator needs to be recharged when not in use. CNA P stated the resident's tubing was extra long so she could go the bathroom with it.

Observation, on 08/23/22 at 12:46 PM, revealed CNA Q, assisted the resident to her room with the rolling walker and portable oxygen. CNA Q did not offer the resident a toileting opportunity and positioned the resident in her bed and placed the nasal cannula from the room oxygen concentrator on the resident. The tubing was in a disorganized pile on the floor beside the oxygen concentrator beside her bed.

Observation, on 08/23/22 at 12:51 PM, revealed the resident got herself up out of bed and ambulated to the bathroom in her room. CNA Q stated the resident does get up by herself and confirmed the resident could trip over the oxygen tubing that was laying on the floor.

Interview, on 08/24/22 at 12:11 PM, with Licensed Nurse (LN) I, revealed she would expect staff to keep the oxygen tubing off the floor and in a plastic bag attached to the oxygen concentrator. LN I stated the resident often took herself to the bathroom, so her tubing was longer than average to enable her to keep it on when in the bathroom. LN I confirmed the tubing could be a trip hazard and staff needed to keep it in a neat coil. Staff should toilet the resident upon return to her room and before/after meals.

Interview, on 08/24/22 at 04:30 PM, with Administrative Nurse D, revealed she expected

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 _____	08/25/2022

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 689	Continued From page 26 staff to keep the oxygen tubing in a manner to prevent falls. Administrative Nurse D stated the oxygen tubing was exceptionally long and the facility needed to find ways to limit the trip hazard. The facility policy "Falls," revised 10/11/21, instructed staff to identify residents for risk of falls and implement interventions to reduce the resident of falls. The facility failed to implement measures to reduce the risk of further falls for this resident with extra long oxygen tubing.	F 689		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F 755		

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 _____	08/25/2022

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 755	Continued From page 27	F 755		

§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 55 residents with 22 selected for review which included 12 residents reviewed for medications. Based on observation, interview and record review, staff failed to follow physician orders for ten of the 12 residents(R)4, R10, R11, R18, R20, R29, R35, R31, R38, and R 50 reviewed for medications.

Findings included:

- Review of R 10's "Physician Order Sheet" undated, revealed diagnoses included atrial fibrillation (rapid, irregular heartbeat), diabetes (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness).

The "Care Plan," reviewed 07/20/22, instructed staff the resident received Eliquis. The care plan instructed staff if the drug must be discontinued in patients, without adequate continuous anticoagulation, it increased the risk of clotting events such as stroke.

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 _____	08/25/2022

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 755	Continued From page 28	F 755		

A "Physician's Order," dated 12/24/21, instructed staff to administer Eliquis (a medication to prevent clot formation) 5 milligrams (mg), twice a day for atrial fibrillation (BID).

Review of the "Hospital and Surgery Reservation" from the vascular surgeon, revealed the resident was scheduled for a vascular procedure on 06/28/22, and it instructed the staff to hold the resident's Eliquis 5 mg, for three days prior to the procedure (06/25, 06/26, 06/27 and 06/28).

A "Physician's Order," dated 06/28/22, instructed staff to restart the Eliquis 5 mg BID on 06/29/22 in the PM.

The MAR contained an entry to hold the Eliquis 5 mg BID on Friday 06/25/22 and to restart the medication pending instructions after the procedure on 06/28/22.

Review of the June 2022 "Medication Administration Record" (MAR) revealed staff did not administer the Eliquis 5 mg BID on 06/24/22 (two doses prior to the ordered stop date of 06/25/22) . Staff did not resume the Eliquis 5 mg for the PM dose on 06/29/22 but administered a PM dose on 06/30/22, (with two more missed doses).

Review of the July 2022 MAR, revealed staff did not administer the Eliquis 5 mg on 07/01/22, 07/02/22, 07/03/22, 07/04/22, 07/05/22 and the 07/06/22 AM dose, (with 10 doses missed).

Interview, on 08/24/22 at 08:07 AM, with Licensed Nurse (LN) G, revealed staff entered the Eliquis order for this resident wrong into the system.

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 _____	08/25/2022

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 755	Continued From page 29	F 755		

Interview, on 08/25/22 at 09:39 AM, with Administrative Nurse F, revealed she would expect the charge to run a report at the end of their shift to see what meds were not signed for and then to investigate why. Administrative Nurse F stated staff entered the Eliquis 5 mg BID hold date and resumption date into the electronic system incorrectly, and confirmed the resident missed 12 doses of the physician ordered medication.

The facility policy "Physician Order Flow Sheet" undated, instructed staff to enter the order in "Physician's Orders," Fax the order to pharmacy, scan the order into the Matrix system, under the correct tab, place a copy of the order in the "Medical Records" box for follow through, document in note in the Matrix all order details including name of medication dose, diagnosis and pull up the EMAR/TAR and ensure the order displays correctly.

The facility failed to ensure staff administered this medication as ordered by the physician to hold and then to restart this resident's Eliquis.

- Review of resident (R)11's "Physician Order Sheet," undated, revealed diagnoses included Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) and dementia (progressive mental disorder characterized by failing memory, confusion).

Review of the "Physician's Orders," revealed the following:

On 12/02/20, original order date, Namenda (a

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 _____	08/25/2022

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 755	Continued From page 30	F 755		

medication used for Alzheimer's disease) staff to administer 10 milligrams (mg) twice a day (BID).

On 03/17/22, original order date, Zoloft (an antidepressant), 100 mg, daily for major depressive disorder.

Review of the July 2022, Medication Administration Record (MAR) revealed staff did not administer Zoloft 100 mg for the morning doses as ordered by the physician, on 07/13/22 through 07/18/22, (for a total of six missed doses of the medication).

Review of the July 2022, MAR revealed staff did not administer Namenda 10 mg, for the morning dose on 07/13, 14,16,17, and 07/18/22. (a total of five missed doses.) Staff did administer the AM dose on 07/15/22.

Interview, on 08/24/22 at 11:30 AM, with Certified Medication Aide (CMA)R, revealed CMAs should check in the medication room for over flow medications to replace medications that were out. CMAs were responsible to order medications in a timely manner.

Interview, on 08/25/22 at 09:39 AM, with Administrative Nurse F, revealed she would expect the charge nurse to run a report at the end of their shift to see what meds were not signed for and then to investigate why. She would expect the CMAs to check the medication room for the medications and if they were not available, to follow up with the charge nurse/pharmacy.

The facility policy "Teachable Moment," dated 06/23/21, instructed staff to not wait until the medication is gone before reordering. If electronic

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 _____	08/25/2022

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 755	Continued From page 31	F 755		

reorders have not arrived, call the pharmacy to see why and/or reorder.

The facility failed to ensure staff ensured timely reordering of medications and investigate medications not administered at the end of each shift to ensure this resident received the medications as ordered by the physician.

- Review of resident (R)18's "Physician Order Sheet," undated, revealed diagnoses included dementia progressive mental disorder characterized by failing memory, confusion) and major mood disorder (major mood disorder).

A "Physician's Order," dated 05/19/22, instructed staff to administer Seroquel (an antipsychotic) 25 milligrams (mg) every hour of sleep for hallucinations.

Review of the May 2022 "Medication Administration Record," (MAR) revealed staff administered Seroquel 25 mg every hour of sleep beginning 05/24/22 (five days after the facility received the order).

Review of the June 2022 "MAR," revealed two missed doses of Seroquel on 06/18/22 and 06/19/22.

Interview, on 08/24/22 at 11:30 AM, with Certified Medication Aide (CMA) R, revealed CMAs should check for medications in the medication room. If the medication was not available staff would need to notify the charge nurse and reorder the medication from the pharmacy.

Interview on 08/25/22 at 09:39 AM, with

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 _____	08/25/2022

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 755	Continued From page 32	F 755		

Administrative Nurse F, revealed she expected the charge nurse to run a report at the end of their shift to see what meds were not signed for and then investigate why. She would expect the CMAs to check the medication room for the medications and if they were not available, to follow up with the charge nurse/pharmacy. Administrative Nurse F stated staff ordered the medication for Seroquel on 05/19/22, with the wrong code and it did not transfer correctly onto the MAR.

The "Physician Order Flow Sheet," undated, instructed staff to pull up the e MAR/TAR and ensure the order displays correctly.

The facility failed to ensure this resident received Seroquel as ordered by the physician.

- Review of resident (R)29's "Physician Order Sheet," undated revealed diagnoses included cerebral vascular infarction (stroke), major depressive disorder (major mood disorder), and bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods).

A "Physician's Order," dated 06/17/22, instructed staff to discontinue Wellbutrin SR (an antidepressant sustained release) 100 milligrams (mg) twice a day, and to then start Wellbutrin XL (extended release) 300 mg, every morning for major depressive disorder.

Review of the June 2022 "Medication Administration Record" (MAR) revealed an entry for Wellbutrin SR (not the ordered XL type of medication) 300 mg daily for bipolar disorder.

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 _____	08/25/2022

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 755	Continued From page 33	F 755		

Staff administered this incorrect medication on 06/18/22, 06/21/22 and 06/22/22 through 06/30/22, (with incorrect administration for a total of 13 doses). Staff failed to discontinue the Wellbutrin SR as ordered on 06/17/22.

Review of the July 2022 MAR revealed an entry for Wellbutrin SR (not the ordered XL type of medication), 300 mg once a day for major depressive disorder. Staff administered this incorrect ordered medication from 07/01 through 07/25/22, for a total of 25 doses.

Interview, on 08/24/22 at 11:30 AM, with Certified Medication Aide (CMA) R, revealed CMAs should check for medications in the medication room. If the medication were not available staff would need to notify the charge nurse and reorder the medication from the pharmacy.

Interview on 08/25/22 at 09:39 AM, with Administrative Nurse F, revealed staff entered Wellbutrin SR 300 mg daily instead of Wellbutrin XL 300 mg daily into the electronic medical record which caused the incorrect MAR entry for Wellbutrin SR 300 mg. The error was caught when another provider instructed staff to discontinue Wellbutrin SR 300 mg and start Wellbutrin XL 300 mg on 07/21/22. Administrative Nurse F stated the facility was aware of the medication errors.

The facility policy "Physician Order Flow Sheet," undated, instructed staff to pull up the e MAR/TAR and ensure the order displayed correctly.

The facility administered this resident's Wellbutrin SR 300 mg daily instead of Wellbutrin XL 300 mg

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 _____	08/25/2022

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 755	Continued From page 34	F 755		

daily as ordered by the physician, for a total of 38 doses.

- Review of Resident (R)4's electronic medical record EMR, under the "Diagnoses" tab, included a diagnosis of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure).

The revised care plan, dated 03/25/22, instructed staff the resident had an alteration in her thought process due to dementia (progressive mental disorder characterized by failing memory, confusion) and took Aricept (medication used to treat dementia of the Alzheimer's type).

Review of a physician's order for R 4, provided by the facility, revealed a new order for Memantine (used to treat moderate to severe dementia of the Alzheimer's type), 5 milligrams (mg), by mouth (po), ordered on 06/05/22. However, review of the resident's Medication Administration Record (MAR), for August 2022, revealed the resident first received the medication on 08/17/22 (over 2 months after the physician ordered it).

On 08/24/22 at 11:38 AM, Licensed Nurse (LN) GG stated when a new order comes through, the nurse was to fill out a fax form and send it to the pharmacy for the medication to be delivered. The nurse would then add the new medication to the MAR.

On 08/25/22 at 09:41 AM, Administrative Nurse F stated, the charge nurse was responsible for checking for new orders throughout the shift. The facility identified not all new orders were being initiated in a timely manner.

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 _____	08/25/2022

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 755	Continued From page 35	F 755		

On 08/25/22 at 11:10 AM, Administrative Nurse D stated, the facility identified not all new orders were being processed correctly. Administrative Nurse D stated it was the expectation that residents get the medications ordered by their physicians in a timely manner.

Review of the facility policy for, process for new orders, undated, included: When receiving a new order, staff were to enter the order into the "Physician's Orders" in the resident's EMR and fax the new medication order to the pharmacy. Staff were then place a copy of the order into the Medical Records box for follow through.

The facility failed to follow physician's orders for over two months, for this dependent resident with Alzheimer's disease.

- Review of Resident (R)50's electronic medical record (EMR), under the "Diagnoses" tab, included a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion).

The revised care plan, dated 05/02/22, instructed staff the resident had exit seeking and wandering behaviors.

Review of the resident's EMR, under the "Orders" tab, revealed an order for Risperidone 0.5 mg, po, with dinner, ordered 07/07/22.

Review of a physician's order, provided by the facility, revealed a physician's order, dated 07/17/22, for Risperidone (used to treat a certain mental/mood disorders), 0.25 milligrams (mg)

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 _____	08/25/2022

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 755	Continued From page 36	F 755		

with breakfast, by mouth (po), to start on 07/18/22.

Review of the resident's Medication Administration Record (MAR), located in the resident's EMR, revealed staff failed to administer the Risperidone 0.25 mg with breakfast, ordered 07/17/22, until the morning of 07/29/22. The resident went 11 days without the ordered medication.

On 08/24/22 at 11:38 AM, Licensed Nurse (LN) GG stated when a new order comes through, the nurse was to fill out a fax form and send to the pharmacy for the medication to be delivered. The nurse would then add the new medication to the MAR.

On 08/25/22 at 09:41 AM, Administrative Nurse F stated, the charge nurse was responsible for checking for new orders throughout the shift. The facility identified not all new orders were being initiated in a timely manner.

On 08/25/22 at 11:10 AM, Administrative Nurse D stated, the facility identified not all new orders were being processed correctly. Administrative Nurse D stated it was the expectation that resident's get the medications ordered by their physician in a timely manner.

Review of the facility policy for, process for new orders, undated, included: When receiving a new order, staff were to enter the order into the "Physician's Orders" in the resident's EMR and fax the new medication order to the pharmacy. Staff were then place a copy of the order into the Medical Records box for follow through.

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 _____	08/25/2022

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 755	Continued From page 37	F 755		

The facility failed to follow physician's orders for change in this dependent resident with behaviors, Risperidone medication.

- Review of Resident (R)35's electronic medical record (EMR), under the "Diagnoses" tab, revealed a diagnosis of constipation (the inability to pass stool).

The care plan, revised 05/04/22, instructed staff the resident required limited assistance of one staff for toileting.

Review of a physician's order, dated 07/07/22, revealed an order for a KUB (A radiographic scan of the kidney, ureter, bladder and the surrounding structures), due to left lower abdominal pain.

Review of an "ID Note", in the resident's EMR, dated 08/16/22 (over a month later), revealed the KUB had not been completed.

On 08/24/22 at 11:38 AM, Licensed Nurse (LN) GG stated when a new order comes through, the nurse was to note the order and schedule the test with the radiographic company. Staff failed to get the KUB ordered for this resident.

On 08/25/22 at 09:41 AM, Administrative Nurse F stated, the charge nurse was responsible for checking for new orders throughout the shift. The facility identified not all new orders were being initiated in a timely manner.

On 08/25/22 at 11:10 AM, Administrative Nurse D stated, the facility identified not all new orders were being processed correctly. The facility has done one to one training with nurses and

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 _____	08/25/2022

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 755	Continued From page 38	F 755		

completing training with agency nurses. Administrative Nurse D stated it was the expectation that residents get radiographic examinations ordered by their physicians in a timely manner.

Review of the facility policy for, process for new orders, undated, included: When receiving a new order, staff were to enter the order into the "Physician's Orders" in the resident's EMR and fax the new medication order to the pharmacy. Staff were then place a copy of the order into the Medical Records box for follow through.

The facility failed to follow physician's orders for this dependent resident with a history of constipation to timely obtain the KUB for testing.

- The diagnosis tab, located at the dashboard in the electronic medical record (EMR), for Resident (R)20, included diagnoses of hypertension (elevated blood pressure), osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid), and chronic pain.

The "Medication Record" for 08/2022, included these physician orders:
1. On 01/19/22, Lidocaine (medication used to relieve pain) pain relief, four percent topical patch, once daily, for low back pain.
2. On 03/07/22, Metoprolol tartrate (medication used to treat hypertension), 50 milligrams (mg), by mouth, twice daily for hypertension.
3. On 06/28/22, hydrocodone-acetaminophen (medication used to treat pain), 7.5 mg/325 mg,

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 _____	08/25/2022

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 755	Continued From page 39	F 755		

by mouth, three times daily, for pain.

The "Progress Note" for the physician visit dated 07/07/22, revealed under the assessment section "hypertension-overmedicated." The progress note included an order to decrease Metoprolol to 25 mg, by mouth, twice daily. The note included a fax date of 07/08/22. Additional orders included:
1. Peri-cream, to rectal area, as needed.
2. Biofreeze (medication used to treat pain), to right hand/elbow/forearm, twice daily as needed.
3. Chest x-ray.
4. Consider CBC (completed blood count-blood test that provides information about the cells in a person's blood), BMP (basic metabolic profile-blood test that measures eight different substances in the blood), and BNP (brain natriuretic peptide-blood test measures levels of a protein in the blood to provide information on how the heart is working).
5. Anusol (medication used to treat irritation/itch/swelling of hemorrhoids) cream, to the rectal area, twice daily.

The physician order tab, located under the attachment link in the EMR, revealed the staff scanned in the physician visit progress note dated 07/07/22, on 07/22/22 (15 days after the physician order).

The "Interdisciplinary Note" (ID) dated 08/05/22, for R20 revealed a Certified Medication Aide (CMA) reported to the charge nurse R20's blood pressure was low this evening, reading 98/54. The charge nurse reviewed the record and found the Metoprolol had parameters for a pulse of less than 50 but no parameters for the blood pressure. Upon reviewing the EMR the nurse located an order dated 07/07/22 (over a month prior), on a

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 _____	08/25/2022

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 755	Continued From page 40	F 755		

progress note to decrease the Metoprolol to 25 mg, by mouth, twice daily and the ID notes lacked any physician order changes. The staff notified the physician on call, which gave orders to:
1. Start Metoprolol, 25 mg, by mouth, twice daily.
2. Obtain labs: CBC, BMP, and BNP.
3. Discontinue the Anusol cream.
4. Discontinue the chest x-ray.
5. Start Biofreeze, to right hand/elbow/forearm, twice daily, as needed.

The "Medication Record" dated 08/2022, for the Lidocaine patch, revealed the staff did not administer the medication due to "med not available."

The "ID note" dated 08/10/22 at 03:17 PM\, revealed R20 was to have a Lidocaine patch placed every morning and removed every evening. It was discovered during medication pass on 08/09/22, that R20 did not have a Lidocaine patch placed.

The facility investigation notes, for 08/09/22, revealed the evening CMA went to remove the patch per the "Medication Record" and R20 lacked a patch.

The "Medication Record" dated 08/14/22, included that on 08/14/22, the staff administered hydrocodone-acetaminophen for the scheduled time of 07:00 PM through 10:00 PM.

The "Individual Residents Controlled Substance Record" for R20 for the hydrocodone-acetaminophen, for the bedtime dose, lacked an entry for 08/14/22. The count was correct indicating the staff did not administer the medication.

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 _____	08/25/2022

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 755	Continued From page 41	F 755		

The "ID note" dated 08/18/22 at 11:16 AM, revealed the staff notified R20's responsible party of a medication error with the hydrocodone/acetaminophen at bedtime on 08/14/22.

On 08/25/22 at 08:41 AM, Licensed Nurse (LN) J stated R20's physician faxes her progress notes, which will include order changes, two to three days after her visit to the facility. The faxes are received through the electronic fax system, which required a staff to have an email address to access the fax system. When a new progress note comes through an email arrives to the nursing staff, director of nursing, quality assurance nurse, medical records, and assistant director of nursing, and a nurse from the assisted living side. We then have a "Physician Order Flow Sheet" that was to be filled out with new physician orders and then attach the printed order to the flowsheet and place in the file box for medical records. The orders were to be noted when processed. LN J stated the flow sheet had been in place for one to two months.

On 08/25/22 at 09:41 AM, interview with Administrative Nurse E and Administrative Nurse F revealed the "Physician Order Flow Sheet" had been in place for "years." The physician progress notes which can include orders comes to the electronic fax system, and they arrive all together from all three halls, any nurse can see the notes. An agency nurse may not have an email to be able to get into the system and there was not always a facility nurse on duty each shift to access the system. When an order comes through, the nurse should print work the order following the "Physician Order Flow Sheet", make

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 _____	08/25/2022

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 755	Continued From page 42	F 755		

a note in the ID notes of the EMR, place the order with the flow sheet in the medical records box, then medical records checks to see if the nurse entered the order correctly into the EMR. The orders scanned in the EMR on 07/22/22, were not entered into the EMR system for the staff to follow. The CMA working on 08/14/22, signed she gave the medication in the EMR, but not on the controlled substance record. The staff were unable to find the Lidocaine patch due to it being removed on 08/08/22.

On 08/25/22 at 11:40 AM, Administrative Nurse D stated the orders received on 07/08/22 and scanned in on 07/22/22 were not processed and should have been. Some of the agency nurses did not have access to the system as that company did not want them to have access and we had to ask for special permission for them to get access for the frequently working agency nurses. The staff failed to check in the overflow for the Lidocaine patch, which was in stock, when they did not apply it on 08/08/22.

The facility policy " Medication Administration" dated 03/15/22, included if the medication ordered was not present to notify the charge nurse, check pharmacy delivery sheet for listing, notify pharmacy to request emergency dose, notify the physician, and retrieve the dose immediately. Prior to administering medication, the staff were to check the medication and dosage schedule on the electronic medication administration record and compare with the medication label.

The "Physician Order Flow Sheet" undated, included for all orders to enter the order in the Physician Orders and document the details of the

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 _____	08/25/2022

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 755	Continued From page 43	F 755		

order (name of medication, dose, diagnosis, treatment location, notification of DPOA (Durable Power of Attorney) and the order sent to the pharmacy. The staff were to pull up the medication record/treatment record to ensure the order displayed correctly.

The facility failed to process accurate physician orders in a timely manner and failed to administer these medications as ordered by the physician for R20.

- The diagnosis tab, located under the attachment link of the dashboard in the electronic medical record (EMR) for Resident (R)31, included a diagnosis of hypertension (high blood pressure).

The physician orders tab in the EMR included an order, dated 01/19/22, for Lisinopril (medication used to treat hypertension), 20 milligrams (mg), every day, for hypertension.

The "Interdisciplinary Notes" located in the EMR, dated 08/05/22 at 12:31 PM, revealed Certified Medication Aide (CMA) OO stated R20 received two doses of Lisinopril on 08/04/22 in the morning. The AM slot in the medication cart for R31 had a medication card of Lisinopril that was in current use for the month with a tablet popped out of the packet for 08/04/22 and another full month card for Lisinopril behind the current month card with one tablet popped out for 08/04/22 also.

The facility investigation notes revealed both cards of Lisinopril in the AM spot had the tablet for 08/04/22 "Popped out." R20 was most likely

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 _____	08/25/2022

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 755	Continued From page 44	F 755		

given two doses of Lisinopril on the morning of 08/04/22.

On 08/23/22 at 10:46 AM, CMA S stated she thought she was working when the medication error happened. At the time of the error, overflow medications were kept in an overflow area of the medication cart in the bottom drawer.

On 08/25/22 at 10:30 AM, Administrative Nurse F stated before the staff administer a medication, the staff should check to make sure they have the right resident, right medication, right dose, right route, and the right time.

On 08/25/22 at 11:42 AM, Administrative Nurse D stated before the staff administer a medication, they should follow the "five rights."

The facility policy "Medication Administration" dated 03/15/22, revealed before administering medication, the staff should check the medication and dosage schedule on the electronic medication administration record (eMAR) and compare with the medication label. The label should be read three times when removing the medication from the drawer, before and after pouring, and document on the eMAR after the staff poured the medication. If there was any discrepancy between the EMAR and the label, staff were to check the physician orders before administering the medication.

The facility failed to compare the medication to the EMAR for R31 resulting failure to follow the physician order for the resident's Lisinopril with administration of two doses of the medication instead of the ordered one.

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 _____	08/25/2022

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 755	Continued From page 45	F 755		

- The diagnosis tab on the dashboard, located in the electronic medical record (EMR) included diagnoses, for Resident (R) 38 of dementia (progressive mental disorder characterized by failing memory, confusion), hypertension (elevated blood pressure), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), atrial fibrillation (rapid, irregular heart beat), and arteriosclerotic heart disease (thickening of the walls of the arteries that supply blood and oxygen to the heart).

The "Interdisciplinary Note" (ID) note dated 08/22/22 at 01:56 PM, for R38 revealed the staff failed to administer medications to the resident as ordered by the physician, when they administered this resident another resident's medications this morning.

The facility investigation notes, for 08/22/22 revealed a Certified Medication Aide (CMA) administered R38 another resident's medications during the morning medication pass. The staff administered Aspirin (nonsteroidal anti-inflammatory medication), Vitamin D3, magnesium, and Zoloft (antidepressant medication). The facility educated the CMA that the resident MAR (medication administration record) has the resident's picture on the top left corner and after the medications are "popped" out of the card they should immediately be taken to the resident.

On 08/23/22 at 10:46 AM, CMA S stated that on 08/22/22 she wrote the name, date, and room number on the medication cups on her medication cart. She had "popped" the medications for R24 and administered them to

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 _____	08/25/2022

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 755	Continued From page 46 R38. CMA S stated she realized she had done that when she returned to the cart to get Miralax (medication used to treat constipation) and saw the medication cup with the room number of R38's. She then reported the mistake immediately to the charge nurse and the director of nursing. On 08/25/22 at 10:30 AM, Administrative Nurse F stated before the staff administer a medication, the staff should check to make sure they have the right resident, right medication, right dose, right route, and the right time. On 08/25/22 at 11:42 AM, Administrative Nurse D stated before the staff administer a medication, they should follow the "five rights." The facility policy "Medication Administration" dated 03/15/22, instructed the staff to identify the resident, and if necessary, verify resident identification with other facility personnel. The facility failed to identify the correct resident before administering medications resulting in the failure to administer R38 the correct medications as ordered by the physician, when R38 received another resident's medications.	F 755		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart.	F 756		

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 _____	08/25/2022

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 756	Continued From page 47	F 756		

§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.
(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.
(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.
(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 55 residents with 22 selected for review including 12 residents reviewed for unnecessary medications. Based on record review and interview, the facility failed to act upon the pharmacy recommendation for one of the residents, Resident (R)20.

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 _____	08/25/2022

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 756	Continued From page 48	F 756		

Findings included:

- The diagnosis tab, located at the dashboard in the electronic medical record (EMR), for Resident (R)20, included a diagnosis of hypertension (elevated blood pressure).

The "Medication Record" for 08/2022, included a physician order with a start date of 03/07/22, for instructions to administer the resident Metoprolol tartrate (medication used to treat hypertension), 50 milligrams (mg), by mouth, twice daily for hypertension.

The "Interdisciplinary Note" (ID) note, dated 05/31/22, revealed the consultant pharmacist reviewed the resident's available chart data and instructed the staff to refer to the recommendation.

The "Note to Attending Physician/Prescriber" with a print date of 05/31/22, revealed R20 was 99 years old and has had several low blood pressures and variable pulses. Please take a moment to review blood pressure and pulse data and consider if medication reduction(s) were appropriate currently, or, provide a statement below acknowledging review and desire to continue present therapy. The form included a physician signature, lacked a date when the physician signed, and lacked a response to agree, disagree, or statement acknowledging review and desire to continue the present therapy. Handwritten on the form included "noted 06/03/22" by Licensed Nurse (LN) I. The facility failed to act upon the pharmacist recommendation to ensure the physician responded to address if a medication reduction was appropriate.

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 _____	08/25/2022

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 756	Continued From page 49	F 756		

The "Progress Note" for the physician visit dated 07/07/22, revealed under the assessment section "hypertension-overmedicated." The progress note included an order to decrease Metoprolol to 25 mg, by mouth, twice daily.

On 08/25/22 at 08:41 AM, LN J stated when there are recommendations from the pharmacy reviews, the staff fax the recommendation to the doctor. If the physician declines the recommendation, we document that in an ID note, and if they agree with the recommendation, we document that in an ID note and what the new order was, then the order would be added to the EMR. LN J stated if the physician signs the recommendation, but does not include a response, she would then call the physician and add the clarification or refax the note and place it in the "report" book until the response received.

On 08/25/22 at 09:41 AM, Administrative Nurse F stated she sends the pharmacy recommendations to the physician, and they are returned via the electronic fax system program to her fax number. Administrative Nurse F stated if the physician signs the pharmacy recommendation form but does not answer a response, the recommendation form should be sent back to the physician. The recommendation printed on 05/31/22 regarding R20's low blood pressures should have been sent back to the physician for a response.

The facility did not provide a policy for processing pharmacy reviews.

The facility failed to act upon the pharmacist recommendation to ensure the physician

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 _____	08/25/2022

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 756	Continued From page 50 responded to the pharmacy consultant recommendation for R20 on 05/31/22 timely. R20 continued with low blood pressures and the physician addressed the low blood pressures on a visit on 07/07/22, with new orders to decrease the medication for hypertension, 37 days after the pharmacy recommendation.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: The facility reported a census of 55 residents with 22 residents selected for review including 12 residents reviewed for unnecessary medications. Based on record review and interview the facility	F 757		

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 _____	08/25/2022

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 757	Continued From page 51	F 757		

failed to provide adequate monitoring for Lasix, Potassium, and Metoprolol medications for one of the sampled residents, Resident (R)20, to ensure no unnecessary medication usage.

Findings included:

- The diagnosis tab, located at the dashboard in the electronic medical record (EMR), for Resident (R)20, included diagnoses of hypertension (elevated blood pressure), congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid), and pulmonary edema (accumulation of extravascular fluid in the lung tissues).

The physician orders, located in the EMR included the following:

1. Lasix (diuretic medication used to treat fluid build-up) 40 milligrams (mg), twice daily, by mouth, for edema, on 05/17/22.

2. Potassium chloride (electrolyte replacement that Lasix excretes from the body), 20 milliequivalents (mEq), twice daily, by mouth, for hypokalemia (low potassium level).

3. Metoprolol tartrate (medication used to treat hypertension), 25 mg, by mouth, twice daily, for hypertension, on 08/05/22.

The "Progress Note" for the physician visit dated 07/07/22, revealed under the assessment section "hypertension-overmedicated." The progress note included an order to decrease Metoprolol to 25 mg, by mouth, twice daily. The note included a fax date of 07/08/22. Additionally, on 07/07/22, the physician ordered laboratory testing to

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 _____	08/25/2022

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 757	Continued From page 52	F 757		

monitor the resident's Lasix, Potassium and Metoprolol with consider CBC (completed blood count-blood test that provides information about the cells in a person's blood), BMP (basic metabolic profile-blood test that measures eight different substances in the blood), and BNP (brain natriuretic peptide-blood test measures levels of a protein in the blood to provide information on how the heart is working). The physician order tab, located under the attachment link in the EMR, revealed the staff scanned in the physician visit progress note dated 07/07/22, on 07/22/22 (15 days after the physician order).

The "Interdisciplinary Note" (ID) dated 08/05/22, for R20 revealed a Certified Medication Aide (CMA) reported to the charge nurse R20's blood pressure was low this evening, reading 98/54. The charge nurse reviewed the record and found the Metoprolol had parameters for a pulse of less than 50 but no parameters for the blood pressure. Upon reviewing the EMR the nurse located an order dated 07/07/22 (over a month prior), on a progress note to decrease the Metoprolol to 25 mg, by mouth, twice daily and the ID notes lacked any physician order changes. The staff notified the physician on call, which gave orders to start Metoprolol, 25 mg, by mouth, twice daily and to obtain labs: CBC, BMP, and BNP.

On 08/25/22 at 08:41 AM, Licensed Nurse (LN) J stated R20's physician faxes her progress notes, which will include order changes, two to three days after her visit to the facility. The faxes are received through the electronic fax system, which required a staff to have an email address to access the fax system. When a new progress note comes through an email arrives to the nursing staff, director of nursing, quality

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 _____	08/25/2022

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 757	Continued From page 53	F 757		

assurance nurse, medical records, and assistant director of nursing, and a nurse from the assisted living side. We then have a "Physician Order Flow Sheet" that was to be filled out with new physician orders and then attach the printed order to the flowsheet and place in the file box for medical records. The orders were to be noted when processed. LN J stated the flow sheet had been in place for one to two months.

On 08/25/22 at 11:40 AM, Administrative Nurse D stated the orders received on 07/08/22 and scanned in on 07/22/22 were not processed and should have been. Some of the agency nurses did not have access to the system as that company did not want them to have access and we had to ask for special permission for them to get access for the frequently working agency nurses.

The "Physician Order Flow Sheet" undated, included for all orders to enter the order in the Physician Orders and document the details of the order (name of medication, dose, diagnosis, treatment location, notification of DPOA (Durable Power of Attorney) and the order sent to the pharmacy. The staff were to pull up the medication record/treatment record to ensure the order displayed correctly.

The facility failed to adequately monitor the resident's Lasix, Potassium and Metoprolol medications use to ensure no unnecessary medication usage or adverse reactions.