STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175302	A. BUILDING _____ B. WING _____	C 12/18/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #189138. The 2567 was electronically sent 12/31/24	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility reported a census of 49 residents. The sample included three residents reviewed for accidents. Based on observation, interview, and record review, the facility failed to prevent an injury to dependent Resident (R) 1 when staff failed to transfer the resident according to the resident's plan of care with two staff present. This failure resulted in R1 obtaining a 2-to-3-centimeter (cm) laceration (a cut in body skin) on her left lower extremity, which required transport to the Emergency Department and 10 sutures to treat the wound. Findings included: - R1's "Physician Order Sheet" (POS), dated 08/16/24, documented the resident had the following diagnoses: dementia (progressive mental disorder characterized by failing memory, confusion), hallucination (sensing things while	F 689		

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

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

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awake that appear to be real, but the mind created), and osteoarthrosis (chronic arthritis without inflammation).

The 08/13/24 "Admission Minimum Data Set" (MDS), documented the resident had severely impaired cognition with a "Brief Interview for Mental Status" (BIMS) score of 07. R1 required a manual wheelchair, propelled by staff for mobility. R1 required total assistance from staff with bed mobility and maximum assistance from staff with transfers. She required total assist with oral hygiene, toileting, dressing, and personal hygiene.

The "Cognitive Loss/Dementia Care Area Assessment" (CAA), dated, 08/19/24, documented the resident had a BIMS score of 07, which indicated severely impaired cognition.

The "ADL Functional/Rehabilitation Potential Care Area Assessment" (CAA), dated, 08/19/24, documented the resident required extensive assistance with Activities of Daily Living (ADL).

The "Fall Care Area Assessment" (CAA), dated, 08/19/24, documented the resident was care planned for staff assistance with transfers due to decline in mobility, increased level of assistance, and decreased safety awareness.

The 11/12/24 "Quarterly" MDS, dated 11/12/24, documented the resident had moderately impaired cognition, with a BIMS score of 8. The resident required maximum assistance by staff with her manual wheelchair. The resident did not have upper or lower functional impairment in Range of Motion. The resident meals were independent. She required partial assist with

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bathing. She required maximum assistance with bed mobility. and transfers,

R1's "Care Plan", dated 08/24/24 instructed staff to know R1 was severely cognitively impaired related to dementia. R1 required substantial/maximum assistance to total dependence by two nursing staff for ADLs.

The "Witness Statement" dated 10/23/24, at approximately 07:45 AM revealed Certified Nurse Aide (CNA) M documented she assisted the resident to stand with a gait belt. When the resident stood up, the resident complained of pain in her leg. CNA M immediately sat her down in wheelchair and observed bleeding from the left lower extremity. She reported to the Licensed Nurse (LN) H, that she did not know how the injury happened.

On 10/23/24 at 07:45 AM the "Health Status Note" documented by LN G revealed he was alerted on 10/23/24 at 07:45 AM that the resident had a skin tear to her shin. LN G cleansed the laceration and applied pressure because the laceration was bleeding profusely. The laceration was located on her left lower extremity and measured 2 to 3 centimeters (cm). At 09:00 AM, the resident's health care provider gave an order to transport the resident to the emergency department (ED) and she left for emergency department (ED) at 09:35 AM.

On 10/23/24 at 01:41 PM the "Health Status Note" documented by LN G revealed the facility received report from the ED notifying them the resident received 10 sutures and that she would be discharged on Keflex (antibiotic medication) four times a day for seven days. The resident's

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sutures would need to be removed in seven days.

R1's "Skin/Wound Note", dated 11/04/24 (after the sutures were removed) revealed R1 had an open area, which measured 3.0 cm by 2.4 cm, which were reinforced with steri-strips and covered with a foam dressing.

On 12/17/24 at 11:18 AM Certified Medication Aide (CMA) R and CNA O transferred R1 from her recliner in her room to her wheelchair, utilizing a gait belt. The resident wore non-slip black shoes. The nursing staff placed foot pedals on the resident's wheelchair and propelled her to the dining room for lunch.

On 12/17/24 at 12:10 PM CMA R reported resident care plans could be found in the Kardex for each of the residents, which included transfer status and for any changes in transfer status. CMA R reported R1 required two nursing staff for transfers.

On 12/17/24 at 01:15 PM LN G reported R1 required two staff assistance for transfer before the incident on 10/23/24 and further reported the resident continued to require two nursing staff for transfers on 12/17/24. LN G stated on 10/23/24 the facility provided education on the "Lifting & Transferring Residents Policy" and resident "Care Plan."

On 12/17/24 at 02:00 PM, Administrative Staff A reported CNA M did not follow R1's care plan by transferring the resident by herself. Administrative Staff A stated the resident's care plan clearly documented the resident required two staff members for transfers. On 10/23/24, the facility provided education on the "Lifting & Transferring

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Residents Policy" and resident "Care Plan." Each can and CMA completed a "Transferring the Resident to a Chair or Wheelchair" competency check off.

The facility "Lifting & Transferring Residents Policy" and "Care Plans", dated 10/01/21, documented the facility will provide a safe work environment for resident care area by providing and requiring the use of safety materials, equipment, and training designed to prevent injury.

The facility failed to prevent an injury to dependent R1 when staff failed to transfer the resident according to the resident's plan of care with two staff present. This failure resulted in R1 obtaining a 2-to-3-centimeter laceration on her left lower extremity, which required transport to the Emergency Department and 10 sutures to treat the wound.