STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175302	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/25/2026

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

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F0000	INITIAL COMMENTS The following citations represent the findings of a Health Recertification Survey and complaint survey regarding allegations in 2663620 and 2563164.	F0000		
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.	F0550		

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 reverse for further 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.

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

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F0550 SS = D	Continued from page 1 §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: The facility reported a census of 53 residents. The sample included 14 residents. Based on interview and record review, the facility failed to provide Resident (R)1 who had a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderately impaired cognition, care in a dignified manner during administration of medication. Findings included: - On 02/24/2026 at 08:32 AM, Licensed Nurse (LN) J moved R1 from the dining room table while she ate her breakfast. LN J propelled R1 approximately 10 feet away from the table toward the lounge that was still visible for residents in dining room. LN J applied gloves completed R1's fingerstick in the lounge. LN J lifted up R1's shirt and exposed her abdomen and administered an injection of insulin to R1's abdomen in the lounge. On 02/24/2026 at 08:39 AM LN J reported that she would always complete R1's fingerstick and administer insulin in the lounge area and reported that the residents that sat in the dining room could observe that. On 02/25/26 at 11:53 AM Administrative Nurse D revealed she expected the staff to provide care in privacy and expected the staff to complete blood sugars and insulin in the resident's room or an area that was not visible for others to observe. The facility's policy "Dignity," dated 02/2015, documented the Community would promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F0550		
F0637 SS = D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a	F0637		

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F0637 SS = D	Continued from page 2 "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is NOT MET as evidenced by: The facility identified a census of 53 residents, with 14 residents sampled. Based on observation, interview, and record review the facility failed to identify a significant change and complete an assessment for one resident reviewed for significant change assessments. Resident (R) 53 had a decline with ambulation, toileting hygiene, transfers, and bed mobility. Findings included: - R53's Electronic Medical Record (EMR) revealed diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), displaced fracture (traumatic bone break where two ends of the bone separate out of their normal positions) intertrochanteric (the area of the hip/thigh bone located between the greater and lesser trochanters left femur (thigh bone), and muscle weakness. R53's 07/15/25 "Significant Change Minimum Data Set" (MDS) documented a Brief Interview for Mental Status (BIMS) of four, which indicated severely impaired cognition. R53's MDS documented that she required moderate assistance with activities of daily living (ADL) including transfers. R53 required maximal assistance with toileting hygiene, and she was independent with bed and wheelchair mobility. R53's MDS documented ambulation was not attempted due to medical conditions or safety concerns. R53's 07/21/25 "Cognitive Loss/Dementia Care Area Assessment" (CAA) revealed R53 had impaired judgment and safety. R53 required 24-hour nursing care in a secure residence. R53's 07/21/25 "ADL Functional/Rehabilitation Potential CAA" did not trigger. R53's 09/16/25 "Medicare 5-day MDS" documented a BIMS score of four. R53's MDS documented she required total assistance with ADLs bed mobility, toileting hygiene, and transfers. Ambulation was not attempted due to medical condition or safety concerns	F0637		

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F0637 SS = D	Continued from page 3 R53's 10/21/25 " Quarterly MDS " documented a BIMS score of three. R53's MDS documented she required total assistance with ADLs bed mobility, toileting hygiene, and transfers. Ambulation was not attempted due to medical condition or safety concerns. R53's EMR lacked evidence of a significant change in condition MDS. R53's 01/30/25 "Care Plan" revealed R53 was able to make major positions changes in bed; R53's care plan was revised on 09/25/25 and R53 staff were to provide one to two maximal assistances to reposition in bed. R53's 10/31/24 "Care Plan" revealed staff were to provide maximal assistance of one for toileting. R53's care plan was revised on 09/25/25 and revealed R53 staff were to provide total assistances for toileting. R53's 07/24/25 "Care Plan" revealed staff were to provide moderate assistance of one for transfers. R53's care plan was revised on 09/25/25 and revealed R53 staff were to provide total assistances with two staff members and mechanical lift for transfers. R53's 07/24/25 "Care Plan" revealed staff instructed R53 ambulated very short distances. Staff were instructed to offer R53 a wheelchair. R53's care plan was revised on 09/25/25 and revealed R53 staff were to provide total assistances with two staff members and mechanical lift for transfers. R53's "Discharge GG Evaluation" on 09/04/2025 at 04:05 PM documented R53 toileting hygiene discharge performance R53 required supervision or touching assistance. R53's bed mobility discharge performance rolls left, and right was independent. R53's transfer discharge performance R53 required supervision or touching assistance. R53 walk 10 feet discharge performance she was independent and required supervision or touching when R53 ambulated 150 feet. R53's "Restorative Nursing Screener / GG Evaluation" on 09/17/2025 at 08:39 AM documented R53 toileting hygiene admission performance R53 required total assistance. R53's bed mobility admission performance rolls left, and right she required total assistance. R53's transfer admission performance R53 required total assistance. R53 walk 10 feet -150 feet admission performance not attempted due to medical condition or safety concerns. R53's "Health Status Note," dated 09/25/2025 at 12:33 PM, documented R53 was a mechanical lift with	F0637		

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F0637 SS = D	Continued from page 4 assistance of two staff members due to left hip fracture. Resident wears incontinence products and is occasionally incontinent of both bowel and bladder and has been using bed pan to promote continence. R53 was dependent on wheelchair for locomotion. On 02/24/26 at 04:32 PM, Certified Nurse Aide (CNA) Q reported R53 requires total assistance with her ADLs after she fractured her left hip. CMA T reported that R53 required verbal cues to complete her ADLs before she fractured her hip. On 02/25/26 at 11:53 AM, Administrative Nurse D and Consultant Nurse GG (Regional RN) the facility currently had no MDS coordinator. Consultant Nurse GG reviewed R53's documented MDSs in R53's EMR and reported that R53 should have had a significant change MDS after she fractured her left hip 09/02/25. On 02/25/26 at 01:00 PM CNA Z reported that R53 requires total assistance with her ADLs after she fractured her left hip. The facility did not provide a policy,	F0637		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F0656		

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F0656 SS = D	Continued from page 5 provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: The facility reported a census of 53 residents; there were 14 residents in the sample. Based on observation, record review and interview, the facility failed to update Resident (R) 36's "Care Plan" with interventions for R36's right hand positioning device to prevent contractions (abnormal fixations of a joint or muscle) indwelling urinary catheter (a device inserted into the bladder that drains urine into a collection bag). Findings included: - R36's Electronic Health Record (EMR) recorded the following diagnoses: hemiplegia/hemiplegia affecting the right side (muscular weakness of one half of the body) benign prostatic hyperplasia (BPH-non-cancerous enlargement of the prostate). R36's "Annual Minimum Data Set" (MDS), dated 1/20/26, documented a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition with no changes in the ADLs. R36's "Annual MDS," dated 01/20/26, documented a BIMS score of 13, indicating intact cognition. The MDS also	F0656		

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F0656 SS = D	Continued from page 6 documented R36 had right side impairment to upper and lower extremities and was dependent on staff for all "Activities of Daily" ADL's. R36's "Care plan," dated 09/06/24, revealed R36 has an ADL self-care deficit associated with cerebral infarction, R36 is totally dependent on a staff member for personal hygiene and oral care. The care plan lacked information regarding an indwelling foley catheter or a device for position of the right hand. R36's "Physician Orders," dated 2/19/26, directed to change the indwelling catheter every four weeks or as needed. Observation on 02/14/26 at 08:12 AM, R36 sat in his recliner in his room. A carrot positioning device laid on the bedside table. During an interview on 02/25/26 at 08:30 AM, Licensed Nurse (LN) G stated any of the staff can update the care plans with interventions such as the carrot positioning device and the indwelling catheter. She said she was unaware R36's "Care Plan" lacked the information. During an interview on 02/25/26 at 11:33 AM, Administrative Nurse D stated she expected all nursing staff to update the care plans. The facilities policy "Care Plan," revised 2/3/25, the person-centered plan of care is developed in conjunction with the resident and or legal representative. To identify the individual's needs, strength, preferences, health status, life history and establish obtainable goals. An appropriate plan of care with services and items the resident is to receive is developed to ensure the highest level of functioning the resident may be expected to obtain.	F0656		
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.	F0684		

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F0684 SS = D	Continued from page 7 This REQUIREMENT is NOT MET as evidenced by: The facility identified a census of 53 residents, with 14 residents sampled, including two residents reviewed for quality of care. Based on observation, interview, and record review, the facility failed to provide a mechanical lift transfer for Resident (R) 53 which resulted in an injury. Findings included: - R53's Electronic Medical Record (EMR) revealed diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), displaced fracture (traumatic bone break where two ends of the bone separate out of their normal positions) intertrochanteric (the area of the hip/thigh bone located between the greater and lesser trochanters) left femur (thigh bone), and muscle weakness. R53's 07/15/25 "Significant Change Minimum Data Set" (MDS) documented a Brief Interview for Mental Status (BIMS) score of four, which indicated severely impaired cognition. R53's MDS documented she had behaviors, wandered, rejected care, had verbal behavioral symptoms directed towards others, and physical behavioral symptoms directed towards others for 1-3 days in the lookback period. R53's MDS documented she required moderate assistance with activities of daily living (ADL) including transfers. R53's "Pressure Ulcer/Injury Care Area Assessment" (CAA) triggered related to potential for pressure injuries. The contributing factors included incontinence and impaired mobility, and the risk factors included skin breakdown and pressure injuries. The CAA noted the care plan was reviewed to reduce the risk of pressure injuries and weekly skin assessment would be completed by a licensed nurse. R53's 10/21/25 "Quarterly" MDS documented a BIMS score of three and documented the resident required total assistance with ADL, bed mobility, toileting hygiene, and transfers. R53's MDS documented she was at risk of developing pressure ulcers, and she had one unhealed, unstageable (depth of the wound is unknown due to the wound bed being covered by a thick layer of other tissue and pus) pressure injury that was not present on admission. R53's MDS documented no pressure reducing device on her bed and she was not on a turn and repositioning program. R53's "Care Plan," dated 09/25/24, revealed R53 required total assistance of two staff with a	F0684		

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F0684 SS = D	Continued from page 8 mechanical lift for transfers. R53's "Incident Progress Note," dated 11/04/25 at 09:25 AM, documented staff reported R53 had a large bruise to the left side of her chest, under her left arm. The note documented R53 said she did not know how she received the bruise. The note included the area was assessed and measured 22.5 centimeters (cm) by 9.5 cm, was purple in color with hints of red scattered throughout, and R53 complained of pain when the area was touched. Review of facility's risk management documentation, dated 11/17/25, revealed the facilty found staff transferring R53 with two staff assistance and a gait belt. The documentation noted R53 was care-planned for two staff assistance and a mechanical lift (for transfers). The documentation included the facility provided education, instructed staff to follow the care plan, and provided instructions on how to locate the care plan and Kardex. On 02/24/2026 at 03:12 PM, Certified Medication Aide (CMA) T reported the staff looked in the EMR in the Kardex to know what skin interventions a resident required. On 02/25/2026 at 09:27 AM, Licensed Nurse (LN) G reported the Certified Nurse Aides (CNA) and CMAs were educated to update the nurse when a resident had a skin concern. LN G stated when a resident had a bruise or skin tear and could not say how that happened or it was not witnessed, the staff completed an incident report. LN G said Administrative Nurse D would complete an investigation. LN G said the CNAs should follow the residents care plan interventions for resident safety. On 02/25/26 at 11:53 AM, Administrative Nurse D said she expected all the staff to follow the care plan to keep residents safe and prevent injuries. The facility's policy "Care Management," dated 02/03/25, documented management of resident care is conducted systematically and comprehensively by interdisciplinary team knowledgeable in current concepts of geriatric care. Resident care is designed to meet a resident's individual needs. Coordination of the plan of care is the responsibility of nursing; however, planning, implementation and evaluation require joint participation by each discipline rendering service.	F0684		
F0686 SS = G	Treatment/Svcs to Prevent/Heal Pressure Ulcer	F0686		

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F0686 SS = G	Continued from page 9 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 identified a census of 53 residents, with 14 residents sampled, including two residents reviewed for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). Based on observation, interview, and record review, the facility failed to identify and implement pressure ulcer preventative measures, consistent with professional standards of practice, to prevent the development of a facility acquired stage three pressure ulcer to Resident (R)53's left heel after R53 returned from the hospital, due to surgical repair of her left hip fracture. Findings included: - R53's Electronic Medical Record (EMR) revealed diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), displaced fracture (traumatic bone break where two ends of the bone separate out of their normal positions) intertrochanteric (the area of the hip/thigh bone located between the greater and lesser trochanters) left femur (thigh bone), and muscle weakness. R53's 07/15/25 "Significant Change Minimum Data Set" (MDS) documented a Brief Interview for Mental Status (BIMS) of four, which indicated severely impaired cognition. R53's MDS documented that she had behaviors, wandered, rejected cares, had verbal behavioral symptoms directed towards others, and physical	F0686		

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F0686 SS = G	Continued from page 10 behavioral symptoms directed towards others for 1-3 days in the lookback period. R53's MDS documented that she required moderate assistance with activities of daily living (ADL), including transfers. R53 required maximal assistance with toileting hygiene, and was independent with bed and wheelchair mobility. R53's MDS documented ambulation was not attempted due to medical conditions or safety concerns. The MDS documented she was at risk of developing pressure ulcers, had no skin issues, no pressure-reducing device in her wheelchair, and was not on a turning and repositioning program. R53's 09/16/25 "Medicare 5-day MDS " documented a BIMS score of four, which indicated severely impaired cognition. R53's MDS documented that she required total assistance with ADLs, bed mobility, toileting hygiene, and transfers. The MDS documented she was at risk of developing pressure ulcers, had an open lesion on her foot, no pressure-reducing device on her bed, and was not on a turning and repositioning program. R53's EMR lacked evidence of a significant change in condition MDS. R53's 10/21/25 "Quarterly" MDS documented the resident had one unhealed and unstageable (depth of the wound is unknown due to the wound bed being covered by a thick layer of other tissue and pus) pressure ulcer, not present on admission. The MDS documented R53 had no pressure-reducing device on her bed, and she was not on a turning and repositioning program. R53's "Pressure Ulcer/Injury Care Area Assessment" (CAA) triggered related to her potential for pressure injuries. The contributing factors included incontinence and impaired mobility, and the risk factors included skin breakdown and pressure injuries. The CAA noted the care plan was reviewed to reduce the risk of pressure injuries, and a weekly skin assessment would be completed by a licensed nurse. R53's "Care Plan," dated 09/25/24, revealed R53 required total assistance of two staff with a mechanical lift for transfers. The staff were instructed to cleanse the left heel with wound cleanser, pat dry with gauze, apply Skin-prep (liquid skin protectant) to peri-wound (skin surrounding the wound), cut the calcium alginate (highly absorbent dressing) to the size of the wound bed, and apply to the wound bed, cover dressing with Aquacel (a soft, sterile dressing). R53's "Care Plan," dated 09/26/25, revealed staff were to provide a pressure-reducing mattress and float both	F0686		

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F0686 SS = G	Continued from page 11 of the resident's heels while in bed, to prevent pressure at the bony prominences. R53's "Braden Scale" (scale used to predict pressure ulcer risk), dated 07/09/25 at 08:08 AM, documented a score of 18, which indicated at risk. R53's "Progress Note," dated 09/02/25 at 09:29 PM, revealed that R53 was admitted to the hospital for a fracture of her left hip. R53's "Skin/Wound Note," dated 09/11/25 at 03:17 PM, documented that staff completed an admission skin and wound assessment after returning from the hospital. The note documented that the resident had no wounds to her back, bottom, and/or feet/heels. R53's "Braden Scale," dated 09/11/25 at 04:55 PM, documented a score of 13, which indicated moderate risk. R53's "Dietary Note," dated 09/15/25 at 01:18 PM, documented no open skin issues. R53's "Skin/Wound Note," dated 09/16/25 at 12:09 PM, documented that staff changed the bandage on R53's left heel and noted the wound was from a blister that opened. The wound bed was pink with a dark center area, with minimal drainage. The edges were present from where the skin was removed. Skin prep was applied to the peri wound, and staff placed a bordered heel dressing. A picture of the wound was taken and sent to the Director of Nursing and the provider. R53's "Skin/Wound Note," dated 09/16/25 at 03:00 PM, documented that the facility received verbal consent from the resident's durable power of attorney (DPOA- a legal document that names a person to make healthcare decisions when the resident is no longer able to) for evaluation and treatment from the wound clinic. R53's first visit to the clinic would be 09/19/25. The note indicated current interventions that were in place and that they were reviewed with the DPOA. R53's "Health Status Note," dated 09/18/25 at 12:16 PM, documented R53 had an open wound on the left heel, required heels to be floated, and the wound to be covered with Aquacel foam dressing. The wound clinic would be in the next day to evaluate. R53's 09/18/25 "Physician's Orders" included for staff to apply skin prep to R53's right heel, every shift, for the prevention of skin breakdown. The order instructed staff to float both of the resident's heels	F0686		

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F0686 SS = G	Continued from page 12 while in bed to prevent pressure of bony prominences, every shift. R53's "Progress Note," dated 09/19/25 at 06:45 AM, documented that staff pulled the sheets back to reposition the resident and saw dry red streaks of blood embedded in the fitted sheet. The staff checked R53's skin and located an open blister on the left heel and assumed R53 rubbed the left heel open against the bed/sheet, exposing the blister. The staff found a flap of skin hanging (from the blister) and noted the blister was not present/noticed prior to this day. R53's "Health Status Note," dated 09/24/25 at 01:39 PM, documented that R53 was discussed in weekly risk management with the interdisciplinary team present for dates 09/17/25 - 09/24/25. The note revealed the resident continued with an open wound to the left heel that was followed by wound clinic. The next visit was scheduled for 09/26/25. Current treatment was to cleanse the area with wound cleanser, apply skin prep to the peri wound, apply calcium alginate, and cover with Aquacel foam dressing. The resident's heels were floated with protective booties while in bed. R53's "Order Note," dated 09/26/25 at 11:12 AM, documented an order received from the wound care clinic provider for the left heel. Staff would cleanse the area with wound cleanser and pat dry with gauze. Apply skin prep to the peri-wound area. Apply a thin layer of Santyl (prescription ointment is used to remove damaged tissue from skin ulcers) ointment to the wound bed. Cut calcium alginate to fit the size of the wound bed and apply it, then cut an additional piece of calcium alginate to cover the remaining open area of the heel. Cover the wound with an Aquacel Foam dressing. Change daily and as needed. R53's 09/29/25 "Physician's Orders" documented the resident had a low air loss mattress and the staff were to check to ensure the mattress was plugged in and inflated to manufacturer settings, every shift. R53's "Nutritional Note" dated 10/01/25 at 11:47 AM documented that R53 received wound care treatment to an open area noted on her left heel. The note further revealed: On 09/19/25, the resident had a new open area to the left heel, which measured 9.73 centimeters (cm) by 4.02 cm by 3.31 cm. On 09/26/25, the resident's left heel open area measured 9.07 cm by 4.00 cm by 3.2 cm.	F0686		

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F0686 SS = G	Continued from page 13 R53's 10/03/25 "Physician's Orders" included providing R53 with ProSource (nutritional supplement to promote wound healing), give 30 milliliters (ml), by mouth two times a day for wound healing. R53's "Order Note," dated 10/10/25 at 08:00 PM, documented that staff were to cleanse the resident's left heel with hypochlorous acid (a natural, weak acid produced by human white blood cells to fight infections and inflammation) and pat dry with gauze. Then, apply skin prep to the peri-wound area, apply a thin layer of Santyl ointment to the wound bed, cut calcium alginate to fit the size of the wound bed and fill the deepest part, cut an additional piece of calcium alginate to cover the remaining opened area, avoiding contact of the peri wound, and cover the wound with an Aquacel foam dressing. The staff were to change the dressing daily and as needed. R53's "Nutritional Note" dated 10/13/25 at 11:02 AM documented the following: On 10/03/25, the left heel open area measured 6.33 cm by 3.38 cm by 2.45 cm. On 10/10/25, the left heel open area measured 2.75 cm by 2.15 cm by 1.78 cm. R53's "Skin Issue Note," dated 11/14/25 at 02:49 PM, documented that the wound characteristics had improved and documented the wound as a Stage 3 (full-thickness pressure injury extending through the skin into the tissue below) pressure ulcer wound, acquired in-house. The wound was noted as greater than three months and staged by the wound clinic. The left heel wound measured 1.7 cm by 1.2 cm by 0.2 cm with 1.5 cm undermining (a serious complication where tissue destruction occurs under the skin edges, creating a hidden pocket or "shelf" beneath intact skin, often making the wound much larger than appears on the surface). R53's 01/05/26 "Physician's Orders" included that the resident had a wound to her left heel, and staff were to cleanse with hypochlorous acid, apply a collagen pad, and cover with bordered foam dressing. Change every three days and as needed for wound healing. R53's EMR lacked documentation of wound clinic notes. On 02/24/26 at 04:32 PM, Certified Nurse Aide (CNA) Q reported that when R53 readmitted from the hospital on 09/11/25, R53 did not have an air mattress on her bed	F0686		

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F0686 SS = G	Continued from page 14 or heel booties. CNA Q reported R53 was not on a turn and reposition schedule and reported she had told the nurse that R53's heels were red. CNA Q reported that R53 received an air mattress and a float for heels after her left heel had a wound. On 02/25/26 at 11:53 AM, Administrative Nurse D and Consultant Nurse GG (Regional RN) reported they expected preventative skin interventions to be in place to avoid a pressure ulcer. Consultant Nurse GG reviewed R53's care plan in EMR and revealed that R53's preventative skin interventions were not provided until after R53 had a pressure ulcer. The facility policy "Skin Integrity: Pressure Ulcer/Injury Prevention, Nursing Intervention and Wound Treatment," dated 10/14/24, documented that all residents are considered to have a potential risk for the development of pressure ulcers. Nursing staff would evaluate skin integrity, implement preventative measures as indicated and treat skin breakdown. Implement pressure ulcer/ injury preventative measures to maintain intact skin.	F0686		
F0689 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 had a census of 53 residents and the sample included 14 residents. Based on observations, record review and interview, the facility failed to ensure an environment free of accident hazards for Resident R 53 who obtained ahip fracture during a fall and R23 when a Certified Nurse Aide transferred her without a gait belt causing a fall. Findings included: - R53's Electronic Medical Record (EMR) revealed diagnoses of dementia (a progressive mental disorder	F0689		

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F0689 SS = G	Continued from page 15 characterized by failing memory and confusion), displaced fracture (traumatic bone break where two ends of the bone separate out of their normal positions) intertrochanteric (the area of the hip/thigh bone located between the greater and lesser trochanters left femur (thigh bone), and muscle weakness. R53's 04/15/25 "Quarterly Minimum Data Set"(MDS) documented a Brief Interview for Mental Status (BIMS) of four, which indicated severely impaired cognition. No behavior. R53's MDS documented that she was independent with transfers and ambulation and had one noninjury fall. R53's 07/15/25 "Significant Change MDS" documented a BIMS of four, which indicated severely impaired cognition. R53's MDS documented she had behaviors, wandered, resident rejected care, verbal behavioral symptoms directed towards others, and physical behavioral symptoms directed towards others for 1-3 days in the lookback period. R53's MDS documented that she required moderate assistance with activities of daily living (ADL), including transfers. R53 required maximal assistance with toileting hygiene, and she was independent with bed and wheelchair mobility. R53's MDS documented ambulation was not attempted due to medical conditions or safety concerns. R53's MDS documented one major fall with injury. R53's 07/21/25 "Falls Care Area Assessment" (CAA) documented CAA triggered related reported falls during the look-back period. Contributing factors include decreased safety awareness. Risk factors include falls and injuries from falls. The care plan would be reviewed to ensure proper interventions are in place to reduce the risk of falls. R53's 10/31/24 "Care Plan" revealed that education was provided to the resident/family/caregivers about safety reminders and what to do if a fall occurred. Staff were directed to ensure R53 were wearing non-skid footwear when ambulating or mobilizing in a wheelchair. Staff were instructed to follow facility fall protocol. Staff were instructed to provide R53 with a soft-touch call light and keep close to R53 when she was alone. R53's 06/04/25 "Care Plan" revealed that the staff were to provide non-slip strips on the floor in front of R53's recliner. R53's 07/02/25 "Care Plan" revealed staff instructed to ensure R53's bags she carried were lightweight to aid in resident balance.	F0689		

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F0689 SS = G	Continued from page 16 R53's 07/24/25 "Care Plan" revealed that R53 ambulated very short distances. Staff were instructed to offer R53 a wheelchair. R53's 07/24/25 "Care Plan" revealed that staff were to provide assistance for R53's transfers. R53's EMR "Fall Risk Evaluation" reviewed from 04/10/25 through 10/11/25 documented that R53 was a high risk for falls. R53's "Progress Note," dated 07/02/25 at 05:02 AM, documented at about 03:55 AM, staff found the resident lying on her left side at the beginning of the hallway. Next to the resident were two full purses and a book she was carrying. R53 was unable to give a description of what happened. The resident voiced that she was hurting once she was turned to her back and observed a massive purple bump on her left forehead near her left eye. R53's hand had a hematoma (a collection of blood trapped in the tissues of the skin or in an organ, resulting from trauma) the size of her hand on the back side, which was growing. Provider and durable power of attorney (DPOA- a legal document that names a person to make healthcare decisions when the resident is no longer able to) were notified, and R53 was transferred to the hospital. R53's "Progress Note," dated 07/02/25 at 12:09 PM, documented R53 returned from the hospital with a left hip fracture (broken bone). R53's "Progress Note," dated 07/08/25 at 12:44 PM, R53 returned from orthopedic appointment to always wear brace except for bathing for six weeks. R53's "Progress Note," dated 08/14/25 AM at 12:06 PM, documented R53 required one staff member's limited assistance with ADLs, transfers, and ambulation. R53 continued carrying both heavy purses while ambulating and got upset at the staff when they tried to carry them for the resident. R53's "Progress Note," dated 08/21/25 AM at 01:48 PM, documented R53 required one staff member's limited assistance with ADLs, transfers, and ambulation. R53 continued carrying both heavy purses while ambulating and got upset at the staff when they tried to carry them for the resident. R53's "Progress Note," dated 09/02/2025 at 11:23 AM, documented that R53 had fallen in the living room at approximately 09:57 AM. R53 was lying on her back,	F0689		

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F0689 SS = G	Continued from page 17 looking up to the ceiling with her legs facing the center of the living room, with pillows under her head. R53 was grimacing with pain and had rapid respirations. Staff reported that R53 had lost her balance and fallen on her left side and was in a left lateral position. Staff reported they assisted R53 to her back. There were no visual injuries to the resident at that time. R53's "Progress Note," dated 09/02/2025 at 11:35 AM, documented orders received to send R53 to the hospital for an evaluation. DPOA notified and transferred R53 at 10:45 AM. R53's "Progress Note," dated 09/02/2025 at 09:29 PM, documented that R53 was admitted to the hospital with a left hip fracture. Review of the facility's "Post Fall Root Cause Analysis," dated 07/07/25, documented that R53 was carrying extremely heavy bags, which caused her to lose her balance and fall. Review of the facility's "Post Fall Root Cause Analysis," dated 09/03/25, documented that staff reported to charge nurse R53 fell in the Haury living room, and as reported, R53 lost her balance and fell to her left side. The resident was unable to report how she fell. Immediate intervention when R53 was walking in a highly congested area, the staff were to walk with the resident. Review of the facility's "Facility Reportable Incident 2606988" dated 09/09/25 documented R53 had tripped on another resident's foot while coming back into the living room, walking between furniture and other residents. Certified Nurse Aide (CNA)/(Life Enrichment Staff) FF assisted R53 to her back. The statements lacked that a staff member witnessed the fall. The facility investigation lacked the video from the camera was reviewed. Review of "Complaint Investigation Witness Statement of Facts" dated 09/02/25 documented Licensed Nurse (LN) EE stated at approximately 09:55 AM LN EE entered the Haury Hall and observed R53 ambulating in the living room area. R53 wore her tennis shoes and carried her pick bag, which appeared to have only a jacket in it. LN EE stated she was standing behind the chair, speaking to CNA FF, and stated she heard R53 hit the ground; however, she stated she did not see the actual fall.	F0689		

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F0689 SS = G	Continued from page 18 Review of “Complaint Investigation Witness Statement of Facts,” dated 09/02/25, documented that CNA FF stated she was talking to someone, and she looked to her right at that time, R53 fell and landed on her left side. CNA FF stated R53 fell hard. On 02/24/26 at 04:32 PM, CNA Q reported that R53 was very unsteady when she walked, and staff were instructed to give her a wheelchair if she was up ambulating. CNA Q reported that R53 continued to carry her heavy pink bag and would not let the staff carry it for her. CNA Q reported that sometimes R53 did not want to use the wheelchair, so staff would walk with her. CNA Q reported that R53’s room was room nine and that it was approximately 100 feet from the lounge. CNA Q reported that R53 did not ambulate after she fractured her left hip. On 02/25/2026 at 10:06 AM, LN K reported that R53 would ambulate with staff assistance. LN K reported that R53 was sleepy, and the staff would assist her into a wheelchair. On 02/25/26 at 01:00 PM, CNA Z reported that R53 required a staff member to walk with her and reported that R53 was unsteady and could not walk long distances. CNA Z reported that staff would offer R53 a wheelchair and R53 could propel herself in the wheelchair. CNA Z reported that R53 carried heavy bags and would not allow the staff to carry the bags for her. On 02/25/25 at 02:30 PM, Administrative Staff A reported that she determined that R53 had tripped over another resident’s foot as she watched the video. Administrative Staff A reported that she failed to document that she reviewed the video in the facility report, and she did not request a download to save the video when R53 fell on 09/02/25. Administrative Staff A reported that the fall was witnessed by CNA FF and requested that she be called for a statement. Administrative Staff A reported that CNA FF had already completed a statement on 09/02/25 that did not have documentation that the fall was witnessed. The facility’s policy “Falls,” dated 11/01/24, documented that residents would be identified for risk of falls and interventions implemented to reduce risk. - R23’s “Electronic Medical Record” (EMR), dated 2/2/26, revealed the following diagnoses: dementia (progressive mental disorder characterized by failing memory, confusion) and abnormal gait and mobility.	F0689		

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F0689 SS = G	Continued from page 19 R23's "Significant Minimum Data Set" (MDS), dated 04/22/25, revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating moderately impaired cognition. She had rejected care for one to three days during the seven-day look-back period. R23 had two or more falls since admission with no injuries. R23's "Quarterly" MDS, dated 01/13/26, revealed a BIMS score of 15, indicating intact cognition. She had verbal and behavioral symptoms directed toward others for one to three days during the look-back period. R23's "Care Plan," dated 08/27/24, noted R23 was at moderate risk for falls related to safety awareness with the diagnosis of dementia. The plan lacked direction to staff related to transfer until 02/18/26, when an intervention was added to the care plan to transfer the resident with a two-person assist and a gait belt. R23's "Nurse's Notes," dated 2/18/26 at 06:20 PM, documented at 04:50 PM during a one-person transfer from the recliner to the wheelchair, R23's knees buckled, which caused her to fall to the floor, landing on her right knee and left cheek. Staff transferred R23 from the floor to the wheelchair with the assistance of two people. A "Nurses Notes," dated 02/24/26 at 04:11 PM, reviewing the fall on 02/18/26 documented R23 was being assisted using a pivot transfer; her knees buckled, and the resident fell to the floor. The staff member was not using the gait belt. Immediate interventions, including one-to-one education with staff to use a gait belt for transfers, were completed. Observation on 02/24/26 at 09:09 AM, R23 was up in her recliner, drinking her coffee. During an interview on 02/24/26 at 10:29 AM, Certified Nurse Aide (CNA) KK revealed R23 now required a two-person transfer. During an interview on 02/25/26 at 11:35 AM, Administrative Nurse D stated that a staff member had transferred R23 without a gait belt, which caused her to fall. Administrative Nurse D said the facility did a teachable moment with the staff member, and she expected the staff to use a gait belt with proper technique on transfer. The facilities policy "Falls", revised 11/1/24, documents that residents will be identified for risk of falls and interventions implemented to reduce risk. The	F0689		

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F0689 SS = G	Continued from page 20 resident's high-risk status will be documented on the comprehensive plan of care or service plan.	F0689		
F0732 SS = C	Posted Nurse Staffing Information CFR(s): §483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors.	F0732		

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

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F0732 SS = C	Continued from page 21 §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: The facility reported a census of 53 residents. Based on observation, interview and record review the facility failed to ensure the posted daily nurse staffing sheets were posted daily as required. Findings included: - An observation on 02/24/26 at 1:38 PM revealed the three houses Haury, Claassen, and Ute did not have an accurate staffing sheet posted. The last date noted was 01/13/26. On 02/25/26 at 12:30 PM, Administrative Staff A stated the staffing sheets should be posted daily with each shift's information completed. The facilities policy "Daily Nurse Staffing Report," reviewed 08/18/25, documented that nursing service is to provide each resident admitted to health care center with the appropriate level of care to attain his/her optimum level of functioning. Daily at the beginning of each shift identify the toral number of staff and actual hours worked for the following licensed and unlicensed staff directly responsible for resident care.	F0732		
F0757 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	F0757		

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F0757 SS = D	Continued from page 22 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 identified a census of 53 residents. The sample included 14 residents, with five residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 1's hypoglycemic (medication used to lower blood glucose levels) medication levels were monitored to determine the effectiveness of her ordered hypoglycemic medication. Findings included: - The Electronic Medical Record (EMR) for R1 documented a diagnosis of diabetes mellitus. R1's 07/29/25 "Annual Minimum Data Set (MDS)" documented a Brief Interview for Mental Status (BIMS) score of 10, which indicated intact moderately impaired cognition. R1's MDS revealed she received seven days of insulin injections and also received hypoglycemic medications. R1's 08/05/25 "Cognitive Loss/Dementia Care Area Assessment" (CAA) documented that R1 had impaired judgment and had memory deficits noted. Needed staff support. R1's "Care Plan," 08/26/2024, revealed an altered endocrine status related to hyperglycemia (greater than normal amount of glucose in the blood) and hypoglycemia (less than normal amount of sugar in the blood) due to	F0757		

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F0757 SS = D	Continued from page 23 the diagnosis of diabetes mellitus. R1's 02/23/26 "Care Plan" lacked monitoring of laboratory for diabetes mellitus. R1's 09/04/24 "Physician Orders" documented Jardiance (medicine used to lower blood sugar), give 25 milligrams (mg), by mouth one time a day for diabetes. R1's 09/04/24 "Physician Orders" documented glargine (long-acting insulin), give 10 units subcutaneously (beneath the skin) at bedtime for diabetes. R1's 09/08/24 "Physician Orders" documented Januvia (used to improve blood sugar control), give 100 mg, by mouth one time a day for diabetes. R1's 10/03/24 "Physician Orders" documented Humalog (rapid-acting insulin), give 10 units subcutaneously (beneath the skin) once a day for hyperglycemia. R1's 10/04/24 "Physician Orders" documented Humalog insulin, give 8 units subcutaneously once a day for hyperglycemia. R1's 07/01/25 "Physician Orders" documented a complete blood count (CBC- laboratory blood test), complete metabolic panel (CMP-laboratory blood test), and hemoglobin A1c (HbA1c-blood test used to evaluate the level of glucose control over the past 90 days) every six months for an old myocardial infarction (heart attack). R1's EMR revealed HbA1c was completed on 07/01/25. R1's EMR revealed that a CBC was completed on 08/01/25. R1's EMR revealed a CMP completed on 01/02/26. R1's EMR lacked evidence that a CBC and HbA1c were completed on 01/02/26. On 02/24/26 at 03:00 PM, R1 lay in bed with eyes closed. On 02/25/2026 at 08:03 AM, Administrative Nurse E reported that R1's CBC and HbA1c were not completed. Administrative Nurse E reported R1's January medication administration record had the CBC, CMP, and HbA1c, but there was no note documenting why they were not completed or rescheduled. Administrative Nurse E reported she expected the physician orders to be followed.	F0757		

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F0757 SS = D	Continued from page 24 On 02/25/2026 10:20 AM, Administrative Nurse E reported that the routine laboratory blood drawings would be completed every Tuesday by the outside laboratory staff on the day shift, and the charge nurse was responsible for having blood drawings completed. The facility's "Drug Regimen Review," dated 08/2024, documented that a resident's medication regimen would be reviewed monthly and as needed by a licensed pharmacist to monitor current or potential impact as indicated by laboratory values. The community would ensure that the pharmacist had access to residents' laboratory tests.	F0757		
F0814 SS = C	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is NOT MET as evidenced by: The facility reported a census of 53 residents. Based on observation and interview, the facility failed to maintain and or dispose of kitchen garbage refuse properly. Findings included: - During the initial tour of the kitchen on 02/23/26 at 08:50 AM, observation of the outside garbage bins with Certified Dietary Manager (CDM) BB revealed one trash bin with trash on top of the bin. During an observation on 02/24/26 at 6:00 PM, the facility has a garbage bin across the street from the facility with a bag of trash on top of the bin. During an observation on 2/25/26 at 7:55 AM, the facility's garbage bin across the street from the facility the lids to the bins were not closed. During an interview on 02/25 at 10:20 AM, CDM BB stated he expected the trash to be inside the bins, not on top, and the lids should be closed. The facility policy "Dumpster and Trash Compactor," undated, documents to ensure lids are correctly closed after use.	F0814		
F0880 SS = F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F0880		

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F0880 SS = F	Continued from page 25 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with	F0880		

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F0880 SS = F	Continued from page 26 residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: The facility reported a census of 53 residents with 14 residents included in the sample. Based on observation, interview, and record review the facility failed to effectively utilize Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high care) and failed to follow established infection control practices related to hand hygiene, peri-care, medication administration, and cleaning of resident nebulizers. The facility further failed to cover resident clean clothing while transporting it through the hallway. Findings included: - On 02/23/26 at 11:22 AM, Certified Medication Aide (CMA) T and Certified Nurse Aide (CNA) M brought Resident (R) 43 to her room in her wheelchair. The entrance door to the resident's room had signage placed directing staff that the resident required enhanced barrier precautions (EBP) when providing direct care, which included catheter care, wound care, transfers, and toileting. R43 required PPE, which included gowns and gloves. The PPE set-up was at the entrance to the resident's room, and CMA T and CNA M applied gloves and positioned a gait belt around R43. The aides reported that R43 needed to lie down to receive wound care on her feet and coccyx (tailbone). CNA N joined CNA M and	F0880		

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F0880 SS = F	Continued from page 27 CMA T to assist with the transfer of the resident. CNA N sanitized his hands and applied gloves, but none of the three staff present put on a gown. One of the aides emptied the resident's urinary catheter without a gown in place. After they transferred R43 from the wheelchair to the bed, they rolled the resident to her right side, placed a turn sheet beneath her, positioned her in the bed, and CNA N then placed his gloved hands in his pockets. CNA M removed her gloves, did not perform hand hygiene, and picked up a sheet and blanket to fold them without performing hand hygiene after removing her gloves. CNA M exited the resident's room without performing hand hygiene. CNA M reported it was her understanding that staff were to use gloves and gowns with EBP when providing direct contact and catheter care. After reading the sign on the resident's door, CNA N, CNA M, and CMA T agreed they should have used a gown as well as gloves when providing direct care to the resident due to wounds and/or a urinary catheter. On 02/23/26 at 12:03 PM, Consultant HH, Consultant II, Consultant JJ, and Administrative Nurse FF provided wound care for R43 without wearing a gown. They confirmed the resident had open wounds on her coccyx, right ankle, and right lateral foot toward the heel. They obtained measurements, pictures, and provided wound care without wearing gowns. On inquiry, Consultant HH stated she did not realize the resident had a catheter, but confirmed she was aware she had wounds. Consultant HH stated the staff should probably wear a gown when providing direct care to R43. On 02/24/26 at 08:32 AM, Licensed Nurse (LN) J positioned R1's feet on her foot pedals prior to moving her from the dining room table. LN J then applied gloves without sanitizing her hands, checked R1's blood sugar, administered the resident's insulin, and assisted R1 back to the table. LN J then went back to the lounge, moved her cart with R1's supplies, took her gloves off, removed the medication cart keys from her pocket, and placed the box back into the cart without sanitizing her hands. On 02/24/26 at 08:39 AM, LN J confirmed she should have washed/sanitized her hands when her gloves came off and did not. On 02/24/26 at 09:22 AM, LN J removed R57's breathing treatment medication from the box and confirmed the medication. She then went to R57's room and knocked on his door. R57's nebulizer (machine used to deliver breathing treatment) mask laid directly on the nightstand, with an unidentified liquid still in the	F0880		

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F0880 SS = F	Continued from page 28 medication chamber. The mask and medication delivery chamber were not taken apart, and/or placed on a barrier, air drying from the prior administration. LN J added the new medication in the nebulizer chamber (with the existing unidentified liquid), placed the mask standing upright on the machine, and told R57 she would be back. LN J then removed the gloves she had worn since she entered the room and performed hand hygiene. LN J reported that R57 was recently admitted to the facility, and he was able to complete his own breathing treatment. She reported that the nebulizer should have been rinsed out and stored in its own box that was kept in the medication room. On 02/24/26 at 03:47 PM, Administrative Nurse E stated she expected staff to rinse out and air dry the nebulizer after each use. On 02/24/26 at 10:57 AM, CMA S and CNA P propelled R4 into her room. After getting the resident to bed, CMA S and CNA P pulled R4's pants down and opened her wet brief. CMA S cleaned R4's peri-area, removed her glove from her left hand, and kept her right one on. She rolled the resident towards the wall, and CNA P cleansed her buttocks. While continuing to wear the gloves she used during peri-care, CNA P opened the drawer again and removed a bottle of powder, which she applied to R 4's front groin area. They then applied a clean brief, pulled up her pants, removed their gloves, and transferred R4 back to her wheelchair without performing hand hygiene after removing their gloves. On 02/24/26 at 11:08 AM, Housekeeping Staff V carried a resident's clean personal clothing on hangers, uncovered, in the hallway. Housekeeping Staff V reported she did not cover the resident's personal clothing when she delivered it. On 02/24/26 at 01:01 PM, LN G entered R15's room, washed her hands, put on gloves, put on a gown, and tied her gown. She used her gloved hands to touch the resident's wheelchair handles to move the wheelchair away from the bed. LN G touched the resident's feet, repositioned him in the bed, opened the wound dressing packages, placed a date on the bandage, removed the soiled dressing from his right foot, picked up the wound cleanser, placed Santyl (debriding ointment) directly on the open wound, and applied dressing with the same gloves. LN G proceeded to provide the same care to the resident's left foot. She did not remove her gloves or perform hand hygiene throughout the observation. On 02/24/26 at 01:32 PM, LN G stated she should have	F0880		

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F0880 SS = F	Continued from page 29 placed a barrier before setting up the resident's wound dressing supplies, changed her gloves between dirty and clean tasks, as well as performed hand hygiene when removing her gloves and prior to reapplying gloves to prevent cross-contamination and/or the spread of infection. On 02/25/26 at 11:33 AM, Administrative Nurse D stated she expected staff to follow EBP protocol, which included personal protective equipment (PPE) as outlined on the signage on the resident's door. She stated gowns and gloves should be worn when providing direct care to residents with catheters, wounds, and anyone with an artificial opening into their body. Hand hygiene should be performed upon entering a resident's room, prior to applying gloves, in between glove changes, after removing gloves, and anytime going from a dirty task to a clean task to prevent cross-contamination and prevent the spread of infection. The facility policy titled "Enhanced Barrier Precautions," dated 02/03/25, included Enhanced Barrier Precautions (EBP), which are an effective infection control intervention used to reduce the transmission of multidrug-resistant organisms in skilled and long-term care nursing facilities. EBP involves the use of PPE, specifically gowns and gloves, during high-contact resident care activities. The facility policy titled "Hand Hygiene," dated 02/03/25, included that all staff members will comply with current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines, as effective hand hygiene reduces the incidence of healthcare. Indications for hand washing include: Before and after removing gloves Before and after medication administration Before and after having direct contact with residents. Before and after contact with residents' intact skin, such as assisting residents with activities of daily living, transfers, and repositioning. Moving from a contaminated body site to a clean body site during resident care. Gloves reduce hand contamination by 70-80%, prevent contamination, and protect elders and healthcare personnel from infection. However, the use of gloves does not eliminate the need for hand hygiene. Change	F0880		

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F0880 SS = F	Continued from page 30 gloves during elder care if moving from a contaminated body site to a clean body site during resident care. The policy titled “Nebulizer Cleaning Instructions,” dated 02/03/25, documented that after each treatment, staff would rinse the resident’s nebulizer and mouthpiece/mask with tap water, allow it to air dry, and store it in an open Ziploc bag or container after the nebulizer components dried. Staff would wipe down the outside of the machine, using a damp cloth. After the last treatment of the day, staff would completely disassemble the nebulizer, including the mouthpiece/mask.	F0880		
F0881 SS = F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is NOT MET as evidenced by: The facility reported a census of 53 residents with 14 included in the sample. Based on interview and record review the facility failed to ensure staff adhered to the principles of antibiotic stewardship through the lack of monitoring for the appropriate use of prescribed antibiotics to prevent antibiotic resistance and the spread of multidrug resistant organisms within the facility. Findings included: 1. Upon request, the facility failed to provide antibiotic and infection surveillance logs for 02/01/26 through 02/24/26, which demonstrated the facility did not track infections/antibiotic use within the facility for this month. The facility further failed to identify any commonalities, patterns, or trends related to infections/antibiotic usage to ensure residents were not administered ineffective antibiotics to prevent antibiotic resistance and the spread of multidrug-resistant organisms. On 02/24/2026 at 02:37 PM, Administrative Nurse E	F0881		

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F0881 SS = F	Continued from page 31 stated the facility used McGreer's Criteria (standardized guidelines used to identify and count infections in long-term care settings) for determining the appropriateness of antibiotic use. Administrative Nurse E verified the facility lacked evidence of antibiotic tracking and trending and/or documentation regarding how a determination of the appropriate use of antibiotics was made when antibiotics were prescribed by a physician. 2. Review of R 9's "Incident Note" dated 02/20/26 at 03:30 PM revealed the resident's physician ordered a urinalysis (UA) with culture and sensitivity. The 02/21/26 at 12:23 PM "Progress Note" included preliminary positive UA results with culture and sensitivity results pending. The 02/23/26 at 09:41 AM "Progress Note" included the UA results and noted orders were received to start Nitrofurantoin (antibiotic), 100 milligrams (mg), by mouth two times a day for five days for urinary tract infection. On 02/25/26 at 09:27 AM, Licensed Nurse (LN) G reported that the provider generally would not start an antibiotic without a culture and sensitivity report. The LN reported the facility used McGeer's Criteria and opened an "Antibiotic Stewardship Assessment". The lab did not always send the results back to the facility, and they would have to call the lab to obtain the findings. LN G then called the lab for R9's culture and sensitivity results and obtained the final report. The LN then reported the results were "negative" for UTI (although the resident was placed on an antibiotic for UTI, two days prior). LN G stated no further testing was indicated. On 02/25/2026 at 04:22 PM, Administrative Nurse D confirmed the above findings and stated R9 should not have received antibiotics for a UTI when her final culture report was negative for UTI. Administrative Nurse D confirmed that antibiotic stewardship should be tracked and monitored for trends and patterns, as well as for the appropriate use to prevent the overuse of antibiotics and the risk to residents of developing multidrug-resistant organisms. The facility's policy "Antibiotic Stewardship," dated 02/04/25, documented that antibiotic stewardship refers to a set of commitments and actions to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. This can be accomplished through improved antibiotic prescribing	F0881		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175302	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWTON PRESBYTERIAN MANOR	**1200 E 7TH STREET , NEWTON, Kansas, 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
F0881 SS = F	Continued from page 32 and management practices to reduce inappropriate use and to ensure that residents receive the right antibiotic for the right indication, dose, and duration.	F0881		