STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 a Health Resurvey. The 2567 was sent electronically on 06/06/22.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: The facility had a census of 32 residents. The sample included 13 residents, with four reviewed for neglect. Based on observation, record review, and interview, the facility failed to ensure Resident (R)22 remained free from neglect when staff failed to provide the necessary care and services during a transfer as directed by R22's plan of care. This deficient practice placed R22 at risk for injury and impaired physical and psychosocial well-being. Findings included:	F 600		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 06/06/2022

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
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 600	Continued From page 1	F 600		

- The Electronic Medical Record (EMR) documented R22 had diagnoses of type 2 diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), dementia without behavioral disturbance (progressive mental disorder characterized by failing memory and confusion), hypertension (high blood pressure), and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness.

R22's "Quarterly Minimum Data Set" (MDS), dated 04/08/22, documented R22 had moderately impaired cognition and required extensive assistance with bed mobility, transfers, dressing, toileting, and personal hygiene. The MDS further documented R22 had unsteady balance, upper impairment on one side and lower impairment on both sides.

The "Activities of Daily Living (ADL) Care Plan," dated 04/20/22, directed staff to transfer the resident with a sit to stand lift (a lift designed to assist residents to rise from a sitting position) and assist of two staff at times and other times he was able to use his walker with one to two staff. The care plan lacked direction to staff to identify when R22 was able to transfer with 1-2 assist using the walker and when R22 required the lift.

The "Facility Investigation," dated 04/29/22 at approximately 07:00 AM, documented Licensed Nurse (LN) I went to R22's room to dress a skin tear on the resident's right elbow. CNA P and R22 reported they were uncertain how R22 sustained the skin tear. The investigation further documented, at 08:00 AM, LN I administered medication to the resident and noticed a skin tear

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 600	Continued From page 2	F 600		

on the resident's left elbow and a hematoma (collection of blood trapped in the tissues of the skin or in an organ, resulting from trauma) on R22's forehead. The investigation documented R22 stated he hit them coming out of the bathroom late the previous night. The investigation documented at 12:30 PM, LN I noted R22 had an abrasion (scrape) to his left knee and a skin tear to his iliac crest (the top of the pelvic bone). LN I asked staff to leave the room so she could talk with the resident. It documented R22 fell that morning when he was transferred from his bed to his recliner without his walker and with only one staff, CNA P, present. The investigation recorded R22 further stated his knees buckled, he hit the floor, and hit his head but he did not want to get anyone into trouble.

A "Nurse's Note," dated 04/29/22 at 01:41 PM, documented LN I educated R22 multiple times about the importance of letting a nurse know what happened and reminded the resident he would not be in any trouble. The note further recorded LN I pulled CNA P off the floor immediately after she was informed of the incident. CNA P wrote a witness statement, and left the facility.

On 05/02/22, an in-service was held to educate all staff on change of condition, types of abuse, types of neglect and retaliation.

On 05/23/22 at 01:50 PM, observation revealed R22 sat in his recliner. R22 wore a short sleeved shirt and had steri strips (adhesive strips used to hold wound edges together) to his right elbow.

On 05/23/22 at 02:00 PM, Administrative Nurse D stated CNA P was no longer allowed to work in the facility. Administrative Nurse D stated staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 600	Continued From page 3	F 600		

were educated on the importance of reporting any change of condition to the charge nurse immediately and staff are to follow the resident's care plan. Administrative Nurse D said staff were given a care sheet at the beginning of the shift that showed how each resident was transferred.

On 05/26/22 at 08:40 AM, CNA O stated after R22 transferred to his recliner, she noticed he had a scrape on his left knee and outer thigh. When she asked the resident how he got the injuries, R22 stated he did not know. CNA O further stated she told the nurse about the injuries.

On 05/26/22 at 09:43 AM, LN G stated R22 got the skin tears from a fall that occurred when a CNA transferred the resident. LN G further stated she did not know a lot about the incident.

The facility's "Abuse and Neglect" policy, dated 02/27/2015, documented the facility would prohibit neglect, mental or physical abuse, including involuntary seclusion and the misappropriation of the property of residents. The policy further documented neglect was the failure to provide goods and services necessary to avoid physical harm, mental languish, or mental illness and staff would report any suspicious event that may constitute abuse or neglect. The facility would track all incidents to identify trends that could constitute abuse or neglect, and any events of unknown origin will be investigated.

The facility failed to prevent an incident of neglect for R22 when staff failed to provide the necessary care and services during a transfer placing the resident at risk for further injury and neglect.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 609	Continued From page 4	F 609		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: The facility had a census of 32 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility staff failed to report an injury of unknown origin to administration staff for one sampled resident, Resident (R) 30, who had a bruise with	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 609	Continued From page 5	F 609		

swelling on top of her forehead. This placed the resident at risk for further injury and unidentified abuse or mistreatment.

Findings included:

- The Electronic Medical Record (EMR) documented R30 had diagnoses of hypertension (high blood pressure), dementia without behavioral disturbance (progressive mental disorder characterized by failing memory and confusion), and type 2 diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin).

The "Quarterly Minimum Data Set" (MDS), dated 04/29/22, documented R30 had moderately impaired cognition and required extensive assistance of two staff for bed mobility, transfers, dressing, toileting, and personal hygiene. The MDS further documented R30 had unsteady balance and and lower impairment on both sides.

The "Cognition Care Plan," dated 04/20/22, documented R30 had impaired cognition related to cognitive function, dementia or impaired thought processes and directed staff to cue, reorient, and supervise as needed.

The "Skin Observation Tool," dated 07/12/21, documented swelling under R30's skin and a bruise measuring 1 centimeter (cm) x 1.5 cm.

The "Nurse's Note," dated 07/12/21 at 02:40 PM, documented a bruise to the top of R30's forehead. The note documented the resident was unable to explain when or how it happened. The note further documented staff would monitor the bruise daily until it healed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 609	Continued From page 6	F 609		

Review of the EMR lacked further documentation regarding the bruise including notification to Administrative Staff A or Administrative Nurse D.

The facility was unable to provide an investigation regarding the bruise on R30's forehead.

On 05/25/22 at 10:00 AM, observation revealed R30 sat in her recliner with her eyes closed. Her wheelchair was placed beside her bed, fall mats on the floor, and nonskid strips in front of her recliner.

On 05/25/22 at 08:50 AM, Certified Nurse Aide (CNA) M stated if a resident had any type of injury, it was reported to the nurse.

On 05/26/22 at 10:40 AM, Licensed Nurse (LN) H stated, if a resident had an injury of unknown origin, she filled out report and gave it to Administrative Nurse D for investigation. LN H further stated, if R30 had a bruise that was not from a lab draw, she would have filled out the report.

On 05/26/22 at 01:00 PM, Administrative Nurse D stated she had not been aware of the bruise otherwise she would have investigated it.

The facility's "Abuse and Neglect" policy, dated February 27, 2015, documented staff would report any suspicious event that may constitute abuse or neglect and the facility would track all incidents to identify trends that could constitute abuse or neglect. The policy further documented, any events of unknown origin would be investigated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 609	Continued From page 7 The facility staff failed to report a bruise of unknown origin to administrative staff for cognitively impaired R30, placing her at risk for further injury and unidentified abuse or mistreatment.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: The facility had a census of 32 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to investigate an injury of unknown origin for one sampled resident, Resident (R) 30, who had a bruise with swelling on top of her forehead. This placed the resident at risk for further injury and unidentified abuse or mistreatment.	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 610	Continued From page 8	F 610		

Findings included:

- The Electronic Medical Record (EMR) documented R 30 had diagnoses of hypertension (high blood pressure), dementia without behavioral disturbance (progressive mental disorder characterized by failing memory and confusion), and type 2 diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin).

The "Quarterly Minimum Data Set" (MDS), dated 04/29/22, documented R30 had moderately impaired cognition and required extensive assistance of two staff for bed mobility, transfers, dressing, toileting, and personal hygiene. The MDS further documented R30 had unsteady balance and and lower impairment on both sides.

The "Cognition Care Plan," dated 04/20/22, documented R30 had impaired cognition related to cognitive function, dementia or impaired thought processes and directed staff to cue, reorient, and supervise as needed.

The "Skin Observation Tool," dated 07/12/21, documented swelling under R30's skin and a bruise measuring 1 centimeter (cm) x 1.5 cm.

The "Nurse's Note," dated 07/12/21 at 02:40 PM, documented a bruise to the top of R30's forehead. The note documented the resident was unable to explain when or how it happened. The note further documented staff would monitor the bruise daily until it healed.

Review of the EMR lacked further documentation regarding the bruise including notification to Administrative Staff A or Administrative Nurse D.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 610	Continued From page 9	F 610		

The facility was unable to provide an investigation regarding the bruise on R30's forehead.

On 05/25/22 at 10:00 AM, observation revealed R30 sat in her recliner with her eyes closed. Her wheelchair was placed beside her bed, fall mats on the floor, and nonskid strips in front of her recliner.

On 05/25/22 at 08:50 AM, Certified Nurse Aide (CNA) M stated if a resident had any type of injury, it was reported to the nurse.

On 05/26/22 at 10:40 AM, Licensed Nurse (LN) H stated, if a resident had an injury of unknown origin, she filled out a report and gave it to Administrative Nurse D for investigation. LN H further stated, if R30 had a bruise that was not from a lab draw, she would have filled out the report.

On 05/26/22 at 01:00 PM, Administrative Nurse D stated she had not been aware of the bruise otherwise she would have investigated it.

The facility's "Abuse and Neglect" policy, dated February 27, 2015, documented staff would report any suspicious event that may constitute abuse or neglect and the facility would track all incidents to identify trends that could constitute abuse or neglect. The policy further documented, any events of unknown origin would be investigated.

The facility failed to investigate a bruise of unknown origin for cognitively impaired R30, placing her at risk for further injury and unidentified abuse or mistreatment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 623	Continued From page 11	F 623		

(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 623	Continued From page 12	F 623		

If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 32 residents. The sample included 13 residents. One resident (R)9 was reviewed for transfer and discharge. Based on record review and interview, the facility failed to provide written notice of discharge when R9 was discharged to an acute care facility.

Findings included:

- The electronic medical record for R9 documented diagnoses of pneumonia (inflammation of the lungs), chronic obstructive pulmonary disease (COPD-a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), hemiplegia and hemiparesis following cerebral infarction affecting left dominant side (muscular weakness of one half of the body and paralysis of one side of the body following a stroke), and congestive heart failure (CHF-a condition with low heart output and the body

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 623	Continued From page 13	F 623		

becomes congested with fluid).

The "Annual Minimum Data Set" (MDS) dated 08/31/21 documented R9 had a Brief Interview for Mental Status (BIMS) score of eight which indicated a moderately impaired cognition. R9 required extensive to total assist of two staff for activities of daily living (ADLs).

The "Quarterly MDS" dated 02/26/22 documented R9 had a BIMS score of 10 which indicated moderately impaired cognition. R9 required extensive to total assist of two staff for ADLs. He required the use of oxygen (O2) therapy.

The "ADL Care Area Assessment (CAA)" dated 09/14/21 documented R9 had hemiplegia following a stroke, and mild cognitive impairment. R9 was non-ambulatory and was dependent on staff for most ADLs.

A "Health Status Note" dated 02/16/22 at 3:05 PM documented R9 was sent to the emergency room at 8:30 AM due to crackles throughout lungs and increased drowsiness and cough. R9's wife notified. Report was given to staff at the hospital. R9 tested positive for COVID -19 (an acute respiratory illness caused by a virus). Resident was sent the hospital. The Administrator and Director of Nursing (DON) was notified.

A "Health Status Note" dated 02/21/22 at 2:19 PM documented R9 would return to the facility that day.

The EMR lacked documentation for a "Notice of Discharge/Transfer" form.

On 05/23/22 at 01:02 PM R9 was observed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 623	Continued From page 14	F 623		

resting in his bed. He had his O2 nasal canula on.

On 05/24/22 at 09:04 AM R9 laid on his back in bed. He wore his O2 per nasal canula on.

On 05/25/22 at 04:50 PM R9 was up in his wheelchair. He used portable O2.

On 05/26/22 at 09:45 AM Licensed Nurse (LN) G stated that when a resident was sent to the hospital or to another facility a discharge summary was sent with the resident a phone call was made to the receiving facility to give them important information on the resident. The family representative was notified by phone of any transfer to another facility, but no written notification was sent to them.

On 05/26/22 at 11:47AM Social Services X stated the facility called the family to notify them when a family member was sent to another facility or the hospital. Social Services X sent an email to the Ombudsman to notify of any transfers/discharges. A written notification of transfer was not ever provided to the family.

On 05/26/22 at 12:00 PM Administrative Staff B stated the facility did not send written notification of transfer to the resident's representative and only a phone call was made to the representative.

On 05/26/22 at 12:56 PM Administrative Nurse D stated that a written notification was not sent to the family representative when a resident was discharged to another facility or had a stay at the hospital.

The facility policy "Discharge Summary and Plan" revised December 2016 lacked documentation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 623	Continued From page 15 for written notice of transfer. The facility failed to provide the resident representative and with written notice of discharge as soon as practicable when R9 was sent to an acute care facility.	F 623		
F 657 SS=E	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 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 16	F 657		

The facility identified a census of 32 residents. The sample included 13 residents reviewed for care plan. Based on observation, interview and record review, the facility failed to revise and update Resident (R)29, R22, R30 and R31s' care plan with interventions aimed to prevent falls and fall related injuries. This placed the residents at risk for ineffective care and monitoring.

Findings included:

- The electronic medical record (EMR) for R29 documented diagnoses of restless leg syndrome (a condition that causes an uncontrollable urge to move the legs, usually because of an uncomfortable sensation), history of stress fracture (a crack in the bone due to repetitive pressure), osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), and artificial left knee joint (a procedure that involves cutting away of damage cartilage and bone).

The "Annual Minimum Data Set" (MDS) dated 08/20/21 documented R29 had a Brief Interview for Mental Status (BIMS) of six which indicated severely impaired cognition. R29 required supervision to limited assistance of one with dressing. She required physical help with transfer only during bathing. R29 had no fall history on admission or since admission.

The "Quarterly MDS" dated 04/26/22 documented R29 had BIMS score of eight which indicated a moderately impaired cognition. R29 required supervision of staff with locomotion on and off unit. R29's balance during transitions and walking was not steady, but able to stabilize without staff assistance. R29 used a walker for a mobility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 17	F 657		

device. R29 had a fall since prior assessment that resulted in an injury.

The "Fall Care Area Assessment" (CAA) dated 09/02/21 documented R29 has had no recent falls and no balance impairment but did have a risk for falls. R29 was independent with mobility and had a steady balance. No history of recent falls was reported.

The "Fall Care Plan" initiated on 10/11/19 and revised on 06/22/21 directed staff: assure R29 was wearing her eyeglasses; assure the floor was free of liquid and foreign objects; encourage her to assume a standing position slowly; R29 used her four wheeled walker independently; keep personal items and frequently used items within reach; keep call light within reach at all times; provide an environment free of clutter; provide proper, well maintained footwear. The Fall Care Plan had new interventions with dates of 03/23/22 and 04/28/22 for physical therapy (PT)/occupational therapy (OT) to evaluate and treat R29.

The "Fall Risk Assessment" under the Forms tab on the following dates 06/01/21, 08/18/21, 11/08/21, 01/31/21, 03/23/2, 04/20/22 and 04/28/22 documented R29 was a high risk for falls.

The EMR documented R29 had falls on these dates: 6/21/21, 03/23/22, and 4/28/22. R29's clinical record lacked evidence of a root cause analysis or resident centered intervention placed to prevent future falls. R29's fall on 04/28/21 resulted in a laceration to the back of her head that measured 0.5 centimeters (cm) by 0.1 cm. PT/OT was ordered for evaluation and treatment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 18	F 657		

On 05/23/22 at 02:50 PM R29 stated she had a recent fall and had hit head.

On 05/24/22 at 12:15 PM R29 ambulated with her four wheeled walker from the dining room to her room, an unsteady gait noted.

On 05/26/22 at 12:35 PM Certified Nurse Aide (CNA) O stated R29 had a couple falls recently. R29 was to wear shoes and wear her glasses. When a resident fell, she would call for assistance and made sure the resident was safe until the nurse arrived to assess the resident then both staff would use a lift to assist a resident off the floor.

On 05/26/22 at 09:45 AM Licensed Nurse (LN) G stated R29 has had a few falls and was receiving therapy.

On 05/26/22 at 10:26 AM LN H stated R29 had a lot of items in her room and would try to walk a lot without the use of her walker that she often forgot. Staff frequently would have to remind R29 to use her walker and the call light when she needed assistance. The care plan interventions for falls would get updated by the nurse or by Administrative Nurse D. A root cause analysis should be part of the fall investigation when it was completed after a fall.

On 05/26/22 at 01:00 PM, Administrative Nurse D stated she had been very busy and had not been able to update all the care plans and verified they needed revised with better interventions to prevent falls.

Upon request a policy for care plan revision was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 19	F 657		

not provided by the facility.

The facility failed to revise R29's care plan with new, meaningful interventions to prevent falls, placing the resident at risk for injury.

- The Electronic Medical Record (EMR) documented R22 had diagnoses of type 2 diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), dementia without behavioral disturbance (progressive mental disorder characterized by failing memory and confusion), hypertension (high blood pressure), and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness.

The "Quarterly Minimum Data Set" (MDS), dated 04/08/22, documented R22 had moderately impaired cognition and required extensive assistance with bed mobility, transfers, dressing, toileting, and personal hygiene. The MDS further documented R22 had unsteady balance, upper impairment on one side and lower impairment on both sides.

The "Fall Risk Assessments," dated 12/01/21, 1/19/22, 1/30/22, 2/7/22, and 04/29/22, documented the resident a high risk for falls.

The "Fall Care Plan," originally dated 10/05/21 documented R22 at risk for falls. The care plan directed staff to ensure the brakes on the wheelchair were locked when the resident went to bed at night and ensure the wheelchair was next to his bed. An update, dated 12/25/21, directed staff to encourage R22 to use his call light and ask for help. An update, dated 01/19/22, directed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 20	F 657		

staff to encourage R22 to use his call light and ask for help. An update dated 02/02/22 directed staff to place non-skid strips in front of the resident's recliner. The "Care Plan" lacked new interventions to prevent further falls.

The EMR documented falls on these dates: 12/25/21, 01/20/22, 01/30/22, 02/02/22, 02/07/22, and 04/29/22. R22's clinical record lacked evidence of a root cause analysis or resident centered intervention placed to prevent future falls.

On 05/25/22 at 09:40 PM, observation revealed R22 laid in his bed waiting to get up for the day. Further observation revealed Certified Nurse Aide (CNA) M and CNA N assisted R22 up to sit on the side of his bed. CNA M placed the sit to stand lift (a lift designed to assist residents to rise from a sitting position) sling (a flexible strap or belt used to support or raise a weight) around the resident's waist and told him to hold onto hand grips. CNA M raised him to a standing position using the lift and sat him down in his wheelchair.

On 05/25/22 at 09:45 AM, CNA M stated R22 had falls when he tried to get up alone and did not call for assistance. CNA M further stated staff use the sit to stand lift with two staff and have not tried to ambulate with him for a few weeks as he did not transfer well.

On 05/26/22 at 09:45 AM, Licensed Nurse (LN) G stated R22 had a few falls and received daily therapy. LN G further stated R22 tried several times to get up on his own and fell because he wanted to be independent.

On 05/26/22 at 01:00 PM, Administrative Nurse D

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 21	F 657		

stated she had been very busy and had not been able to update all the care plans and verified they needed revised with better interventions to prevent falls.

Upon request a policy for care plan revision was not provided by the facility.

The facility failed to revise R221's care plan with new, meaningful interventions to prevent falls, placing the resident at risk for injury.

- The Electronic Medical Record (EMR) documented R30 had diagnoses of hypertension (high blood pressure), dementia without behavioral disturbance (progressive mental disorder characterized by failing memory and confusion), and type 2 diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin).

The "Quarterly Minimum Data Set" (MDS), dated 04/29/22, documented R30 had moderately impaired cognition and required extensive assistance of two staff for bed mobility, transfers, dressing, toileting, and personal hygiene. The MDS further documented R30 had unsteady balance, lower impairment on both sides, and one non injury fall since prior assessment.

The "Fall Risk Assessment," dated 10/14/20, 01/01/21, 04/01/22, and 05/11/22, documented the resident a high risk for falls.

The "Fall Care Plan," originally dated 01/21/20 documented R30 at risk for falls. The care plan directed staff to provide proper, well maintained footwear for the resident, keep her call light in reach at all times and encourage her to use it,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 22	F 657		

provide an environment free of clutter, and assess for bathroom needs frequently each shift. The update, dated 04/26/20, directed staff to put a sign up in her room to remind R30 to call for help. The update, dated 06/27/20, directed staff to keep her walker within reach. The update, dated 08/18/20, directed staff to encourage the resident to use her call light and to take R30 to the bathroom every two hours while awake. The update, dated 04/01/22, directed staff to keep R30's walker within reach when she was in the recliner. The "Care Plan" lacked new interventions to prevent further falls.

The EMR documented falls on these dates: 10/14/20, 12/14/20, 01/02/21,12/21/28, 04/01/22, 04/11/22, and 05/11/22.

On 05/25/22 at 08:50 AM, observation revealed R30 sat in her wheelchair and waited to be transferred into her recliner. Further observation revealed CNA M placed the sit to stand lift (a lift designed to assist residents to rise from a sitting position) sling (a flexible strap or belt used to support or raise a weight) around the resident's waist and told her to hold onto hand grips. CNA N raised her to a standing position using the lift and CNA N guided her to the recliner and the resident was lowered into her recliner. CNA N placed the resident's feet up, covered her with a blanket, and gave R30 her call light.

On 05/25/22 at 08:55 AM, CNA M stated R30 had falls when she tried to get up alone and did not remember to use her call light. CNA M further stated staff take the resident to the bathroom before and after meals, using only the sit to stand lift because she is not steady to stand with her walker. CNA M further stated therapy staff were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 23	F 657		

the only ones who ambulated the resident.

On 05/26/22 at 10:40 AM, Licensed Nurse (LN) H stated R30 had falls because of her dementia and not remembering to call for assistance. LN H stated nursing staff were responsible to put interventions in to place immediately after a fall and if someone had frequent falls, the administrative staff implemented different interventions.

On 05/26/22 at 01:00 PM, Administrative Nurse D stated she had been very busy and had not been able to update all the care plans and verified they needed revised with better interventions to prevent falls.

Upon request a policy for care plan revision was not provided by the facility.

The facility failed to revise R30's care plan with new, meaningful interventions to prevent falls, placing the resident at risk for injury.

- The Electronic Medical Record (EMR) documented R31 had diagnoses of vascular dementia without behavioral disturbance (problems with reasoning, planning, judgement, memory and other thought processes caused by impaired blood supply to the brain), anxiety (a feeling of worry, nervousness, or unease), cerebrovascular disease (an area of the brain is temporarily or permanently affected by bleeding of one or more of the cerebral blood vessels), altered mental status (changes in cognition, mood, or behavior), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 24	F 657		

R31's "Annual Minimum Data Set" (MDS), dated 04/29/22, documented the resident had moderately impaired cognition and required extensive assistance of one staff for bed mobility, transfer, dressing, toileting, and personal hygiene. The MDS further documented R31 had unsteady balance, functional impairment was not assessed, and two falls with injury since prior assessment.

The "Fall Risk Assessments," dated 11/3/20, 11/9/20, 11/30/20, 12/8/20, 12/25/20, 01/18/21, 01/19/21, 03/31/21, 04/22/21, 02/05/22, 03/10/22, 04/18/22, and 05/16/22, documented the resident a high risk for falls.

The "Fall Care Plan," originally dated 06/01/20, documented R31 was a high risk for falls due to unsteady gait and directed staff to encourage and remind the resident to use her call light for assistance. Updates, dated 07/13/20, 11/30/20, 12/31/20,1/13/21, and 1/17/21 directed staff to encourage R31 to call for assistance. Updates, dated 12/13/20, 05/15/21, 07/11/21, 10/03/21, 01/19/22, and 01/29/22, directed staff to educate R31 on the importance of wearing shoes or non-skid socks when up and ensure shoes fit properly.
The "Care Plan" lacked new interventions to prevent further falls

The EMR documented falls on these dates: 11/03/20, 11/09/20, 11/30/20, 12/08/20, 12/25/20, 01/18/21, 01/19/21, 03/31/21, 04/22/21, 02/05/22, 03/10/11, 04/18/22, and 05/15/22.

On 05/25/22 at 09:30 AM, observation revealed Certified Nurse Aide (CNA) N placed a gait belt around R31's waist to assist her to transfer into

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 25 her recliner. Further observation revealed R 31 used her left hand to assist with the transfer but was unable to use her right hand as it remained at her side. CNA N stated the resident had right sided weakness and required assistance with transfer. On 05/25/22 at 09:30 AM, CNA N stated R31 had a lot of falls because she does not like to use her call light and call for assistance. CNA N further stated R31 used to have a motion alarm, but they took it away after R31 got upset and would swing her leg at it to set it off. On 05/26/22 at 09:43 AM, Licensed Nurse (LN) G stated it was a full team effort for interventions for the resident to prevent falls due to R31's dementia and she cannot remember to use her call light. LN G further stated R31 was "stubborn" and did not like to ask for assistance. On 05/26/22 at 01:00 PM, Administrative Nurse D stated she had been very busy and had not been able to update all the care plans and verified they needed revised with better interventions to prevent falls. Upon request a policy for care plan revision was not provided by the facility. The facility failed to revise R31's care plan with new, meaningful interventions to prevent falls, placing the resident at risk for injury.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 684	Continued From page 26	F 684		

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.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 32 residents. The sample included 13 residents, with one reviewed for change of condition. Based on observation, record review, and interview, the facility failed to follow up with care in a timely period consistent with standards of nursing care after Resident (R) 31 developed increased weakness in her right arm. This placed R31, who had a history of a stroke at increased risk for physical decline and delay in treatment.

Findings included:

- The Electronic Medical Record (EMR) documented diagnoses of vascular dementia without behavioral disturbance (problems with reasoning, planning, judgement, memory and other thought processes caused by impaired blood supply to the brain), cerebrovascular disease (an area of the brain is temporarily or permanently affected by bleeding of one or more of the cerebral blood vessels) and cerebral infarction (CVA-occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it).

R31's "Annual Minimum Data Set" (MDS), dated 04/29/22, documented R31 had moderately impaired cognition and required extensive assistance of one staff for bed mobility, transfer,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 684	Continued From page 27	F 684		

dressing, toileting, and personal hygiene. The MDS further documented the resident had unsteady balance and her functional impairment was not assessed.

The "Alteration in Neurological Status Care Plan," dated 05/11/22, directed staff to monitor, document, and report as needed signs and symptoms of tremors, rigidity, dizziness, changes in level of consciousness, and slurred speech.

The "Nurse's Note," dated 05/06/21 at 03:08 AM, documented staff observed R31 was not using her right arm as much as her left. The note further documented R31 reported increased weakness in her right arm.

The "Nurse's Note," dated 05/06/21 at 06:39 PM, documented R31 had not been using her right arm. The note recorded R31 could squeeze with right hand but could not grasp, and could not lift her right arm without assistance. The note further documented R31 had a history of CVA.

The "Nurse's Note," dated 05/07/21 at 02:33, documented the facility notified the resident's Durable Power of Attorney (DPOA) and physician of the increased right-side weakness to see if the physician wanted the resident evaluated in the emergency room (ER) . The note documented the physician's nurse stated she was waiting to see what R1's family wanted.

The "Nurse's Note," dated 05/07/21 at 08:20 PM, documented R31's right arm was still weaker than the left arm.

The "Nurse's Note," date 05/10/21 at 01:44 PM, documented the facility staff contacted R31's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 684	Continued From page 28	F 684		

physician to check if the physician wanted an appointment made for the resident.

The "Nurse's Note," dated 05/13/21 at 05:36 PM, documented the facility staff contacted the physician to report R31 continued with weakness and inability to use her right arm. The physician ordered a computerized tomography scan (CT-combines a series of x-rays from different angles around the body to provide more detailed information than regular x-rays do).

The "Nurse's Note," dated 05/14/21 at 03:28 PM, documented R31 went to the clinic for a CT of her head.

The "CT Final Report," dated 05/17/21, documented no acute intracranial (within the skull) process identified but significant white matter disease likely secondary to chronic small vessel ischemia (inadequate blood supply).

On 05/25/22 at 09:30 AM, observation revealed Certified Nurse Aide (CNA) N placed a gait belt around R31's waist to assist her to transfer into her recliner. Further observation revealed R 31 used her left hand to assist with the transfer but was unable to use her right hand as it remained at her side. CNA N stated the resident had right sided weakness and required assistance with transfer.

On 05/26/22 at 09:43 AM, Licensed Nurse (LN) G stated, if a resident had a change in condition, the physician and family are notified immediately for new orders. LN G further stated she was unaware of the residents change in condition.

On 05/26/22 at 01:00 PM, Administrative Nurse D

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 684	Continued From page 29 stated when a resident had a change of condition, the nurse should contact the physician and follow-up to get new orders. The facility's "Change In Condition" policy, dated February 2021, documented the facility would promptly notify the resident's attending physician or physician on call when there had been a significant change in the resident's physical, emotional, and mental condition. the policy further documented the nurse would record in the resident's medical record information relative to changes in the resident's medical/mental condition or status and if the need to alter the resident's medical treatment significantly. The facility failed to notify the physician timely and follow-up with the physician after R31 had right arm weakness and was unable to use her arm. This placed the resident at risk for further decline and delayed treatment.	F 684		
F 689 SS=E	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 32 residents. The sample included 13 residents with nine reviewed for accidents. Based on observation, record review, and interview, the facility failed to	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 30	F 689		

complete a root cause analysis to identify causative factors and failed to implement meaningful, resident centered interventions for five sampled residents, Resident (R) 22, R30, R31, and R29, who were at risk and had falls. This placed the residents at increased risk for falls and fall related injury.

Findings included:

- The Electronic Medical Record (EMR) documented R22 had diagnoses of type 2 diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), dementia without behavioral disturbance (progressive mental disorder characterized by failing memory and confusion),
hypertension (high blood pressure), and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness.

The "Quarterly Minimum Data Set" (MDS), dated 04/08/22, documented R22 had moderately impaired cognition and required extensive assistance with bed mobility, transfers, dressing, toileting, and personal hygiene. The MDS further documented R22 had unsteady balance, upper impairment on one side and lower impairment on both sides.

The "Fall Risk Assessments," dated 12/01/21, 1/19/22, 1/30/22, 2/7/22, and 04/29/22, documented the resident a high risk for falls.

The "Fall Care Plan," originally dated 10/05/21 documented R22 at risk for falls. The care plan directed staff to ensure the brakes on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 31	F 689		

wheelchair were locked when the resident went to bed at night and ensure the wheelchair was next to his bed. An update, dated 12/25/21, directed staff to encourage R22 to use his call light and ask for help . An update, dated 01/19/22, directed staff to encourage R22 to use his call light and ask for help. An update dated 02/02/22 directed staff to place non-skid strips in front of the resident's recliner.

The EMR documented falls on these dates: 12/25/21, 01/20/22, 01/30/22, 02/02/22, 02/07/22, and 04/29/22. R22's clinical record lacked evidence of a root cause analysis or resident centered intervention placed to prevent future falls.

On 05/25/22 at 09:40 PM, observation revealed R22 laid in his bed waiting to get up for the day. Further observation revealed Certified Nurse Aide (CNA) M and CNA N assisted R22 up to sit on the side of his bed. CNA M placed the sit to stand lift (a lift designed to assist residents to rise from a sitting position) sling (a flexible strap or belt used to support or raise a weight) around the resident's waist and told him to hold onto hand grips. CNA M raised him to a standing position using the lift and sat him down in his wheelchair.

On 05/25/22 at 09:45 AM, CNA M stated R22 had falls when he tried to get up alone and did not call for assistance. CNA M further stated staff use the sit to stand lift with two staff and have not tried to ambulate with him for a few weeks as he did not transfer well.

On 05/26/22 at 09:45 AM, Licensed Nurse (LN) G stated R22 had a few falls and received daily therapy. LN G further stated R22 tried several

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 32	F 689		

times to get up on his own and fell because he wanted to be independent.

On 05/25/22 at 04:35 PM, Administrative Nurse D stated, she does not do root cause analysis on the falls and stated she should, but hasn't.

The facility's "Falls and Fall Risk, Managing" policy, dated March 2018, documented staff would identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The policy further documented if falling recurs, despite initial interventions, staff would implement additional or different interventions or indicate why the current approach remains relevant. If underlying causes cannot be readily identified or corrected, staff would try various interventions, based on assessment of the nature or category of falling, until falling was reduced or stopped, or until the reason for the continuation of the falling was identified as unavoidable.

The facility failed to complete a root cause analysis to identify causative factors and failed to implement meaningful, resident centered interventions for cognitively impaired R22, who had multiple falls, placing the resident at risk for further falls and injury.

- The Electronic Medical Record (EMR) documented R30 had diagnoses of hypertension (high blood pressure), dementia without behavioral disturbance (progressive mental disorder characterized by failing memory and confusion), and type 2 diabetes mellitus (when the body cannot use glucose, not enough insulin

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 33	F 689		

made or the body cannot respond to the insulin).

The "Quarterly Minimum Data Set" (MDS), dated 04/29/22, documented R30 had moderately impaired cognition and required extensive assistance of two staff for bed mobility, transfers, dressing, toileting, and personal hygiene. The MDS further documented R30 had unsteady balance, lower impairment on both sides, and one non injury fall since prior assessment.

The "Fall Risk Assessment," dated 10/14/20, 01/01/21, 04/01/22, and 05/11/22, documented the resident a high risk for falls.

The "Fall Care Plan," originally dated 01/21/20 documented R30 at risk for falls. The care plan directed staff to provide proper, well maintained footwear for the resident, keep her call light in reach at all times and encourage her to use it, provide an environment free of clutter, and assess for bathroom needs frequently each shift. The update, dated 04/26/20, directed staff to put a sign up in her room to remind R30 to call for help. The update, dated 06/27/20, directed staff to keep her walker within reach. The update, dated 08/18/20, directed staff to encourage the resident to use her call light and to take R30 to the bathroom every two hours while awake. The update, dated 04/01/22, directed staff to keep R30's walker within reach when she was in the recliner.

The EMR documented falls on these dates: 10/14/20, 12/14/20, 01/02/21,12/21/28, 04/01/22, 04/11/22, and 05/11/22.

On 05/25/22 at 08:50 AM, observation revealed R30 sat in her wheelchair and waited to be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 34	F 689		

transferred into her recliner. Further observation revealed CNA M placed the sit to stand lift (a lift designed to assist residents to rise from a sitting position) sling (a flexible strap or belt used to support or raise a weight) around the resident's waist and told her to hold onto hand grips. CNA N raised her to a standing position using the lift and CNA N guided her to the recliner and the resident was lowered into her recliner. CNA N placed the resident's feet up, covered her with a blanket, and gave R30 her call light.

On 05/25/22 at 08:55 AM, CNA M stated R30 had falls when she tried to get up alone and did not remember to use her call light. CNA M further stated staff take the resident to the bathroom before and after meals, using only the sit to stand lift because she is not steady to stand with her walker. CNA M further stated therapy staff were the only ones who ambulated the resident.

On 05/26/22 at 10:40 AM, Licensed Nurse (LN) H stated R30 had falls because of her dementia and not remembering to call for assistance. LN H stated nursing staff were responsible to put interventions in to place immediately after a fall and if someone had frequent falls, the administrative staff implemented different interventions.

On 05/25/22 at 04:35 PM, Administrative Nurse D stated she did not do root cause analysis on the falls. She said she should but has not. Administrative Nurse D stated she was aware R30 has had a lot of falls and duplicate interventions.

The facility's "Falls and Fall Risk, Managing" policy, dated March 2018, documented staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 35	F 689		

would identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The policy further documented if falling recurs, despite initial interventions, staff would implement additional or different interventions or indicate why the current approach remains relevant. If underlying causes cannot be readily identified or corrected, staff would try various interventions, based on assessment of the nature or category of falling, until falling was reduced or stopped, or until the reason for the continuation of the falling was identified as unavoidable.

The facility failed to complete a root cause analysis to identify causative factors and failed to implement meaningful, resident centered interventions for cognitively impaired R30, who had multiple falls, placing the resident at risk for further falls and injury.

- The Electronic Medical Record (EMR) documented R31 had diagnoses of vascular dementia without behavioral disturbance (problems with reasoning, planning, judgement, memory and other thought processes caused by impaired blood supply to the brain), anxiety (a feeling of worry, nervousness, or unease), cerebrovascular disease (an area of the brain is temporarily or permanently affected by bleeding of one or more of the cerebral blood vessels), altered mental status (changes in cognition, mood, or behavior), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).

R31's "Annual Minimum Data Set" (MDS), dated 04/29/22, documented the resident had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 36	F 689		

moderately impaired cognition and required extensive assistance of one staff for bed mobility, transfer, dressing, toileting, and personal hygiene. The MDS further documented R31 had unsteady balance, functional impairment was not assessed, and two falls with injury since prior assessment.

The "Fall Risk Assessments," dated 11/3/20, 11/9/20, 11/30/20, 12/8/20, 12/25/20, 01/18/21, 01/19/21, 03/31/21, 04/22/21, 02/05/22, 03/10/22, 04/18/22, and 05/16/22, documented the resident a high risk for falls.

The "Fall Care Plan," originally dated 06/01/20, documented R31 was a high risk for falls due to unsteady gait and directed staff to encourage and remind the resident to use her call light for assistance. Updates, dated 07/13/20, 11/30/20, 12/31/20,1/13/21, and 1/17/21 directed staff to encourage R31 to call for assistance. Updates, dated 12/13/20, 05/15/21, 07/11/21, 10/03/21, 01/19/22, and 01/29/22, directed staff to educate R31 on the importance of wearing shoes or non-skid socks when up and ensure shoes fit properly.

The EMR documented falls on these dates: 11/03/20, 11/09/20, 11/30/20, 12/08/20, 12/25/20, 01/18/21, 01/19/21, 03/31/21, 04/22/21, 02/05/22, 03/10/11, 04/18/22, and 05/15/22.

On 05/25/22 at 09:30 AM, observation revealed Certified Nurse Aide (CNA) N placed a gait belt around R31's waist to assist her to transfer into her recliner. Further observation revealed R 31 used her left hand to assist with the transfer but was unable to use her right hand as it remained at her side. CNA N stated the resident had right

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 37	F 689		

sided weakness and required assistance with transfer.

On 05/25/22 at 09:30 AM, CNA N stated R31 had a lot of falls because she does not like to use her call light and call for assistance. CNA N further stated R31 used to have a motion alarm, but they took it away after R31 got upset and would swing her leg at it to set it off.

On 05/26/22 at 09:43 AM, Licensed Nurse (LN) G stated it was a full team effort for interventions for the resident to prevent falls due to R31's dementia and she cannot remember to use her call light. LN G further stated R31 was "stubborn" and did not like to ask for assistance.

On 05/25/22 at 04:35 PM, Administrative Nurse D stated, she does not do root cause analysis on the falls and stated she should but has not..

The facility's "Falls and Fall Risk, Managing" policy, dated March 2018, documented staff would identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The policy further documented if falling recurs, despite initial interventions, staff would implement additional or different interventions or indicate why the current approach remains relevant. If underlying causes cannot be readily identified or corrected, staff would try various interventions, based on assessment of the nature or category of falling, until falling was reduced or stopped, or until the reason for the continuation of the falling was identified as unavoidable.

The facility failed to complete a root cause

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 38	F 689		

analysis to identify causative factors and failed to implement meaningful, resident centered interventions for cognitively impaired R31, who had multiple falls, placing the resident at risk for further falls and injury.

- The electronic medical record (EMR) for R29 documented diagnoses of restless leg syndrome (a condition that causes an uncontrollable urge to move the legs, usually because of an uncomfortable sensation), history of stress fracture (a crack in the bone due to repetitive pressure), osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), and artificial left knee joint (a procedure that involves cutting away of damage cartilage and bone).

The "Annual Minimum Data Set" (MDS) dated 08/20/21 documented R29 had a Brief Interview for Mental Status (BIMS) of six which indicated severely impaired cognition. R29 required supervision to limited assistance of one with dressing. She required physical help with transfer only during bathing. R29 had no fall history on admission or since admission.

The "Quarterly MDS" dated 04/26/22 documented R29 had BIMS score of eight which indicated a moderately impaired cognition. R29 required supervision of staff with locomotion on and off unit. R29's balance during transitions and walking was not steady, but she was able to stabilize without staff assistance. R29 used a walker for a mobility device. R29 had a fall since prior assessment that resulted in an injury.

The "Fall Care Area Assessment" (CAA) dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 39	F 689		

09/02/21 documented R29 had no recent falls and no balance impairment but did have a risk for falls. R29 was independent with mobility and had a steady balance. No history of recent falls was reported.

The "Fall Risk Assessment" under the Forms tab on the following dates 06/01/21, 08/18/21, 11/08/21, 01/31/21, 03/23/2, 04/20/22 and 04/28/22 documented R29 was a high risk for falls.

The "Fall Care Plan" initiated on 10/11/19 and revised on 06/22/21 directed staff to assure R29 wore her eyeglasses, assure the floor was free of liquid and foreign objects, and encourage her to assume a standing position slowly. R29 used her four wheeled walker independently. The care plan directed staff to keep personal items and frequently used items within reach and keep the call light within reach at all times. The care plan directed staff to provide an environment free of clutter, and provide proper, well maintained footwear. The "Fall Care Plan" had new interventions with dates of 03/23/22 and 04/28/22 for physical therapy (PT)/occupational therapy (OT) to evaluate and treat R29.

The EMR documented R29 had falls on these dates: 6/21/21, 03/23/22, and 4/28/22. R29's clinical record lacked evidence of a root cause analysis or resident centered intervention placed to prevent future falls. R29's fall on 04/28/21 resulted in a laceration to the back of her head that measured 0.5 centimeters (cm) by 0.1 cm. PT/OT was ordered for evaluation and treatment.

On 05/23/22 at 02:50 PM R29 stated she had a recent fall and had hit head.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 40	F 689		

On 05/24/22 at 12:15 PM R29 ambulated with her four wheeled walker from the dining room to her room unassisted. She had an unsteady gait.

On 05/26/22 at 12:35 PM Certified Nurse Aide (CNA) O stated R29 had a couple falls recently and said R29 was to wear shoes and glasses. CNO O stated when a resident fell, she would call for assistance and made sure the resident was safe until the nurse arrived to assess the resident then both staff would use a lift to assist a resident off the floor.

On 05/26/22 at 09:45 AM Licensed Nurse (LN) G stated R29 has had a few falls and was receiving therapy.

On 05/26/22 at 10:26 AM LN H stated R29 had a lot of items in her room and would try to walk a lot without the use of her walker that she often forgot. LN H said staff frequently had to remind R29 to use her walker and the call light when she needed assistance. LN h said the care plan interventions for falls were updated by the nurse or by Administrative Nurse D. She further stated a root cause analysis should be part of the fall investigation when it was completed after a fall.

On 05/26/22 at 04:35 PM Administrative Nurse D stated she did not do a root cause analysis on falls and stated she should, but just has not.

The facility "Falls and Fall Risk, Managing" policy dated March 2018, documented staff would identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The policy further

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 41 documented if falling recurs, despite initial interventions, staff would implement additional or different interventions or indicate why the current approach remains relevant. If underlying causes cannot be readily identified or corrected, staff would try various interventions, based on assessment of the nature or category of falling until falling was reduced or stopped, or until the reason for the continuation of the falling was identified as unavoidable. The facility failed to complete a root cause analysis to identify causative factors and failed to implement meaningful, resident-centered interventions for cognitively impaired R29, who had multiple falls, placing R29 at risk for further falls and injury.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: The facility identified a census of 32 residents. The sample included 13 residents. Based on observations, record review and interview, the facility failed to ensure resident (R)9 and R4's oxygen (O2) tubing was dated and stored in a plastic bag when not in use. This deficient practice left R9 and R4 at risk for respiratory	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 695	Continued From page 42	F 695		

complication and increased risk for bacteria formation.

Findings included:

- The electronic medical record for R9 documented diagnoses of pneumonia (inflammation of the lungs), chronic obstructive pulmonary disease (COPD-a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), hemiplegia and hemiparesis following cerebral infarction affecting left dominant side (muscular weakness of one half of the body and paralysis of one side of the body following a stroke), and congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid).

The "Annual Minimum Data Set" (MDS) dated 08/31/21 documented R9 had a Brief Interview for Mental Status (BIMS) score of eight which indicated a moderately impaired cognition. R9 required extensive to total assist of two staff for activities of daily living (ADLs).

The "Quarterly MDS" dated 02/26/22 documented R9 had a BIMS score of 10 which indicated moderately impaired cognition. R9 required extensive to total assist of two staff for ADLs. He required the use of oxygen (O2) therapy.

The "ADL Care Area Assessment (CAA)" dated 09/14/21 documented R9 had hemiplegia following a stroke, and mild cognitive impairment. R9 was non-ambulatory and was dependent on staff for most ADLs.

The "Oxygen Therapy Care Plan" revised on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 695	Continued From page 43	F 695		

09/21/21 documented R9 was always to have two liters (L) O2 per nasal canula (a hollow tube used to deliver supplemental O2) or mask as needed.

The May "Order Summary Report" documented an order dated 06/28/19 for O2 at two L per nasal canula as needed.

The "Treatment Administration Report" (TAR) for R9 documented an order for O2 at two L per nasal canula as needed.
The TAR lacked instruction on O2 equipment maintenance/changing.

The facility "Nurse Night Shift Cleaning Schedule" for 05/01/21 through 05/07/21 had been signed off by staff for O2 tubing to be replace on the first of every month and as needed.
On 05/23/22 at 01:02 PM R9 was observed resting in his bed. He had his O2 nasal canula on. The tubing lacked a date.

On 05/24/22 at 09:04 AM R9 laid on his back in bed. He wore his O2 per nasal canula on. No date was visible on the O2 tubing.

On 05/25/22 at 04:50 PM R9 was up in his wheelchair. He used portable O2. The regular O2 tubing laid on top of R9's bed and was not placed in a bag.

On 05/26/22 at 12:35 PM Certified Nurse Aide (C NA) O stated that the O2 tubing should be stored in a bag when not in use. She was not sure who was responsible for changing out the O2 tubing, but thought it was changed weekly or maybe only monthly. If the tubing needed to be replaced, she would get a new one from the supply room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 695	Continued From page 44	F 695		

On 05/26/22 at 09:45 AM Licensed Nurse (LN) G stated the overnight nurse was responsible for replacing the O2 tubing at the beginning of every month. The tubing should be dated when changed. The breathing treatment mask and tubing for nasal canula should be stored in a plastic bag labeled with the resident's name and the date it was changed. LN G said nothing was documented on the TAR when the tubing was to be changed, but the facility did have a nightly cleaning schedule that listed that tubing should be changed monthly.

On 05/26/22 at 10:26 AM LN H stated she thought the O2 tubing for R9 was changed out weekly. LN H said the night shift nurse typically did change the tubing, so she was not positive how often it was changed. LN H stated the tubing should be dated and stored in a bag when it was not in use.

On 05/26/22 at 12:56 PM Administrative Nurse D stated that the O2 tubing was to be changed out monthly by the overnight nurse. Administrative Nurse D said staff did not document on the TAR anywhere when the O2 tubing was changed out. She further stated the facility had a "Nurse Night Shift Cleaning Schedule" that had a place to sign off monthly that the tubing had been changed. Administrative nurse D said the tubing should be dated when changed and place in a plastic bag when not in use.
The facility policy (awaiting to receive).

The facility failed to ensure that R9's O2 tubing was properly stored in a bad when not in used and failed to ensure the new O2 tubing was dated when changed. This placed R9 at risk for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 695	Continued From page 45	F 695		

respiratory complications and increased infection.

- The electronic medical record (EMR) for R4 documented diagnoses of shortness of breath, fracture of left ulna (one of two bones that make up the forearm), and dementia with behavioral disturbance (progressive mental disorder characterized by failing memory, confusion).

The "Annual Minimum Data Set" (MDS) dated 07/16/21 documented R4 had a Brief Interview for Mental Status (BIMS) score of 14 which indicated intact cognition. R4 was independent to supervision her activities of daily living (ADLs) and required the assistance of one staff with dressing. R4 required O2 therapy while a resident.

The Quarterly MDS dated 03/11/22 documented R4 had a BIMS score of 14 which indicated intact cognition. R4 required limited to extensive assist of one staff member for ADLs. She required O2 therapy while a resident.
The "ADL Care Area Assessment" (CAA) dated 07/29/21 documented R4 was usually performed ADL's independently. R4 required supervision with ambulation on occasion. R4 was independent with ambulation with no assistive device.

The "Oxygen Therapy Care Plan" revised on 05/21/21 documented O2 settings: O2 via two liters (L) per nasal canula (a hollow tube used to administer supplemental O2) at bedtime.

The May 2022 "Order Summary Report" documented an order dated 10/20/20 for O2 at two L per minute via nasal canula at bedtime for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 695	Continued From page 46	F 695		

shortness of breath.

The May 2022 "Treatment Administration Report" (TAR) for R4 documented an order for O2 at two L per nasal canula as needed.
The TAR lacked instruction on O2 equipment maintenance/changing.

The facility "Nurse Night Shift Cleaning Schedule" for 05/01/21 through 05/07/21 was signed off by staff for O2 tubing to be replace on the first of every month and as needed.

On 05/23/22 at 10:23 AM R4 sat in a chair in her room. R4's O2 tubing laid on top of the O2 concentrator (a device used to provide supplemental O2). The tubing was not dated and was not stored in a plastic bag.

On 05/24/22 at 07:52 AM R4 sat in her recliner doing a word search puzzle. R4's O2 tubing/nasal canula was draped over the O2 concentrator and was not stored in a plastic bag; no date was visible on the tubing.

On 05/25/22 at 09:32 AM R4 sat in her dimly lit room in her wheelchair. R4's undated O2 tubing/nasal canula was draped over the O2 concentrator and was not in a plastic bag.

On 05/26/22 at 12:35 PM Certified Nurse Aide (C NA) O stated that the O2 tubing should be stored in a bag when not in use. She was not sure who was responsible for changing out the O2 tubing, but thought it was changed weekly or maybe only monthly. If the tubing needed to be replaced, she would get a new one from the supply room.

On 05/26/22 at 09:45 AM Licensed Nurse (LN) G

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 695	Continued From page 47	F 695		

stated the overnight nurse was responsible for replacing the O2 tubing at the beginning of every month. The tubing should be dated when changed. The breathing treatment mask and tubing for nasal canula should be stored in a plastic bag labeled with the resident's name and the date it was changed. LN G said nothing was documented on the TAR when the tubing was to be changed, but the facility did have a nightly cleaning schedule that listed that tubing should be changed monthly.

On 05/26/22 at 10:26 AM LN H stated she thought the O2 tubing for R9 was changed out weekly. LN H said the night shift nurse typically did change the tubing, so she was not positive how often it was changed. LN H stated the tubing should be dated and stored in a bag when it was not in use.

On 05/26/22 at 12:56 PM Administrative Nurse D stated that the O2 tubing was to be changed out monthly by the overnight nurse. Administrative Nurse D said staff did not document on the TAR anywhere when the O2 tubing was changed out. She further stated the facility had a "Nurse Night Shift Cleaning Schedule" that had a place to sign off monthly that the tubing had been changed. Administrative Nurse D said the tubing should be dated when changed and place in a plastic bag when not in use.

The undated facility "Oxygen Therapy - Prevention of Infection" policy documented: the purpose of this procedure was to guide prevention of infection associated with respiratory therapy tasks and equipment. Change the O2 cannula and tubing used every seven days, or as needed. Keep the oxygen canula and tubing used

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 695	Continued From page 48 as needed in a plastic bag when not in use. Wash filters from O2 concentrator every seven days with soap and water. The facility failed to ensure that R4's O2 tubing was properly stored in a bad when not in used and failed to ensure the new O2 tubing was dated when changed. This placed R4 at risk for respiratory complications and increased infection.	F 695		
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. §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	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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		

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 had a census of 32 residents. The sample included 13 residents, with five reviewed for unnecessary medications. Based on observations, record review, and interview, the facility's failed to ensure the Consultant Pharmacist (CP)followed up with monthly with recommendations to change R31's inappropriate diagnosis for the Seroquel (antipsychotic medication) [medication used to treat psychosis and other mental emotional conditions]). The facility further failed to ensure staff followed up on the CP recommendation from June 2021. This deficient practice placed R31 at risk for adverse side effects related to antipsychotic use.

Finding included:

- The "Electronic Medical Record (EMR) documented diagnoses of vascular dementia without behavioral disturbance (problems with reasoning, planning, judgement, memory and other thought processes caused by impaired blood supply to the brain), anxiety (a feeling of worry, nervousness, or unease), cerebrovascular disease (an area of the brain is temporarily or permanently affected by bleeding of one or more

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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	F 756		

of the cerebral blood vessels), altered mental status (changes in cognition, mood, or behavior), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).

R31's "Annual Minimum Data Set" (MDS), dated 04/29/22, documented the resident had moderately impaired cognition and required extensive assistance of one staff for bed mobility, transfer, dressing, toileting, and personal hygiene. The MDS documented the resident received antipsychotic medication on a routine basis.

The "Psychotropic Medication Care Plan," dated 05/11/22, directed staff to administer medication as ordered, monitor for side effects and effectiveness. The care plan documented R31's medications would be reviewed by the pharmacist consultant monthly, the physician every 60 days, and by both as needed.

The "Physician Orders," dated 06/01/20, directed staff to administer Seroquel, 12.5 milligrams (mg) by mouth, in the evening, for the altered mental status.

The "Medication Regimen Review," dated 06/15/21, recommended a change to the diagnosis as the use of antipsychotic medication was discouraged for the diagnosis of altered mental status.
R31's clinical record lacked evidence the physician responded to the recommendation and/or the facility followed up with the physician regarding the recommendations.

The "Medication Regimen Reviews, dated July 2021-May 2022, failed to identify the inappropriate diagnosis for the use of Seroquel.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 51 On 05/25/22 at 08:32 AM, observation revealed Licensed Nurse (LN) G administered R31's morning medications, LN G told the resident what each medication was; R31 took her medications without difficulty. On 05/26/22 at 09:43 Am, LN G stated she was not aware of what would be an inappropriate diagnosis for the use of Seroquel medication. On 05/26/22 at 1:00 PM, Administrative Nurse D verified the diagnosis for the Seroquel medication. The facility's "Antipsychotic Medication Use" policy, dated December 2016, documented the resident would only receive antipsychotic medication when necessary to treat specific conditions for which that are indicated and effective. The policy further documented diagnosis of specific condition for which antipsychotic medications as necessary to treat would be based on a comprehensive assessment of the resident. The facility failed to ensure the CP followed up monthly with recommendations to change R31's inappropriate diagnosis for the Seroquel medications, and failed to follow up on the CP recommendation from June 2021 placing the resident at risk for adverse side effects.	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	F 757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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		

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 had a census of 32 residents. The sample included 13 residents, with five residents' reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to provide interventions for lack of bowel movements for one sampled resident, Resident (R) 31, who had a history of constipation (difficulty in emptying the bowels).. This placed the resident at risk for complications related to constipation.

Findings included:

- The Electronic Medical Record (EMR) documented R31 had diagnoses of constipation, congestive heart failure (a condition with low heart output and the body becomes congested with fluid), and hypertension (high blood

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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		

pressure).

R31's "Annual Minimum Data Set" (MDS), dated 04/29/22, documented the resident had moderately impaired cognition and required extensive assistance of one staff for bed mobility, transfer, dressing, toileting, and personal hygiene. The MDS documented the resident was always continent of bowel.

R31's EMR lacked documentation a "Bladder and Bowel Assessment" was completed.

The "Black Box Warning Care Plan," dated 05/11/22, directed staff to monitor for constipation and notify the charge nurse for changes.

The "Physician Orders," dated 06/02/20, directed staff to administer MiraLAX (a laxative used for constipation), 17 grams (gm), by mouth in the morning and mix in 4-8 ounces (oz) of fluid of choice.

The "Physician Orders," dated 12/06/20, directed staff to administer bisacodyl suppository (a laxative used to treat constipation), 10 milligrams (mg) rectally, as needed for constipation greater than two days, not to exceed two consecutive days.

The "Bowel Monitoring Record," dated February and March 2022, revealed R31 did not have a bowel movement for the following days:
02/13/22-02/16/22 (4 consecutive days)
02/28-03/05/22 (6 consecutive days)

The "Bowel Monitoring Record," dated April 2022, revealed R31 did not have a bowel movement for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 54 the following days: 04/07/22-04/11/22 The "Medication Administration Record," dated February, March, and April 2022, lacked documentation the staff provided interventions of physician ordered bisacodyl or performed bowel assessments during the lack of bowel elimination on the above dates. On 05/25/22 at 08:32 AM, observation revealed Licensed Nurse (LN) G administered R31's morning medications. LN G told the resident what each medication was, and R31 took her medications without difficulty. LN G asked R31 if she wanted her MiraLAX mixed into her coffee or juice, and R31 stated she did not want her MiraLAX at that time. On 05/26/22 at 09:43 AM, LN G stated staff had a log they looked at for bowel management. LN G said staff did not let the resident go longer than three days without interventions. LN G stated a less aggressive intervention was tried first, and the effectiveness was documented in the progress note. On 05/26/22 at 01:00 PM, Administrative Nurse D stated staff should follow the bowel management protocol for R31. Upon request, a policy for the facility's Bowel Protocol was not provided from the facility. The facility failed to monitor bowel movements and provide interventions for R31, who had a history of constipation, placing the resident at risk for impaction and decline.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 758	Continued From page 55 CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 758	Continued From page 56	F 758		

appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 32 residents. The sample included 13 residents, with five reviewed for unnecessary medications. Based on observations, record review, and interview, the facility failed to ensure an appropriate diagnosis for Resident (R) 31's Seroquel (antipsychotic medication [medication used to treat psychosis and other mental emotional conditions]). placing R31 at risk for adverse side effects.

Finding included:

- The Electronic Medical Record (EMR) documented R31 had diagnoses of vascular dementia without behavioral disturbance (problems with reasoning, planning, judgement, memory and other thought processes caused by impaired blood supply to the brain), anxiety (a feeling of worry, nervousness, or unease), cerebrovascular disease (an area of the brain is temporarily or permanently affected by bleeding of one or more of the cerebral blood vessels), altered mental status (changes in cognition, mood, or behavior), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 758	Continued From page 57	F 758		

R31's "Annual Minimum Data Set" (MDS), dated 04/29/22, documented the resident had moderately impaired cognition and required extensive assistance of one staff for bed mobility, transfer, dressing, toileting, and personal hygiene. The MDS documented the resident received antipsychotic medication on a routine basis.

The "Psychotropic [affecting thought or mood] Medication Care Plan," dated 05/11/22, directed staff to administer medication as ordered, monitor for side effects and effectiveness. The care plan documented R31's medications were reviewed by the pharmacist consultant monthly, the physician every 60 days, and by both as needed.

The "Physician Orders," dated 06/01/20, directed staff to administer Seroquel 12.5 milligrams (mg) by mouth, in the evening, for a diagnosis of altered mental status.

On 05/25/22 at 08:32 AM, observation revealed Licensed Nurse (LN) G administered R31's morning medications, LN G told the resident what each medication was; R31 took her medications without difficulty.

On 05/26/22 at 09:43 Am, LN G stated she was not aware of what was considered an inappropriate diagnosis for the use of Seroquel.

On 05/26/22 at 1:00 PM, Administrative Nurse D verified the diagnosis of altered mental status was not the appropriate diagnosis for the Seroquel medication.

The facility's "Antipsychotic Medication Use" policy, dated December 2016, documented the resident would only receive antipsychotic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 758	Continued From page 58 medication when necessary to treat specific conditions for which that are indicated and effective. The policy further documented diagnosis of specific condition for which antipsychotic medications are necessary to treat would be based on a comprehensive assessment of the resident. The facility failed to ensure an appropriate diagnosis for R31's Seroquel, placing the resident at risk for adverse side effects.	F 758		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §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 §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 880	Continued From page 59	F 880		

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 880	Continued From page 60	F 880		

IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:
The facility identified a census of 32 residents. Based on observation, record review and interview, the facility failed to ensure staff followed infection control standard of practice. The facility failed to practice proper hand hygiene while serving residents their meals in the dining room. The facility failed to provide a clean barrier under the glucometer (instrument used to calculate blood glucose) while obtaining blood glucose reading. The facility failed to ensure staff sanitized the facility glucometer after each use. The facility failed to properly store the scoop for the ice chest in a sanitary manner. This placed the residents at risk for increased infection and transmission of communicable disease.

Findings included:

- On 05/23/22 at 11:10 AM Dietary Staff CC and Dietary Staff DD donned a hairnet and gloves as they came out of the kitchen area carrying trays with the plates and bowls of food on them to serve to residents. Gloves were not removed after serving food from the tray.

On 05/23/22 at 11:14 AM Dietary Staff CC walked out of the kitchen with the same gloves on and delivered a couple residents their plates of food. Gloves were not removed after food delivery, no hand hygiene was performed.

On 05/23/22 at 11:16 AM Dietary Staff CC walked out of the kitchen carrying another tray of food to deliver to residents in dining area. Dietary Staff CC did not remove gloves or do hand hygiene before coming out of kitchen.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 880	Continued From page 61 On 05/23/22 at 11:30 AM Dietary Staff DD walked out of the kitchen area wearing gloves carrying a tray with plates of food for residents. She placed a plate of food in front of a resident and delivers a plate of food to another resident. Dietary Staff DD returns to the kitchen carrying the tray. The gloves were not removed and not hand hygiene was performed. On 05/24/22 at 11:01 AM Certified Medication Aide (CMA) R obtained a finger stick blood sugar on R30. CMA R gathered the supplies needed to obtain the blood sample (glucometer, alcohol swab, lancet pen (a device with a needle used to puncture the skin), gauze pad, test strip). CMA R sanitized her hands and applied clean gloves. CMA R knocked on R30's door and entered room. CMA R explained to R30 what she was going to do. CMA R sat the glucometer on the arm of R30's recliner (no clean barrier was placed under the glucometer). CMA R opened the alcohol wipe and wiped R30's finger and allowed it to dry, then she placed the lancet pen against R30's finger and engaged the needle to puncture the skin. The droplet of blood was placed on the test strip and inserted into the machine. CMA R removed the test strip from the glucometer and the needle from the lancet pen and placed them in the sharps container. CMA R removed her gloves and gathered the glucometer and lancet pen and exited R30's room and returned to the medication cart and sanitized her hands after she sat the glucometer on the cart. CMA R gathered supplies to obtain another blood sugar on another resident and went to the resident's room. The glucometer was not sanitized after either use on these residents.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 880	Continued From page 62	F 880		

On 05/25/22 at 03:42 PM CNA O filled the resident's water mugs with fresh ice. CNA O did not perform hand hygiene as she exited each room. The ice scoop was not properly stored in a plastic bag or storage bin after ice was scooped out of the ice chest.

On 05/26/22 at 12:10 PM Dietary Staff BB stated she assumed it was ok for the staff to wear the same gloves when serving food, as long as they did not touch any food or other surfaces while carrying the trays. She further stated so much had changed in the last couple of years due to COVID (a serious respiratory illness caused by a virus).

On 05/26/22 at 09:45 AM Licensed Nurse (G) stated that she did the facility infection control reporting. Administrative Nurse D had the certification and oversaw and inspected everything she did. LN G stated that the glucometer should be sanitized after each resident and that a barrier of some type should be placed underneath of the glucometer when used. LN G stated there should be a plastic bag or a holder for the ice scoop on the cart when not in use in between scooping ice for the residents. She further stated that hand hygiene should be done before and after care was performed on a resident, after using the bathroom, and after serving food but she was not certain about the dietary policy for that.

On 05/26/22 at 12:56 PM Administrative Nurse D stated she expected staff to clean the glucometer after each us on a resident. The facility has been working on trying a different system to obtain more glucometers or for each resident to have their own. Administrative Nurse D stated a barrier

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 880	Continued From page 63	F 880		

should be placed under the glucometer when obtaining a blood sugar. She further stated there should be a bag on the cart that the ice scoop was stored in when not in use.

The facility policy "Blood Sampling - Capillary (Finger Sticks)" revised September 2014 documented: always ensure that blood glucose meters intended for reuse are cleaned and disinfected between resident uses. Steps in the procedure included to wash hands, don gloves and place blood glucose monitoring device on a clean field.

The facility "Food Preparation and Service" policy revised September 2017 documented: food and nutrition services staff, including nursing services personnel, wash their hands before serving food to residents. Employees also wash their hands after collecting soiled plates and food waste prior to handling food trays. Bare hand contact with food is prohibited. Gloves should be worn during food service and when handling food directly and change in between tasks. Disposable gloves were single-use items and were discarded after each use.

The facility failed to ensure that staff practiced hand hygiene while serving residents in the dining area. The facility failed to ensure staff cleaned and/or sanitized reusable blood glucose monitoring equipment before being used on the next resident. The facility failed to ensure that staff placed a barrier down on a surface before placing the glucometer on a surface. And the facility failed to maintain and keep an ice scoop clean and sanitized after each use. These deficient practices left the facility's residents vulnerable for the potential spread of infection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175419	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

(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 880	Continued From page 64 and disease to the residents of the facility.	F 880		