STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175310	A. BUILDING _____ B. WING _____	06/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAY CENTER PRESBYTERIAN MANOR	924 8TH STREET CLAY CENTER, KS 67432

(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 electronically sent to the facility on 6/25/19.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 06/25/2019

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

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F 550	Continued From page 1	F 550		

from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 29 residents. The sample included 12 residents. Based on observation, record review, and interview the facility failed to promote respect and dignity for 1 of 12 sampled residents. (#3)

Findings included:

- Resident #3's quarterly (MDS) Minimum Data Set assessment, dated 3/24/19, documented the resident had a (BIMS) Brief Interview for Mental Status Score of 3, indicating severe cognitive impairment. The assessment documented the resident required extensive assistance of 2 staff for bed mobility, transfers, dressing, toileting, personal hygiene, and extensive assistance of 1 staff for eating. The assessment further revealed the resident had a below the knee amputation of his/her right lower leg.

The 9/5/18 (CAA) Care Area Assessment for (ADLs) Activities of Daily Living documented the resident did not always want to feed him/herself and required staff assistance.

The 4/18/19 care plan documented the resident used a bedside table in the dining room to eat and at times would spit out his/her food. The care plan directed staff to leave the residents foot

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F 550	Continued From page 2	F 550		

pedal on his/her wheelchair until the staff were ready to transfer the resident to remind him/her to stay seated.

On 6/20/19 at 8:30 AM, observation revealed the resident's wheelchair wheels had dried food and the cushion on the elevated foot pedal had various dried stains and dried food particles on it.

On 6/24/19 at 8:25 AM, observation revealed the resident's wheelchair cushion had crumbs and dried food stains on it, and the cushion on the elevated foot pedal had various dried stains and dried food particles on it.

On 6/24/19 at 8:45 AM, Nurse Aide O verified the wheelchair, wheelchair cushion, and foot pedal cushion were dirty and had dried food particles. Nurse Aide O stated the night shift staff were responsible for cleaning the resident's wheelchair.

On 6/24/19 at 9:50 AM, Administrative Nurse D stated the resident's wheelchair was cleaned on night shift, but staff should make sure the resident's wheelchair and cushions were cleaned after each meal.

The facility's Resident Rights and Responsibilities policy, dated 5/1/19, documented the facility would ensure the residents' right to a dignified existence, self-determination and person-centered care with access to persons and services inside and outside the facility. The facility would treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his/her quality of life, recognizing each resident's individuality.

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F 550	Continued From page 3 The facility failed to provide cares in a manner that promoted and enhanced quality of life, dignity, and respect for Resident #3, who's wheelchair, wheelchair cushion, and foot pedal cushion were dirty with crumbs and dried food substances.	F 550		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 584		

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F 584	Continued From page 4 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: The facility had a census of 29 residents. The sample included 12 residents. Based on observation, record review, and interview the facility failed to provide a safe, clean, comfortable environment for the 29 residents residing in the facility. Findings included: - On 6/20/19 at 8:20 AM, during the environmental tour revealed the following: Sunflower Hall: Resident #9's and #8's bottom of door with black scuff marks approximately 2 (ft) foot long by 5 inches wide. Spa room bottom of door with black scuff marks approximately 2 ft long by 2 ft wide. Utility room door with black scuff marks approximately 2 ft by 2 ft on bottom of door. Resident #5's carpet in doorway with a dark stain approximately 4 ft by 3 ft.	F 584		

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F 584	Continued From page 5	F 584		

Meadowlark Lane:
Resident #23's and #16's, room carpet with dark colored stains approximately 4 ft by 3 ft.

Resident #3's and #26's bottom of door with approximately 2 ft by 2 ft black scuff marks.

Resident #6's bottom of door with 2 ft by 2 ft black scuff marks.

Resident #24's room carpet with dark stains in middle of the room approximately 4 ft by 4 ft.

A strong urine odor was observed 3 of the 4 days of the survey at the end of the Meadowlark Lane hall.

Dining Room:
Carpeting in middle of the room with approximately a 1 ft ripple.

The 22 ft long silver metal strip across the center of the dining room floor, with numerous stains, dark stains and dried crusty particles on the carpet.

15 of the dining room chair with dried crusty substance on the seats and legs of the chairs.

On 6/20/19 at 9:40 AM, Maintenance Staff U and Administration Staff A verified the above findings.

The 7/2018 Safe and Homelike Environment policy states the facility will provide a safe, clean, comfortable and homelike environment. Housekeeping and Maintenance services will be provided as necessary to maintain a sanitary and orderly environment and are to minimize odors

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F 584	Continued From page 6 and clean areas appropriately. The facility failed to provide a safe, functional, sanitary environment, placing the 29 residents who reside in the facility at risk for not living in a home-like environment.	F 584		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for	F 604		

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F 604	Continued From page 7	F 604		

restraints.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 29 residents. The sample included 12 residents, with 1 reviewed for restraints. Based on observation, record review, and interview the facility failed to ensure the resident was free of a physical restraint (any manual method, physical or mechanical device/equipment or material that limits a resident's freedom of movement and cannot be removed by the resident in the same manner as it was applied by staff. The resident's physical condition and his/her cognitive status may be contributing factors in determining whether the resident has the ability to remove it). (#3)

Findings included:

- Resident #3's quarterly (MDS) Minimum Data Set assessment, dated 3/24/19, documented the resident had a (BIMS) Brief Interview for Mental Status Score of 3, indicating severe cognitive impairment. The assessment documented the resident required extensive assistance of 2 staff for bed mobility, transfers, dressing, toileting, and personal hygiene. The assessment further revealed the resident had a wandering and elopement alarm and had no physical restraints (any manual method, physical or mechanical device/equipment or material that limits a resident's freedom of movement and cannot be removed by the resident in the same manner as it was applied by staff. The resident's physical condition and his/her cognitive status may be contributing factors in determining whether the resident has the ability to remove it).

The 9/5/18 (CAA) Care Area Assessment for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 604	Continued From page 8	F 604		

pressure ulcer documented the resident required extensive staff assistance with (ADLs) Activities of Daily Living.

The 4/18/19 care plan documented the resident liked to turn on his/her left side while in bed and directed staff to check the resident's position so he/she did not get too close to the side of the bed. The 6/19/19 care plan update documented the resident used a wedge cushion (used for resident's who need better alignment) to help with positioning due to his/her pressure ulcer.

The medical record lacked a physical restraint assessment and a recent physical therapy or occupational therapy assessment for the use of the restraint.

On 6/18/19 at 2:41 PM, observation revealed the resident in bed, uncovered, lying on his/her left side, with a wedge cushion placed under the resident's bottom sheet on his/her left side. Further observation revealed the resident attempted multiple times to swing his/her right leg stump over the wedge cushion, shake the positioning rail (a rail that aides in turning and repositioning within the bed), and take his/her top sheet and wind it through the positioning rail.

On 6/19/19 at 2:11 PM, observation revealed the resident lying on his/her left side in bed pulling on his/her call light. Further observation revealed a wedge cushion under the bottom sheet of the bed, on the left side of the resident, positioned where the top of the cushion sits from mid chest to his/her knees. Continued observation revealed the resident pulling on his/her call light that was attached to the resident's positioning rail.

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F 604	Continued From page 9	F 604		

On 6/24/19 at 7:52 AM, observation revealed the resident lying on his/her back, eyes closed and the wedge cushion under the resident's bottom sheet on his/her left side of the bed.

On 6/19/19 at 2:15 PM, Medication Aide M stated the wedge cushion was placed on the resident's left side to position him/her off of his/her left side, and stated the resident was able to reposition him/herself while in bed. Medication Aide M verified the resident was lying on his/her left side and the wedge cushion was not used properly for positioning.

On 6/24/19 at 8:25 AM, Nurse Aide N removed the wedge cushion from the resident's left side of the bed and stated the cushion was used for positioning the resident off of his/her left side due to a pressure ulcer on the resident's buttocks. Nurse Aide N stated the resident was able to reposition him/herself while in bed.

On 6/24/19 at 9:50 AM, Administrative Nurse D stated the wedge cushion was used to position the resident off of his/her left side and stated he/she would contact the therapy department to find an alternative to using the wedge cushion, as it was not appropriate to use for the resident.

The facility's Restraint Use policy, dated 6/1019, documented the resident had the right to be free from physical or chemical restraints imposed for the purposes of discipline or convenience and not required to treat the resident's medical symptoms. The policy documented before using a device for mobility or transfer, an assessment should include a review of the resident's bed mobility, would the use of a device assist the resident to turn from side to side, or is the

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F 604	Continued From page 10 resident totally immobile and unable to change position without assistance. The facility failed to use an appropriate positioning device for Resident #3, restricting his/her freedom from movement, placing the resident at risk for injury.	F 604		