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| CLAY CENTER PRESBYTERIAN MANOR | 924 8TH STREET CLAY CENTER, KS 67432 |

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| F 000 | INITIAL COMMENTS<br><br>The following citations represent the findings of a Health Resurvey. | F 000 | | |
| F 677 SS=E | ADL Care Provided for Dependent Residents<br>CFR(s): 483.24(a)(2)<br><br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br>This REQUIREMENT is not met as evidenced by:<br>The facility had a census of 29 residents. The sample included 16 residents. Based on observation, record review and interview the facility failed to ensure 5 of 5 dependent residents reviewed for (ADLs) Activities of Daily Living, received cueing and staff assistance with eating their meals.(#6,#130,#3, #18, and #27)<br><br>Findings included:<br><br>- Resident #6's quarterly (MDS) Minimum Data Set assessment, dated 6/22/18, documented the resident had a (BIMS) Brief Interview for Mental Status score of 1, which indicated severe cognitive impairment. The MDS documented the resident had behaviors of inattention, disorganized thinking, had no swallowing disorders or dental issues, and required limited staff assistance with eating.<br><br>The 6/28/18 revised care plan documented the resident had impaired physical function related to Parkinson's disease, received a fortified diet, frequent snacks between meals, and supplements twice a day. The care plan documented the resident's favorite foods were ice | F 677 | | |

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

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

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| F 677 | Continued From page 1 | F 677 | | |

cream, grape juice and cappuccino. The care plan instructed staff to assist the resident with selections of food and encourage him/her to keep within his/her dietary needs/requirements. The care plan documented the resident would frequently refuse assistance.

The 4/12/18 (RD) Registered Dietician note documented the resident's intake was low and instructed staff to continue to encourage the resident to eat. The note documented the resident received a regular fortified food diet and supplements twice a day.

On 9/11/18 at 11:47 AM, observation revealed the resident sat in a wheelchair at the dining room table, staff served the resident a bowl of pistachio salad, 240 (cc) cubic centimeter of water and 240 cc of juice, in a handle cup with a lid. Observation revealed the resident took a bite of his/her salad, then, rearranged his/her silverware, placed his/her napkin on his/her lap, folded and refolded the napkin several times, and looked around the room and at other residents seated at his/her table. The resident took another bite of his/her salad and drank some of his/her fluids. Observation revealed dietary staff served the resident salisbury steak, cooked sliced carrots, and at 12:30 PM Nurse Aide M sat between the resident and another resident, cut up the resident's steak offered him/her a bite, and the resident took a bite. Observation revealed Nurse Aide M offered the resident another bite of the steak and the resident shook his/her head indicating no, then he/she offered the resident a bite of his/her carrots and the resident accepted the bite. Further observation revealed Nurse Aide M left the table, and the resident picked at his/her food and does not take any more bites. Further

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observation revealed at 1:00 PM the resident had the same plate of food and no staff available to assist.

On 9/17/18 at 8:36 AM, Medication Aide N stated staff find out in report which residents require assistance with meals each day. Medication Aide N stated staff try to leave food for the residents, who require assistance with eating, food on the table for a short time after being served, but not more then 1/2 hour.

On 9/17/18 at 8:40 AM, Nurse G stated he/she goes to the dining room to help assist residents with their meals, if he/she is not busy with other tasks. Nurse G stated the facility had quite a few residents that require staff assistance with eating and staff leave their trays at the table no more than 1/2 hour after being served.

On 9/17/18 at 8:47 AM, Administrative Nurse D stated he/she expected staff to sit down with the residents who need assistance with eating until they finish eating, but if one staff attempts to assist a resident with eating, and the resident refuses their help, another staff should come and take their place.

On 9/17/18 at 9:45 AM, Administrative Nurse D verified the facility had 27 residents who required some type of staff assistance with meals.

The facility's undated Feeding the Person policy documented staff should prepare residents' food for eating, identify foods as they serve them, alternate between solid and liquid foods, allow enough time for chewing and swallowing, and encourage the resident to eat as much as possible.

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| F 677 | Continued From page 3<br><br>The facility's 7/17 Resident Rights policy documented the facility will 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 policy documented the facility would care for each resident in a manner that promotes maintenance or enhancement of his/her quality of life, recognizing each resident's individuality.<br><br>The facility failed to provide staff assistance to dependent Resident #6 with meals.<br><br>- This deficient practice also effected resident # 3, who's 7/25/18 care plan documented the resident required extensive assistance with ADLs such as eating and observation revealed the staff failed to provide the resident staff assistance throughout his/her meal.<br><br>Resident #18, who's 8/13/18 care plan documented the resident required set up with staff supervision with eating, and may need reminded to continue to eat. Observation revealed the staff failed to provide the resident assistance throughout his/her meal.<br><br>Resident # 21 who's 8/21/18 care plan instructed staff to offer the resident assistance with meal. Observation revealed the staff failed to provide the resident staff assistance throughout his/her meal.<br><br>Resident #27, who's 8/27/18 care plan documented the resident frequently required staff assistance with eating. Observation revealed the staff failed to provide the resident staff assistance throughout his/her meal. | F 677 | | |

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| F 677 | Continued From page 4<br><br>The facility failed to provide necessary services to maintain good nutrition for Residents #6, #21, #3, #18, and #27, by not providing staff assistance with eating their meals as care planned, placing them at risk for decline, such as weight loss or nutritional deficit. | F 677 | | |
| F 686 SS=D | Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br>The facility had a census of 29 residents. The sample included 17 residents of which 1 was reviewed for pressure ulcers. Based on observation, record review and interview, the facility failed to implement effective interventions to prevent the development and promote healing for 1 of 1 sampled resident, who developed a facility acquired pressure ulcer.(#2)<br><br>Findings included:<br><br>- Resident #2's (POS) physicians order sheet, | F 686 | | |

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dated 8/20/18, revealed the resident 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) with other circulatory complications, disorder of veins, acquired absence right below the knee aftercare of surgical amputation, heart failure, dementia (progressive mental disorder characterized by failing memory, confusion) without behavioral symptoms, age related physical debility (physical weakness, especially as a result of illness), left heel wound, and tremors.

The quarterly (MDS) Minimum Data Set assessment, dated 6/5/18, recorded the resident had moderate cognitive impairment, needed extensive assistance of 1 to 2 staff for bed mobility, transfers, toilet use, dressing, personal hygiene, eating and had functional range of motion limitation of one side of lower extremity, always incontinent of bladder and bowel, was at risk for pressure ulcers, had MASD (Moisture-associated skin damage- (MASD: inflammation or skin erosion caused by prolonged exposure to a source of moisture such as urine, stool, sweat, wound drainage, saliva or mucous) and non surgical dressing other than to feet.

The MDS, dated 9/5/18, recorded the resident had moderately impaired cognition, required extensive assistance of 1 or 2 staff with bed mobility, transfers, toilet use, dressing, eating, had limitation of functional range of motion on one side lower extremity, and had a limb prosthesis (an artificial body part, such as a leg) always incontinent of bladder and bowel, was at risk for pressure ulcers, and had MASD.

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The Pressure ulcer CAA (Care Area Assessment) dated 9/7/18, recorded the resident required extensive staff assistance with activities of daily living, had diagnosis of DM, had a history of sores on his/her feet, and was incontinent of bladder and bowel.

The 6/20/18 care plan did not address skin or pressure ulcer concerns, but the resident had health status factors such as amputation.

The 7/23/18 care plan update documented the resident was at risk for pressure ulcers, had a foam mattress to reduce pressure, liked to turn to the left side of the bed, and instructed staff to check frequently to make sure his/her position changes to avoid skin breakdown.

The 8/17/18 care plan update documented the resident had an open area to his/her left gluteal fold (pertaining to the buttocks or buttocks muscles), and directed staff to monitor and change the dressing frequently.

The 8/24/18 care plan update instructed staff to add an air mattress to the bed.

The 9/6/18 care plan update documented the resident liked to be up in the wheelchair or recliner, and instructed staff to position him/her so that weight shifts away from the left gluteal area.

The 9/12/18 care plan update instructed staff to not use incontinent garments, to check for incontinence all three shifts, and change the wet to dry dressing every 4 hours to the wound, and as needed.

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The 7/5/18 fax to the physician recorded the resident's pressure ulcer as a stage 1, measuring 0.8 (cm) centimeters in length by 0.5 cm in width, no depth, no drainage, and staff requested to apply KerraFoam (an absorbent foam dressing dressing designed for wound drainage) 3 inch x 3 inch dressing, use of wound cleanser. The fax was returned and signed by the physician.

The 7/17/18 fax to the physician expressed concerns with MASD, the open area to the resident's left gluteal fold persisted, and staff requested therapy treatment to change to Calmaseptine ointment to the affected area, 2 times a day and as needed until healed, and discontinue KerraFoam dressing. The fax was returned and signed by the physician.

The 8/21/18 fax to the physician requested KerraFoam dressing to the resident's left buttock every 3 to 7 days and the physician signed the request.

The 8/27/18 physician progress note documented the resident had an ulcer to his/her buttock.

The 9/10/18 physician progress note documented the wound was necrotic and planned to debride (medical removal of dead, damaged, or infected tissue to improve the healing potential for the remaining healthy tissue) the area.

The 9/12/18 physician progress note documented sharp debridement of the wound, 4 cm x 4 cm, and directed staff to apply wet to dry dressings (involves placing moist saline gauze onto the wound bed, then allowing it to dry and adhere to the tissue in the wound bed) for debridement.

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The Wound Assessment Record documented the following:

7/3/18-gluteal fold, 0.8 cm x 0.5 cm, partial thickness, occurred at CCPM (Clay Center Presbyterian Manor), 3 inch x 3 inch KerraFoam dressing, physician and wife notified.

7/11/18 skin condition, MASD, 3.5 cm x 3.5 cm x 0 cm in depth, serosanguineous (semi-thick reddish drainage) drainage to left buttock, round area KerraFoam dressing changed.

7/17/18, wound remains moist and raw, MASD, 1.5 cm x 0.75 cm wound, will request change of therapy.

7/24/18, MASD, 1.7 cm x 1.0 cm x 0 cm, serosanguineous drainage, no dressing, KerraFoam dressing not staying on site, edges roll, open area decreasing in size, will use Calvida Skin Protectant with each toileting until healed.

8/8/18, no reference to gluteal wound, documentation recorded no new areas of concern.

8/15/18, MASD, gluteal fold 1.25 cm x 0.75 cm, no drainage, healing healthy intact surrounding skin, no dressing.

8/21/18, MASD, 2.75 cm x 2.0 cm, with bloody/serosanguineous drainage, wound bed raw, KerraFoam applied.

8/28/18 center of wound blackish/yellow/beige around the edge, pink color area peeling beyond edges, 3 cm x 2 cm, serosanguineous drainage, new KerraFoam placed. Placed head of bed

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rotated so if he/she wants to turn toward the door he/she will be turning to the right side, air mattress placed on bed. Position resident off the left gluteal fold, cushion to prop him/her to the right when up in the wheelchair or recliner, to see doctor for evaluation during rounds.

9/6/18 MASD, 3 cm x 2 cm the center of the wound blackish/yellow/beige, pink colored area peeling beyond the edges, KerraFoam, and continued measures as previously described.

9/12/18 MASD, wound debrided by doctor today, 4 cm x 3.5 cm x 2.0 cm bloody/serosanguineous drainage. New orders initiated.

The 9/11/18 Registered Dietician recommended Arginade 1 package, 2 times a day for wound healing and the physician signed recommendation.

On 9/13/18 at 1:33 PM, observation revealed the resident resting in bed, on his/her right side, a pillow behind his/her back, and facing the door.

On 9/13/18 at 11:50 PM, observation of wound care preformed by Staff Nurse H to left gluteal fold area, revealed the area dressed with 4 x 4 gauze and secured with paper tape. No drainage noted on the outer dressing. Once dressing was removed observation revealed an open wound, round to oblong in shape, edges well defined and the wound bed with granulation type tissue of 50% and tanish tissue 50%. Staff Nurse H, explained the area first presented looking like a bruised area, he/she did not know what the cause was. Staff Nurse H reported the wound had worsened over the previous weekend.

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On 9/13/18 at 4:20 PM, observation with Staff Nurse I revealed the wound measured 1.5 cm x 3.2 cm x 2.1 cm. No drainage noted on the dressing, the wound edges well defined, surrounding tissue dark purple color approximately 2 cm wide. Staff Nurse I explained the area presented as a bruised area with the top layer of skin removed, like that of a blister with a thin layer of skin was off. Staff Nurse I also stated the weekend staff alerted him/her of a significant decline in the wound.

On 9/13/18 at 1:30 PM, Physician GG, stated the facility had notified him/her of the skin condition on 7/3/18. The area presented as a bruised area. Physician GG was not able to verify the area was a deep tissue wound, but stated the wound was a grade 2. Physician GG also stated he/she debrided the area on the 9/12/18 and was not able to completely remove the affected tissue related to the resident being on blood thinners and risk of increased bleeding. He/she ordered the wet to dry dressing changes to aid in debridement of the wound bed. Physician GG commented that unfortunately the wound will be difficult to heal due to the diagnosis and complex conditions of this resident.

On 9/13/18 at 3:00 PM, Administrative Nurse D stated the area initially presented as a bruised area, and the staff completed weekly wound assessments. Administrative Nurse D verified the resident had care issues related to his/her diabetes, dementia, and right below knee amputation related to history of osteomyelitis. Administrative Nurse D, also verified he/she had not observed the wound.

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| F 686 | Continued From page 11<br>The 6/25/18 facility's Skin Integrity, pressure/injury prevention, nursing intervention and would guidelines, recorded nursing staff will evaluate skin integrity, implement measures as indicated and treat skin break down. Identify residents at risk for pressure ulcers/injury. Initiate and implement preventive measures to maintain intact skin and initiate and implement wound treatment orders when pressure ulcer/injuries and/or wounds are present or acquired.<br><br>The facility failed to implement interventions to prevent the development of a facility acquired pressure ulcer for Resident #2, who developed skin breakdown to the right gluteal fold area, placing the resident at risk for continued breakdown. | F 686 | | |
| F 689 SS=E | Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>The facility had a census of 29 residents. The sample included 17 residents. Based on observation and interview, the facility failed to ensure the environment remained free of accident hazards, by leaving a chemical in an unlocked cabinet, in the south kitchenette, and accessible to the facility's 5 cognitively impaired, independently mobile residents. | F 689 | | |

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| F 689 | Continued From page 12<br><br>Findings included:<br><br>- On 9/11/18 at 7:36 AM, observation revealed, a spray bottle of Ecolab A-456 (disinfectant cleaner), with no ounces listed on the bottle, in an unlocked cabinet, in the south kitchenette.<br><br>On 9/11/18 at 7:36 AM, Administrative Nurse D verified the above finding and stated the bottle should be in a locked area. Administrative Nurse D stated 5 cognitively impaired, independently mobile residents resided in the facility.<br><br>The facility's 1/13/1997 Safety Guidelines policy documented solutions and caustic supplies were properly labeled and placed in appropriate containers. When these supplies were not in use, they were stored in a locked cabinet. Hazardous substances were not left at any time or stored in areas accessible to residents.<br><br>The facility failed to ensure an environment free of accident hazards for the 5 cognitively impaired, independently mobile residents in the facility, placing them at risk for an avoidable accident. | F 689 | | |
| F 812 SS=F | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. | F 812 | | |

| 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 _____ | 09/17/2018 |

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

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|---|---|---|---|---|
| F 812 | Continued From page 13 | F 812 | | |

(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.
(iii) This provision does not preclude residents from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 29 residents. The sample included 17 residents. Based on observation, record review and interview the facility failed to store, prepare, distribute and serve food under sanitary conditions, for the 29 residents who receive their meals from the facility kitchen.

Findings included:

- On 9/11/18 at 11:42 AM, during the kitchen tour, observation revealed the following:

5 ceiling vents approximately 4 (ft) feet by 2 ft with rust colored areas over the entire area, above the food preparation areas.

A wall return vent, approximately 4 ft by 2 ft, with a gray substance over the entire area.

A large floor fan in the kitchen, with a gray substance on the edges of all blades, blowing directly on the food preparation area.

The 2 door oven had 1 burner with a rust colored area, approximately quarter size, and the remaining 5 burners had rust colored areas in

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| F 812 | Continued From page 14 | F 812 | | |

cracks in between them. Both ovens had numerous rust colored areas inside of the ovens and food particles on the lip of the front of each oven.

All kitchen baseboards, water pipes, drainage pipes had a black colored substance on them.

On 9/11/18 at 11:47 AM, Dietary Manager BB verified the above findings and stated staff scrub the oven monthly to the best of their abilities. Dietary Manager BB stated the kitchen did not have a deep cleaning schedule. Dietary Manager BB stated maintenance should be cleaning the vents on their preventative maintenance list.

On 9/12/18 at 10:47 AM, during environmental tour with Maintenance Staff U verified ceiling vents with rust colored areas and return air vent in the wall with a gray substance and stated staff clean them on a monthly basis.

Review of the daily stove cleaning schedule for the month of September 2018 lacked documentation from 9/5-9/12/18 regarding cleaning of the stove.

The maintenance work order for quarterly cleaning of ventilation grates documented last time vent grates were cleaned was 7/21/18.

The facility's Sanitation policy, dated 10/1/1996, documented all utensils, counters, shelves and equipment would be kept clean, maintained in a good repair and would free from breaks, corrosion, open seams, cracks and chipped areas.

The facility failed to store, prepare, distribute and

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| F 812 | Continued From page 15<br>serve food in under sanitary conditions, placing the residents at risk for receiving contaminated food. | F 812 | | |