STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N018008	A. BUILDING: _____ B. WING _____	12/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARKANSAS CITY PRESBYTERIAN MANOR	1711 N 4TH STREET ARKANSAS CITY, KS 67005

(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) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey with attached complaint number 176871 for the above named facility conducted on 12/27/2022.	S 000		
S3081 SS=D	26-41-201 (c) Functional Capacity Screen Reassessment (c) Designated facility staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-201 (c)(1) The facility reported a census of thirteen residents. The sample included three "Residents'" (R's). Based on record review and interview the "Administrator" (A) failed to ensure the "Licensed Nurse" (LN) conducted a "Functional Capacity Screen" (FCS) at least once every 365 days for R1. Findings included: - Record review on 12/27/22 for R1 revealed and admission date of 07/11/2018 with	S3081		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N018008	A. BUILDING: _____ B. WING _____	12/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARKANSAS CITY PRESBYTERIAN MANOR	1711 N 4TH STREET ARKANSAS CITY, KS 67005

(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) COMPLETE DATE
S3081	Continued From page 1 diagnoses of unspecified dementia, unspecified atrial fibrillation, anemia, and long-term use of anti-coagulants. Record review on 12/27/22 of R1 FCS dated 07/30/21 identified the resident required supervision with bathing and dressing. She was independent with toileting, transferring, walking, and eating. She was continent of bladder and understood others and was able to make herself understood. She lacked the ability to manage her own medications and had impaired long-term memory, impaired memory recall and impaired decision making. She used a four wheeled walker for mobility and was marked with falls. Interview on 12/27/22 at 03:15 PM with LN A, she confirmed the FCS dated 07/30/21 was the most recent FCS in the resident record. The "Administrator" (A) failed to ensure the "Licensed Nurse" (LN) conducted a "Functional Capacity Screen" (FCS) at least once every 365 days for R1.	S3081		
S3092 SS=D	26-41-202 (d) Negotiated Service Agreement Revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements:(1) At least once every 365 days; (2) following any significant change in condition, as defined in K.A.R. 26-39-100; (3) at least quarterly, if the resident receives assistance with eating from a paid nutrition assistant; and	S3092		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N018008	A. BUILDING: _____ B. WING _____	12/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARKANSAS CITY PRESBYTERIAN MANOR	1711 N 4TH STREET ARKANSAS CITY, KS 67005

(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) COMPLETE DATE
S3092	Continued From page 2 (4) if requested by the resident or the resident ' s legal representative, facility staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-202 (d)(3) The facility reported a census of thirteen residents. The sample included three "Residents'" (R's). Based on record review and interview the "Administrator" (A) failed to ensure the "Licensed Nurse" (LN) reviewed and if necessary, revised the "Negotiated Service Agreement" (NSA) at least once every 365 days for R1. Findings included: - Record review on 12/27/22 for R1 revealed and admission date of 07/11/2018 with diagnoses of unspecified dementia, unspecified atrial fibrillation, anemia, and long-term use of anti-coagulants. Record review on 12/27/22 of R1 NSA dated 07/30/21 identified the following healthcare services/ and instructed staff to provide: supervision with bathing, monitor for changes in mobility status while using her four wheeled walker, and administer her medications Interview on 12/27/22 at 03:15 PM with LN A, she confirmed the NSA dated 07/30/21 was the most recent NSA in the resident record.	S3092		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N018008	A. BUILDING: _____ B. WING _____	12/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARKANSAS CITY PRESBYTERIAN MANOR	1711 N 4TH STREET ARKANSAS CITY, KS 67005

(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) COMPLETE DATE
S3092	Continued From page 3 The "Administrator" (A) failed to ensure the "Licensed Nurse" (LN) reviewed and if necessary, revised the "Negotiated Service Agreement" (NSA) at least once every 365 days for R1.	S3092		