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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey. The 2567 was sent electronically on 03/17/23.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: The facility had a census of 29 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to accurately code the Minimum Data Set (MDS) assessment for two of the 13 residents which had falls. The deficient practice placed the residents at risk of inaccurate care needs for Resident (R) 3 and R19. Findings included: - R3's Electronic Medical Record (EMR) recorded diagnoses of an interior trochanter fracture (top portion into hip socket) of right femur (thigh bone), adjustment disorder (an emotional or behavioral reaction to a stressful event or change in a person's life) with delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), pain, repeated falls and insomnia (inability to sleep). The EMR "Interdisciplinary Notes" recorded R3 fell on 08/10/22, 08/16/22, 08/22/22 and 08/23/22. R3's "Nursing Home Medicare A Skilled Payment	F 641		

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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End (NPE)," dated 09/27/22, lacked documentation of falls during since the prior assessment.

The EMR "Interdisciplinary Notes" recorded R3 fell on 09/30/22, 10/03/22, 10/04/22, 10/07/22, 10/13/22, and 10/23/22.

R3's "Significant Change Minimum Data Set" (MDS), dated 10/28/22, lacked documentation of falls since prior assessment.

On 03/07/23 at 01:35 PM, Administrative Nurse E verified R3 had numerous falls and verified the falls had not been coded on the MDS. Administrative Nurse E stated she lacked coding the falls and would submit a correction for the fall section of the MDS.

The facility's "MDS Data Accuracy" policy, dated 06/10/19, documented it was the responsibility of those who complete sections of the MDS to ensure date entered accurately reflect the resident's status and is coded accordingly to the Resident Assessment Instrument (RAI) manual guidelines. If MDS documentation inaccuracies or disparities are ascertained, the process of editing the documentation source, in addition to correction MDS will be instated. Validating MDS data for accuracy, prevents any issue with supportive documentation not matching the MDS and can help protect against any documentation issues arising in survey or audits.

The facility failed to correctly code the MDS, placing R3 at risk for incomplete assessment and inaccurate care needs related to falls.
- R19's Electronic Medical Record (EMR) recorded diagnoses of hypertension (high blood

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pressure), chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should) and back pain.

The EMR "Interdisciplinary Notes" recorded R19 had fallen on 06/11/22.

R19's "Quarterly Minimum Data Set" (MDS), dated 08/14/22, lacked documentation of falls since the prior assessment.

The EMR "Interdisciplinary Notes" recorded R19 fell on 01/05/23 and 01/23/23.

R19's "Quarterly MDS," dated 02/06/23, lacked documentation of falls since the prior assessment.

On 03/07/23 at 01:27 PM, Administrative Nurse E verified R19 had numerous falls and verified the falls had not been coded on the MDS. Administrative Nurse E stated she lacked coding the falls and would submit a correction for the fall section on the MDS.

The facility's "MDS Data Accuracy" policy, dated 06/10/19, documented it was the responsibility of those who complete sections of the MDS to ensure data entered accurately reflect the resident's status and is coded accordingly to the Resident Assessment Instrument (RAI) manual guidelines. If MDS documentation inaccuracies or disparities are ascertained, the process of editing the documentation source, in addition to correcting the MDS, will be initiated. Validating MDS data for accuracy, prevents any issue with supportive documentation not matching the MDS and can help protect against any documentation issues arising in survey or audits.

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F 641	Continued From page 3 The facility failed to correctly code the MDS, placing R19 at risk for incomplete assessment and inaccurate care needs related to falls.	F 641		
F 657 SS=D	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: The facility had a census of 29 residents. The sample included 13 residents, with eight reviewed	F 657		

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for behaviors. Based on observation, record review, and interview, the facility failed to revise one care plan for antidepressant medication (class of medications used to treat mood disorders and relieve symptoms of depression) for one sampled resident, Resident (R) 9. This placed the resident at risk for inaccurate side effect monitoring.

Findings included:

- The Electronic Medical Record (EMR) documented R9 had diagnoses of depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, and emptiness), adjustment disorder (an emotional or behavioral reaction to a stressful event or change in a person's life), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and dementia without behavioral disturbance (progressive mental disorder characterized by failing memory, or confusion).

The "Quarterly Minimum Data Set" (MDS), dated 02/13/23, documented R9 had intact cognition and required extensive assistance of two staff for bed mobility, transfer, dressing, toileting, and personal hygiene. The MDS further documented R9 had physical and verbal behaviors towards others four to six days, other behaviors one to three days, feeling bad about herself two to six days, and R9 received antidepressant) medications during the look back period.

The "Care Plan," dated 02/23/23, originated on 04/05/21, documented R9 received Zoloft, (an antidepressant medication), and directed staff to monitor for side effects such as somnolence

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(drowsiness), insomnia (persistent problems falling and staying asleep), headache, anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), constipation (difficult bowel movements), and diarrhea (loose, watery stools).

The "Physician Order," dated 11/04/22, originally ordered 03/14/21, directed staff to administer Zoloft, 100 milligrams (mg), by mouth, daily, for depression. The Zoloft medication was discontinued 01/09/23.

The "Physician Order," dated 11/04/22, originally ordered 08/25/22, directed staff to administer Zoloft, 50 milligrams (mg), by mouth, daily, for depression. The Zoloft medication was discontinued 01/09/23.

The "Physician Order," dated 01/09/23, directed staff to administer desvenlafaxine succinate (an antidepressant that also treats anxiety), 25 mg, by mouth daily.

On 03/02/23 at 08:09 AM, observation revealed R9 was verbally aggressive with staff stating they were incompetent and should not be working.

On 03/07/23 at 10:27 AM, Administrative Nurse E stated that usually social service would update the care plans regarding behaviors and medications and stated there was not a social service person working at this time so she would revise the care plan and remove the inaccurate medication and add in the new medication and side effects.

The facility "Care Plan" policy, dated 07/28/22, documented a person-centered plan of care

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F 657	Continued From page 6 would be reviewed and revised quarterly if needed, annually and when a significant change occurred. The team would utilize the results of the assessments to develop, review and revise the resident's comprehensive plan of care. The facility failed to revise R9's care plan with the appropriate antidepressant medication. This placed the resident at risk for inaccurate side effect monitoring.	F 657		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: The facility had a census of 29 residents. The sample included 13 residents, with eight reviewed for behaviors. Based on observation, record review, and interview, the facility failed to provide medically- related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being for one sampled resident, Resident (R) 9, who had behaviors. This placed the resident at risk for further decline of her emotional and mental well-being. Findings included: - The Electronic Medical Record (EMR) documented R9 had diagnoses of depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, and emptiness), adjustment disorder (an emotional or behavioral reaction to a stressful	F 745		

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event or change in a person's life), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and dementia without behavioral disturbance (progressive mental disorder characterized by failing memory, or confusion).

The "Quarterly Minimum Data Set" (MDS), dated 02/13/23, documented R9 had intact cognition and required extensive assistance of two staff for bed mobility, transfer, dressing, toileting, and personal hygiene. The MDS further documented R9 had physical and verbal behaviors towards others four to six days, other behaviors one to three days, felt bad about herself two to six days, and received antidepressant (medication used to treat mood disorders and relieve symptoms of depression) medications.

The "Care Plan," dated 02/23/23, documented R9 could be short tempered and easily angered, had socially inappropriate behavior, offensive/defensive behaviors as evidenced by verbal outburst, demeaning comments when staff attemptedt to help but did not meet R9's standards. The care plan further documented staff should assess R9's mood and behavior when approaching her and request a second staff member. R9's behavior would be managed to ensure optimal quality of life over the next 90 days. R9 was purposeful, threatening to others, and had physical behaviors of hitting and pinching others; R9 participated in psychological services.

The "Nurse's Note," dated 11/30/22 at 07:33 PM, documented R9 was verbally and physically abusive and scratched a Certified Nurse Aide (CNA) in two places and grabbed the CNA by the neck of her shirt.

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The "Nurse's Note," dated 12/14/22 at 07:30 PM, documented R9 tried to hit a CNA three times and pushed the mechanical lift into the CNA's leg.

The "Nurse's Note," dated 12/15/23 at 02:52 AM, documented R9 called a CNA a demeaning offensive name related to the CNA's weight. The note further documented staff placed R9's phone on the bedside table from the bed and R9 accused her of stealing her phone.

The "Nurse's Note," dated 12/15/22 at 03:26 AM, documented R9 stated staff were too stupid to do things right after staff cleaned R9's floor and picked up extra cleansing wipes the resident had pulled out of the package and threw on the floor. The note further documented R9 became upset when staff threw the wipes away because she felt they were still clean.

The "Social Service Note," dated 12/15/22 at 04:04 PM, documented the Social Services Designee (SSD) met with R9 to discuss various topics ranging from Quality of Care to how R9 feels no one visits her. The note further documented R9 continued to have long and short-term memory challenges as demonstrated when R9 was asked what the date was and what major holiday was next week. R9 stated that she had a birthday later in the month and she would be 49 years old. The note documented the SSD did not correct R9 as her birthday was in February and she would be 94 years old.

The "Nurse's Note," dated 12/18/22 at 01:01 PM, documented two staff reported that R9 called them names, screamed at them, and hit one of them in the eye. The note further documented

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staff left R9 in a safe place and left the room.

The "Nurse's Note," dated 12/18/22 at 08:19 PM, documented R9 scratched a CNA on the arm and called the CNA names. The note further documented R9 wiped herself after urinating, held out the cleansing wipe and stated," do you want to sniff it?" The note documented R9 continued to be verbally abusive and as the CNA started to lotion R9's legs, she started kicking at him.

The "Nurse's Note," dated 12/25/22 at 10:21 PM, documented R9 was verbally abusive to staff and stated, verbalized offensive religious connotations and used profanity, and continued to call staff stupid and dumb.

The "Nurse's Note," dated 12/28/22 at 10:38 PM, documented R9 scratched a CNA on the arm when the CNA tried to turn off R9's call light. the note further documented R9 refused to let staff turn it off and tried to kick the CNA in the face.

The "Nurse's Note," dated 01/10/23 at 10:00 PM, documented during bedtime cares R9 hit, kicked, and tried to pull a CNA's hair. The note further documented when R9 asked the CNA to get something out of her walker, when the CNA reach to get the item, she accused the CNA of stealing something. When the CNA asked R9 what she wanted, she stated "I don't want anything." Staff left R9 in bed and left the room. The note further documented R9 called down to the nurse's station and stated staff left her room and did not put her head up along with a list of cares staff did not do. The nurse stated, cares were not completed due to her hitting and kicking, and the CNA's went back to R9's room to finish her cares.

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The "Nurse's Note," dated 01/31/23 at 01:15 AM, documented a resident had wandered into R9's room and R9 started throwing stuff at the resident to get her to leave the room. The note further documented staff arrived at the room quickly and escorted the confused resident out of the room and was not hit by the flying debris. The note further documented R9 was encouraged to call out for staff or use her call light instead of throwing things. R9 stated she understood and "will see" the next time the resident wandered into her room.

The "Nurse's Note," dated 02/01/23 at 05:48 AM, documented R9s stated the CNA did not know what she was doing and should go back to school. The note further documented R9 told the CNA, "you should die, I do not want you in here anymore."

The "Nurse's Note," dated 02/13/23 at 04:37 AM, documented R9 call staff names and told them how worthless they were and should not be working with older people due to their incompetency.

The "Nurse's Note," dated 02/27/23 at 05:41 AM, documented R9 had called staff names all shift and had swung her walker at a staff member. The note further documented staff stopped the walker from hitting him when he grabbed the wheels of the walker and when R9 told him to let go, he did.

The "Nurse's Note," dated 03/02/23 at 08:36 AM, documented R9 hit two different staff on their arms four times, called them names and belittled them.

On 03/01/23 at 03:34 PM, R9 stated her husband

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had passed away, they would have been married 75 years and she really missed him. R9 stated this several times during the conversation as well talking about her grandchildren and great grandchildren. R9 stated she had two sisters who were still alive but had lost both brothers. During the conversation, R9 kept bringing up her husband and how sad she was that he was no longer with her.

On 03/02/23 at 08:09 AM, observation revealed R9 was verbally aggressive with staff stating they were incompetent and should not be working. R9 stated the Certified Medication (CMA) should be fired and would not take her medication until R9 was finished putting on her makeup.

On 03/02/023 at 11:01 AM, CNA N stated R9 had hit, slapped, and even thrown her walker at her during cares. CNA N further stated R9 had found out she was pregnant and had made derogatory remarks about the baby and how she pitied the baby for having CNA N as her mother. CNA N stated when R9 got "nasty," she got the nurse to assist and stated R9 would get more abusive if you did not gossip with her.

On 03/02/23 at 05:00 PM, Administrative Staff A stated the facility had a social worker that was not in the building but would come to the facility weekly and as needed. Administrative Staff A stated she was unsure if the social worker had visited with R9.

On 03/06/23 at 02:12 PM, CNA M stated when R9 got nasty, she goes to the nurse for assistance and stated she was unsure what would trigger the behaviors except R9 did not like the mechanical lift.

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On 03/07/23 at 08:15 AM, Licensed Nurse (LN) G stated R9 was verbally and physically abuse to staff and she would often go in to assist the CNA's. LN F further stated when she was assisting, R9 was not physically abusive but would continue to be verbally abusive. LN G stated R9 did have a mental health nurse that would visit with her, but was unsure how often. LN G stated the facility did not have a SSD or anyone providing social work services.

On 03/07/23 at 12:35 PM, Administrative Nurse D stated there was not a social service person in the building, but they had a social worker that would come to the building weekly . Administrative Nurse D was unsure if R9 had been seen recently. Administrative Nurse D further stated, she visited with R9 weekly about behaviors but had not documented the visits or what had been discussed. Administrative Nurse D stated the facility had sent a referral to a behavior unit in September but at that time there was not a bed available and when there was a bed, R9 refused to go, so they along with the family opted for medication at this time. Administrative Nurse D stated a mental health nurse did visit with R9 on a regular basis.

The facility "Social Worker" policy, dated October 13, 2021, documented the social services director was a qualified social worker or social service designee and was responsible for assistance in meeting the social and emotional needs of residents. The medically related social services are provided to maintain or improve resident's ability to maintain highest level of function, mental and psychosocial needs. The social service provided assistance with behavioral problems

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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 745	Continued From page 13 and provided corrective action for the resident's needs. The social service makes supportive visits to residents and performed needed services, communications with the family or friends, coordinates resources and services to meet resident needs. The facility failed to provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being for one sampled resident, R9, who had behaviors. This placed the resident at risk for further decline of her emotional and mental well-being.	F 745		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use 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	F 758		

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F 758	Continued From page 14	F 758		

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 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 29 residents. The sample included 13 residents, with six reviewed for unnecessary medications. Based on observations, record review, and interview, the facility failed to ensure an appropriate indication for use for one of six sampled residents, Resident (R) 28's antipsychotic (a medication used to treat any major mental disorder characterized by a gross impairment in reality testing) medication, Seroquel. This placed the resident at risk for adverse side effects related to antipsychotic use.

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F 758	Continued From page 15	F 758		

Findings included:

- The Electronic Medical Record (EMR) for R28 documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) and diabetes mellitus type 2 (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin).

The "Admission Minimum Data Set" (MDS), dated 01/30/23, documented R28 had severely impaired cognition and required supervision of one staff for transfers, ambulation, eating ad limited assistance of one staff for bed mobility, dressing, and toileting. The assessment further documented R28 had inattention, disorganized thinking, physical and verbal behaviors, rejection of care , wandering, and did not receive any medications during the lookback period.

R28's "Care Plan," dated 02/03/23, documented R28 had a behavior problem and directed staff to monitor and document her behaviors. The update, dated 02/13/23, directed staff to administer Seroquel as ordered, monitor and report any side effects.

The "Physician Orders," dated 02/17/23, directed staff to administer Seroquel, 25 milligrams (mg) by mouth at bedtime for behaviors.

On 03/02/23 at 11:32 AM, observation revealed R28 in the dining room participating in group exercises.

On 03/06/23 at 05:00 PM, Administrative Nurse D verified behaviors was not an appropriate diagnosis for the Seroquel medication and stated

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F 758	Continued From page 16 R28 would be evaluated by the mental health nurse due to her dementia. The facility "Psychoactive Psychopharmacological Medications" policy, dated 07/05/22, documented psychotropic medications are given to treat specific conditions, diagnoses, and was documented in the clinical record. The facility failed to ensure an appropriate indication for the use of R28's Seroquel, placing the resident at risk for adverse side effects.	F 758		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (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 13 residents. Based on	F 812		

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F 812	Continued From page 17	F 812		

observation, record review, and interview, the facility failed to store, prepare, and serve food in a sanitary condition for 28 residents who resided in the facility and received meals from the facility kitchen, which placed the resident at risk for food borne illness.

Finding included:

-On 03/02/23 at 12:00 PM, observation revealed foods prepared in the kitchen located in the basement of the facility, loaded into a heat preserving cart and taken to the elevator up to the long- term care unit of the facility. The hot food items then transferred to the steam table in the kitchenette. Dietary Staff (DS) CC then observed checking the food temperatures with an electronic thermometer. The Fahrenheit (F.) temperature of the following foods were as followed:
Rice at 174 F.
Broccoli 168 F.
Mashed Potatoes 177 F.
Asparagus 165 F.
Shredded/Deboned Chicken 125 F.
Ground Chicken 123 F.
Pureed Chicken 112 F.
Pureed Broccoli 122 F.

DS CC then placed the serving utensils in the food items to begin the plating process. As DS CC began the first plate, this surveyor inquired if DS CC knew the holding temperature of food prior to being served. DS CC stated she did not know what the holding/serving temperature and stated the food was always hot from the kitchen. Another Dietary staff member then in the kitchenette stated the food would have to return to the steamer in the kitchen to be heated to the correct holding temperature. Dietary staff

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F 812	Continued From page 18	F 812		

removed and covered for transport back to kitchen, all the chicken and broccoli from the steam table, placed in back into the heat preserving cart and back to the kitchen for reheating. The serving utensils were placed on a plate and remained on the steam table cart.

On 03/02/23 at 12:25 PM the heat preserving cart was returned to the kitchenette and foods placed into the steam table, the temperatures were taken with the results of:
Shredded/Deboned Chicken 150 F.
Ground Chicken 166 F.
Pureed Chicken 140 F.
Pureed Broccoli 140 F.

The facility's "Reheating of Food on the Nursing Unit Sanitation and Infection Control" policy, dated 11/2017, documented when food is transported to an auxiliary serving site or nursing unit, the temperatures need to be taken and recorded prior to meal distribution. Hot food must be held at or above 135 degrees. If hot food temperature falls below 135, the hot food must be reheated two hours or less.

The facility failed to ensure the holding temperature of transported food items which placed the residents at risk for food borne illness.