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 _____	05/02/2024

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

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S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey with attached complaint numbers 184224, 183688, 181813, and 181525for the above named facility conducted on 05/01/24 and 05/02/24.	S 000		
S3026 SS=G	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: K.A.R.26-41-101 (f) (1) (B) The facility reported a census of 10 residents. The sample included 4 "Residents'" (R)'s . Based on record review and interview the Administrator failed to protect R4 from neglect after facility "Certified Nursing Aide" (CNA) A found her on the floor at approximately 04:45 AM and called for help from CNA B to assist R4 off the floor. CNA's A and B failed to notify the facility "Licensed Nurse" (LN) prior to assisting R4 off the floor and they further failed to notify the LN of finding R4 on the floor after they assisted R4 back to her recliner. This resulted in R4 not receiving a nursing assessment after an	S3026		

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

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S3026	Continued From page 1	S3026		

unwitnessed fall which resulted in the delayed treatment of a right humeral neck fracture and a right humeral head dislocation , as was documented in the resident electronic "Interdisciplinary Notes" at 04:56 PM, approximately twelve hours after CNA A and CNA B assisted R4 off the floor.

Findings included:

- Record review for R4 revealed an admission date of 04/02/21 with diagnoses of Alzheimer's disease, anxiety, restlessness, wandering, essential hypertension, insomnia, glaucoma, decreased white bleed cell count, chronic fatigue, and depression.

Review of R4's "Functional Capacity Screen" dated 03/23/23 revealed R4 required supervision with bathing, and dressing. She was continent and was independent with toileting. She was independent with transfers and mobility, and she did not use a mobility device. She had impaired long-term memory and impaired memory recall. She was marked with falls, and she was able to make herself understood and she understood others.

Review of R4's combined "Negotiated Service Agreement" (NSA)/" Health Service Plan" (HSP) dated 03/23/23 instructed facility staff to provide the following health services: staff to provide supervision with R4's bathing and dressing. R4 was independent with mobility and transferring. Staff were to monitor and identify for fall risk.

Review of R4's electronic medical record under

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S3026	Continued From page 2	S3026		

the "Interdisciplinary Notes" tab revealed the following entries:

07/14/23 at 12:46 PM Resident complained of right shoulder pain and declined to raise her right arm. "Primary Care Provider" (PCP) and the resident's "Durable Power of Attorney" (DPOA) were notified.

07/14/23 at 04:56 PM Mobile X Ray obtained an X Ray of R4's right shoulder and right humerus.

07/14/23 at 05:31 PM the facility received the final report of R4's X Ray, which confirmed a commuted fracture of the right humeral neck with an inferior dislocation of the humeral head.

R4's "Interdisciplinary Notes" lacked an entry made of the resident being assisted off of the floor.

Record review of CNA A's signed and notarized witness statement dated 07/21/23 revealed she checked on R4 during a routine "Bed Check" and found R4 on the floor. CNA A wrote that she called for assistance from CNA B to assist R4 from the floor. She wrote that vital signs were obtained.

Record review of CNA B's signed and notarized witness statement dated 07/21/23 revealed that she was called by CNA A to assist with getting R4 up from the floor. She wrote that she went and retrieved the equipment to obtain R4's vital signs and assisted CNA A in getting R4 up from the floor.

Review of the facility policy titled "Falls" Revised

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S3026	Continued From page 3 10/12/22 revealed the following information: Under the section titled "Fall Occurrence" were the following instructions: 6. Notify responsible party, physician and "Registered Nurse" (RN) supervisor. If off hours notify RN on call. 8. Residents with unwitnessed falls shall be considered to have hit their head unless they are a reliable historian and can definitely say they did not hit their head. Baseline neurological checks will be done on residents that are observed on the floor or have unwitnessed falls. R4'S electronic medical record lacked documentation of neurological checks being performed, and further lacked documentation of the RN being notified of R4 being found on the floor. Interview on 05/02/24 at approximately 02:00 PM with RN's C and D confirmed CNA A and CNA B did not call the LN on duty at the time they found R4 on the floor, and they further confirmed that CNA A and CNA B did not tell the on coming staff that R4 was found on the floor. RN C confirmed that the staff on duty on the morning of 07/14/23 at approximately 11:45 AM the facility staff reported to her that R4 would not use her right arm. RN C stated that during the investigation she observed on the facility video footage CNA A walking into R4's room at 04:45 AM. The Administrator failed to protect R4 from neglect after CNA A found her on the floor at approximately 04:45 AM and called for help from CNA B to assist R4 off the floor. CNA's A and B failed to notify the LN prior to assisting R4 off the floor and they further failed to notify the LN of	S3026		

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S3026	Continued From page 4 finding R4 on the floor after they assisted R4 back to her recliner. This resulted in R4 not receiving a nursing assessment after an unwitnessed fall which resulted in the delayed treatment of a right humeral neck fracture and a right humeral head dislocation which was diagnosed by X-Ray, that was documented in the resident electronic "Interdisciplinary Notes" at 04:56 PM, which was approximately twelve hours after CNA A and CNA B assisted R4 off the floor.	S3026		
S3215 SS=E	26-41-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as	S3215		

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S3215	Continued From page 5 recommended by the manufacturer or pharmacy provider may request that the medication be stored by the facility. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-205 (h) (4) The facility reported a census of 10 residents. Based on observation and interview the Administrator failed to ensure the "Licensed Nurse" (LN) or "Certified Medication Aide" (CMA) did not use insulin medications beyond the manufacturer's or pharmacy provider's recommended date of expiration. Findings included: - Observation on 05/01/24 at approximately 12:10 PM of the "Assisted Living Medication" cart revealed the in the second drawer down a pen of Insulin Glargine labeled with R5's name on it. The pen lacked a date of when the pen was opened. In the third drawer down a Lantus insulin pen labeled with R6's name on it. The pen lacked a date of when the pen was opened. Interview on 05/01/24 at approximately 12:30 PM with LN E and CMA F confirmed the insulin pens lacked a date of when they were opened, and further lacked a beyond use date.	S3215		

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S3215	Continued From page 6 Glargine Insulin Pen manufacture recommended to store at room temperature for up to 28 days after removing from cool storage. Lantus Insulin Pen manufacture recommended to store at room temperature and after 28 days throw away the opened pen even it is still contained insulin. The Administrator failed to ensure the LN or CMA did not use insulin medications beyond the manufacturer's or pharmacy provider's recommended date of expiration.	S3215		
S3320 SS=F	28-39-254 CONSTRUCTION (a) The assisted living facility or residential health care facility shall be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel and the public. (b) All new construction, renovation, remodeling and changes in building use in existing buildings shall comply with building and fire codes, ordinances and regulations enforced by city, county, and state jurisdictions, including the state fire marshal. (c) New construction, modifications and equipment shall conform to the following codes and standards: (1) Title III of the Americans with disabilities act, 42 U.S.C. 12181, effective as of January 26, 1992; and	S3320		

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S3320	Continued From page 7 (2) "Food Service Sanitation Manual," health, education, and welfare (HEW) publication no. FDA 78-2081, as in effect on July 1, 1981. This REQUIREMENT is not met as evidenced by: K.A.R. 28-39-254 (a) The facility reported a census of 10 residents. 5 residents who resided in the "Assisted Living" and 5 residents who resided in a secured specialty unit. Based on observation and interview the Administrator failed to ensure the specialty unit was maintained to protect the health and safety of 5 residents. Findings included: - Observation on 05/01/24 at approximately 12:40 PM of the specialty unit opened public bathroom revealed a white storage cabinet that was not secure and contained one container of Sani Cloths, 1 tube of Bo'A anti-fungal cream and one can of Prime Fresh Linen air freshener. Interview on 05/02/24 at approximately 05:20 PM with RN's C and D, confirmed all chemicals and over the counter treatments were to be secured in the specialty unit. The Administrator failed to ensure the specialty unit was maintained to protect the health and safety of 5 residents.	S3320		