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 _____	08/14/2024

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 sent electronically on 08/21/24.	F 000		
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	F 657		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 08/21/2024

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.

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 _____	08/14/2024

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 657	Continued From page 1	F 657		

sample included 12 residents, with three reviewed for skin conditions not pressure-related. Based on observation, record review, and interview, the facility failed to revise the care plan with interventions to prevent and treat skin tears and bruises for Resident (R) 19, who received skin tears and bruises during combative outbursts. This placed R19 at risk for further skin injury and pain due to uncommunicated care needs.

Findings included:

- The Electronic Medical Record (EMR) for R19 recorded diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion" with other behavioral disturbances, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and pain.

The "Significant Change Minimum Data Set" (MDS), dated 05/23/24, documented R19 had moderately impaired decision-making skills. R19 was dependent on staff for toileting, dressing, and personal hygiene; she required substantial assistance with transfers and bathing. R19 required partial assistance with mobility. The MDS documented R19 had rejection of care, physical and verbal behaviors for four to six days, and other behaviors for one to three days of the observation period. R19 had delusions (untrue persistent beliefs or perceptions held by a person although evidence shows it was untrue) and hallucinations (sensing things while awake that appear to be real, but the mind created).

R19's "Care Plan," dated 07/26/24, directed staff to complete a skin inspection with all cares and

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 _____	08/14/2024

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 657	Continued From page 2	F 657		

weekly bathing, observe for redness, open areas, scratches, cuts, and bruises, and report changes to the nurse. The care plan lacked direction to staff on the prevention of skin tears and bruises related to resistance or combativeness.

The "Nurse's Note," dated 05/23/24 at 12:53 AM, documented R19 had multiple bruises to her bilateral arms. Her left upper arm bruise measured 3.5 centimeters (cm) x 6 cm, a left upper forearm bruise was 4 cm x 7 cm, a left wrist bruise measured 1.5 cm x 3 cm, a left elbow bruise was 2 cm x 1.5 cm, the back of her right hand had a bruise that was 8 cm x 8 cm, and her right upper forearm had a bruise 6 cm x 6 cm. The note documented all the bruises were purple and documented R19 was combative with staff during care and hit the south wall next to her bed.

The "Nurse's Note," dated 05/26/24 at 05:00 PM, documented R19 was combative with staff during care. She hit, kicked, screamed, and cried. During care, R19 received a skin tear to her right forearm which measured 2.5 cm x 2.5 cm. The note documented staff cleansed the area and Kerofoam (non-adherent sterile dressing) was applied.

The "Nurse's Note," dated 06/05/24 at 05:44 AM, documented at 04:30 AM staff assisted R19 to the bathroom. The resident became combative, and staff noted R19 had blood on her right wrist. The edges of a skin tear were approximated and a foam dressing was applied.

The "Nurse's Note," dated 06/21/24 at 08:45 PM, documented R19 became combative with staff. She hit, bit, and pinched staff. The note further documented staff found a skin tear on R19's right

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 _____	08/14/2024

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 657	Continued From page 3	F 657		

forearm which measured 0.5 cm x 1.5 cm. The area was cleansed and an Aquacel (a soft, sterile dressing) was applied.

The "Nurse's Note," dated 07/23/23 at 09:54 PM, documented that during bedtime care R19 became combative and hit the back of her right forearm on the wall in the bathroom which caused a skin tear that measured 2 cm. The area was cleansed and two Band-Aids were applied.

The "Nurse's Note," dated 08/12/24 at 01:10 AM, documented R19 was extremely aggressive, screamed, and fought staff. The note documented that as staff attempted to provide personal care to R19, she tried to bite staff, and she took her doll and hit the wall. She hit her knuckles on the wall. The note further documented R19 continually had bruising on her arms and hands due to her hitting the wall.

The "Nurse's Note," dated 8/12/14 at 01:58 PM, documented R19 was very upset while three staff took her to the restroom. Staff tried to reassess R19 after she calmed down a little, but she was still upset. The note further documented two staff grabbed her arms and another staff member grabbed her hands so they could get R19's incontinence brief on and off. R19 was placed back into her wheelchair and was taken to a table to eat.

On 08/14/24 at 12:00 PM, observation revealed a foam dressing on R19's left forearm.

On 08/12/24 at 04:15 PM, Administrative Nurse D stated the care plan should reflect R19's skin integrity and provide direction to staff on how to prevent skin tears and bruises on R19 when she

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 _____	08/14/2024

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 657	Continued From page 4 was combative. The facility's "Care Plan" policy, dated 07/28/22, documented the person-centered plan of care was developed for each resident by the interdisciplinary team through assessments within the established timeframes according to state and federal regulations. The person-centered care plan would be reviewed and revised quarterly if needed, annually, and when significant changes occur. The facility failed to revise the care plan with interventions to prevent and treat skin tears and bruises for R19. This placed R19 at risk for further skin injury and pain due to uncommunicated care needs.	F 657		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility had a census of 29 residents. The sample included 12 residents, with five reviewed for accidents. Based on observation, record review, and interview, the facility failed to ensure Resident (R)1 remained free from preventable accidents when staff failed to ensure R1 was positioned on the bed properly before placing her legs in bed, causing her to roll out of bed. This	F 689		

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 _____	08/14/2024

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 689	Continued From page 5	F 689		

placed the resident at risk for injury related to preventable accidents.

Findings Included:

- The Electronic Medical Record (EMR) for R1 documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion) without behavioral disturbance, pain, a history of falls, abnormalities of gait and mobility, and hypertension (high blood pressure).

The "Significant Change Minimum Data Set" (MDS), dated 07/01/24, documented R1 had significantly impaired cognition and required substantial assistance with toileting, dressing, mobility, and transfers. R1 had no functional impairment and had no falls.

The "Fall Risk Assessment." dated 05/03/24, documented R1 was a high risk for falls.

R1's "Care Plan," dated 05/22/24 and initiated on 10/20/22, directed staff to ensure her bed was in the position that was easiest for her to access or exit. The update, dated 06/20/23, documented R1 needed a safe environment with even floors free from spills and/or clutter; adequate glare-free light, a working and reachable call light, the bed in a low position at night, handrails on the walls, and her personal items within reach.

The "Nurse's Note," dated 08/07/24 at 07:48 PM, documented staff walked R1 to her bed and told her to lie down. The note recorded that as the Certified Nurse Aide (CNA) grabbed R1's legs to put them into the bed, R1 slipped off the bed and was between the bed and the arm of the recliner.

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 _____	08/14/2024

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 689	Continued From page 6 The note documented three staff assisted R1 up and back into bed. On 08/13/24 at 11:30 AM, observation revealed CNA N and CNA O placed a gait belt around R1's wait, placed her walker in front of her, had her stand up, and walked with her to the bathroom. On 08/12/24 at 04:15 PM, Licensed Nurse (LN) G stated R1 had not had incidents or falls that she was aware of. LN G stated that R1 was a two-person transfer. On 08/13/24 at 08:30 AM, Administrative Nurse D stated she was unaware of the incident with R1 and said it should be reported to administration to complete an investigation and educate staff. On 08/13/24 at 03:45 PM, CNA M stated she was unaware of any falls or the incidents of R1 slipping off the bed. CNA M stated R1 was a two-person transfer and staff were to make sure R1's bed was in a low position at night. The facility's "Lifting and Transferring Resident" policy, dated 10/11/21, documented that staff are accountable for utilizing proper body mechanics, lifting techniques, and resident safety. The facility failed to ensure R1 remained free from preventable accidents. This placed the resident at risk for injury related to accidents.	F 689		
F 741 SS=D	Sufficient/Competent Staff-Behav Health Needs CFR(s): 483.40(a)(1)(2) §483.40(a) The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to	F 741		

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 _____	08/14/2024

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 741	Continued From page 7	F 741		

provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with §483.71. These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for:

§483.40(a)(1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.71, and

§483.40(a)(2) Implementing non-pharmacological interventions.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 29 residents. The sample included 12 residents, with five reviewed for behaviors. Based on observation, record review, and interview, the facility failed to follow the plan of care and provide appropriate behavioral health care for Resident (R) 19, who had behaviors and was combative with care. This deficient practice resulted in skin tears and bruises and placed R19 at risk for impaired quality of life.

Findings included:

- The Electronic Medical Record (EMR) for R19 recorded diagnoses of dementia (a progressive

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 _____	08/14/2024

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 741	Continued From page 8	F 741		

mental disorder characterized by failing memory and confusion" with other behavioral disturbances, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and pain.

The "Significant Change Minimum Data Set" (MDS), dated 05/23/24, documented R19 had moderately impaired decision-making skills. R19 was dependent on staff for toileting, dressing, and personal hygiene; she required substantial assistance with transfers and bathing. R19 required partial assistance with mobility. The MDS documented R19 had rejection of care, physical and verbal behaviors for four to six days, and other behaviors for one to three days of the observation period. R19 had delusions (untrue persistent beliefs or perceptions held by a person although evidence shows it was untrue) and hallucinations (sensing things while awake that appear to be real, but the mind created).

R19's "Care Plan," dated 07/11/24 and initiated on 02/03/23, documented that if R19 became agitated or combative, ensure she was safe, leave her alone and reapproach her later. The plan directed staff to offer alternative ways to safely relieve her anger such as sitting and talking with her or walking away and giving her space so that she could calm down. The care plan documented R19 had a history of hitting people and disrobing in public and directed staff to monitor her behaviors. The care plan directed staff to be aware of symptoms or triggers, confining situations, and pressure to make decisions or choices. The update, dated 03/20/23, directed staff to offer R19 activities, her baby doll, or stuffed animals when she had exit-seeking behaviors. The care plan lacked

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 _____	08/14/2024

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 741	Continued From page 9	F 741		

direction to staff on the prevention of skin tears and bruises related to resistance or combativeness.

The "Nurse's Note," dated 05/23/24 at 12:53 AM, documented R19 had multiple bruises to her bilateral arms. Her left upper arm bruise measured 3.5 centimeters (cm) x 6 cm, a left upper forearm bruise was 4 cm x 7 cm, a left wrist bruise measured 1.5 cm x 3 cm, a left elbow bruise was 2 cm x 1.5 cm, the back of her right hand had a bruise that was 8 cm x 8 cm, and her right upper forearm had a bruise 6 cm x 6 cm. The note documented all the bruises were purple and documented R19 was combative with staff during care and hit the south wall next to her bed.

The "Nurse's Note," dated 05/26/24 at 05:00 PM, documented R19 was combative with staff during care. She hit, kicked, screamed, and cried. During care, R19 received a skin tear to her right forearm which measured 2.5 cm x 2.5 cm. The note documented staff cleansed the area and Kerofoam (non-adherent sterile dressing) was applied.

The "Nurse's Note," dated 06/05/24 at 05:44 AM, documented at 04:30 AM staff assisted R19 to the bathroom. The resident became combative, and staff noted R19 had blood on her right wrist. The edges of a skin tear were approximated and a foam dressing was applied.

The "Nurse's Note," dated 06/21/24 at 08:45 PM, documented R19 became combative with staff. She hit, bit, and pinched staff. The note further documented staff found a skin tear on hR19's right forearm which measured 0.5 cm x 1.5 cm. The area was cleansed and an Aquacel (a soft,

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 _____	08/14/2024

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 741	Continued From page 10	F 741		

sterile dressing) was applied.

The "Nurse's Note," dated 07/23/23 at 09:54 PM, documented that during bedtime care R19 became combative and hit the back of her right forearm on the wall in the bathroom which caused a skin tear that measured 2 cm. The area was cleansed and two Band-Aids were applied.

The "Nurse's Note," dated 08/12/24 at 01:10 AM, documented R19 was extremely aggressive, screamed, and fought staff. The note documented that as staff attempted to provide personal care to R19, she tried to bite staff, and she took her doll and hit the wall. She hit her knuckles on the wall. The note further documented R19 continually had bruising on her arms and hands due to her hitting the wall.

The "Nurse's Note," dated 8/12/14 at 01:58 PM, documented R19 was very upset while three staff took her to the restroom. Staff tried to reassess R19 after she calmed down a little, but she was still upset. The note further documented two staff grabbed her arms and another staff member grabbed her hands so they could get R19's incontinence brief on and off. R19 was placed back into her wheelchair and was taken to a table to eat.

On 08/12/24 at 01:40 PM, observation revealed R19 cried in the dining room as staff took her into the bathroom. R19 stated she did not want to go into the bathroom and staff continued to tell her they needed to take her. Continued observation revealed R19 yelled in the bathroom and multiple staff went in and out of the bathroom during the encounter.

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 _____	08/14/2024

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 741	Continued From page 11	F 741		

On 08/13/24 at 9:45 PM, Licensed Nurse (LN) H stated R19 had aggressive behaviors. LN H said when R19 was combative, staff were directed to leave her alone and reapproach her later.

On 08/13/24 at 03:45 PM, Certified Nurse Aide (CNA) M stated R19 had a lot of behaviors and could get combative. CNA M further stated that during her shift, staff tried to have three staff present in R19's room to provide care so that they could hurry up and get her care done.

On 08/12/24 at 04:15 PM, Administrative Nurse D stated staff should follow the care plan and when R19 was combative, staff should make sure she was safe and reapproach her later. Administrative Nurse D further stated three staff in the room would be overwhelming to R19 and said education would be provided to staff on how to approach R19.

The facility's "Behavioral Health Services" policy, dated 10/27/22, documented that staff providing behavioral health services are an integral part of the person-centered environment involving an interdisciplinary approach to care with qualified staff that demonstrates the competencies and skills necessary to provide mental health and behavioral health services, non-pharmacological interventions would be implemented for residents with identified behavioral health training consistent with provisions of the policy and procedure at the time of employment, prior to caring for any resident with identified behavioral health issues.

The facility failed to follow the plan of care for R19 during combative outbursts and resistance to care. This resulted in skin tears and bruises, and

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 _____	08/14/2024

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 741	Continued From page 12 further placed R19 at risk for impaired quality of life.	F 741		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: The facility had a census of 29 residents. The sample included 12 residents, with five reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to monitor and provide interventions for bowel management for one sampled resident, Resident (R) 19. This placed the resident at risk for fecal impaction and physical decline.	F 757		

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 _____	08/14/2024

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 757	Continued From page 13	F 757		

Findings included:

- The Electronic Medical Record "EMR" for R19 recorded diagnoses of dementia (progressive mental disorder characterized by failing memory and confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), diabetes mellitus (DM-when the body cannot use glucose, not enough sepsis made or the body cannot respond to the insulin), pain, and constipation (difficulty in emptying the bowels).

The "Significant Change Minimum Data Set", dated 05/23/24, documented R19 had moderately impaired decision-making skills. R19 was dependent on staff for personal hygiene, toileting, and dressing; R19 required substantial assistance with transfers. The MDS documented R19 was occasionally incontinent of bowel.

R19's"Care Plan," dated 07/11/24 and initiated on 07/26/23, directed staff to follow the facility's bowel protocol for bowel management and administer medications for constipation prevention as ordered. The care plan directed staff to monitor for changes in her mental status, new-onset confusion, agitation, abdominal distension, vomiting, small loose or hard stools, bowel sounds, and fecal impaction.

R19's "Bowel and Bladder Screen," dated 03/18/24, documented R19 was always incontinent of bowel and had routine bowel elimination patterns.

The "Physician's Order," dated 01/03/24, directed staff to administer magnesium hydroxide (a laxative), 400 milligrams (mg)/5 milliliters (ml), by

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 _____	08/14/2024

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 757	Continued From page 14	F 757		

mouth, every eight hours, as needed, for constipation.

The "Physician's Order," dated 01/11/24, directed staff to administer MiraLax (a laxative), 17 grams (gm), by mouth, as needed, daily, for constipation.

R19's "Bowel Monitoring Record," dated July 2024, documented R19 did not have a bowel movement for the following days:
07/06/24-07/11/24 (six consecutive days)

The "Medication Administration Record" (MAR). dated July 2024, lacked documentation the staff provided the physician-ordered interventions during the lack of bowel elimination on the above dates.

On 08/12/24 at 03:45 PM, observation revealed R19 wheeled into her bathroom. She pulled on the waistband of her pants and stated she needed to go to the bathroom.

On 08/12/24 at 03:45 PM, Licensed Nurse (LN) G stated R19 required assistance from staff with toileting. LN G said when R19 had a bowel movement, the staff would document it, and a report was generated for residents who had not had a bowel movement.

On 08/13/24 at 03:50 PM, Certified Nurse Aide (CNA) M stated she documented if the resident had a bowel movement.

On 08/14/24 at 09:15 AM, Administrative Nurse D verified staff had not provided interventions to R19 when she had not had a bowel movement for six days. Administrative Nurse D stated after

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 _____	08/14/2024

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 757	Continued From page 15 three days, staff should follow the facility bowel protocol. The facility's "Bowel Elimination" policy, dated 04/03/19, documented the facility's established guidelines for monitoring individual bowel function to promote regularity of bowel functions and avoid possible complications such as constipation, obstruction, or other complications by utilizing a multidisciplinary approach. If a resident did not have a bowel movement in three days, or nine consecutive shifts or has positive signs and symptoms of constipation, the LN would perform an evaluation to include auscultation and palpation, the physician would be notified of bowel status and assessment findings including medication utilization. The facility failed to monitor and provide interventions for bowel management for R19. This placed the resident at risk for fecal impaction and physical decline.	F 757		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper	F 761		

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 _____	08/14/2024

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 761	Continued From page 16	F 761		

temperature controls, and permit only authorized personnel to have access to the keys.

§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
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 store and label biologicals as required when staff failed to place an open date on Resident (R) 17's Novolog (rapid-acting medication that works by lowering levels of glucose in the blood) flex pen (a device used to inject insulin). This placed the resident at risk of receiving an expired and ineffective dose of insulin.

Findings included:

- On 08/12/24 at 08:15 AM, observation of the treatment cart revealed R17's Novolog flex pen without an open date or discard date.

On 08/12/24 at 08:15 AM, Licensed Nurse (LN) I verified the above finding. LN I stated the insulin should be labeled with an open date. LN I discarded the insulin pen in the Sharps container on the treatment cart.

On 08/14/24 at 11:30 AM, Administrative Nurse D

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 _____	08/14/2024

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 761	Continued From page 17 stated she expected staff to label open insulin pens with the date opened whenever staff get a new pen for R17. Medlineplus.gov documented all unrefrigerated, open pens of Novolog can be used within 28 days, but after that time they must be discarded. The facility's "Vials and Ampules or Injectable Meds Policy," revised 10/8/21, documented the date opened should be recorded on multidose vials (on the vial label or an accessory label affixed for that purpose). The facility failed to place open and/or discard dates on R17's Novolog flex pen. This placed the resident at risk of receiving an expired or ineffective dose of insulin.	F 761		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and	F 851		

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 _____	08/14/2024

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 851	Continued From page 18	F 851		

psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping).

§483.70(p)(2) Submission requirements.
The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following:
(i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS);
(ii) Resident census data; and
(iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual).

§483.70(p)(3) Distinguishing employee from agency and contract staff.
When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency.

§483.70(p)(4) Data format.
The facility must submit direct care staffing information in the uniform format specified by CMS.

§483.70(p)(5) Submission schedule.
The facility must submit direct care staffing

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 _____	08/14/2024

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 851	Continued From page 19	F 851		

information on the schedule specified by CMS, but no less frequently than quarterly.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 29 residents. Based on observation, interview, and record review, the facility failed to submit complete and submit accurate staffing information through Payroll Based Journaling (PBJ) as required. This deficient practice placed the residents at risk for unidentified and ongoing inadequate nurse staffing.

Findings included:

- The PBJ report provided by the Centers for Medicare & Medicaid Services (CMS) for Fiscal year (FY) Quarter 3 2023 (April 1 - June 30) indicated the facility did not have licensed nurse coverage 24 hours a day, seven days a week on six dates.

A review of the facility licensed nurse timeclock data for the dates listed on the PBJ revealed a licensed nurse was on duty for 24 hours a day seven days a week.

On 08/12/24 at 09:52 AM observation revealed a registered nurse on duty in the facility.

On 08/12/24 at 03:22 PM Administrative Staff A verified the facility did not send in the correct data to CMS for payroll-based data and stated the facility had new staff and was unaware the information was incorrect.

The facility's undated," PBJ Reporting Procedure Policy," documented PBJ hours must be reported to CMS on a minimum of a quarterly basis,

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 _____	08/14/2024

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 851	Continued From page 20 although it is highly recommended the hours be loaded and /or entered on a monthly basis. The facility failed to submit accurate PBJ data which placed the residents at risk for unidentified and ongoing inadequate staffing.	F 851		