STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175301	A. BUILDING _____ B. WING _____	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICHITA PRESBYTERIAN MANOR	4700 W 13TH STREET NORTH WICHITA, KS 67212

(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 Recertification Survey and complaint survey KS00195191.	F 000		
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: The facility reported a census of 46 residents. The sample included 12 residents sampled. Based on interview, observation, and record review, the facility failed to inform Resident (R)37 and/or his representative regarding the risks related to psychotropic (alters mood or thoughts) medications. These practices had the potential to lead to negative and unwarranted physical side effects.	F 552		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175301	A. BUILDING _____ B. WING _____	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICHITA PRESBYTERIAN MANOR	4700 W 13TH STREET NORTH WICHITA, KS 67212

(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 552	Continued From page 1	F 552		

Findings included:

- Review of the Electronic Health Record (EHR) for R37 included diagnoses of Pick's Disease (a form of brain disorder occurring in middle age, characterized by slow disintegration of intellect, personality, and emotions), unspecified dementia with behavioral disturbance (dementia without a specific diagnosis where the individual experiences disruptive or challenging behaviors in addition to cognitive decline), and anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).

The "Admission Minimum Data Set (MDS)," dated 07/26/24, documented a Brief Interview of Mental Status (BIMS) score of 99, indicating the resident was unable to complete the assessment. The MDS indicated that R37 had behavior symptoms with physical and verbal behaviors directed toward others.

The "Cognitive Loss/Dementia Care Area Assessment (CAA)," dated 07/26/24, documented the resident was unable to complete the BIMS assessment and had physical and verbal behaviors directed towards others The CAA documented R37 rejected care.

R37's "Quarterly MDS," dated 04/25/25, documented a BIMS score of zero which indicated severe cognitive impairment. The MDS noted R37 had physical and other behaviors.

R37's "Care Plan" dated 08/28/24 documented R37 had dementia with cognitive loss. An intervention dated 12/16/24 included the administration of ordered medications with orders

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175301	A. BUILDING _____ B. WING _____	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICHITA PRESBYTERIAN MANOR	4700 W 13TH STREET NORTH WICHITA, KS 67212

(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 552	Continued From page 2	F 552		

to monitor side effects and effectiveness; and to monitor, document, and report any changes in cognitive function.

R37's EHR documented an order dated 07/16/24 for Seroquel (an atypical antipsychotic medication used to treat a range of mental health conditions).

R37's EHR documented an order for lorazepam (an antianxiety medication) daily at 05:00 PM dated 10/17/24.

R37's EHR documented an order for lorazepam as needed (PRN) every six hours for 14 days dated 04/01/25.

R37's EHR lacked evidence R37, or his representative received education and/or informed consent with regards to the lorazepam use including reason for use, expected therapeutic benefits and potential risks and side effects.

On 05/21/25 at 02:15 PM R37 sat in a wheelchair watching TV in the common area.

During an interview on 05/27/25 at 12:50 PM, Administrative Nurse D confirmed that there was not any medication informed consent documented for R37. She stated that the Veteran's Administration provider for R37 had refused to provide any medication education to his representative.

During an interview on 05/28/25 at 09:05 AM, Licensed Nurse (LN) J reported that prior to starting any new psychotropic medication or dosage change, she provided education to the resident and/or resident's representative about

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175301	A. BUILDING _____ B. WING _____	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICHITA PRESBYTERIAN MANOR	4700 W 13TH STREET NORTH WICHITA, KS 67212

(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 552	Continued From page 3 the medication, and she obtained informed consent. During an interview on 05/28/25 at 09:22 AM, LN K stated that as a nurse it was her responsibility to obtain informed consent, and she provided education to the resident and/or their representative about any psychotropic medication before the dosage was changed or it was started. Facility policy "Psychoactive Psychopharmacological Medications," dated 04/15/25, indicated that prior to initiating or increasing psychotropic medications, the resident, family, and/or resident representative would be informed of the benefits, risks, and alternatives of the medication, included would be the black box warnings for antipsychotic medications.	F 552		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: The facility reported a census of 46 residents. The sample included 12 residents. Based on observation, interview, and record review, the facility failed to assess Resident (R) 22 to ensure it was clinically appropriate to leave medication at the resident's bedside for the resident to self-administer. This placed the resident at risk for medication errors and ineffective medication regimens.	F 554		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175301	A. BUILDING _____ B. WING _____	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICHITA PRESBYTERIAN MANOR	4700 W 13TH STREET NORTH WICHITA, KS 67212

(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 554	Continued From page 4	F 554		

Findings included:

- During an observation on 05/21/25 at 08:40 AM, Resident (R) 22 had medication on her bedside table. The cup contained Plavix (an antiplatelet medication) 75 milligrams (mg), cranberry tablet 500mg, gabapentin 100 mg (a medication to treat epilepsy and nerve pain), Miralax (stool softener), potassium 20 milliequivalents, pramipexole (medication to treat Parkinson ' s symptoms and restless leg) 0.25 mg, Prevagen (a dietary supplement to improve brain function) 10mg, vitamin C 500 mg, Zyrtec (allergy medication) 10 mg, Eliquis (a blood thinner) 2.5mg, Lasix (medication used to promote the formation and excretion of urine) 40mg, Metamucil (a bulk-forming laxative) three capsules, Mucinex (decongestant) 1200mg extended release, Preservision one capsule (vitamin for eye health, Tessalon Perles 1 cap (cough suppressant, Tussin CF liquid 10ml (cough suppressant). R22 stated the facility staff do not watch her take medication except at night because they give it to her on a spoon. R22 stated she did not know what medications were in her cups and what they were for.

R22 ' s "Care Plan" lacked documentation that staff could leave medications in her room for R22 to take later.

R22 ' s "Evaluations" tab and medical record lacked evidence of an assessment which indicated the resident was able to safely able to keep medications at her bedside and take the medications unattended by staff.

During an interview on 05/21/25 at 08:37 AM, Certified Medication Aide (CMA) R stated the staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175301	A. BUILDING _____ B. WING _____	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICHITA PRESBYTERIAN MANOR	4700 W 13TH STREET NORTH WICHITA, KS 67212

(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 554	Continued From page 5 left R22's medications on her bedside table in her room. CMA R stated staff returned to R22's room after breakfast to make sure the resident took the medications. During an interview on 05/21/25 at 08:39 AM, Licensed Nurse (LN) H stated staff left the pills for R22 in her room. LN H said this is how staff have always done it. LN H stated they thought R22's "Care Plan" indicated it was ok to leave the medications in the room for R22 to self-administer but after review of the plan, they verified R22 had not been cared planned to leave the medications in her room. During an interview on 05/21/25 at 08:50 AM, Administrative Nurse D stated staff can only leave medications in the residents ' room if the resident had a "Self-administration Assessment" completed and the resident was appropriate to take their own medications. The facility ' s policy "Medication Administration" dated 02/03/25 documented that staff were to prepare one resident's medication and observe the resident take the medications to ensure the medications are swallowed.	F 554		
F 605 SS=D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2), 483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or	F 605		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175301	A. BUILDING _____ B. WING _____	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICHITA PRESBYTERIAN MANOR	4700 W 13TH STREET NORTH WICHITA, KS 67212

(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 605	Continued From page 6	F 605		

convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).

§483.12
The resident has the right to be free from abuse, neglect, misappropriation of
resident property, and exploitation as defined in this subpart. This includes but is
not limited to freedom from corporal punishment, involuntary seclusion and any
physical or chemical restraint not required to treat the resident's medical
symptoms.
§483.12(a) The facility must-. . .
§483.12(a)(2) Ensure that the resident is free from . . . chemical restraints
imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms.
. . . .
§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.

§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-
(1) In excessive dose (including duplicate drug therapy); or
(2) For excessive duration; or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175301	A. BUILDING _____ B. WING _____	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICHITA PRESBYTERIAN MANOR	4700 W 13TH STREET NORTH WICHITA, KS 67212

(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 605	Continued From page 7	F 605		

(3) Without adequate monitoring; or
(4) Without adequate indications for its use; or
(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or
(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.

§483.45(e) Psychotropic Drugs. 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 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175301	A. BUILDING _____ B. WING _____	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICHITA PRESBYTERIAN MANOR	4700 W 13TH STREET NORTH WICHITA, KS 67212

(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 605	Continued From page 8	F 605		

§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 reported a census of 46 residents. The sample included 12 residents with five sampled for unnecessary medications. Based on observation, interview, and record review, the facility failed to perform an assessment for side effects related to ongoing antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) use for Resident (R)37. This deficient practice placed R37 at risk for adverse reactions and complications related to psychotropic (alters mood or thought) medication.

Findings included:

- Review of the Electronic Health Record (EHR) for R37 included diagnoses of Pick ' s Disease (a form of brain disorder occurring in middle age, characterized by slow disintegration of intellect, personality, and emotions), unspecified dementia with behavioral disturbance (dementia without a specific diagnosis where the individual experiences disruptive or challenging behaviors in addition to cognitive decline), and anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).

The "Admission Minimum Data Set (MDS)," dated 07/26/24, documented a Brief Interview of Mental Status (BIMS) score of 99, indicating the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175301	A. BUILDING _____ B. WING _____	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICHITA PRESBYTERIAN MANOR	4700 W 13TH STREET NORTH WICHITA, KS 67212

(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 605	Continued From page 9	F 605		

resident was unable to complete the assessment. The MDS indicated that R37 had behavior symptoms with physical and verbal behaviors directed toward others.

The "Cognitive Loss/Dementia Care Area Assessment (CAA)," dated 07/26/24, documented the resident was unable to complete the BIMS assessment and had physical and verbal behaviors directed towards others The CAA documented R37 rejected care.

R37's "Quarterly MDS," dated 04/25/25, documented a BIMS score of zero which indicated severe cognitive impairment. The MDS noted R37 had physical and other behaviors.

R37's "Care Plan" dated 08/28/24 documented R37 had dementia with cognitive loss. An intervention dated 12/16/24 included the administration of ordered medications with orders to monitor side effects and effectiveness; and to monitor, document, and report any changes in cognitive function.

R37's EMR documented an order dated 07/16/24 for Seroquel (an atypical antipsychotic medication used to treat a range of mental health conditions).

R37's EMR lacked evidence of any assessment to identify abnormal involuntary movements related to the use of Seroquel.

On 05/21/25 at 02:15 PM R37 sat in a wheelchair watching TV in the common area.

During an interview on 05/22/25 at 09:14 AM, Licensed Nurse (LN) H reported that residents are monitored for increased sedation or change

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175301	A. BUILDING _____ B. WING _____	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICHITA PRESBYTERIAN MANOR	4700 W 13TH STREET NORTH WICHITA, KS 67212

(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 605	Continued From page 10 in mental status when they are taking any psychotropic medication, and an Abnormal Involuntary Movement Scale (AIMS- a standardized tool used to assess involuntary movements, which can be a side effect of antipsychotic medications) LN H said the AIMS assessment should be performed quarterly and when started on any antipsychotic medication. She stated that nurses performed the AIMS assessments. During an interview on 05/22/25 at 09:21 AM, LN I reported that an AIMS assessment was done at admission, if a resident was started on any antipsychotic medication, and also quarterly. During an interview on 05/22/25 at 10:05 AM, Administrative Nurse D stated that an AIMS assessment was to be performed upon admission if an antipsychotic was started, and then every six months. Facility policy "Abnormal Involuntary Movement Scale (AIMS)," dated 02/03/25, indicated the facility would use the AIMS to monitor residents that took antipsychotics on a regularly scheduled basis. The AIMS would be performed on a semi-annually by the Social Service Director/Designee with a licensed primary care provider or licensed nurse as backup. Facility policy "Psychoactive Psychopharmacological Medications," dated 04/15/25, indicated that an AIMS will be completed for residents taking antipsychotic medication on admission, every six months and as needed.	F 605		
F 677 SS=D	ADL Care Provided for Dependent Residents	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175301	A. BUILDING _____ B. WING _____	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICHITA PRESBYTERIAN MANOR	4700 W 13TH STREET NORTH WICHITA, KS 67212

(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 677	Continued From page 11 CFR(s): 483.24(a)(2) §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; This REQUIREMENT is not met as evidenced by: The facility identified a census of 46 residents. The sample included 12 residents. Based on observation, interview and record review, the facility failed to provide Resident (R) 10 with activities of daily living (ADL) services, including shaving of facial hair. This placed the resident at risk for decreased quality of life and poor hygiene. Findings included: - R10's Electronic Medical Record (EMR) revealed diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion) and anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R10's "Admission Minimum Data Set" (MDS) dated 04/17/25 revealed a Brief Interview for Mental Status (BIMS) score of seven indicating severely impaired cognition. The MDS recorded R10 had behaviors, including rejection of care one to three days during the observation period. The MDS recorded R10 required assistance with toileting, showering, dressing, and personal hygiene. The "Functional Abilities Care Area Assessment" dated 04/17/25 indicated R10 had a diagnosis of dementia that could affect balance, safety awareness, and judgment.	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175301	A. BUILDING _____ B. WING _____	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICHITA PRESBYTERIAN MANOR	4700 W 13TH STREET NORTH WICHITA, KS 67212

(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 677	Continued From page 12 R10's "Care Plan dated 04/14/25 R10 had an ADL self-care performance deficit related to dementia. The plan directed staff to provide bathing and showering, check nail length, trim and clean on bath day and as necessary; staff were to report any changes to the nurse. The daily "Task" section of R10's EMR, reviewed on 05/28/25, revealed R10 refused care only once in the past 30 days. On 05/21/25 at 08:59 AM observation revealed R10 had facial hair and dirty fingernails. On 05/28/25 at 10:15 AM Certified Nurse Aide (CNA) M said that if a resident refused to be shaved, she documented it in the EMR and then let the charge nurse know. On 05/27/25 at 02:15 PM Administrative Nurse D stated she expected the nursing staff to provide the residents with ADL assistance with grooming during morning care or showers. The facility did not provide a policy for activities for daily living as requested on 05/27/25.	F 677		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences,	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175301	A. BUILDING _____ B. WING _____	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICHITA PRESBYTERIAN MANOR	4700 W 13TH STREET NORTH WICHITA, KS 67212

(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 695	Continued From page 13	F 695		

and 483.65 of this subpart.
This REQUIREMENT is not met as evidenced by:
The facility census totaled 46 residents with 12 residents in the sample. Based on observation, interview and record review the facility failed to provide sanitary respiratory care and services when staff failed to clean the nebulizer (a device for administering inhaled medication) after each use for Resident (R) 45. This placed the resident at risk for infection and increased respiratory complications.

Finding included:

- R45's Electronic Medical Record (EMR) dated 11/12/24 revealed a diagnosis of spinal bifida (a birth defect that can cause respiratory problems).

Review of the "Five Day Medicare Minimal Data Set" (MDS) dated 02/10/25 revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. R45 requires partial assistance to complete toileting/showers.

R45's "Quarterly MDS" dated 02/03/25 noted that R45 BIMS score remained the same and no other changes were noted.

R45's "Care Plan" dated 02/18/25 revealed the care plan lacked information on the use of the nebulizer and or the care of the nebulizer.

R45's "Physician Orders" dated 05/16/25 revealed ipratropium albuterol inhalation solution (a medication used in a nebulizer to open airways) 0.5 mg/2/5 mg/3 ml two times a day.

During a observation on 05/20/24 at 04:42 PM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175301	A. BUILDING _____ B. WING _____	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICHITA PRESBYTERIAN MANOR	4700 W 13TH STREET NORTH WICHITA, KS 67212

(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 695	Continued From page 14 R45's nebulizer was attached to the tubing on the bedside table with clear liquid in the bottom of the chamber. During a observation on 05/22/25 at 08:02 AM R45's nebulizer was attached to the tubing with clear liquid in the chamber sitting on the bedside table. On 05/22/25 at 08:02 AM R45 revealed she had not had a treatment yet that morning and the nebulizer was still attached to the tubing from the last treatment the previous night. On 05/22/25 at 10:25 AM Licensed Nurse LN G revealed the protocol for nebulizer treatment was to separated the nebulizer, rinse, place on a towel to dry and then place in the bag. On 05/22/25 at 10:55 AM Administrative Nurse D stated she expected the nurses to clean the nebulizer after each use. The facility's "Nebulizer Cleaning Instructions" policy dated 02/03/25 documented after each treatment, the nebulizer mouthpiece and cup will be rinsed out and allowed to air dry. Then place the parts in a bag. After the last meal of the day, wash all pieces in mild soap and water. Then soak in vinegar water, rinse, and leave to dry on a paper towel. When the nebulizer is dry, place in a plastic bag. The facility's "Oxygen Therapy" policy dated 02/03/25 documented when oxygen tubing is not in use, it was to be placed in a plastic bag.	F 695		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175301	A. BUILDING _____ B. WING _____	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICHITA PRESBYTERIAN MANOR	4700 W 13TH STREET NORTH WICHITA, KS 67212

(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 756	Continued From page 15 §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175301	A. BUILDING _____ B. WING _____	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICHITA PRESBYTERIAN MANOR	4700 W 13TH STREET NORTH WICHITA, KS 67212

(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 756	Continued From page 16	F 756		

This REQUIREMENT is not met as evidenced by:
The facility reported a census of 46 residents with 12 residents sampled which included five residents for unnecessary medications. Based on observation, interview, and record review the facility's pharmacist failed to identify and report irregularities to the attending physician, the facility's medical director, and the director of nursing for Resident (R)18 related to monitoring his pulse for effectiveness and side effects of antihypertensive medications as ordered by the physician. This placed the residents at risk for unnecessary medications and related side effects.

Findings included:

- A review of the R18's "Physician Orders," dated 10/07/21, revealed diagnoses that included slow transit constipation, pain, dementia (a progressive mental disorder characterized by failing memory, and confusion), and hypertension (high blood pressure).

The 12/20/24 "Admission Minimum Data Set" (MDS) documented R18 had Brief Interview for Mental Status (BIMS) score of nine, indicating moderate cognitive impairment. The MDS documented she was always continent of bowel and required partial to moderate assistance with toileting. The MDS noted R18 received scheduled and as needed (PRN) medication for pain.

The "Quarterly MDS" dated 03/30/25 documented R18 had a BIMS score of eight, indicating moderate cognitive impairment. The MDS documented she was occasionally incontinent of bowel. The MDS noted R18 only received

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175301	A. BUILDING _____ B. WING _____	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICHITA PRESBYTERIAN MANOR	4700 W 13TH STREET NORTH WICHITA, KS 67212

(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 756	Continued From page 17	F 756		

scheduled medications for pain.

The "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA), dated 12/21/24, documented she was occasionally incontinent and required staff assistance for toileting, transfers, and toileting hygiene care. The MDS documented she had a diagnosis of dementia that could impair thinking processes that relate to everyday life.

R18 "Care Plan" dated 04/01/25, directed staff to administer medications as ordered by the physician and monitor for adverse reactions and side effects of medication, which included constipation. The plan directed staff the resident was at risk for adverse reactions related to multiple medications with black box warnings (BBW-severe side effects) and adverse side effects which included constipation. The plan directed staff to request the physician and pharmacy consultant to review and evaluate medications and address the recommendations.

R18's POS dated 04/15/25 documented metoprolol succinate extended-release tablet (medication used to treat high blood pressure), give 50 milligrams (mg), by mouth, in the evening related to hypertension; hold and notify the nurse if the pulse is less than 60 beats per minute (BPM) and/or the systolic blood pressure (SBP-top number, the force your heart exerts on the walls of your arteries each time it beats) is less than 110 millimeters (mm) of Mercury (Hg), ordered 12/09/24.

R18's "Medication Administration Records" (MAR) and "Treatment Administration Records" (TAR) dated 04/01/2025 through 05/22/25 lacked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175301	A. BUILDING _____ B. WING _____	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICHITA PRESBYTERIAN MANOR	4700 W 13TH STREET NORTH WICHITA, KS 67212

(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 756	Continued From page 18	F 756		

documentation related to R18's pulse as ordered by the physician.

Review of R18's "Pharmacy Monthly Medication Regimen Review," lacked evidence the consultant pharmacist identified and reported the lack of pulse measurements for parameters as ordered by the physician on 12/15/24, 01/01/2025, 02/14/25, 03/12/25, 04/16/25, and 05/12/25.

On 05/27/25 at 01:16 PM R18 sat in her recliner in her room, flipping through the pages of a photo album.

On 05/27/25 at 01:48 PM Certified Medication Aide (CMA) S stated when medication has a physician ordered parameters for blood pressure and/or pulse to hold the medication, the MAR should have a flagged area to document the pulse and blood pressure. CMA S said the nurse should be notified, and the nurse would follow up with an assessment and notify the physician when indicated for further instructions. CMA S verified R18's record lacked documentation of the resident's pulse being obtained as ordered by the physician.

On 05/27/25 at 02:04 PM, Licensed Nurse (LN) I verified R18's electronic record lacked documentation to reflect monitoring the resident's pulse for the physician-ordered hold parameters. She stated she thought the pharmacist should have identified that during the monthly pharmacy review. LN I said when medications have physician-ordered pulse and blood pressure parameters the MAR should alert and have an area to document the pulse and blood pressure. LN I said the nurse should be notified and follow

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175301	A. BUILDING _____ B. WING _____	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICHITA PRESBYTERIAN MANOR	4700 W 13TH STREET NORTH WICHITA, KS 67212

(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 756	Continued From page 19 up with an assessment and notify the physician when indicated for further instructions. LN I verified R18's record lacked documentation of the resident's pulse being obtained as ordered. LN I reported R18 should have pulses documented in addition to the blood pressure to determine the effects and potential risks of receiving metoprolol. On 5/22/25 at 11:18 AM, Consultant GG reviewed R18's electronic record and verified the above findings. She stated tR18 should have had pulse monitored daily related to the parameters for holding metoprolol for pulse of less than 60 BPM, which was not done when the order was entered. Consultant HH stated she expected the pharmacist to review the medication monitoring to include the pulse, but said she did not know if that was identified as a concern on monthly regimen review. The facility did not provide a policy to address the pharmacist's identifying and reporting irregularities in monitoring medications outside of prescribed parameters and/or monitoring the side effects or adverse effects for residents taking medications.	F 756		
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	F 757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175301	A. BUILDING _____ B. WING _____	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICHITA PRESBYTERIAN MANOR	4700 W 13TH STREET NORTH WICHITA, KS 67212

(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 20 §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 reported a census of 46 resident with 12 residents sampled which included five residents for unnecessary medications. Based on observation, interview, and record review the facility failed to monitor for effectiveness and side effects of antihypertensive medications as ordered by the physician and for side effects, including constipation related to the use of pain medication for Resident (R) 18. This placed the resident at risk for unnecessary medications and related side effects. Findings included: - A review of the R18's "Physician Orders," dated 10/07/21, revealed diagnoses that included slow transit constipation, pain, dementia (a progressive mental disorder characterized by failing memory, and confusion), and hypertension (high blood pressure). The 12/20/24 "Admission Minimum Data Set" (MDS) documented R18 had Brief Interview for Mental Status (BIMS) score of nine, indicating	F 757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175301	A. BUILDING _____ B. WING _____	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICHITA PRESBYTERIAN MANOR	4700 W 13TH STREET NORTH WICHITA, KS 67212

(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 21	F 757		

moderate cognitive impairment. The MDS documented she was always continent of bowel and required partial to moderate assistance with toileting. The MDS noted R18 received scheduled and as needed (PRN) medication for pain.

The "Quarterly MDS" dated 03/30/25 documented R18 had a BIMS score of eight, indicating moderate cognitive impairment. The MDS documented she was occasionally incontinent of bowel. The MDS noted R18 only received scheduled medications for pain.

The "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA), dated 12/21/24, documented she was occasionally incontinent and required staff assistance for toileting, transfers, and toileting hygiene care. The MDS documented she had a diagnosis of dementia that could impair thinking processes that relate to everyday life.

R18 "Care Plan" dated 04/01/25, directed staff to administer medications as ordered by the physician and monitor for adverse reactions and side effects of medication, which included constipation. The plan directed staff the resident is at risk for adverse reactions related to multiple medications with black box warnings (BBW-severe side effects) and adverse side effects which included constipation. The plan directed staff to request the physician and pharmacy consultant to review and evaluate medications and address the recommendations.

R18's POS dated 04/15/25 documented metoprolol succinate extended-release tablet (medication used to treat high blood pressure), give 50 milligrams (mg), by mouth, in the evening

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175301	A. BUILDING _____ B. WING _____	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICHITA PRESBYTERIAN MANOR	4700 W 13TH STREET NORTH WICHITA, KS 67212

(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 22	F 757		

related to hypertension; hold and notify the nurse if the pulse is less than 60 beats per minute (BPM) and/or the systolic blood pressure (SBP-top number, the force your heart exerts on the walls of your arteries each time it beats) is less than 110 millimeters (mm) of Mercury (Hg), ordered 12/09/24.

R18's "Medication Administration Records" (MAR) and "Treatment Administration Records" (TAR) dated 04/01/2025 through 05/22/25 lacked documentation related to R18's pulse as ordered by the physician.

Review of the "Pharmacy Monthly Medication Regimen Review," lacked evidence the consultant pharmacist identified and reported the lack of pulse measurements for parameters as ordered by the physician on 12/15/24, 01/01/2025, 02/14/25, 03/12/25, 04/16/25, and 05/12/25.

R18's "Physician Orders" (POS) dated 04/15/25 documented to give Tramadol (narcotic pain medication) 50 mg, one-half tablet PRN daily for increased pain, ordered 04/16/25.

R18's MAR, dated 05/01/25 through 05/22/25, revealed the resident received Tramadol 50 mg on 05/05/25, 05/09/25, 05/11/25, 05/12/25, and 05/15/25. The MAR noted the medication was effective for pain and was identified as having associated BBW.

R18's "Task-Bowel Movement" entries dated 04/22/25 through 05/21/25 (30 days) revealed R18 had no documented bowel movements (BM) for three or more days on the following occasions: On 04/22/25 at 09:21 PM, the resident had a BM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175301	A. BUILDING _____ B. WING _____	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICHITA PRESBYTERIAN MANOR	4700 W 13TH STREET NORTH WICHITA, KS 67212

(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 23	F 757		

The next BM was on 05/01/25 at 10:49 AM, (nine days later). The next BM was on 05/06/ 25 at 12:31 PM, (five days later). The next BM was on 05/09/25 at 09:59 PM (three days later). The next BM was on 5/13/25 at 09:30 PM (four days later). The next BM was on 05/17/25 at 04:08 PM (4 days later).

R18's medical record lacked evidence the facility assessed for complications of constipation during the above periods with no BM.

The facility's undated "Standing Orders," included the following protocol for the treatment of residents without a BM for three consecutive days: Give milk of magnesia (laxative) 30 milliliters (ml) by mouth. If no results within 24 hours give Lactulose (laxative) 20 ml every two hours up to three doses. If no results, give Dulcolax suppository (laxative) 10mg, If no results give a Fleets enema (introduction of a solution into the rectum for cleansing or therapeutic purposes), if no results notify the physician.

On 05/27/25 at 01:16 PM, R18 sat in her recliner in her room, flipping through the pages of a photo album.

On 05/27/25 at 01:48 PM Certified Medication Aide (CMA) S stated when medication has a physician ordered parameters for blood pressure and/or pulse to hold the medication, the MAR should have a flagged area to document the pulse and blood pressure. CMA S said the nurse should be notified, and the nurse would follow up with an assessment and notify the physician when indicated for further instructions. CMA S verified R18's record lacked documentation of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175301	A. BUILDING _____ B. WING _____	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICHITA PRESBYTERIAN MANOR	4700 W 13TH STREET NORTH WICHITA, KS 67212

(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 24	F 757		

resident's pulse being obtained as ordered by the physician. CMA S verified the facility had a bowel protocol to address constipation for residents who had not had a bowel movement in three days. She stated the night shift nurse pulled a report generated from the electronic record which flags if a resident does not have a BM in three days. CMA S said she received the report from the nurse with instructions to initiate the protocol. She reported she was not aware if R18 had constipation.

On 05/27/25 at 02:04 PM, Licensed Nurse (LN) I verified R18's electronic record lacked documentation to reflect monitoring the resident's pulse for the physician-ordered hold parameters. She stated she thought the pharmacist should have identified that during the monthly pharmacy review. LN I said when medications have physician-ordered pulse and blood pressure parameters the MAR should alert and have an area to document the pulse and blood pressure. LN I said the nurse should be notified and follow up with an assessment and notify the physician when indicated for further instructions. LN I verified R18's record lacked documentation of the resident's pulse being obtained as ordered. LN I reported R18 should have pulses documented in addition to the blood pressure to determine the effects and potential risks of receiving metoprolol. She reported she was not aware of R18's concerns with constipation, and that R18 was able to take herself to the bathroom. LN I confirmed the facility had a bowel protocol.

On 5/22/25 at 11:18 AM, Consultant GG reviewed R18's electronic record and verified the above findings. She stated the facility had standing orders for a BM protocol when there was no BM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175301	A. BUILDING _____ B. WING _____	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICHITA PRESBYTERIAN MANOR	4700 W 13TH STREET NORTH WICHITA, KS 67212

(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 25 in three days. Additionally, she confirmed R18 should have had her pulse monitored daily related to the parameters for holding metoprolol for a pulse of less than 60 BPM, which was not done when the order was entered. Consultant HH stated she expected the pharmacist to review the medication monitoring to include the pulse, but said she did not know if that was identified as a concern on the monthly regimen review. The facility did not provide a policy to address the administration of medication outside of prescribed parameters and/or monitor the side effects or adverse effects for residents taking medications.	F 757		
F 761 SS=E	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 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	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175301	A. BUILDING _____ B. WING _____	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICHITA PRESBYTERIAN MANOR	4700 W 13TH STREET NORTH WICHITA, KS 67212

(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 26	F 761		

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 reported a census of 46 residents. Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals used in the facility were labeled and stored in locked compartments and permitted only authorized personnel to have access to the keys. This placed the residents at risk for medication errors, ineffective medication regimens, and diversions.

Findings included:

- During an observation of the Medication Room on 05/22/25 at 11:30 AM, the medication refrigerator lacked temperature documentation for 15 days in January 2025, 17 days in February 2025, 24 days in March 2025, 15 days in April 2025, and 12 days in May 2025 from 05/01/25 to 05/20/25.

During an observation on 05/22/25 at 11:43 AM, the unlocked treatment cart contained scissors and insulin (hormone used to treat high blood glucose). Observation revealed a Humalog (fast-acting insulin) insulin pen was opened on 04/23/25 and should have been discarded on 05/20/25. It was in the cart on 05/22/25. Further observation revealed a Lantus (long-acting insulin) insulin pen was opened but not dated.

During an interview on 05/22/25 at 11:30 AM, LN I stated the temperature of the refrigerator should be documented by the night nurse every night.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175301	A. BUILDING _____ B. WING _____	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICHITA PRESBYTERIAN MANOR	4700 W 13TH STREET NORTH WICHITA, KS 67212

(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 27 During an interview on 05/22/25 at 11:30 AM, LN I stated the insulin pens should be dated when they are opened and thrown away when they expire. LN I stated the treatment cart should be locked when staff were not with the cart. During an interview on 05/22/25 at 12:12 PM, Administrative Nurse D reported staff were to assess and record the medication refrigerator temperatures daily. Administrative nurse D said all medication and treatment carts were to be locked when staff were away from the carts. Administrative Nurse D verified all insulin were to be dated when they were opened, and the Humalog should have been discarded at 28 days. The facility ' s policy "Medication Administration" dated 02/03/25 documented staff should never leave the medication cart opened and unattended unless locked. The facility ' s policy "Medication Administration" dated 02/03/25 documented that medications requiring refrigeration were to be kept between 36 degrees Fahrenheit and 46 degrees Fahrenheit. Outdated and expired medications were to be immediately removed and disposed of according to procedures for medication storage.	F 761		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175301	A. BUILDING _____ B. WING _____	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICHITA PRESBYTERIAN MANOR	4700 W 13TH STREET NORTH WICHITA, KS 67212

(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 880	Continued From page 28	F 880		

diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175301	A. BUILDING _____ B. WING _____	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICHITA PRESBYTERIAN MANOR	4700 W 13TH STREET NORTH WICHITA, KS 67212

(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 880	Continued From page 29	F 880		

must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 46 residents. The sample included 12 residents. Based on observation, interview, and record review, the facility failed to disinfect the shared sit-to-stand lift (a mechanical lift) after use and failed to utilize proper respiratory infection control methods. This placed the residents at risk for infections.

Findings included:

- Observation on 05/20/25 at 03:00 PM, staff used the sit-to-stand on Resident (R) 12. Staff then took the sit-to-stand lift out of R12's room and placed it in R7 ' s room without disinfecting it.

Ongoing observation on 05/20/25 at 03:20 PM revealed staff transferred R7 with the sit-to-stand lift, then took the lift to the hall.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175301	A. BUILDING _____ B. WING _____	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICHITA PRESBYTERIAN MANOR	4700 W 13TH STREET NORTH WICHITA, KS 67212

(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 880	Continued From page 30	F 880		

Observation on 05/20/25 at 04:42 PM, R14 ' s nebulizer was on the bedside table still attached to the tubing; it had a clear liquid in the bottom of the chamber.

Observation on 05/21/25 at 08:23 AM, R8 ' s oxygen tubing was strung across the room on the floor with the part of the nasal canula that went into the nose resting on the floor.

Observation on 05/22/25 at 08:01 AM, R14 ' s nebulizer was still attached to the tubing with clear liquid in the chamber. R14 revealed that she had not had a treatment yet this morning. The nebulizer still attached to the tubing located on the bedside table was from the night before.

Observation on 05/22/25 at 09:34 AM, Certified Medication Aide (CMA) R pushed a cart of lost and found clothes through the hallway, uncovered for residents to look at. CMA R left the uncovered cart of clothing in the living area on 05/22/25 at 01:40 PM.

During an interview on 05/22/25 at 10:15 AM, Certified Nurse Aide (CNA) M stated that the CNAs do not disinfect the lifts between residents. CNA M said the housekeepers were to wipe down the equipment between residents.

During an interview on 05/22/25 at 10:32 AM, Housekeeping Staff U revealed that she wiped the sit to stand lift and Hoyer lift down when they were in the hallway while she wiped down the handrail, but did not wipe them down between the residents.

During an interview on 05/22/25 at 10:25,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175301	A. BUILDING _____ B. WING _____	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICHITA PRESBYTERIAN MANOR	4700 W 13TH STREET NORTH WICHITA, KS 67212

(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 880	Continued From page 31	F 880		

Licensed Nurse (LN) G stated the protocol for nebulizer treatments was for the staff to separate the nebulizer, rinse the parts, and place it on a towel to dry. LN G said that after the parts were dry, they placed them into a bag.

During an interview on 05/22/25 at 01:43 PM, Administrative Nurse F stated that the CNAs should clean the lift and any equipment that went from resident to resident between each use Administrative Nurse E said clothing should be covered when in a hallway or in a common area. Administrative nurse E said nebulizers and oxygen tubing should be cleaned appropriately and placed in a bag.

During an interview on 05/22/25 at 10:55 AM, Administrative Nurse D stated it was the responsibility of the nursing staff to clean the sit-to-stand and full body sling lifts in between the residents, not housekeeping ' s responsibility. Administrative Nurse D expected the nursing staff to clean the nebulizers after each use, rinse the nebulizer, let it dry on a towel, then place into a bag.

The facility's "Nebulizer Cleaning Instructions" policy dated 02/03/25 documented after each treatment, the nebulizer mouthpiece and cup will be rinsed out and allowed to air dry. Then place the parts in a bag. After the last meal of the day, wash all pieces in mild soap and water. Then soak in vinegar water, rinse, and leave to dry on a paper towel. When the nebulizer is dry, place in a plastic bag.

The facility's "Oxygen Therapy" policy dated 02/03/25 documented when oxygen tubing is not in use, it was to be placed in a plastic bag.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175301	A. BUILDING _____ B. WING _____	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICHITA PRESBYTERIAN MANOR	4700 W 13TH STREET NORTH WICHITA, KS 67212

(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 947 SS=E	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: The facility reported a census of 46 residents. Five Certified Nurse Aide (CNA) staff, who worked in the facility were reviewed for required in-service training. Based on interview and record review, the facility failed to develop, implement, and permanently maintain an in-service training program for Certified Nurse Aide (CNAs) with the required topics and no less than 12 hours per year when one of the five nurse aides sampled lacked the required training hours. This placed the residents at risk for decreased quality of care. Findings included: - On 05/21/25 at 02:43 PM, review of training	F 947		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175301	A. BUILDING _____ B. WING _____	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICHITA PRESBYTERIAN MANOR	4700 W 13TH STREET NORTH WICHITA, KS 67212

(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 947	Continued From page 33 records Certified Nurse Aide (CNA) N revealed CNA N had ten- and one-half hours of documented training. On 05/22/25 12:12 PM, Administrative Nurse D confirmed that CNAs were required to have 12 hours of training annually and stated that CNA N did not have the appropriate training and there were no records of additional training for this CNAs. The facility's "Education" policy documented that all staff receive appropriate training in or to ensure the safety and well-being of all residents.	F 947		