STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175309	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/13/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS Th following citations are the result of a Health Recertification Survey and complaint investigation 1548870 2567 was sent electronically on 08.20.25	F0000		
F0689 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 reported a census of 46 residents. The sample included 16 residents, which included seven residents reviewed for accidents. Based on observation, interview, and record review, the facility failed to provide an environment free of accident hazards when Certified Nurse Aide (CNA) M assisted a cognitively impaired resident, Resident (R) 46, with locomotion in the hallway without the use of wheelchair pedals. This deficient practice placed R46 at risk for accidents. Findings included: - Review of the Electronic Health Record (EHR) documented R46 had diagnoses which included dementia (a progressive mental disorder characterized by failing memory and confusion), long-term use of anticoagulants (a class of medications used to prevent the blood from clotting), and generalized muscle weakness. R46's 02/14/25 "Annual Minimum Data Set" (MDS) documented a Brief Interview for Mental Status (BIMS)	F0689		

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 reverse for further 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.

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

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F0689 SS = D	Continued from page 1 score of three, which indicated severely impaired cognition. The assessment documented R46 utilized a wheelchair and/or walker for locomotion and required setup assistance to wheel 50 feet with two turns and supervision assistance to wheel 150 feet in the corridors. The 02/14/25 “Cognitive Loss / Dementia Care Area Assessment” (CAA) documented R46 had a diagnosis of dementia and required staff to reorient R46 as needed, but with short-term success. The 02/14/25 “Falls CAA” documented R46 had a history of falls and included falls with fractures (broken bones) prior to admission. R46 utilized a wheelchair for most of her locomotion and was able to self-propel at times, and required staff assistance at times for locomotion. R46’s 07/25/25 “Quarterly MDS” documented a BIMS score of three, which indicated severely impaired cognition. The assessment documented R46 utilized a wheelchair and/or walker for locomotion and required setup assistance to wheel 50 feet with two turns and supervision assistance to wheel 150 feet in the corridors. R46’s 06/27/24 “Care Plan”, reviewed 08/12/25, documented the resident had impaired mobility with impaired physical function. The plan documented R46 required substantial/maximal assistance with transfers and wheelchair locomotion. R46 would sometimes propel herself in her wheelchair for short distances with her feet, dated 06/27/24 and revised on 02/28/25. R46’s “Care Plan” instructed staff to lock R46’s wheelchair for all transfers and position R46’s feet on the foot pedals for all assisted wheelchair locomotion. During an observation on 08/12/25 at 02:20 PM, CNA M assisted R46 from the common area down a corridor to R46’s room, and the wheelchair did not have foot pedals. R46 held her feet off the floor during assisted wheelchair locomotion. On 08/12/25 at 02:25 PM, CNA M revealed she assisted R46 to her room via R46’s wheelchair. CNA M confirmed the wheelchair did not have pedals installed. CNA M stated the wheelchair pedals should have been installed prior to assisted wheelchair locomotion. On 08/12/25 at 02:35 PM, Licensed Nurse (LN) G reported that all residents being assisted with wheelchair locomotion should have their feet set on the foot pedals prior to the wheelchair going into motion.	F0689		

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F0689 SS = D	Continued from page 2 On 08/12/25 at 02:45 PM, Administrative Nurse D said that all residents should have foot pedals installed on the wheelchair with their feet set on the foot pedals prior to assisted wheelchair locomotion. Administrative Nurse D said that the wheelchairs have bags attached to the back of the wheelchairs so residents who prefer to self-propel can have the pedals stowed in the bag for easy access by staff when assisted wheelchair locomotion is required. Administrative Staff D revealed the facility's expectation was for staff to place foot pedals on the wheelchair and for staff to ensure the resident's feet are safely on the pedals prior to assisted wheelchair locomotion. On 08/13/25 at 08:10 AM, Administrative Nurse D revealed the facility did not have a policy related to the use of wheelchair pedals and that the facility expected staff to follow the standard of practice. The facility did not provide a policy.	F0689		
F0732 SS = C	Posted Nurse Staffing Information CFR(s): 483.35(i)(1)-(4) §483.35(i) Nurse Staffing Information. §483.35(i)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(i)(2) Posting requirements. (i) The facility must post the nurse staffing data	F0732		

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F0732 SS = C	Continued from page 3 specified in paragraph (i)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(i)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(i)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: The facility reported a census of 46 residents. Based on record review and interview, the facility failed to display accurate and identifiable staffing information, which contained the actual nursing hours worked, for the 46 residents who resided in the facility. Findings included: - Review of the facility's "Daily Nurse Staffing Report" from 07/10/25 through 08/10/25 revealed the actual hours worked had not been completed on the daily nurse staffing report. On 08/13/25 at 10:00 AM, Administrative Nurse D confirmed the actual hours worked were not completed on the daily staffing sheets, as required. The facility policy for "Daily Nurse Staffing Report," revised 02/03/25, included: At the beginning of each shift, the form shall identify the actual shift hours expected to be worked by licensed and unlicensed staff directly responsible for resident care.	F0732		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F0812		

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F0812 SS = F	Continued from page 4 The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: The facility reported a census of 46 residents with one kitchen. Based on observation, record review, and interview, the facility failed to prepare and serve food under sanitary conditions, to prevent the potential for food borne illness and decreased palatability. This puts the residents at risk for illness and weight loss. Findings included: During an initial tour of the resident kitchen on 08/11/25 at 09:05 AM, the following areas of concern were noted in the freezer: Two Ziplock bags of hamburger patties were unsealed, and the bag was wide open, exposing the contents to air. A Ziplock bag of chicken strips was unsealed, and the bag was wide open, exposing the contents to air. A Ziplock bag of potato wedges was unsealed, and the bag was wide open, exposing the contents to air. During the subsequent tour of the kitchen on 08/12/25 at 09:30 AM, two of the four cutting boards had deep grooves and scratches. The other two had multiple	F0812		

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F0812 SS = F	Continued from page 5 scratches. On 08/11/25 at 09:05 AM, Dietary Staff BB stated he was aware that items in the freezer should be sealed to avoid freezer burn. He immediately sealed the Ziplock bags. On 08/12/25 at 09:30 AM, Dietary Staff BB stated the cutting boards needed to be free from scratches and grooves. Dietary Staff BB stated he has ordered new cutting boards.	F0812		
F0880 SS = D	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 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;	F0880		

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F0880 SS = D	Continued from page 6 (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 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. Based on observation, interview and record review, the facility failed to maintain an effective infection control program related to the delivery of laundry to the residents' rooms. This deficient practice had the potential to lead to the cross-contamination and spread of communicable diseases to the residents of the facility. Findings included: On 08/11/25 at 10:35 AM, Laundry V and Laundry W were observed delivering laundry to three resident rooms.	F0880		

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F0880 SS = D	Continued from page 7 Laundry V and Laundry W did not perform hand hygiene before they entered the residents' rooms or after they exited the residents' rooms. On 08/11/25 at 10:37 AM, Laundry V and Laundry W stated they were informed by a former supervisor that hand hygiene between resident rooms stopped when the COVID-19 (highly contagious respiratory virus) pandemic ended. On 08/11/25 at 10:40 AM, Housekeeping U revealed the facility's expectation was that hand hygiene should be performed with alcohol based hand rub (ABHR – isopropyl alcohol hand sanitizer) when going from one resident's room to another, and actual hand washing with soap and water after every fourth or fifth time of using ABHR. On 08/11/25 at 11:25 AM, Administrative Nurse E stated hand hygiene should be performed by all staff when entering and/or exiting residents' rooms. On 08/11/25 at 11:27 AM, Administrative Nurse D revealed the facility's expectation was for staff to perform hand hygiene with ABHR if hands are not visibly soiled and with actual soap and water after the fourth use of ABHR. Administrative Nurse D and Administrative Nurse E confirmed staff should have performed hand hygiene after leaving one resident room prior to going into a different resident's room. The facility's "Hand Hygiene" policy, revised 02/03/25, documented all staff would comply with hand hygiene guidelines and gave indications for hand-washing that included before and after direct contact with residents and before and after contact with inanimate objects in the vicinity of residents.	F0880		