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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that all alleged violations	F 609		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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involving mistreatment, are reported immediately to the Kansas Department of Aging and Disability, but no later than 24 hours after an unusual occurrence occurred, for one of 12 sampled residents for abuse. (Resident (R) 2)

Findings include:

Review of R 2's "Face Sheet" indicated the resident had diagnosis of Parkinson's Disease.

Review of the quarterly "Minimum Data Set (MDS)" assessment (assessment used in long-term care facilities), dated 06/08/18 indicated the following: Section C. the resident had scored of 7 on the Brief Interview for Mental Status, which indicates moderate cognitive impairment and Section G, indicated the resident required extensive two staff assist for bed mobility.

A care plan titled "Impaired Physical Function" dated 2/20/17, revealed the resident was "extensive to almost total assistant with activities of daily living such as ...check and change in bed ..."

Review of a care plan titled, "I Have Delusions," dated 2/20/17, had the intervention of "I get more restless in the eve (evening) hours. My delusions revolve around my wife. I will get all worked up physically act out e.g. (examples) pull call light out of the wall and scream out and thrash around in bed. These behaviors impact my comfort and wellbeing. I cont. (continue) Seroquel for these delusions and failed other meds to manage." This intervention was added on 8/22/18.

Review of a care plan, titled "Socially

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Inappropriate Behavior, sometimes have verbal behavior including inappropriate sexual and racial comment such as "get that wild Indian away from me," dated 2/20/17 revealed interventions of "My behavior(s) have an impact on others as evidenced by disrupting the milieu by attempting to wave down staff members and hollering at them for help. I told activity staff that I wave people down in the halls instead of using my call light as it gets attention. Please redirect any inappropriate comments as not to validate these behaviors. Please have a 2nd staff if needed when I demonstrate these types of behaviors. I may refuse baths and it will be a difficult balance to determine personal choice and need for hygiene/bath. Please inform my charge nurse or IDT (Interdisciplinary Team) of behaviors to determine if a pattern or trigger exists (sic). My wife has been educated on plan of care on 12/30/16 and again on 1/17/17."

Review of the "Interdisciplinary Note", dated 07/24/18 at 6:41 AM, indicated "Resident yelling this morning around 0530 [5:30 AM] for help. This nurse went to the room when she found the CNA [Certified Nursing Assistant] in the room. The resident has sustained a skin tear on the left hand and was bleeding. Kerlix [type of dressing] wrapped around the skin tear. This nurse informed the ADON [Assistant Director of Nursing] who arrived and attended to the resident."

An "Interdisciplinary Note" dated 07/24/18 at 10:39 AM, indicated, "this RN was in the office at 525 [5:25 AM] when resident's assigned nurse reported that he had received a "bad" skin tear to his hand. Went to resident's room to find him in bed with blood on his shirt and his right hand

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wrapped in Kerlix with blood seeping through. Resident was saying It hurts...I held resident's hand and talked to him to calm him down, then went to get supplies and another CNA to assist in getting resident out of bed and cleaned up. Returned to room and assisted in moving resident from bed to wheelchair with his lift. Unwrapped the Kerlix to discover a notable, approximately 3 x [by] 3 cm [centimeters] skin tear on the dorsal side of the right hand, medial to the first digit with a moderated to large loss of tissue. There was still a moderate amount of blood coming from the wound area. Cleansed with saline, patted dry as best I could it still bleeding, covered with Kerraform [type of dressing], and applied pressure. Assisted CNA in changing resident's shirt when the area began to bleed again. On further inspection it appears that the tear extends out onto the first digit. Added gauze to area and wrapped hand in Kerlix. Report given to oncoming RN about situation and dressing.

Review of a witness statement, dated 07/24/18, no time and signed by CNA Q indicated he was changing the resident's brief and when the resident was rolled over the CNA noticed blood on the resident's right hand.

Review of an "investigation" dated 07/24/18, no time, indicated "Conclusion of Investigation-Interventions. The facts of this investigation reveal that while changing the resident's brief in the morning, the resident's hand scraped the wall, either by spasm or during the turn, causing a skin tear to occur. This is substantiated by the blood found on the sheet in between the bed and the wall. The facts of investigation do not support an allegation of

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F 609	Continued From page 4 abuse, neglect or misappropriation of resident property. This Occurrence is not of unknown or unexplained origin. Corrective measures to strive to prevent a re-occurrence include: Staff were re-educated on the need for two people to assist when making transfers with the resident due to his tendency fail his arms during care and transfers." During an interview on 09/25/18 at 10:10 AM, the Director of Nursing (DON) stated the incident should have been reported to the state agency. The DON indicated she did not think the incident had been reported. During an interview on 9/25/18, at 1:55 PM, the Administrator indicated the DON was the abuse coordinator. During an interview on 9/25/18 at 3:50 PM, the Regional Nurse RN, indicated the unusual occurrence was not reported to the state agency. During an interview on 09/27/18 at 6:55 AM, the DON confirmed that the unusual occurrence was not reported to the state agency. Review of the facility's policy titled, "ANE: Abuse Prevention, Reporting and Investigation-Staff Treatment of Participants," revised 2014, revealed " ...6. Reporting a. The executive director or designee, in conjunction with the health services director or designee, notifies the following of a suspected abuse occurrence: i. state licensing/certification agency - within 24 hours ..."	F 609		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)	F 623		

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F 623	Continued From page 5 §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or	F 623		

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F 623	Continued From page 6 (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice.	F 623		

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If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 36 residents. The sample included 12 residents. Based on record review, observation, and interviews the facility failed to ensure 1 (#35) resident/responsible party sampled for hospitalization received written notification of the reason for the hospitalization.

Findings included:

- The Electronic Medical Record (EMR), for resident #35 listed diagnoses of malaise (vague uneasy feeling of body weakness, distress or discomfort), atrial fibrillation (rapid, irregular heart beat), and chronic obstructive pulmonary disease (progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing).

The Admission Minimum Data Set (MDS) dated 9/6/18, documented the resident had a Brief

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F 623	Continued From page 8 Interview for Mental Status (BIMS) score of 11, which indicated moderately impaired cognition. He/she required limited to extensive staff assistance for Activities of Daily Living (ADLs). The ADL Care Area Assessment (CAA) dated 9/6/18, documented he/she received therapy services to help his/her independence. The ADL Care Plan dated 8/31/18, documented he/she required facility staff assistance for all ADLs. The nurse's progress note dated 9/18/18, documented he/she admitted to the hospital for cellulitis (skin infection caused by bacteria characterized by heat, redness, and swelling) of the right arm. On 9/26/18 at 9:45 AM he/she rested in his/her bed. His/her right arm had no redness or swelling. On 9/27/18 at 8:31 AM administrative nursing staff D stated the facility staff did not send written notification regarding the hospital discharge to the resident or his/her family. The facility's Discharge Process Policy dated 07/2017 did not document the required written notification to the family/responsible party as part of the policy. The facility failed to ensure this resident/responsible party received written notification of the reason for his/her hospitalization.	F 623		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)	F 756		

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F 756	Continued From page 9 §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. This REQUIREMENT is not met as evidenced by:	F 756		

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The facility identified a census of 36 residents. The sample included 12 residents, with 5 residents sampled for medication review. Based on observation, record review, and interview, the facility's consultant pharmacist failed to identify irregularities in blood glucose levels for resident #23.

Findings include:

- Resident #23's September 2018 electronic medical record documented diagnoses of Type 2 Diabetes Mellitus (A chronic condition that affects the way the body processes blood glucose).

The quarterly (MDS) Minimum Data Set assessment, dated 8/3/18, documented the resident had a (BIMS) Brief Interview of Mental Status score of 09, which indicated the resident had moderately impaired cognition. The MDS documented the resident required supervision with no set up for walking in room and corridor, and locomotion on unit., supervision with set up assist for eating, supervision with one-person physical assist for bed mobility, transfer, dressing, and limited physical assist of one person for toileting and personal hygiene. The MDS documented resident received insulin and injections for 7 days of the look back period. The 5/9/2018 care plan documented the resident had potential for hypo/hyper glycemia due to diagnosis of Type 2 Diabetes Mellitus. The care plan instructed staff to notify physician if resident's blood sugar was below 70 or above 450.

Review of (EMR) Electronic Medical Record for August and September 2018 indicated resident received Levemir (long acting) Insulin 100 unit/mL

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(milliliter) 15 units subcutaneously daily at bedtime and Novolog (short acting) Insulin 100 unit/mL 7 units subcutaneously three times daily before meals for Type 2 Diabetes Mellitus.

The 4/27/2018 physician order stated notify primary care physician if (CBG) capillary blood glucose less than 70 or greater than 450.

Review of the (EMR) electronic medical record documented blood glucose levels of 60 on 9/4/18, 63 on 9/3/18, 67 on 09/02/2018, 65 on 8/30/18, 65 on 8/15/18, 67 on 8/10/18 and 64 on 8/8/18. The EMR and paper chart lacked evidence of notification to the physician.

The pharmacist's medication regimen review for August and September 2018 lacked documentation of blood glucose monitoring and physician notification for blood glucoses outside of ordered parameters.
On 09/26/18 at 11:02 AM the resident was seated on the seat of his/her rolling walker next to the medication cart and conversed with the nurse.

On 09/26/18 03:24 PM Licensed Nurse H stated the pharmacist reviewed resident medications every month, the nurses and doctor reply to them. The results of the pharmacist review were shared verbally, and in the working care plan book.

On 09/27/18 at 07:22 AM Administrative Nursing Staff E confirmed that the EMR documented blood glucose levels below the ordered parameters and confirmed there was no documentation or record of physician notification on those dates when blood glucose was below parameter.

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F 756	Continued From page 12 On 09/27/18 at 07:47 AM Administrative Nursing Staff D verbalized agreement with Administrative Nurse E in that there were several instances of blood glucose levels below 70 documented with no record of physician notification. Administrative Nurse D stated it was his/her expectation that the nurse would have notified the physician of blood glucose levels outside of ordered parameters. On 9/28/18, the consulting pharmacist was unavailable for comment. The facility failed to ensure the consultant pharmacist monitored and reported seven instances of low blood glucose which placed resident #23 at risk for hypoglycemia. Resident #23 received insulin daily	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 §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	F 757		

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§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 36 residents. The sample included 12 residents of which 5 were reviewed for unnecessary medications. Based on observation, record review and interview, the facility failed to adequately monitor blood sugars as prescribed for 1 of 5 residents reviewed. Resident #23 received daily insulin.

Findings included:

- Resident #23 September 2018 electronic medical record documented diagnoses of Type 2 Diabetes Mellitus (A chronic condition that affects the way the body processes blood glucose).

The quarterly (MDS) Minimum Data Set assessment, dated 8/3/18, documented the resident had a (BIMS) Brief Interview of Mental Status score of 09, which indicated the resident had moderately impaired cognition. The MDS documented the resident required supervision with no set up for walking in room and corridor, and locomotion on unit., supervision with set up assist for eating, supervision with one-person physical assist for bed mobility, transfer, dressing, and limited physical assist of one person for toileting and personal hygiene. The MDS documented resident received insulin and injections for 7 days of the look back period.
The 5/9/2018 care plan documented the resident had potential for hypo/hyper glycemia due to diagnosis of Type 2 Diabetes Mellitus. The care plan instructed staff to notify physician if

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175305	A. BUILDING _____ B. WING _____	09/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE PRESBYTERIAN MANOR	1429 KASOLD DR LAWRENCE, KS 66049

(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
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resident's blood sugar was below 70 or above 450.

Review of (EMR) Electronic Medical Record for August and September 2018 indicated resident received Levemir (long acting) Insulin 100 unit/mL 15 units subcutaneously daily at bedtime and Novolog (short acting) Insulin 100 unit/mL 7 units subcutaneously three times daily before meals for Type 2 Diabetes Mellitus.

The 4/27/2018 physician order stated notify primary care physician if (CBG) capillary blood glucose less than 70 or greater than 450.

Review of the (EMR) electronic medical record documented blood glucose levels of 60 on 9/4/18, 63 on 9/3/18, 67 on 09/02/2018, 65 on 8/30/18, 65 on 8/15/18, 67 on 8/10/18 and 64 on 8/8/18. The EMR and paper chart lacked evidence of notification to the physician.

On 09/27/18 at 07:22 AM Administrative Nursing Staff E confirmed that the (EMR) Electronic Medical Record documented blood glucose levels below the ordered parameters and confirmed there was no documentation or record of physician notification on those dates when blood glucose was below parameter.

On 09/27/18 at 07:47 AM Administrative Nursing Staff D verbalized agreement with Administrative Nurse E in that there were several instances of blood glucose levels below 70 documented with no record of physician notification. Administrative Nurse D stated it was his/her expectation that the nurse would have notified the physician of blood glucose levels outside of ordered parameters.

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F 757	Continued From page 15 On 09/26/18 at 11:02 AM resident was observed seated on seat of rolling walker next to the medication cart conversing with the nurse. Put the observation after the record review and before the interviews. On 09/27/18 at 08:27 AM Licensed Nursing staff H stated the nurses would obtain blood glucose readings and document results in the (EMR) Electronic Medical Record. Licensed Nurse Staff H stated the resident had physician ordered parameters in the charts from the physician and if a result were outside of that parameter, the nurse would call the physician. The facility's January 2016 Notification Parameters-Primary Care Provider (PCP) policy documented the licensed nurse would have the responsibility of contacting the physician and documenting notification in the resident's record and a physician's order supersedes parameters suggested in policy. The facility failed to notify the attending physician when the resident had blood glucose level below ordered parameter placing resident at risk for hypoglycemia.	F 757		