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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey.	F 000		
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is	F 315		

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

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incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 40 residents. The sample included 10 residents, of which 2 residents were reviewed for indwelling urinary catheter. Based on observation, record review and interview, the facility failed to obtain a physician ordered follow-up (UA) Urinalysis (examination of urine) following treatment for a (UTI) Urinary Tract Infection (an infection in any part of your urinary system) for 1 of 2 sampled residents. (#39)

Findings included:

- Resident #39's diagnoses from the signed physician's orders, dated 3/21/17, included urinary retention (lack of ability to urinate and empty the bladder) and (BPH) Benign Prostrate Hypertrophy (common, noncancerous enlargement of the prostate gland (a walnut-sized gland located between the bladder and the penis).

The quarterly (MDS) Minimum Data Set assessment, dated 12/10/16, recorded a (BIMS) Brief Interview for Mental Status score of 14, which indicated the resident had intact cognition. The MDS indicated the resident required limited assistance of 1 staff for bed mobility, supervision with assistance of 1 staff for transfers, extensive assistance of 1 staff for toileting, and had an indwelling urinary catheter.

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The (CAA) Care Area Assessment for urinary incontinence/indwelling catheter, dated 3/20/17, recorded staff had performed a straight catherization (catheter is inserted only long enough to drain the bladder) on the resident on 12/9/15, resulting in a large amount of post voided residual (urine test measures the amount of urine left in the bladder after urination) with bladder scans noted. The CAA further indicated staff performed frequent straight catheterization procedures (catheter is inserted only long enough to drain the bladder) completed in a 24-48 hour period and received a physician's order for insertion of a urinary catheter until follow up appointment on 12/23/15.

The 12/2006 care plan, reviewed on 3/14/17, instructed staff to provide urinary catheter care every shift, and change the urinary catheter drainage bag every 30 days, and as needed. The care plan further documented the resident demonstrated bladder spasms when he/she had a urinary tract infection or retained urine.

The 1/16/17 physician's order instructed staff to administer Cefpodoxime, (an antibiotic), 100 (mg) milligrams, every 12 hours, by mouth, until 1/22/17.

The 1/20/17 physician's order instructed staff to obtain a follow-up UA on 1/26/17.

The 1/20/17 nurse's note revealed staff had received a physician's phone order to obtain an

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UA with culture and sensitivity, three days after the antibiotic was finished, with a UA to be obtained on 1/26/17.

Review of the resident's medical record revealed the UA was not obtained on 1/26/17, as physician ordered, but was obtained on 2/3/17.

Further review of the resident's medical record revealed the facility had not informed the physician the staff failed to obtain the 1/26/17 ordered UA until 2/3/17 (8 days later).

The 2/3/17 UA indicated the resident had an UTI.

On 4/4/17 at 10:15 AM, observation revealed the resident walking in the hallway with his/her walker and companion. Further observation revealed the resident had a slow steady gait, wore non skid shoes, and the resident's urinary catheter leg bag was covered with his/her slacks.

On 4/6/17 at 11:15 AM, Administrative Nurse A verified the staff had not obtained the follow up UA, as physician ordered on 1/26/17, until 2/3/17 (8 days later).

On 4/6/17 at 11:15 AM, Administrative Nurse D verified the facility had not obtained the 1/26/17 physician ordered follow up UA.

On 4/10/17 at 9:31 AM, Nurse B verified the staff

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F 315	Continued From page 4 had not documented the follow up 1/26/17 UA order in the lab computer system and the nurse should have called the resident's physician to inform him/her the UA had not been obtained on 1/26/17, as ordered. On 4/10/17 at 1:00 PM, Nurse D verified the lack of documentation of the 1/26/17 physician's ordered follow-up UA in the lab computer system. The 1/2016 facility's medication orders or renewal policy recorded new orders or changes in orders were entered electronically into the facility's clinical software. The Director of Nursing, or designee who also is a licensed nurse, was assigned the responsibility of ensuring orders are accurate with discrepancies brought to the attention of the Director of Nursing. The facility failed to obtain a follow up UA for Resident #39, as physician ordered on 1/26/17, until 2/3/17, 8 days later, placing the resident at risk for prolonging treatment for a UTI.	F 315		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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	F 329		

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F 329	Continued From page 5 (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-- (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; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: The facility had a census of 40 residents. The sample included 10 residents of which 5 were reviewed for unnecessary medications. Based on observation, record review and interview the facility failed to ensure 2 of the 5 sampled residents did not receive unnecessary medications. The facility lacked documentation of Resident #16 physician's ordered fasting blood sugars and 2 hour (PP) Post Prandial (after eating) blood sugars in August 2016 or February	F 329		

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2017. The facility failed to follow up on a pharmacy consultant recommendation in July 2016, for Resident #4 requesting a fasting lipid panel which the physician did not respond to until December 2016, and then declined the recommendation.

Findings included:

- Resident #16's diagnoses signed physician's orders, dated 2/22/17, included psychosis (any major mental disorder characterized by a gross impairment in reality testing).

The 5 day (MDS) Minimum Data Set assessment, dated 2/8/17, recorded the resident had short term and long term memory loss, moderately impaired daily decision making, and inattention behaviors, which fluctuated. The MDS recorded the resident received 7 days of an antipsychotic medication.

The (CAA) Care Area Assessment for psychotropic drug use, dated 5/9/16, recorded the interdisciplinary team would continue to monitor and communicate with the resident and his/her family, when the pharmacist or physician requested medication changes and use of psychotropic medications.

The 2/11/17 care plan instructed staff to administer the physician ordered medications.

The 3/1/16 physician orders instructed staff to obtain fasting and 2 hour PP blood sugars with a glucometer, (instrument used to calculate blood glucose), every 6 months related to antipsychotic medication use, in August 2016 and February 2017, and notify the physician if the blood sugar

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was <65 or >300.

Review of the resident's medical record revealed no fasting or 2 hour PP blood sugars were obtained in August 2016.

Further review of the resident's medical record revealed no PP blood sugar were performed on 2/3/17.

On 4/10/17 at 7:20 AM, observation revealed the well groomed resident, seated in his/her wheelchair, at the breakfast table.

On 4/10/17 at 11:20 AM, Administrative Nurse A verified no documentation staff obtained the resident's fasting or 2 hour PP blood sugar in August 2016 or as physician ordered or a 2 hour PP blood sugar obtained in February 2017.

The 1/20/16 facility's blood glucose monitoring policy recorded the blood testing was ordered by the primary care provider for the time of day and frequency. The policy stated the blood glucose monitoring on Caretracker is maintained for each resident when monitoring is ordered.

The facility failed to obtain physician ordered blood sugars for Resident #16 in August 2016 and February 2017, which placed the resident at risk for elevated blood sugars due to taking antipsychotic medication.
- The signed physician's order sheet (POS) dated 3/21/17 for resident #4 revealed a diagnosis of hyperlipidemia (a condition in which there is too much cholesterol in the blood).

The annual (MDS) Minimum Data Set

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Assessment, dated 6/25/16, revealed a BIMS score of 1, which indicated severely impaired cognition. He/she required extensive assistance of one staff for bed mobility, transfers, dressing, toileting, bathing, and locomotion on the unit. He/she required limited assistance of one staff for personal hygiene.

The (CAA) Care Area Assessment, dated 6/25/16, for cognition, documented no changes had been noted in the resident's day to day functioning. The resident was unable to comprehend some things and his/her thought process was very slow.

The quarterly MDS, dated 12/26/16, revealed staff assessed the resident's cognitive skills as severely impaired. The resident required extensive assistance of one staff for bed mobility, transfers, locomotion on the unit, dressing, toileting, personal hygiene, and bathing.

The care plan, dated 12/27/16, documented the resident received Pravastatin for hyperlipidemia.

The (POS) physician order statement, dated 3/21/17, documented an order for Pravastatin 10 milligrams (mg) daily, for hyperlipidemia.

Review of the medical record revealed the most recent lipid profile drawn on 4/14/15.

On 04/06/2017 at 7:33 AM, observation revealed the resident sat at the dining room table with 2 other residents.

On 04/10/17 at 2:07 PM Administrative Nursing Staff A verified a lipid profile had not been completed since 5/14/15. He/she acknowledged

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F 329	Continued From page 9 the pharmacy consultant made a recommendation for one in July of 2016. The facility's policy "Drug Regimen Review", revised 3/20/17, documented the facility encouraged the physician to act on the report from the consulting pharmacist. The facility failed to follow up with the physician regarding a lipid profile blood test, to determine the effectiveness of Pravastatin for Resident #4.	F 329		
F 428 SS=D	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (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. (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.	F 428		

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(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.

(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:
The facility had a census of 40 residents. The sample included 10 residents of which 5 were reviewed for unnecessary medications. Based on observation, record review and interview the facility's consultant pharmacist failed to report drug irregularities to the (DON) Director of Nursing and/or Medical Director, and the resident's physician, for 2 of the 5 sampled residents. The facility lacked documentation of Resident #16 physician's ordered fasting blood sugars and 2 hour (PP) Post Prandial (after eating) blood sugars in August 2016 or February 2017. The facility failed to follow up on a

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pharmacy consultant recommendation in July 2016, for Resident #4 requesting a fasting lipid panel which the physician did not respond to until December 2016, and then declined the recommendation.

Findings included:

- Resident #16's diagnoses signed physician's orders, dated 2/22/17, included psychosis (any major mental disorder characterized by a gross impairment in reality testing).

The 5 day (MDS) Minimum Data Set assessment, dated 2/8/17, recorded the resident had short term and long term memory loss, moderately impaired daily decision making, and inattention behaviors, which fluctuated. The MDS recorded the resident received 7 days of an antipsychotic medication.

The (CAA) Care Area Assessment for psychotropic drug use, dated 5/9/16, recorded the interdisciplinary team would continue to monitor and communicate with the resident and his/her family, when the pharmacist or physician requested medication changes and use of psychotropic medications.

The 2/11/17 care plan instructed staff to administer the physician ordered medications.

The 3/1/16 physician orders instructed staff to obtain fasting and 2 hour PP blood sugars with a glucometer, (instrument used to calculate blood glucose), every 6 months related to antipsychotic medication use, in August 2016 and February 2017, and notify the physician if the blood sugar was <65 or >300.

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Review of the resident's medical record revealed no fasting or 2 hour PP blood sugars were obtained in August 2016.

Further review of the resident's medical record revealed no PP blood sugar were performed on 2/3/17.

Review of the resident's medical record revealed the facility's pharmacy consultant had not identified and addressed with the facility's (DON) Director of Nursing and/or Medical Director, and the resident's physician, on his/her monthly visits on 9/14/16 or 3/23/17, the missing physician ordered blood sugars for the months of August 2016 or February 2017.

On 4/10/17 at 7:20 AM, observation revealed the well groomed resident, seated in his/her wheelchair, at the breakfast table.

On 4/10/17 at 11:20 AM, Administrative Nurse A verified no documentation staff obtained the resident's fasting or 2 hour PP blood sugar in August 2016 or as physician ordered or a 2 hour PP blood sugar obtained in February 2017.

The 1/20/16 facility's blood glucose monitoring policy recorded the blood testing was ordered by the primary care provider for the time of day and frequency. The policy stated the blood glucose monitoring on Caretracker is maintained for each resident when monitoring is ordered.

The 1/2016 facility's drug regimen review policy recorded the consultant pharmacist would

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conduct (MRR) Medical Record Reviews to identify irregularities and clinical significant risks and/or actual or potential adverse consequences, which may result from or be associated with medications. The pharmacist will address copies of the resident's MRRs to the Health Service Director, the attending physician and to the Medical Director. The facility staff should ensure the attending physician, Medical Director, and the Health Service Director were provided copies of the MRRs, any irregularities, significant risk or actual/potential adverse consequences should be identified in the report.

The facility's pharmacy consultant failed to identify and address with the resident's physician, Director of Nursing, and/or Medical Director to ensure staff were performing physician ordered blood sugars for Resident #16 in August 2016 and February 2017, which placed the resident at risk for elevated blood sugars due to taking an antipsychotic medication.
- The signed physician's order sheet (POS) dated 3/21/17 for resident #4 revealed a diagnosis of hyperlipidemia (a condition in which there is too much cholesterol in the blood).

The annual (MDS) Minimum Data Set assessment, dated 6/25/16 revealed a BIMS score of 1, which indicated severely impaired cognition. He/she required extensive assistance of one staff for bed mobility, transfers, dressing, toileting, bathing, and locomotion on the unit. He/she required limited assistance of one staff for personal hygiene.

The (CAA) Care Area Assessment, dated 6/25/16, for cognition, documented no changes had been noted in the resident's day to day

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functioning. The resident was unable to comprehend some things and his/her thought process was very slow.

The quarterly MDS, dated 12/26/16, revealed staff assessed the resident's cognitive skills as severely impaired. The resident required extensive assistance of one staff for bed mobility, transfers, locomotion on the unit, dressing, toileting, personal hygiene, and bathing.

The care plan, dated 12/27/16, documented the resident received Pravastatin for hyperlipidemia.

The (POS) physician's order sheet, dated 3/21/17, documented an order for Pravastatin 10 milligrams (mg) daily, for hyperlipidemia.

Review of the medical record revealed the most recent lipid profile drawn on 4/14/15.

The pharmacist recommendation for the month of July 2016 was to consider monitoring a fasting lipid panel annually since none had been done in the last 12 months.

The clinical record documented the physician acknowledged the pharmacist recommendation on 12/6/16.

On 04/06/2017 at 7:33 AM, the resident sat at the dining room table with 2 other residents.

On 04/10/17 at 2:07 PM Administrative Nursing Staff A verified a lipid profile had not been completed since 5/14/15. He/she acknowledged the pharmacy consultant made a recommendation for one in July of 2016.

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 _____	04/12/2017

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
F 428	Continued From page 15 The 1/2016 facility's drug regimen review policy recorded the consultant pharmacist would conduct (MRR) Medical Record Reviews to identify irregularities and clinical significant risks and/or actual or potential adverse consequences, which may result from or be associated with medications. The pharmacist will address copies of the resident's MRRs to the Health Service Director, the attending physician and to the Medical Director. The facility staff should ensure the attending physician, Medical Director, and the Health Service Director were provided copies of the MRRs, any irregularities, significant risk or actual/potential adverse consequences should be identified in the report. The facility's pharmacy consultant failed to identify and address with the resident's physician, Director of Nursing, and/or Medical Director to ensure staff followed up with the physician regarding a lipid profile blood test, to determine the effectiveness of Pravastatin for Resident #4, as the pharmacy consultant recommended in July 2016. The facility failed to follow up on recommendations from the consultant pharmacist for this cognitively impaired resident.	F 428		