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EMPORIA PRESBYTERIAN MANOR	2300 INDUSTRIAL ROAD EMPORIA, KS 66801

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #_KS00151914. This 2567 was electronically sent to the facility on 05/13/21.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility reported a census of 38 residents with 13 selected for review, including five residents reviewed for accidents. Based on observation, record review, and interview, the facility failed to ensure interventions implemented after Resident (R)5 had a fall to prevent further falls. Findings included: - The "Physician Orders," dated 03/08/21, included diagnoses for Resident (R)37 included history of falling, vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain)with behaviors, and wandering.	F 689		

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

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The Significant Change "Minimum Data Set" (MDS), dated 07/25/20, assessed R5 with a "Brief Interview of Mental Status Score" (BIMS) of two, indicating severely impaired cognition. She required extensive assist of one for bed mobility, limited assist of one for transfers and locomotion on the unit, she did not ambulate in her room, and extensive assist of two or more for toilet use. She required limited assistance of two or more for walking. R5's balance during transitions and walking were not steady and she was only able to stabilize with staff assistance. She used a walker and wheelchair for mobility and had one non-injury fall since the last assessment.

The "Falls Care Area Assessment," (CAA), dated 07/28/20, revealed that R5 had impaired cognition and required assistance to complete her activities of daily living (ADL's) and mobility. She had a non-injury fall.

The quarterly MDS dated 10/23/20, assessed R5 with a BIMS score of three, indicating severe cognitive impairment. She required extensive assistance of two or more for bed mobility, transfers, and toileting. She did not walk in her room and required limited assistance of two or more for walking in the corridor. There were not changes to her balance during transitions and walking and she continued to use a walker and a wheelchair for mobility. R5 has two non-injury falls since the last assessment.

The quarterly MDS dated 01/22/21, assessed R5 with a BIMS score of two. She required extensive assistance of one for bed mobility and extensive assist of two for toilet use. R5 required limited assistance of one for transfers and locomotion. She did not ambulate in her room, however, she

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did ambulate in the corridor with limited assistance of two or more staff. There were no changes to her balance during walking or transitions and she continued to use the walker or wheelchair for mobility. She had one non-injury fall since the last assessment.

The quarterly MDS dated 04/23/21, assessed R5 with a BIMS score of three. She required extensive assistance of one for bed mobility, transfers, and toilet use, and did not walk in her room. R5 required supervision and assistance of one with walking in the corridor and there were no changes to her balance during transitions and walking. She continued to use the same devices for mobility and had one non-injury fall and two or more injury falls (except major) since the last assessment.

The "Fall Risk Assessment Score," dated 11/08/20, indicated R5 was a high risk for falls.

The "Care Plan," dated 04/26/21, included, but was not limited to, the following fall interventions:

1. On 11/22/18, R5 had auto-lock brakes applied to her wheelchair.

2. On 11/22/18, staff were to ensure the slip-resistant mat was on the seat of her wheelchair.

3. On 10/01/19, staff were to place her wheelchair within easy reach/easy access of her bed when she was in bed.

4. On 12/06/19, a foot bed cradle was to be placed to prevent her blankets from being

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entangled in her feet.

5. On 01/04/20, staff should secure the resident's blankets with plastic clips over her foot cradle.

6. On 09/03/20, staff should ensure the slip-resistant mat was on the seat of her wheelchair. This intervention was already placed on 11/22/18.

7. On 12/31/20, staff should ensure a slip-resistant mat was between the wheelchair cushion and the seat of the wheelchair.

8. On 03/08/21, staff were to check her finger stick blood sugar for one week at 09:00 AM. However, the facility failed to implement an intervention to prevent further falls.

9. On 03/30/21, staff were to obtain a urine sample for analysis due to changes in her behavior. However, the facility failed to implement an intervention to prevent further falls.

10. On 04/24/21, staff adjusted the wheelchair seat to tilt down in the back and up in the front.

The electronic medical record (EMR), revealed R5 had falls on the following dates: 12/07/20, 12/31/20, 03/06/21, 03/28/21, and 04/24/21.

The "Interdisciplinary Notes" (ID), dated 12/07/20 indicated R5 was found lying on the floor about 09:19 AM.

The "Investigation/Follow Up Report," dated 12/10/20, indicated the intervention was to have staff place auto-lock brakes to her wheelchair. The care plan had this intervention put in place

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on 11/22/18. The facility failed to implement a new intervention to prevent further falls.

The "ID" notes, dated 12/31/21, indicated that about 10:20 AM, staff found the resident on the floor. The intervention was to lotion her legs and place a slip-resistant mat into her wheelchair. The care plan had the intervention in place on 11/22/18 to have a slip-resistant mat in place on the seat of the wheelchair. This intervention was repeated on 09/03/20. The facility failed to ensure the slip-resistant mat was in place to the wheelchair and added a new intervention to ensure a skip-resistant mat was between the wheelchair seat and the cushion.

The "ID" notes, dated 03/06/21, revealed at about 09:40 AM, housekeeping staff alerted nursing staff to the dining area. R5 was lying on the floor in front of her wheelchair and the resident received two skin tears to her right upper wrist. Staff applied a slip-resistant mat to the seat of her wheelchair before assisting her back to the wheelchair. The facility failed to ensure the slip-resistant mat was in place to her wheelchair.

The "Investigation/Follow Up Report," dated 03/08/21, revealed staff were to assess her blood sugar daily at 09:00 AM for one week. The care plan lacked a new intervention to prevent further falls.

The "ID" notes, dated 03/28/21, revealed at 07:35 PM, staff found R5 on the floor and she received a small abrasion beneath her left knee.

The "Investigation/Follow Up Report," dated 03/30/21, revealed staff were to obtain a urine specimen for analysis due to changes in her

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behavior. The care plan lacked an immediate intervention to prevent further falls.

The "ID" note, on 04/24/21, revealed that R5 slipped off the edge of her wheelchair and fell to her knees. Staff placed a slip-resistant mat on her wheelchair pad to prevent further falls. The facility failed to ensure a slip-resistant mat was in place as previously care planned.

On 05/04/21 at 09:14 AM, R5 was in her bed, the resident's wheelchair was parked at the end of the bed, and the bed lacked a foot cradle. The facility failed to keep the wheelchair within easy reach and the foot cradle in place as her individualized care plan instructions.

On 05/05/21 at 01:45 PM, Certified Nurse Aide (CNA) N revealed that R5 should have a slip-resistant mat on the top of her wheelchair cushion.

On 05/05/21 at 01:47 PM, CNA M was not sure if R5 had the slip-resistant mat on her wheelchair cushion.

On 05/05/21 at 01:48 PM CNA N and CNA M were going to assist R5 to stand to check for placement of a slip-resistant mat, when CNA N revealed there was no need to stand the resident up, as she located the slip-resistant mat a bag that hung from the back of her wheelchair. The mat had numerous folds to it and had debris stuck to it.

On 05/05/21 at 01:52 PM, CNA N and CNA M assisted the resident to stand to replace the slip-resistant mat on the top of the cushion. R5 had one in place between the resident's

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wheelchair seat and the wheelchair cushion.

On 05/05/21 at 01:59 PM, CNA O revealed that R5 would sometimes remove the slip-resistant mat herself, and that she was unaware if R5 should have a mat between the seat and the cushion of the wheelchair. CNA O stated that R5 used to have a foot cradle on her bed but did not have a foot cradle anymore, and when a resident had a fall, staff try to figure out why the resident fell and see if there was anything staff could do so the resident would not have another fall. CNA O stated that notifications of new falls and interventions were communicated to her by email, report, or by the charge nurse, and that the nurse would be informed if an intervention was not working.

On 05/05/21 at 02:11 PM, Licensed Nurse (LN) G revealed that when a resident had a fall, a new intervention should be implemented at the time of the fall. The nurse should update the care plan and the new intervention should be communicated in shift report.

On 05/05/21 at 02:15 PM, Administrative Nurse E stated when a resident had a fall, the nurse on duty should update the care plan with a new fall intervention. The quality assurance nurse, the director of nursing, and administrator would review the fall and the intervention and would update the care plan at that time to include an additional or changed intervention. Administrative Nurse E was not sure if the food cradle should be removed from the care plan or not and the intervention for the fall on 12/31/21 was for an additional slip-resistant mat so he had one under and on top of the wheelchair cushion. Furthermore, she confirmed that a urine sample

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F 689	Continued From page 7 for analysis and to check finger stick blood sugars was not an immediate intervention to prevent further falls. Interventions should not be duplicated. On 05/05/21 at 02:30 PM, Administrative Nurse D revealed that R5's foot cradle was found on her roommates bed, the slip-resistant mat was a duplicate intervention and it should be in place on the cushion and under the wheelchair cushion. Furthermore, Administrative Nurse D reported immediate interventions should be placed when a resident had a fall. The intervention for checking R5's urine for analysis and fingerstick blood sugars for a week were not immediate interventions to prevent further falls. The facility policy "Accidents and Incidents," revised 04/08/19, lacked instruction to the staff on what measures to take when a resident has a fall. The facility failed to ensure appropriate interventions implemented after Resident (R)5 had repeated falls, to prevent further falls.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(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. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must	F 690		

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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.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is 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 reported a census of 38 with 13 residents selected for review including one resident reviewed for urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag.) Based on observation, interview, and record review, the facility failed to keep the catheter drainage bag from touching directly on the floor for Resident (R)4, creating a risk for developing urinary tract infections.

Findings included:

- The "Order Summary Report," dated 03/16/21, for Resident (R)4, included diagnoses of flaccid

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(weak, soft and flabby) neurogenic bladder(dysfunction of the urinary bladder caused by a lesion of the nervous system), and multiple sclerosis (progressive disease of the nerve fibers of the brain and spinal cord.)

The annual "Minimum Data Set" (MDS) dated 05/04/20, assessed R4 with a "Brief Interview of Mental Status" (BIMS) score of 12, indicating moderately impaired cognition. R4 required extensive assist of two person for toilet and had an indwelling urinary catheter in place.

The "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA), dated 05/06/20, revealed R4 had a long-term suprapubic catheter (urinary bladder catheter inserted through the skin) that was maintained by the staff and he was at risk for urinary tract infections related to the long-term indwelling, suprapubic catheter use.

The quarterly MDS, dated 02/02/21, assessed R4 with a BIMS score of 13, indicating intact cognition. He continued to require extensive two-person assistance for toileting and continued to have an indwelling catheter in place.

The "Care Plan," dated 02/02/21, revealed that R4 had a long-term indwelling catheter, staff were to monitor the catheter drainage bag to ensure the bag did not touch the floor.

On 05/03/21 at 03:36 PM, R4 sat in his recliner, in his room, and the catheter drainage bag touched directly on the floor. The catheter bag lacked a barrier between the manufacturer's urinary drainage bag and the floor.

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F 690	Continued From page 10 On 05/04/21 at 01:30 PM, R4 satin his recliner. The resident's catheter drainage bag was in contact with the floor. The catheter bag lacked a barrier between the manufacturer's urinary drainage bag and the floor. On 05/05/21 at 09:57 AM, R4 sat in his recliner and the catheter drainage bag continued to rest directly on the floor. The catheter bag lacked a barrier between the manufacturer's urinary drainage bag and the floor. On 05/05/21 at 10:30 AM, Certified Medication Aide (CMA) R, confirmed the bag should not touch the floor. On 05/05/21 at 10:43 AM, Administrative Nurse D, stated the urinary catheter drainage bag should not touch the floor. The facility policy, "Catheter Care-Urinary Foley," dated 06/10/19, lacked guidance on positioning of catheter drainage bag, to prevent infection. The facility failed to keep R4's urinary catheter drainage bag from touching directly on the floor, that could increase the risk for this resident that required a suprapubic catheter, from developing a urinary related infection.	F 690		
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	F 695		

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practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 38 residents with 13 selected for review, which included three residents sampled for respiratory care. Based on observation, interview, and record review, the facility failed to provide appropriate respiratory care in maintaining respiratory equipment to prevent the spread of infection, consistent with standards of practice and person centered care plan for three Residents (R)33 related to storage of the oxygen tubing and cannula when not in use and changing of the oxygen concentrator's humidifier bottle and tubing/cannula. R 37, related to storage of the nasal cannula and tubing when not in use, and R 1 the cleaning of the concentrator filter.

Findings included:

- Review of Resident (R)33's undated "Physician Orders," documentation included diagnoses history of nicotine dependency, and encounter for palliative care (end of life care).

The admission "Minimum Data Set" (MDS) dated 04/03/2021, documentation included the "Brief Interview for Mental Status" (BIMS) score of 14, which indicated cognitively intact. The resident received oxygen prior to admission and continued to require oxygen after admission .

The care plan (CP), dated 04/07/2021, directed staff the resident received oxygen by way of nasal cannula, P.R.N (as needed), per physician orders to maintain her oxygen saturation rate at or above

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90 percent.. Staff should ensure her oxygen tubing, humidifier bottle, and other supplies labeled when changed and stored in a bag when not in use, to prevent cross contamination and the spread of infection.

Review of the "Physician Orders", dated 03/27/2021, documented Oxygen, two to four liters, per nasal cannula prn (as needed) for shortness of air or resident comfort.

On 05/03/2021 at 12:35 PM, 33's had the oxygen nasal annular positioned in her nose. The oxygen concentrator was set a two liters per minute. Staff failed to date the humidifier bottle and tubing/annular. to determine the duration of the used oxygen supplies. There was not a bag for storage of the tubing when not in use.

On 05/04/2021 at 09:05 Am, The humidifier bottle and tubing/annular remained undated, and Continued to lack a bag for storage of the tubing when not in use.

On 05/04/2021 at 01:45 PM, Certified Nurse Aide (C.N.A.) P stated the oxygen tubing and cannulas should be stored in a bag when not in use to prevent infections. She confirmed the nurse was responsible for changing the humidifier bottles and tubing.

On 05/04/2021 at 02:20 PM, Licensed Nurse (LN) K reported changing of the oxygen equipment which included nasal cannula with tubing and humidifier bottles should be done by the night shift nurse weekly. She reported tubing and humidifier bottles should be labeled with the date changed. She stated the tubing and cannulas should be stored in a bag when not in use to

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prevent cross contamination.

On 05/04/2021 at 02:51 PM, LN K verified the oxygen concentrator's humidifier bottle and tubing/cannula lacked a date that indicated when last changed and there was not a bag for storage of the tubing when not in use.

On 05/05/2021 at 09:17 AM, LN L stated she thought humidifier bottles were changed monthly. She was not sure who was responsible for changing out the oxygen supplies. LN L stated the tubing and humidifier bottles should be labeled with the date when changed. Oxygen tubing and cannulas should be labeled with the date when changed.

On 05/05/2021 at 09:48 AM, Administrative Nurse D stated oxygen tubing should be dated and labeled when changed by the night nurse on a weekly basis. She stated the policy documented monthly but the nurse on nights changed them out on a weekly basis. She reported that tubing and cannulas should be stored in a bag when not in use and a bag should be located on the concentrator to ensure access for storage when not in use.

The facility policy for "Oxygen Therapy", dated 10/2016, documentation included these delivery devices would be maintained in a sanitary manner. Change disposable prefilled humidifier bottles every 30 days. Change tubing once a week or when soiled. Date, time, and initial the tubing when changed. Non-disposable humidifier bottles should be changed every seven days. When the device was not in use, store the device in a plastic or other bag to keep the tubing and the device off the floor.

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The facility failed to provide appropriate respiratory care in maintaining respiratory equipment to prevent the spread of infection, consistent with standards of practice and the person-centered care plan for this resident who required oxygen.

- The "Physician Orders," dated 03/19/21, for Resident (R)37, included diagnoses of dependence on supplemental oxygen and chronic respiratory failure with hypoxia (inadequate supply of oxygen).

The annual "Minimum Data Set" (MDS), dated 01/19/21, assessed R37 with a "Brief Interview of Mental Status" (BIMS) score of 13, indicating cognition intact, and did not require oxygen therapy.

The quarterly MDS, dated 04/20/21, revealed no changes in cognition but she required oxygen therapy.

The "Care Plan," dated 04/21/21, revealed R37 had a history of impaired gas exchange due to chronic respiratory failure with hypoxia and she used oxygen via nasal cannula per her physician orders and as needed. Staff were to ensure the oxygen tubing labeled, bagged, and changed to reduce the risk of respiratory infection.

The "Physician Orders," dated 03/19/21, included an order, dated 01/31/21, for oxygen as needed.

The "Treatment Administration Record" (TAR), from 02/01/21 to 05/05/21 revealed the resident

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F 695	Continued From page 15	F 695		

did not require the as needed oxygen. Staff should change the oxygen tubing weekly, when the resident required the as needed oxygen.

Review of the "Interdisciplinary Notes", from 01/31/21 to 05/05/21, revealed the resident required the oxygen on 12 different days.

On 05/03/21 at 01:22 PM, observation revealed the resident had an oxygen concentrator at her bedside. The resident's oxygen nasal cannula tubing was not stored in a bag or labeled with a date, and the oxygen tubing wrapped around the oxygen concentrator handle at the top of the machine.

On 05/04/21 at 08:39 AM, revealed no changes to the storage or labeling of the oxygen nasal cannula tubing for R37.

On 05/05/21 at 08:45 AM, revealed no changes to the storage or labeling of the oxygen nasal cannula tubing for R37.

On 05/03/21 at 01:23 PM, R37 revealed she should wear the oxygen every night.

On 05/05/21 at 09:33 AM, Licensed Nurse (LN) G revealed that R37 used oxygen previously when she had COVID-19 and staff were to change the tubing weekly, as needed.

On 05/05/21 at 02:51 PM, Administrative Nurse D revealed staff should document on the TAR when the resident required oxygen and that the tubing should be stored in a bag when not is use.

The facility policy "Oxygen Therapy," revised 10/2016, directed staff to change the oxygen

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tubing once a week or when soiled, date/time/initial tubing when changed, and when not in use, the tubing should be stored in a plastic or other bag.

The facility failed to appropriately change, label, and store the oxygen nasal cannula for R37 to avoid contamination and increase the risk of a respiratory infection.

-The "Order Summary Report," dated 03/03/21, for Resident (R)1, included diagnoses of personal history of nicotine dependence and emphysema (long-term, progressive disease of the lungs characterized by shortness of breath.)

The annual "Minimum Data Set" (MDS), dated 01/25/21, assessed R 1 with a Brief Interview of Mental (BIMS) score of 10, indicating moderately impaired cognition and she received oxygen therapy.
The "Care Plan," dated 04/27/21, instructed staff to ensure the oxygen tubing, canister, and other oxygen supplies labeled, bagged, and changed to reduce the risk of infection.

The "Order Summary Report, " dated 03/03/21, included an order dated 06/16/20, to change the disposable humidifier bottle every 30 days, and change the oxygen tubing and clean the oxygen concentrator filter once weekly on Wednesdays on the night shift.

On 05/03/21 at 01:14 PM, observation revealed R1's humidifier bottle unlabeled and the oxygen concentrator filter had a build-up of lint.

On 05/04/21 at 10:49 AM, the oxygen

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F 695	Continued From page 17 concentrator filter continued to have a build-up of lint and the humidifier bottle continued to lack a date. On 05/04/21 at 02:44 PM, Licensed Nurse (LN) J stated the oxygen humidifier bottle should be changed monthly and as needed. The filters should be cleaned weekly. LN J confirmed the humidifier lacked a date. On 05/04/21 at 04:00 PM, Administrative Nurse D confirmed the oxygen humidifier bottle should be labeled upon attaching to the concentrator and the oxygen concentrator filter should be cleaned weekly. The facility policy, "Oxygen Therapy," dated 10/2016, indicated the disposable prefilled humidifier bottle should be changed every 30 days or as needed, and to date and initial each disposable humidifier bottle when changed or if contaminated. The policy also directed staff to wash the concentrator filter weekly with warm tap water and dry thoroughly before replacing the filter. The facility failed to clean R1's oxygen concentrator filter to prevent a build-up of lint. In addition, the facility failed to date and initial the disposable prefilled humidifier bottle when opened appropriately to prevent contamination.	F 695		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §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.	F 756		

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§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:
The facility reported a census of 38 residents with 13 selected for review including five reviewed for unnecessary medications. Based on interview and record review, the pharmacy consultant failed

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for one of the residents, to report irregularities to the facility for Resident (R)5, when the facility failed to hold a medication used to treat heart conditions when her pulse was out of parameters on five occasions and failed to notify the physician when her pulse was out of parameters on two occasions, placing her at risk for further decreased heart rate.

Findings included:

- The "Physician Orders," dated 03/08/21, included diagnoses of atrial fibrillation (rapid, irregular heartbeat), presence of a cardiac pacemaker, and heart failure.

The "Significant Change Minimum Data Set," (MDS), dated 07/25/20, assessed R5 with a diagnoses of heart failure and hypertension (elevated blood pressure).

The quarterly MDS, dated 01/22/21, included the same diagnoses.

The "Care Plan," dated 04/26/21, revealed that the staff should take R5's apical pulse (a pulse site on the left side of the chest over the heart) prior to administration of digoxin (medication used to treat heart conditions) and hold the medication if R5's pulse was less than 60 (beats per minute), and notify they physician if R5's pulse was less than 50 (beats per minute).

The "Physician Orders," dated 03/08/21, included an order dated 12/11/15, for digoxin, 125 micrograms (mcg), daily, for atrial fibrillation. Take R5's pulse prior to administration and hold if her apical pulse is less than 60 and notify her physician if her apical pulse is less than 50.

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The "Medication Administration Record" (MAR), dated 02/2021, 03/2021, and 04/2021, revealed:

1. On 02/02/21, R5 had a pulse of 57, and the staff administered digoxin.

2. On 02/14/21, R5 had a pulse of 48, below the parameters that required physician notification.

3. On 02/22/21, R5 had a pulse of 55, and the staff administered digoxin.

4. On 02/23/21, R5 had a pulse of 59, and the staff administered digoxin.

5. On 03/03/21, R5 had a pulse or 49, below the parameters that required physician notification.

6. On 04/02/21, R5 had a pulse of 56, and the staff administered the digoxin, then later notified the physician they administered the medication when the pulse was out of parameters.

7. On 04/03/21, R5 had a pulse or 55, and the staff administered the digoxin.

Review of the electronic medical record (EMR) lacked documentation that the staff notified the physician when R5's pulse was below 50, the ordered parameters.

The "Interdisciplinary Disciplinary" (ID) notes, revealed that on 02/10/21, and 04/14/21, there were no concerns with the monthly pharmacy review. On 03/19/21 the notes revealed a concern, however, it was not related to R5's digoxin therapy.

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On 05/05/21 at 09:40 AM, Licensed Nurse (LN) G stated if R5's pulse was below 50, the physician would be notified per phone call and the notification would be documented in the progress notes. LN G stated that the EMR lacked physician notification for R5's pulse when it was below 50 on 02/14/21 and 03/03/21. Furthermore, LN G confirmed that the digoxin should not have been administered on 02/02, 02/22, 02/23, 04/02, and 04/03/21.

On 05/05/21 at 10:32 AM, Administrative Nurse D stated that on the MAR the staff should enter the pulse and mark the medication as held and notify the physician as ordered.

On 05/05/21 at 11:23 AM, Administrative Nurse D confirmed the digoxin was not held on the above dates and she was not able to find physician notification when R5's pulse was below 50.

On 05/11/21 at 05:12 PM, pharmacy Consultant staff GG stated that she had made herself a note to monitor it on March 19th, 2021, however she failed to notify the facility, as she was going to "See if it was an ongoing problem" or not.

The facility's policy for "Drug Regimen Review", revised 06/10/19, revealed a drug regimen review included a review of drug regimen to identify, and if possible, prevent potential clinically Significant medication adverse consequences. Any irregularities, significant risks or actual /potential adverse consequences should be identified in the report.

The pharmacy Consultant staff GG failed to report irregularities to the attending physician, the facility's medical director, and the director of

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F 756	Continued From page 22 nursing, so they could be acted upon, for this resident that required monitoring of her pulse with medication used to treat her heart condition.	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 §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 38 residents with 13 selected for review including five sampled for unnecessary medications. Based on interview and record review, the facility failed to hold one of the five residents, Resident (R)5, medication used to treat heart conditions, when her pulse was out of the physician ordered parameters on five occasions and failed to notify the physician	F 757		

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when her pulse was out of parameters on two occasions, placing her at risk for further decreased heart rate.

Findings included:

- The "Physician Orders," dated 03/08/21, included diagnoses of atrial fibrillation (rapid, irregular heartbeat), presence of a cardiac pacemaker, and heart failure.

The "Significant Change Minimum Data Set," (MDS), dated 07/25/20, assessed R5 with a diagnoses of heart failure and hypertension (elevated blood pressure).

The "Care Plan," dated 04/26/21, revealed staff should assess R5's apical pulse (a pulse site on the left side of the chest over the heart) prior to administration of digoxin (medication used to treat heart conditions) and hold the medication if R5's pulse was less than 60 beats per minute, and notify they physician if R5's pulse was less than 50 beats per minute.

The "Physician Orders," dated 03/08/21, included an order dated 12/11/15, for digoxin, 125 micrograms (mcg), daily, for atrial fibrillation. Take R5's pulse prior to administration and hold if her apical pulse is less than 60 and notify her physician if her apical pulse is less than 50.

The "Medication Administration Record" (MAR), dated 02/2021, 03/2021, and 04/2021, revealed:

1. On 02/02/21, R5 had a pulse of 57, and staff administered digoxin.

2. On 02/14/21, R5 had a pulse of 48, below the

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parameters that required physician notification.

3. On 02/22/21, R5 had a pulse of 55, and the staff administered digoxin.

4. On 02/23/21, R5 had a pulse of 59, and the staff administered digoxin.

5. On 03/03/21, R5 had a pulse or 49, below the parameters that required physician notification.

6. On 04/02/21, R5 had a pulse of 56, and the staff administered the digoxin, then later notified the physician they administered the medication when the pulse was out of parameters.

7. On 04/03/21, R5 had a pulse or 55, and the staff administered the digoxin.

Review of the electronic medical record (EMR) lacked documentation that the staff notified the physician when R5's pulse was below 50, the ordered parameters.

On 05/05/21 at 09:40 AM, Licensed Nurse (LN) G reported if R5's pulse was below 50, the physician should be notified per phone call and the notification would be documented in the progress notes. LN G stated that the EMR lacked physician notification for R5's pulse when it was below 50 on 02/14/21 and 03/03/21. Furthermore, LN G confirmed that the digoxin should not have been administered on 02/02, 02/22, 02/23, 04/02, and 04/03/21.

On 05/05/21 at 10:32 AM, Administrative Nurse D stated staff should document the resident's pulse on the MAR. Staff should also document, on the MAR, when the medication was held. Staff should

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F 757	Continued From page 25 notify the physician, as ordered, when the resident's pulse was below the physician ordered parameters. On 05/05/21 at 11:23 AM, Administrative Nurse D confirmed the digoxin was not held on the above dates and she was not able to find physician notification when R5's pulse was below 50. The facility policy "Notification Parameters-Primary Care Provider (PCP)," revised 06/10/19, included the licensed nurses have the responsibility of contacting a primary care provider any time a resident has developed a clinical problem requiring primary care provider intervention. Documentation in the medical record should include assessment findings, all attempts to contact the primary care provider, information provided, and the provider's response. The facility failed to hold a medication used to treat heart conditions when R5's pulse was out of parameters on five occasions and failed to notify the physician when her pulse was out of parameters on two occasions, placing her at risk for further decreased heart rate.	F 757		
F 880 SS=F	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	F 880		

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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 §483.70(e) 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 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMPORIA PRESBYTERIAN MANOR	2300 INDUSTRIAL ROAD EMPORIA, KS 66801

(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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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 38 residents. Based on observation, interview and record review the facility failed to provide a sanitary environment to help prevent cross contamination and the spread of infections, to the residents of the facility, as exhibited by the communal shower room/bath house had a used, unlabeled toothbrush that was stored on the back of the sink, an unlabeled used comb with hair in the sink, a used unlabeled roll on deodorant stored on the sink, a used bar of soap stored on a shelf behind the whirlpool. In addition, the laundry staff transported uncovered linen to the memory care unit. Furthermore, direct care staff placed urine soaked, soiled linen on the carpeted floor of Resident (R)7,and failed to sanitize the soiled mattress prior to applying clean linen.

Findings Included:

- During the initial tour of the facility, on 05/03/21

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at 12:49 PM, revealed the following concerns in the resident's shower room/bath house:

1.) An unlabeled used toothbrush on the back of the sink covered with a washcloth laying across the bristles.

2.) An unlabeled comb with hair in the sink.

3.) Two unlabeled used roll-on deodorants laying on the sink.

4.) A used bar of soap laying on a shelf behind the whirlpool.

On 05/03/2021 at 12:52 PM, Licensed Nurse (LN) L verified the above findings. She stated residents individual personal care items should not be left in a shared/communal area. Personal care items should be labeled with the resident's name and stored in a sanitary manner in the resident's room when not in use.

On 05/05/2021 at 09:48 AM, Administrative Nurse D confirmed personal hygiene items should not be left in a shared bathing area where they could be used by other residents. She stated staff should store personal care items in the resident's room, when not in use. Additionally, resident's personal hygiene items should be labeled to identify who they belong to and stored in a sanitary manner to prevent cross contamination.

The facility policy for "Infection Control," dated 05/11/2020," documentation included precautions to avoid sharing non-critical resident care equipment between residents. The policy lacked address of personal hygiene items storage.

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The facility failed to provide a sanitary environment to help prevent cross contamination and the spread of infections, for the residents of the facility.

- The facility reported a census of 16 residents on the memory care unit. Observations revealed the following items of concern:

On 05/03/21 at 11:42 AM, observed housekeeping staff U transported an uncovered linen cart in the memory care unit to the linen closet and placed linens out of the cart into the closet.

On 05/03/21 at 11:45 AM, housekeeping staff U reported that she "Forgot" to cover the cart and reported staff should cover the linen carts during transport.

On 05/03/21 at 11:46 AM, housekeeping staff U then continued to push the uncovered linen cart down the memory care unit to the exit door of the unit.

On 05/05/21 at 05:30 PM, Administrative staff A was alerted to the uncovered cart in the memory care unit.

The facility policy "Laundry," dated 10/02/17, lacked instruction on storage/handling of clean linens when taking to resident areas to distribute.

The facility failed to manage linens appropriately to prevent contamination.

- Observation, on 05/04/21 at 08:45 AM, Licensed Nurse (LN) I and Certified Nurse Aide

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(CNA) M assisted Resident (R)7 in her room out of her bed and into her chair. After transferring R7 out of bed, CNA M placed three soiled blankets from the bed onto the carpeted floor, stripped the linens off of the bed, informed LN I that the linens had been soaked through with urine, then placed the wet soiled linens on the carpeted floor. CNA M left R7's room to obtain a blue cloth laundry bag, returned to the resident's room, and placed the soiled linens in the laundry bag. CNA M failed to sanitize the urine-soaked mattress and placed clean linens back onto the soiled bed.

On 05/04/21 at 09:04 AM, CNA M confirmed the mattress should be sanitized before applying the clean linens. Soiled and used linens should not be placed on the floor.

On 05/06/21 at 05:30 PM, Administrative Nurse D stated that linens should not be on the floor and the mattress should be sanitized.

The facility policy "Laundry," dated 10/02/17, lacked instructions to not store clean and/or soiled linens on the floor.

The facility failed to sanitize a mattress contaminated with urine before proceeding to apply clean linens and failed to keep soiled linens off the carpeted floor to prevent contamination of the linens and the floor.