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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wichita Presbyterian Manor	4700 W 13th Street North Wichita, KS 67212

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. The facility reported a census of 46 residents. The sample included 12 residents sampled. Based on interview, observation, and record review, the facility failed to inform Resident (R)37 and/or his representative regarding the risks related to psychotropic (alters mood or thoughts) medications. These practices had the potential to lead to negative and unwarranted physical side effects. Findings included: - Review of the Electronic Health Record (EHR) for R37 included diagnoses of Pick's Disease (a form of brain disorder occurring in middle age, characterized by slow disintegration of intellect, personality, and emotions), unspecified dementia with behavioral disturbance (dementia without a specific diagnosis where the individual experiences disruptive or challenging behaviors in addition to cognitive decline), and anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The admission Minimum Data Set (MDS), dated 07/26/24, documented a Brief Interview of Mental Status (BIMS) score of 99, indicating the resident was unable to complete the assessment. The MDS indicated that R37 had behavior symptoms with physical and verbal behaviors directed toward others. The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 07/26/24, documented the resident was unable to complete the BIMS assessment and had physical and verbal behaviors directed towards others The CAA documented R37 rejected care. R37's Quarterly MDS, dated 04/25/25, documented a BIMS score of zero which indicated severe cognitive impairment. The MDS noted R37 had physical and other behaviors. R37's Care Plan dated 08/28/24 documented R37 had dementia with cognitive loss. An intervention dated 12/16/24 included the administration of ordered medications with orders to monitor side effects and effectiveness; and to monitor, document, and report any changes in cognitive function. R37's EHR documented an order dated 07/16/24 for Seroquel (an atypical antipsychotic medication used to treat a range of mental health conditions). R37's EHR documented an order for lorazepam (an antianxiety medication) daily at 05:00 PM dated 10/17/24. R37's EHR documented an order for lorazepam as needed (PRN) every six hours for 14 days dated 04/01/25. (continued on next page)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R37's EHR lacked evidence R37, or his representative received education and/or informed consent with regards to the lorazepam use including reason for use, expected therapeutic benefits and potential risks and side effects. On 05/21/25 at 02:15 PM R37 sat in a wheelchair watching TV in the common area. During an interview on 05/27/25 at 12:50 PM, Administrative Nurse D confirmed that there was not any medication informed consent documented for R37. She stated that the Veteran's Administration provider for R37 had refused to provide any medication education to his representative. During an interview on 05/28/25 at 09:05 AM, Licensed Nurse (LN) J reported that prior to starting any new psychotropic medication or dosage change, she provided education to the resident and/or resident's representative about the medication, and she obtained informed consent. During an interview on 05/28/25 at 09:22 AM, LN K stated that as a nurse it was her responsibility to obtain informed consent, and she provided education to the resident and/or their representative about any psychotropic medication before the dosage was changed or it was started. Facility policy Psychoactive Psychopharmacological Medications, dated 04/15/25, indicated that prior to initiating or increasing psychotropic medications, the resident, family, and/or resident representative would be informed of the benefits, risks, and alternatives of the medication, included would be the black box warnings for antipsychotic medications.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 46 residents. The sample included 12 residents. Based on observation, interview, and record review, the facility failed to assess Resident (R) 22 to ensure it was clinically appropriate to leave medication at the resident's bedside for the resident to self-administer. This placed the resident at risk for medication errors and ineffective medication regimens. Findings included: - During an observation on 05/21/25 at 08:40 AM, Resident (R) 22 had medication on her bedside table. The cup contained Plavix (an antiplatelet medication) 75 milligrams (mg), cranberry tablet 500mg, gabapentin 100 mg (a medication to treat epilepsy and nerve pain), Miralax (stool softener), potassium 20 milliequivalents, pramipexole (medication to treat Parkinson ' s symptoms and restless leg) 0.25 mg, Prevagen (a dietary supplement to improve brain function) 10mg, vitamin C 500 mg, Zyrtec (allergy medication) 10 mg, Eliquis (a blood thinner) 2.5mg, Lasix (medication used to promote the formation and excretion of urine) 40mg, Metamucil (a bulk-forming laxative) three capsules, Mucinex (decongestant) 1200mg extended release, Preservision one capsule (vitamin for eye health, Tessalon [NAME] 1 cap (cough suppressant, Tussin CF liquid 10ml (cough suppressant). R22 stated the facility staff do not watch her take medication except at night because they give it to her on a spoon. R22 stated she did not know what medications were in her cups and what they were for. R22 ' s Care Plan lacked documentation that staff could leave medications in her room for R22 to take later. R22 ' s Evaluations tab and medical record lacked evidence of an assessment which indicated the resident was able to safely able to keep medications at her bedside and take the medications unattended by staff. During an interview on 05/21/25 at 08:37 AM, Certified Medication Aide (CMA) R stated the staff left R22's medications on her bedside table in her room. CMA R stated staff returned to R22's room after breakfast to make sure the resident took the medications. During an interview on 05/21/25 at 08:39 AM, Licensed Nurse (LN) H stated staff left the pills for R22 in her room. LN H said this is how staff have always done it. LN H stated they thought R22's Care Plan indicated it was ok to leave the medications in the room for R22 to self-administer but after review of the plan, they verified R22 had not been cared planned to leave the medications in her room. During an interview on 05/21/25 at 08:50 AM, Administrative Nurse D stated staff can only leave medications in the residents ' room if the resident had a Self-administration Assessment completed and the resident was appropriate to take their own medications. The facility ' s policy Medication Administration dated 02/03/25 documented that staff were to prepare one resident's medication and observe the resident take the medications to ensure the medications are swallowed.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. The facility reported a census of 46 residents. The sample included 12 residents with five sampled for unnecessary medications. Based on observation, interview, and record review, the facility failed to perform an assessment for side effects related to ongoing antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) use for Resident (R)37. This deficient practice placed R37 at risk for adverse reactions and complications related to psychotropic (alters mood or thought) medication. Findings included: - Review of the Electronic Health Record (EHR) for R37 included diagnoses of Pick ' s Disease (a form of brain disorder occurring in middle age, characterized by slow disintegration of intellect, personality, and emotions), unspecified dementia with behavioral disturbance (dementia without a specific diagnosis where the individual experiences disruptive or challenging behaviors in addition to cognitive decline), and anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The admission Minimum Data Set (MDS), dated 07/26/24, documented a Brief Interview of Mental Status (BIMS) score of 99, indicating the resident was unable to complete the assessment. The MDS indicated that R37 had behavior symptoms with physical and verbal behaviors directed toward others. The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 07/26/24, documented the resident was unable to complete the BIMS assessment and had physical and verbal behaviors directed towards others The CAA documented R37 rejected care. R37's Quarterly MDS, dated 04/25/25, documented a BIMS score of zero which indicated severe cognitive impairment. The MDS noted R37 had physical and other behaviors. R37's Care Plan dated 08/28/24 documented R37 had dementia with cognitive loss. An intervention dated 12/16/24 included the administration of ordered medications with orders to monitor side effects and effectiveness; and to monitor, document, and report any changes in cognitive function. R37's EMR documented an order dated 07/16/24 for Seroquel (an atypical antipsychotic medication used to treat a range of mental health conditions). R37's EMR lacked evidence of any assessment to identify abnormal involuntary movements related to the use of Seroquel. On 05/21/25 at 02:15 PM R37 sat in a wheelchair watching TV in the common area. During an interview on 05/22/25 at 09:14 AM, Licensed Nurse (LN) H reported that residents are monitored for increased sedation or change in mental status when they are taking any psychotropic medication, and an Abnormal Involuntary Movement Scale (AIMS- a standardized tool used to assess involuntary movements, which can be a side effect of antipsychotic medications) LN H said the AIMS assessment should be performed quarterly and when started on any antipsychotic medication. She stated that nurses performed the AIMS assessments. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/22/25 at 09:21 AM, LN I reported that an AIMS assessment was done at admission, if a resident was started on any antipsychotic medication, and also quarterly. During an interview on 05/22/25 at 10:05 AM, Administrative Nurse D stated that an AIMS assessment was to be performed upon admission if an antipsychotic was started, and then every six months. Facility policy Abnormal Involuntary Movement Scale (AIMS), dated 02/03/25, indicated the facility would use the AIMS to monitor residents that took antipsychotics on a regularly scheduled basis. The AIMS would be performed on a semi-annually by the Social Service Director/Designee with a licensed primary care provider or licensed nurse as backup. Facility policy Psychoactive Psychopharmacological Medications, dated 04/15/25, indicated that an AIMS will be completed for residents taking antipsychotic medication on admission, every six months and as needed.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 46 residents. The sample included 12 residents. Based on observation, interview and record review, the facility failed to provide Resident (R) 10 with activities of daily living (ADL) services, including shaving of facial hair. This placed the resident at risk for decreased quality of life and poor hygiene. Findings included: - R10's Electronic Medical Record (EMR) revealed diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion) and anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R10's admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of seven indicating severely impaired cognition. The MDS recorded R10 had behaviors, including rejection of care one to three days during the observation period. The MDS recorded R10 required assistance with toileting, showering, dressing, and personal hygiene. The Functional Abilities Care Area Assessment dated 04/17/25 indicated R10 had a diagnosis of dementia that could affect balance, safety awareness, and judgment. R10's Care Plan dated 04/14/25 R10 had an ADL self-care performance deficit related to dementia. The plan directed staff to provide bathing and showering, check nail length, trim and clean on bath day and as necessary; staff were to report any changes to the nurse. The daily Task section of R10's EMR, reviewed on 05/28/25, revealed R10 refused care only once in the past 30 days. On 05/21/25 at 08:59 AM observation revealed R10 had facial hair and dirty fingernails. On 05/28/25 at 10:15 AM Certified Nurse Aide (CNA) M said that if a resident refused to be shaved, she documented it in the EMR and then let the charge nurse know. On 05/27/25 at 02:15 PM Administrative Nurse D stated she expected the nursing staff to provide the residents with ADL assistance with grooming during morning care or showers. The facility did not provide a policy for activities for daily living as requested on 05/27/25.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility census totaled 46 residents with 12 residents in the sample. Based on observation, interview and record review the facility failed to provide sanitary respiratory care and services when staff failed to clean the nebulizer (a device for administering inhaled medication) after each use for Resident (R) 45. This placed the resident at risk for infection and increased respiratory complications. Finding included: - R45's Electronic Medical Record (EMR) dated 11/12/24 revealed a diagnosis of spinal bifida (a birth defect that can cause respiratory problems). Review of the Five Day Medicare Minimal Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. R45 requires partial assistance to complete toileting/showers. R45's Quarterly MDS dated 02/03/25 noted that R45 BIMS score remained the same and no other changes were noted. R45's Care Plan dated 02/18/25 revealed the care plan lacked information on the use of the nebulizer and or the care of the nebulizer. R45's Physician Orders dated 05/16/25 revealed ipratropium albuterol inhalation solution (a medication used in a nebulizer to open airways) 0.5 mg/2/5 mg/3 ml two times a day. During a observation on 05/20/24 at 04:42 PM R45's nebulizer was attached to the tubing on the bedside table with clear liquid in the bottom of the chamber. During a observation on 05/22/25 at 08:02 AM R45's nebulizer was attached to the tubing with clear liquid in the chamber sitting on the bedside table. On 05/22/25 at 08:02 AM R45 revealed she had not had a treatment yet that morning and the nebulizer was still attached to the tubing from the last treatment the previous night. On 05/22/25 at 10:25 AM Licensed Nurse LN G revealed the protocol for nebulizer treatment was to separated the nebulizer, rinse, place on a towel to dry and then place in the bag. On 05/22/25 at 10:55 AM Administrative Nurse D stated she expected the nurses to clean the nebulizer after each use. The facility's Nebulizer Cleaning Instructions policy dated 02/03/25 documented after each treatment, the nebulizer mouthpiece and cup will be rinsed out and allowed to air dry. Then place the parts in a bag. After the last meal of the day, wash all pieces in mild soap and water. Then soak in vinegar water, rinse, and leave to dry on a paper towel. When the nebulizer is dry, place in a plastic bag. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Oxygen Therapy policy dated 02/03/25 documented when oxygen tubing is not in use, it was to be placed in a plastic bag.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. The facility reported a census of 46 residents with 12 residents sampled which included five residents for unnecessary medications. Based on observation, interview, and record review the facility's pharmacist failed to identify and report irregularities to the attending physician, the facility's medical director, and the director of nursing for Resident (R)18 related to monitoring his pulse for effectiveness and side effects of antihypertensive medications as ordered by the physician. This placed the residents at risk for unnecessary medications and related side effects. Findings included: - A review of the R18's Physician Orders, dated 10/07/21, revealed diagnoses that included slow transit constipation, pain, dementia (a progressive mental disorder characterized by failing memory, and confusion), and hypertension (high blood pressure). The 12/20/24 admission Minimum Data Set (MDS) documented R18 had Brief Interview for Mental Status (BIMS) score of nine, indicating moderate cognitive impairment. The MDS documented she was always continent of bowel and required partial to moderate assistance with toileting. The MDS noted R18 received scheduled and as needed (PRN) medication for pain. The Quarterly MDS dated 03/30/25 documented R18 had a BIMS score of eight, indicating moderate cognitive impairment. The MDS documented she was occasionally incontinent of bowel. The MDS noted R18 only received scheduled medications for pain. The Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA), dated 12/21/24, documented she was occasionally incontinent and required staff assistance for toileting, transfers, and toileting hygiene care. The MDS documented she had a diagnosis of dementia that could impair thinking processes that relate to everyday life. R18 Care Plan dated 04/01/25, directed staff to administer medications as ordered by the physician and monitor for adverse reactions and side effects of medication, which included constipation. The plan directed staff the resident was at risk for adverse reactions related to multiple medications with black box warnings (BBW-severe side effects) and adverse side effects which included constipation. The plan directed staff to request the physician and pharmacy consultant to review and evaluate medications and address the recommendations. R18's POS dated 04/15/25 documented metoprolol succinate extended-release tablet (medication used to treat high blood pressure), give 50 milligrams (mg), by mouth, in the evening related to hypertension; hold and notify the nurse if the pulse is less than 60 beats per minute (BPM) and/or the systolic blood pressure (SBP- top number, the force your heart exerts on the walls of your arteries each time it beats) is less than 110 millimeters (mm) of Mercury (Hg), ordered 12/09/24. R18's Medication Administration Records (MAR) and Treatment Administration Records (TAR) dated 04/01/2025 through 05/22/25 lacked documentation related to R18's pulse as ordered by the physician. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R18's Pharmacy Monthly Medication Regimen Review, lacked evidence the consultant pharmacist identified and reported the lack of pulse measurements for parameters as ordered by the physician on 12/15/24, 01/01/2025, 02/14/25, 03/12/25, 04/16/25, and 05/12/25. On 05/27/25 at 01:16 PM R18 sat in her recliner in her room, flipping through the pages of a photo album. On 05/27/25 at 01:48 PM Certified Medication Aide (CMA) S stated when medication has a physician ordered parameters for blood pressure and/or pulse to hold the medication, the MAR should have a flagged area to document the pulse and blood pressure. CMA S said the nurse should be notified, and the nurse would follow up with an assessment and notify the physician when indicated for further instructions. CMA S verified R18's record lacked documentation of the resident's pulse being obtained as ordered by the physician. On 05/27/25 at 02:04 PM, Licensed Nurse (LN) I verified R18's electronic record lacked documentation to reflect monitoring the resident's pulse for the physician-ordered hold parameters. She stated she thought the pharmacist should have identified that during the monthly pharmacy review. LN I said when medications have physician-ordered pulse and blood pressure parameters the MAR should alert and have an area to document the pulse and blood pressure. LN I said the nurse should be notified and follow up with an assessment and notify the physician when indicated for further instructions. LN I verified R18's record lacked documentation of the resident's pulse being obtained as ordered. LN I reported R18 should have pulses documented in addition to the blood pressure to determine the effects and potential risks of receiving metoprolol. On 5/22/25 at 11:18 AM, Consultant GG reviewed R18's electronic record and verified the above findings. She stated tR18 should have had pulse monitored daily related to the parameters for holding metoprolol for pulse of less than 60 BPM, which was not done when the order was entered. Consultant HH stated she expected the pharmacist to review the medication monitoring to include the pulse, but said she did not know if that was identified as a concern on monthly regimen review. The facility did not provide a policy to address the pharmacist's identifying and reporting irregularities in monitoring medications outside of prescribed parameters and/or monitoring the side effects or adverse effects for residents taking medications.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. The facility reported a census of 46 resident with 12 residents sampled which included five residents for unnecessary medications. Based on observation, interview, and record review the facility failed to monitor for effectiveness and side effects of antihypertensive medications as ordered by the physician and for side effects, including constipation related to the use of pain medication for Resident (R) 18. This placed the resident at risk for unnecessary medications and related side effects. Findings included: - A review of the R18's Physician Orders, dated 10/07/21, revealed diagnoses that included slow transit constipation, pain, dementia (a progressive mental disorder characterized by failing memory, and confusion), and hypertension (high blood pressure). The 12/20/24 admission Minimum Data Set (MDS) documented R18 had Brief Interview for Mental Status (BIMS) score of nine, indicating moderate cognitive impairment. The MDS documented she was always continent of bowel and required partial to moderate assistance with toileting. The MDS noted R18 received scheduled and as needed (PRN) medication for pain. The Quarterly MDS dated 03/30/25 documented R18 had a BIMS score of eight, indicating moderate cognitive impairment. The MDS documented she was occasionally incontinent of bowel. The MDS noted R18 only received scheduled medications for pain. The Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA), dated 12/21/24, documented she was occasionally incontinent and required staff assistance for toileting, transfers, and toileting hygiene care. The MDS documented she had a diagnosis of dementia that could impair thinking processes that relate to everyday life. R18 Care Plan dated 04/01/25, directed staff to administer medications as ordered by the physician and monitor for adverse reactions and side effects of medication, which included constipation. The plan directed staff the resident is at risk for adverse reactions related to multiple medications with black box warnings (BBW-severe side effects) and adverse side effects which included constipation. The plan directed staff to request the physician and pharmacy consultant to review and evaluate medications and address the recommendations. R18's POS dated 04/15/25 documented metoprolol succinate extended-release tablet (medication used to treat high blood pressure), give 50 milligrams (mg), by mouth, in the evening related to hypertension; hold and notify the nurse if the pulse is less than 60 beats per minute (BPM) and/or the systolic blood pressure (SBP- top number, the force your heart exerts on the walls of your arteries each time it beats) is less than 110 millimeters (mm) of Mercury (Hg), ordered 12/09/24. R18's Medication Administration Records (MAR) and Treatment Administration Records (TAR) dated 04/01/2025 through 05/22/25 lacked documentation related to R18's pulse as ordered by the physician. Review of the Pharmacy Monthly Medication Regimen Review, lacked evidence the consultant pharmacist identified and reported the lack of pulse measurements for parameters as ordered by the physician on 12/15/24, 01/01/2025, 02/14/25, 03/12/25, 04/16/25, and 05/12/25. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R18's Physician Orders (POS) dated 04/15/25 documented to give Tramadol (narcotic pain medication) 50 mg, one-half tablet PRN daily for increased pain, ordered 04/16/25. R18's MAR, dated 05/01/25 through 05/22/25, revealed the resident received Tramadol 50 mg on 05/05/25, 05/09/25, 05/11/25, 05/12/25, and 05/15/25. The MAR noted the medication was effective for pain and was identified as having associated BBW. R18's Task-Bowel Movement entries dated 04/22/25 through 05/21/25 (30 days) revealed R18 had no documented bowel movements (BM) for three or more days on the following occasions: On 04/22/25 at 09:21 PM, the resident had a BM. The next BM was on 05/01/25 at 10:49 AM, (nine days later). The next BM was on 05/06/ 25 at 12:31 PM, (five days later). The next BM was on 05/09/25 at 09:59 PM (three days later). The next BM was on 5/13/25 at 09:30 PM (four days later). The next BM was on 05/17/25 at 04:08 PM (4 days later). R18's medical record lacked evidence the facility assessed for complications of constipation during the above periods with no BM. The facility's undated Standing Orders, included the following protocol for the treatment of residents without a BM for three consecutive days: Give milk of magnesia (laxative) 30 milliliters (ml) by mouth. If no results within 24 hours give Lactulose (laxative) 20 ml every two hours up to three doses. If no results, give Dulcolax suppository (laxative) 10mg, If no results give a Fleets enema (introduction of a solution into the rectum for cleansing or therapeutic purposes), if no results notify the physician. On 05/27/25 at 01:16 PM, R18 sat in her recliner in her room, flipping through the pages of a photo album. On 05/27/25 at 01:48 PM Certified Medication Aide (CMA) S stated when medication has a physician ordered parameters for blood pressure and/or pulse to hold the medication, the MAR should have a flagged area to document the pulse and blood pressure. CMA S said the nurse should be notified, and the nurse would follow up with an assessment and notify the physician when indicated for further instructions. CMA S verified R18's record lacked documentation of the resident's pulse being obtained as ordered by the physician. CMA S verified the facility had a bowel protocol to address constipation for residents who had not had a bowel movement in three days. She stated the night shift nurse pulled a report generated from the electronic record which flags if a resident does not have a BM in three days. CMA S said she received the report from the nurse with instructions to initiate the protocol. She reported she was not aware if R18 had constipation. (continued on next page)

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	175301	A. Building B. Wing	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wichita Presbyterian Manor	4700 W 13th Street North Wichita, KS 67212

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/27/25 at 02:04 PM, Licensed Nurse (LN) I verified R18's electronic record lacked documentation to reflect monitoring the resident's pulse for the physician-ordered hold parameters. She stated she thought the pharmacist should have identified that during the monthly pharmacy review. LN I said when medications have physician-ordered pulse and blood pressure parameters the MAR should alert and have an area to document the pulse and blood pressure. LN I said the nurse should be notified and follow up with an assessment and notify the physician when indicated for further instructions. LN I verified R18's record lacked documentation of the resident's pulse being obtained as ordered. LN I reported R18 should have pulses documented in addition to the blood pressure to determine the effects and potential risks of receiving metoprolol. She reported she was not aware of R18's concerns with constipation, and that R18 was able to take herself to the bathroom. LN I confirmed the facility had a bowel protocol. On 5/22/25 at 11:18 AM, Consultant GG reviewed R18's electronic record and verified the above findings. She stated the facility had standing orders for a BM protocol when there was no BM in three days. Additionally, she confirmed R18 should have had her pulse monitored daily related to the parameters for holding metoprolol for a pulse of less than 60 BPM, which was not done when the order was entered. Consultant HH stated she expected the pharmacist to review the medication monitoring to include the pulse, but said she did not know if that was identified as a concern on the monthly regimen review. The facility did not provide a policy to address the administration of medication outside of prescribed parameters and/or monitor the side effects or adverse effects for residents taking medications.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. The facility reported a census of 46 residents. Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals used in the facility were labeled and stored in locked compartments and permitted only authorized personnel to have access to the keys. This placed the residents at risk for medication errors, ineffective medication regimens, and diversions. Findings included: - During an observation of the Medication Room on 05/22/25 at 11:30 AM, the medication refrigerator lacked temperature documentation for 15 days in January 2025, 17 days in February 2025, 24 days in March 2025, 15 days in April 2025, and 12 days in May 2025 from 05/01/25 to 05/20/25. During an observation on 05/22/25 at 11:43 AM, the unlocked treatment cart contained scissors and insulin (hormone used to treat high blood glucose). Observation revealed a Humalog (fast-acting insulin) insulin pen was opened on 04/23/25 and should have been discarded on 05/20/25. It was in the cart on 05/22/25. Further observation revealed a Lantus (long-acting insulin) insulin pen was opened but not dated. During an interview on 05/22/25 at 11:30 AM, LN I stated the temperature of the refrigerator should be documented by the night nurse every night. During an interview on 05/22/25 at 11:30 AM, LN I stated the insulin pens should be dated when they are opened and thrown away when they expire. LN I stated the treatment cart should be locked when staff were not with the cart. During an interview on 05/22/25 at 12:12 PM, Administrative Nurse D reported staff were to assess and record the medication refrigerator temperatures daily. Administrative nurse D said all medication and treatment carts were to be locked when staff were away from the carts. Administrative Nurse D verified all insulin were to be dated when they were opened, and the Humalog should have been discarded at 28 days. The facility ' s policy Medication Administration dated 02/03/25 documented staff should never leave the medication cart opened and unattended unless locked. The facility ' s policy Medication Administration dated 02/03/25 documented that medications requiring refrigeration were to be kept between 36 degrees Fahrenheit and 46 degrees Fahrenheit. Outdated and expired medications were to be immediately removed and disposed of according to procedures for medication storage.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. The facility reported a census of 46 residents. The sample included 12 residents. Based on observation, interview, and record review, the facility failed to disinfect the shared sit-to-stand lift (a mechanical lift) after use and failed to utilize proper respiratory infection control methods. This placed the residents at risk for infections. Findings included: - Observation on 05/20/25 at 03:00 PM, staff used the sit-to-stand on Resident (R) 12. Staff then took the sit-to-stand lift out of R12's room and placed it in R7 ' s room without disinfecting it. Ongoing observation on 05/20/25 at 03:20 PM revealed staff transferred R7 with the sit-to-stand lift, then took the lift to the hall. Observation on 05/20/25 at 04:42 PM, R14 ' s nebulizer was on the bedside table still attached to the tubing; it had a clear liquid in the bottom of the chamber. Observation on 05/21/25 at 08:23 AM, R8 ' s oxygen tubing was strung across the room on the floor with the part of the nasal canula that went into the nose resting on the floor. Observation on 05/22/25 at 08:01 AM, R14 ' s nebulizer was still attached to the tubing with clear liquid in the chamber. R14 revealed that she had not had a treatment yet this morning. The nebulizer still attached to the tubing located on the bedside table was from the night before. Observation on 05/22/25 at 09:34 AM, Certified Medication Aide (CMA) R pushed a cart of lost and found clothes through the hallway, uncovered for residents to look at. CMA R left the uncovered cart of clothing in the living area on 05/22/25 at 01:40 PM. During an interview on 05/22/25 at 10:15 AM, Certified Nurse Aide (CNA) M stated that the CNAs do not disinfect the lifts between residents. CNA M said the housekeepers were to wipe down the equipment between residents. During an interview on 05/22/25 at 10:32 AM, Housekeeping Staff U revealed that she wiped the sit to stand lift and Hoyer lift down when they were in the hallway while she wiped down the handrail, but did not wipe them down between the residents. During an interview on 05/22/25 at 10:25, Licensed Nurse (LN) G stated the protocol for nebulizer treatments was for the staff to separate the nebulizer, rinse the parts, and place it on a towel to dry. LN G said that after the parts were dry, they placed them into a bag. During an interview on 05/22/25 at 01:43 PM, Administrative Nurse F stated that the CNAs should clean the lift and any equipment that went from resident to resident between each use Administrative Nurse E said clothing should be covered when in a hallway or in a common area. Administrative nurse E said nebulizers and oxygen tubing should be cleaned appropriately and placed in a bag. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/22/25 at 10:55 AM, Administrative Nurse D stated it was the responsibility of the nursing staff to clean the sit-to-stand and full body sling lifts in between the residents, not housekeeping ' s responsibility. Administrative Nurse D expected the nursing staff to clean the nebulizers after each use, rinse the nebulizer, let it dry on a towel, then place into a bag. The facility's Nebulizer Cleaning Instructions policy dated 02/03/25 documented after each treatment, the nebulizer mouthpiece and cup will be rinsed out and allowed to air dry. Then place the parts in a bag. After the last meal of the day, wash all pieces in mild soap and water. Then soak in vinegar water, rinse, and leave to dry on a paper towel. When the nebulizer is dry, place in a plastic bag. The facility's Oxygen Therapy policy dated 02/03/25 documented when oxygen tubing is not in use, it was to be placed in a plastic bag.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. The facility reported a census of 46 residents. Five Certified Nurse Aide (CNA) staff, who worked in the facility were reviewed for required in-service training. Based on interview and record review, the facility failed to develop, implement, and permanently maintain an in-service training program for Certified Nurse Aide (CNAs) with the required topics and no less than 12 hours per year when one of the five nurse aides sampled lacked the required training hours. This placed the residents at risk for decreased quality of care. Findings included: - On 05/21/25 at 02:43 PM, review of training records Certified Nurse Aide (CNA) N revealed CNA N had ten- and one-half hours of documented training. On 05/22/25 12:12 PM, Administrative Nurse D confirmed that CNAs were required to have 12 hours of training annually and stated that CNA N did not have the appropriate training and there were no records of additional training for this CNAs. The facility's Education policy documented that all staff receive appropriate training in or to ensure the safety and well-being of all residents.