STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175304	A. Building B. Wing	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emporia Presbyterian Manor	2300 Industrial Road Emporia, KS 66801

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41121 The facility reported a census of 46 residents with six residents selected for review and four residents sampled for notification of change. Based on record review and interview, the facility failed to notify the physician timely regarding lack of monthly catheter changes and failed to assess, document, and notify the physician with a change in condition when staff alerted the Licensed Nurse of swelling and redness to R2's penis and scrotum on 08/14/24 at 09:00 PM. On 08/15/24 at 03:52 PM, over 18 hours later, R2 required emergency medical transport for further evaluation and treatment. Findings included: - The Diagnosis tab for Resident (R) 2 included diagnoses of hemiplegia (paralysis of one side of the body) following cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) affecting his right dominant side, aphasia (condition with disordered or absent language function), neuromuscular dysfunction of the bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying), and need for assistance with personal care. The Annual Minimum Data Set (MDS) dated [DATE], assessed R2 with a Brief Interview of Mental Status (BIMS) score of 15 indicating intact cognition, he did not reject care, and had an indwelling catheter (tube placed in the bladder to drain urine into a collection bag). The Urinary Incontinence and Indwelling Catheter Care Area assessment dated [DATE] revealed due to R1's aphasia, he communicated by nodding, shaking his head, using hand gestures, and non-discernable vocalizations. R2 had a catheter due to neurogenic bladder, wore a leg bag for the catheter, and usually emptied himself per his preference. R2 usually did toilet transfers himself but would be safer with allowing staff to assist him. The Quarterly MDS dated [DATE], assessed R2 with a BIMS score of 13, indicating intact cognition, he rejected care daily, and continued to have an indwelling catheter. (continued on next page)

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

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plan dated 08/12/21, revealed R2 may resist staff attempts to provide catheter care and the staff were to ensure he had the supplies to do his own cares at those times as he may of felt capable he could do it himself. The staff were to change his catheter every 30 days and R2 would frequently refuse to allow staff to do so. The staff were to observe for any pain and/or discomfort related to the use of the catheter and notify his physician as needed. R2 did not always get the valve tightened after draining his bag and it would leak, so the staff were to ensure his brief and clothes were clean and dry. Record review of the Electronic Treatment Administration Record (eTAR), dated April 2024 through August 2024, for R2 revealed the staff last changed his urinary catheter on 04/15/24. The eTAR instructed the staff to change the catheter monthly on the 15th and as needed. On 05/15/24, LN G documented a N for the catheter change, indicated treatment not administered. On 06/15/24 LN G documented a R for R2's catheter change, indicated resident refused. On 07/15/24 LN G documented R for R2s catheter change. The Interdisciplinary Notes dated 05/07/24 through 05/27/24 lacked notification to the physician regarding catheter change not administered. The facility failed to notify the physician R2's catheter did not get changed. The Interdisciplinary Notes lacked any entries between 08/07/24 at 03:21 PM and 08/15/24 at 03:03 PM. The Interdisciplinary Notes dated 06/20/24, revealed R2's physician was in the facility to see resident and discussed refusal of catheter changes. The facility failed to notify the physician until five days after the refusal. The Interdisciplinary Notes dated 07/18/24 revealed R2's physician was in the building and discussed resident refusal of catheter change. The facility failed to notify the physician until three days after the refusal. The Interdisciplinary Notes dated 08/15/24 at 03:03 PM, by LN H revealed R2 complained of not feeling well and pointed to his head when asked about pain. R2 accepted Tylenol (analgesic medication). A Certified Nurse Aide (CNA), lacked name, reported R2 had swelling of his scrotum and penis. LN H and Consultant Staff GG went to R2's room to assess and noted R2's penis and scrotum were swollen and red throughout, without warmth or tenderness to touch. The Interdisciplinary Notes dated 08/15/24 at 03:31 PM, by LN H revealed Consultant Staff GG seen R2 in the facility for a 60-day visit. Via a physician visit form, R2 had scrotal cellulitis (skin infection caused by bacteria) and catheter issues. The physician ordered Rocephin (antibiotic), one gram, intramuscular, every 24 hours, for three days, and Bactrim DS (antibiotic), twice daily, by mouth, for 14 days. The Interdisciplinary Notes dated 08/15/24 at 03:55 PM, by LN H revealed R2 had blood urine output, complained of increased pain, and feeling the need to empty his bladder. R2 agreed to go to the emergency room for evaluation. The staff called 911 and R2 left the facility with emergency medical services at 03:52 PM. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/20/24 at 08:35 AM, LN G stated she did not call R2's physician when he refused for his catheter to be changed. On 08/20/24 at 11:08 AM, LN H stated one of the CNA's, she could not recall who for sure alerted her on 08/15/24 that R2 had redness and swelling of his penis and scrotum. LN H stated R2 appeared not to feel very well, there was very little urine in his bag, and his urine was red. Consultant GG went with her to assess R2 and ordered Rocephin injection for three days and Bactrim DS for 14 days. LN H stated Administrative Nurse E accompanied her to tale with R2 about the Rocephin injection and Administrative Nurse E assisted R2 to the bathroom and emptied his urinary drainage bag which did not have much in it. R2 complained of feeling a lot of pressure and agreed to being sent out. Consultant Staff GG stated we could send him out if R2 became worse. LN H stated R2 was willing to go, and allowed the injection, which is how she knew he was not feeling well at all. LN H stated she did not receive any information in report about R2 having swelling and/or redness of his penis and scrotum. Additionally, LN H stated she would get report from the night shift of R2's refusal for the catheter to be changed, she did not try to change it when reported to her, she let Administrative Nurse D know, and waited for direction on how to go about that but did not receive any. LN H was not aware if the physician had been notified of not of R2's refusals, and stated if a resident refused she would fax the doctor to report the refusal. On 08/20/24 at 12:14 PM, Administrative Nurse E stated the CNA's (lacked names) told LN I about R2 having swelling to his penis and scrotum, and LN I did not document about it or report it on. The CNA's reported to LN H R2's complaint of pain and the swelling of his penis and scrotum, who did not know what the CNA's were talking about. Consultant Staff GG was in the facility at that time and so he went with LN H to look at R2. Administrative Nurse E stated LN H asked her to verify the Rocephin mixture with her and then she went with LN H to R2's room. Administrative Nurse E stated R2's penis was swollen and huge and one testicle was enormous and red and she could tell R2 did not feel well. Administrative Nurse E stated R2 had his leg beg and asked if he wanted it emptied, the bag lacked any fluids and inside the bag was a deep dark red/maroon color. Administrative Nurse E stated she informed R2 there was nothing in it, R2 denied emptying it when asked, and told R2 after pressing on bladder if he was not urinating, he should go to the hospital, which he agreed, and was sent to the emergency room . Administrative Nurse E stated LN H read R2's notes in the chart and it lacked documentation about the swelling. Administrative Nurse E stated what the CNA's observed on 08/14/24 should have been documented, reported to next shift, the on-call physician notified, and/or should have shipped him out. On 08/20/24 at 12:27 PM, attempted to interview LN I, which was unsuccessful. On 08/20/24 at 12:34 PM, attempted to interview CNA P, which was unsuccessful. On 08/20/24 at 12:36 PM, attempted to interview CNA Q, which was unsuccessful. On 08/20/24 at 12:38 PM, CNA LL stated on 08/14/24 she was in R2's room with CMA R and CNA M. CMA R assisted R2 to the bathroom while CNA LL and CNA M changed his sheets. CNA LL R2 could not stand for very long and normally R2 took himself to the bathroom. We had tried to put his catheter bag the correct way, but he would not let us, and she was not sure if he had urine in the bag or not because she was not close enough. CNA LL stated she did not bring up to the charge nurse, could not remember who it was, about needing help with toileting, but mentioned R2's catheter bag. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/20/24 at 02:00 PM CNA M stated she along with CMA R assisted R2 to the bathroom and get his sheets changed on 08/14/24, as R2 had a bowel accident. CNA M stated he had come out of his room and had feces coming out of his gown and showed us he was swollen. CNA M stated R2 required assistance of two in the bathroom and usually does on his own, but that night he struggled to standing up for very long. CNA M stated R2's urine in the drainage bag was dark red, looked lie blood, and his penis and scrotum were red and swollen. CNA M stated she reported to LN I around 09:00 PM on 08/14/24 the condition of R2's penis, scrotum, and the appearance of blood in his catheter bag, who said he was busy at the time but would go check on it. On 08/20/24 at 03:25 PM, Administrative Nurse D stated she expected LN I to assess R2 and report his change of condition, swelling, and urine color in the catheter bag to the physician. On 08/20/24 at 04:15 PM, CMA R stated on 08/14/24 she had assisted R2 in the bathroom and tried to do catheter care the best she could. CMA R stated R2's penis and scrotum, the whole area was bulging and red. CMA R stated R2 had come out of his room, which was strange as he liked to stay in his room. CMA R stated in the bathroom R2 required two staff to get him up and clean him after a bowel movement. CMA R stated she reported that to LN I as well as the catheter bag, at first, she has thought the bag looked purple and was full of blood, but then went back and told LN I it was just urine. CMA R stated she told LN I R2's penis and scrotum looked inflamed and did not look right. CMA R stated after that LN I had a phone call and did not know if he looked at R2 or not. The facility policy Notification Parameters - Primary Care Provider [PCP] dated 10/13/21, revealed Licensed Nurses have the responsibility of contacting a PCP any time a resident has developed a clinical problem requiring PCP intervention. Prior to contacting the PCP, an assessment must be performed by the Licensed Nurse. The following information should be available and provided to the PCP, as appropriate: vital signs, findings from a complete focused head-to-toe assessment, current mental status and whether it was a change, current diagnoses, allergies, current medications, relevant laboratory work/diagnostic studies, actions already taken, presence of advance directives, and hospice care/comfort measures. If situations requiring immediate action, contact emergency medical services to request immediate transport to the hospital. Notify attending PCP of the transport as soon as possible. The staff were to document in the clinical record assessment findings, all attempts to contact the PCP, information provided to the PCP, PCP's response and orders, resident status and response. For non-immediate notifications, the staff should notify the physician during normal office hours and generally not later than the next regular office day. The facility failed to notify the physician timely regarding lack of monthly catheter changes for May, June, and July 2024 for R2. The facility failed to assess R2 and notify the physician of R2's condition changes timely on 08/14/24 at 09:00 PM, who then over 18 hours later, required emergency medical transport for further evaluation and treatment on 08/15/24 at 03:52 PM.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41121 The facility reported a census of 46 residents with five residents selected for review, including three residents sampled for accidents. Based on record review and interview, the facility failed to investigate a fall on 07/16/24, conduct a complete assessment, and implement a new intervention following the fall for Resident (R)1, that had previous falls in the facility. On 07/17/24, R1 had an additional fall, which the facility failed to complete an assessment and implement a new intervention following the fall. Additionally, the facility failed to notify the responsible party and the physician following falls on 07/16/24 and 07/17/24. Findings included: - The Diagnosis tab lacked diagnosis for R1. The Minimum Data Set (MDS) tab in the electronic medical record revealed R1 entered the facility on 07/12/24 and discharged on [DATE]. The Admission MDS was not due during R1's stay. The Fax sheet dated 07/12/24, from the physician office included diagnoses for medication use, which included mixed incontinence and dystonia (impairment in muscle tone). The Baseline Care Plan dated 07/12/24 at 09:19 AM, located in the attachment tab, revealed R1 was orientated to person and place and had upper and lower dentures. He used a walker for mobility and required supervision for walking, limited to extensive assistance for transfers, and limited assistance for bed mobility. R1 had incontinent and continent episodes of bowel and bladder and required staff assistance with peri-care. R1 was a fall risk and interventions included a low bed and a wireless bed alarm/pad. The Fall Risk Assessment Tool dated 07/13/24, assessed R1 with a risk score of 18 indicating a high risk for falls. The facility Incident log, dated 05/21/24 through 08/19/24, revealed R1 fell on [DATE] at 07:00 PM and acquired a skin tear, and again on 07/14/24 at 09:50 PM. The log lacked any additional falls. The Interdisciplinary Notes dated 07/12/24, revealed the facility installed a handlebar in front of the toilet in R1's room to prevent falls. The Interdisciplinary Notes dated 07/12/24 through 07/17/24 revealed R1 fell four times during his six-day stay at the facility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Interdisciplinary Notes dated 07/13/24 at 11:14 PM, revealed at 07:00 PM, an unidentified Certified Nurse Aide (CNA) notified Licensed Nurse (LN) G that R1 was on the floor. LN G assessed R1 to be alert and oriented, sitting on the floor by the nurse's station door with one hand holding onto a chair. R1 had a skin tear to his right elbow. The assessment revealed the fall was witnessed by three unidentified CNA's/Certified Medication Aides (CMA's). R1 required two facility staff to assist him to a chair. R1 stated he was standing up to go to his room and missed his walker handle and fell bottom down. The facility staff reminded R1 to never get up alone without nurse's help. The Interdisciplinary Note dated 07/14/24 at 11:20 PM, revealed at approximately 09:50 PM, an unidentified CNA notified LN G that R1 was sitting on the floor facing his bed with a new brief in his hand. R1 stated he slid from the bed when trying to reach for something. R1 required two staff to assist him to bed and they placed a fall mattress next to his bed. The Interdisciplinary Notes dated 07/15/24 at 11:40 AM, revealed response received from his physician about R1's diagnoses which included R1 had dementia (progressive mental disorder characterized by failing memory, confusion). The Interdisciplinary Notes dated 07/16/24 at 05:25 AM, revealed at approximately 05:00 AM, an unidentified CNA notified LN G that R1 was bleeding from his mouth. LN G examined R1, who had a small bleeding open wound on the inside of the upper lip, which looked like he bit his lip. The Interdisciplinary Notes dated 07/16/24 at 10:01 AM, revealed R1 came out to breakfast and LN J examined his mouth and a cut was present on his upper lip. R1 stated he lost some of his teeth. LN J examined and R1 did not have his lower denture in place and a chipped tooth to the right front upper denture plate. R1 stated he fell out of bed onto the floor. The facility failed to fully investigate the fall, conduct neurological checks (an assessment of sensory neurons and motor responses, to determine whether the nervous system is impaired), and implement a new intervention following the fall to prevent further falls. Furthermore, the facility failed to notify the responsible party and the physician. The Interdisciplinary Notes dated 07/17/24 at 11:26 AM, revealed an unidentified CNA informed LN K that R1 was sitting on his fall mat. R1 was on a fall mat with just a brief on and required two staff to assist him to the edge of the bed. The note lacked any further information regarding the fall, lacked assessment of resident for injury, lacked any new interventions following the fall, and lacked notification to the responsible party and the physician. The facility Notification Report dated 07/13/24 through 08/20/24, for R1 revealed the facility notified R1's family member and the physician on 07/13/24 at 07:30 PM and of his fall. On 07/14/24 at 10:20 PM the facility notified R1's family member and at 10:50 PM notified R1's physician. The report lacked a fall on 07/16/24 and 07/17/24. On 08/20/24 at 01:55 PM, LN L reported when a resident reports a fall and unseen by staff or evidence of and /or injury evident, that would be treated as a fall. LNL stated when a resident falls, the staff were to notify the physician, responsible party and Administrative Nurse D. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/20/24 at 02:10 PM, R1's family member stated the staff informed her of the fall in the dining room and the next day when she came in R1 told her he had stumbled on the bed on his way back from the bathroom a little after 03:00 AM. The family member stated two days later the same thing happened during the night, R1 had tripped fell towards the side of the bed and when he was talking, she noticed he did not have his bottom plate in and the big tooth on the top plate was broken. R1's family member stated she was not made aware of those falls and when addressed with Administrative Nurse D why the staff did not notify her, Administrative Nurse D responded probably because it was the middle of the night. R1's family member stated she had told the facility to call her or text, she had her phone with her 24 hours a day, seven days a week. R1's family member stated it was that day she informed the facility she was going to take him home and did the following day as she felt the facility had neglected him. On 08/20/24 at 03:00 PM, attempted to reach CNA N for an interview, which was unsuccessful. On 08/20/24 at 03:03 PM, attempted to reach CNA O for an interview, which was unsuccessful. On 08/20/24 at 03:15 PM, attempted to reach LN G for an interview, which was unsuccessful. On 08/20/24 at 03:20 PM, Administrative Nurse D reported when a resident falls, staff were to use the facility's standard fall protocol, assess for injury, start vital signs, and start neurological checks if the fall had been unwitnessed or if there was a suspicion or observation of them hitting their head. Follow up vital signs are to be done for 72 hours after a fall, and notification to the physician and the family after every fall. If a resident with cognitive impairment says they fell out of the bed, then that should be investigated. Each fall should have a new intervention put in place. The facility policy Fall dated 10/12/22, revealed following a fall the staff were to assess the resident for injury, treat the initial injury, obtain a complete set of vital signs including one orthostatic (measurements of blood pressure and pulse taken with the patient in the supine, sitting, and standing positions to assess low blood pressure and possible blood pooling in the lower extremities resulting in dizziness) blood pressure, and blood sugar if indicated. The staff were to document assessment of resident and investigative elements, review the Fall Intervention Reference sheet for ideas and document in the care plan. Residents with unwitnessed falls should be considered to have hit their head unless they are a reliable historian and can definitely say they did not hit their head. Baseline neurological checks will be done on residents observed on the floor or have unwitnessed falls. With the occurrence of a fall, the staff were to notify the responsible party, physician, and the Registered Nurse (RN) supervisor. If off hours, the staff were to notify the RN on call. The facility failed to investigate a fall on 07/16/24, conduct a complete assessment, and implement a new intervention following the fall for Resident (R)1, that had previous falls in the facility. On 07/17/24, R1 had an additional fall, which the facility failed to complete an assessment and implement a new intervention following the fall. Additionally, the facility failed to notify the responsible party and the physician following the falls on 07/16/24 and 07/17/24.