STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175305	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lawrence Presbyterian Manor	1429 Kasold Dr Lawrence, KS 66049

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 35 residents. The sample included 12 residents with one resident reviewed for treatment and services to prevent pressure ulcers (localized injury to the skin and underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and friction). Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 2's low air loss mattress was set at the appropriate setting for R2's weight, who was prone to pressure-related injury. This placed R2 at increased risk for the development of pressure ulcers and the development of new pressure ulcers. Findings included: - R2's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of dementia (a progressive mental disorder characterized by failing memory, and confusion), Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness)with Lewy body's, neurocognitive disorder (a type of progressive dementia that leads to a decline in thinking, reasoning, and independent function) psychotic disorder (a collection of symptoms that affect the mind, where there has been some loss of contact with reality), and hypertension (HTN-elevated blood pressure). The Significant Change in Status Minimum Data Set (MDS) dated [DATE] for R2 documented a Brief Interview of Mental Status (BIMS) score of zero. The MDS documented R2 was at risk for developing pressure ulcers. The MDS documented R2 was dependent on staff for all activities of daily living (ADLs). The Pressure Ulcer Care Area Assessment (CAA) dated 04 /01/24 documented R2 was at risk for pressure injury. The CAA documented a Braden (a tool developed to foster early identification of patients at risk for forming pressure ulcers) and pressure ulcer risk screening was completed. R2 had no skin issues at that time. R2's Care Plan dated 04/04/24 documented R2 was at risk for pressure ulcers and other skin impairments. The plan of care documented that every nursing shift would check to ensure a low-loss air mattress was plugged in and inflated. The plan of care for R2 dated 04/30/24 documented that every nursing shift would check the redness on R2's left gluteal (pertaining to the buttocks or buttocks muscles) area and apply barrier cream after incontinence care. The plan of care did not indicate the setting for a low-air loss mattress. R2's EMR under the Orders tab dated 04/01/24 revealed the following physician orders: (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Every nursing shift to check and ensure the air mattress was plugged in and inflated. R2's EMR under the Weights/Vital Sign tab revealed her current weight was 140.50 pounds on 05/05/24. On 05/29/24 at 01:35 PM R2 laid in her bed, turned to her left side. She had a washcloth on her forehead. R2's low air loss mattress was set at 210 pounds. On 05/30/24 at 07:07 AM R2 laid in her bed on her back with her eyes shut. R2's low air loss mattress was set at 210 pounds. On 05/08/24 at 09:41 AM, Licensed Nurse (LN) G stated the adjustments for setting on R2's bed were not in the EMR. She stated the order directed nursing to check to ensure the bed was plugged in and the mattress was inflated. LN G stated she thought checking settings was part of the order. LN G said she thought the setting on the mattress should be closer to R2's weight, but she was unsure. On 05/08/24 at 12:44 PM, Administrative Nurse D stated the facility did not take care of the low air loss mattress settings. He stated the settings were adjusted when the hospice set up the mattress. Administrative Nurse D stated facility staff had an order to check the mattress, not the settings. He stated the facility was working on putting something in place to ensure the settings were correct on mattresses that had weight settings. The facility's Skin Integrity policy revised on 10/22 documented that all residents are considered to some risk for the development of pressure ulcers and injuries. Nursing staff will evaluate skin integrity and tissue tolerance, implement preventative measures as indicated, and treat skin breakdown. The primary care provider admission orders authorize approval to begin using established skin and wound treatment guidelines. Dressing changes are performed by a licensed nurse. Licensed nurses may delegate minor skin tear treatments and preventative treatments in closed areas. The facility failed to ensure the low air loss mattress was set at the appropriate setting for R2's weight, who was prone to pressure-related injury. This placed R2 at increased risk for the development of pressure ulcers and the development of new pressure ulcers.

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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 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** 41037 The facility identified a census of 35 residents. The sample included 12 residents with one resident reviewed for respiratory care. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 27's continuous positive airway pressure (CPAP- ventilation device that blows a gentle stream of air into the nose to keep the airway open during sleep) mask was stored in a sanitary manner to decrease exposure and contamination. This deficient practice placed R27 at an increased risk of developing respiratory infection. Findings included: - R27's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of asthma (a disorder of narrowed airways that causes wheezing and shortness of breath), pulmonary nodule, and obstructive sleep apnea (a disorder of sleep characterized by periods without respirations). The Significant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 14 which indicated intact cognition. The Quarterly MDS dated [DATE] documented a BIMS score of 14 which indicated intact cognition. The MDS documented that R27 used a non-invasive mechanical ventilator during the observation period. R27's Activities of Daily Living (ADLs)Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 01/04/24 documented R27 required extensive assistance with her ADLs. R27's Care Plan dated 03/26/24 documented R27 was to wear her CPAP at night with no oxygen. R27's EMR under the Orders tab revealed the following physician orders: CPAP at night for obstructive sleep apnea dated 01/03/24. On 05/06/24 at 10:20 AM R27 lay on her bed. Her CPAP mask laid directly on her bedside table unbagged. On 05/08/24 at 09:07 AM R27 laid on her bed as she watched TV. R27's CPAP mask laid directly on the bedside table unbagged. On 05/08/24 at 10:25 AM, Certified Nurse Aide (CNA) O stated she believed the CPAP mask should be stored in a plastic bag like oxygen was stored when R27 was not wearing it. CNA O stated she had never removed R27's CPAP mask in the morning, R27 was usually awake when she entered R27's room. On 05/08/24 at 10:35 AM, Licensed Nurse (LN) G stated R27's CPAP mask should be bagged when not in use. LN G stated R27's daughter replaced the CPAP mask and cleaned the mask periodically when she visited her mother. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/08/24 at 12:44 PM, Administrative Nurse D stated CPAP masks should be stored in a container on the table, along with a cleaning solution. Administrative Nurse D stated the nursing staff should clean the CPAP mask. The facility was unable to provide a policy related care of respiratory equipment. The facility failed to ensure R27's CPAP mask was stored in a sanitary manner to decrease exposure and contamination. This deficient practice placed R27 at an increased risk of developing respiratory infection.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 41037 The facility identified a census of 35 residents. The sample included 12 residents and five Certified Nurse Aides (CNAs) reviewed for performance evaluations and the associated in-service training. Based on record review and interview, the facility failed to ensure two of the five CNA staff reviewed had the required yearly performance evaluations completed. This placed the residents at risk for inadequate care. Findings included: - A review of the facility's staffing list revealed the following CNAs were employed with the facility for more than 12 months: CNA N, hired on 01/10/14 had no yearly performance evaluations upon request. CNA M, hired on 05/26/22 had no yearly performance evaluations upon request. On 05/08/24 at 12:44 PM, Administrative Nurse D stated in August 2023, he started to get all the nursing staff's yearly performance reviews up to date. Administrative Nurse D stated he had not completed CNA M and CNA N at this time. Administrative Nurse D stated he had not received the self-performance paperwork back from CNA M and CNA N. Administrative Nurse D stated he started a performance improvement plan on the topic in December 2023. The facility's Staff Competency policy last reviewed on 10/11/21 documented all staff would receive education and training applicable to their position and job description. Checklists, Relias courses, and competency testing would be used to ensure staff are appropriately trained for the position. All clinical employees must complete the competency test at their annual review. The facility failed to ensure two of the five CNA staff reviewed had the required yearly performance evaluations completed. This placed the residents at risk for inadequate care.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 41037 The facility identified a census of 35 residents. Based on observation, record review, and interviews, the facility failed to retain the daily posted nursing staffing data for the 18 months as required. Findings included: - Review of the daily posted nursing staffing data provided by the facility lacked any posted nursing staffing data for December 2023 (31 days). On 05/08/24 at 12:44 PM, Administrative Nurse D stated the nursing staff scheduler was responsible for ensuring the daily posted nursing hours form was retained for the required 18 months. Administrative Nurse D stated the previous staff member who was responsible for maintaining the posted nursing staff hours had not retained the forms as required. The facility ' s Daily Nurse Staffing Report policy last reviewed on 10/11/21 documented that the nursing service was to provide each resident admitted to the health care center with the appropriate level of care to attain his/her optimum level of functioning. Nursing service was staffed, organized, and equipped to provide nursing care on a 24-hour-a-day basis. Daily resident census and staffing information was available to the public. The facility would maintain the Daily Nurse Staffing Form for a minimum of 18 months and file it in the business office. The facility failed to retain the daily posted nursing staffing data for the 18 months as required.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility had a census of 35 residents. The sample included 12 residents with five reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure nonpharmacological interventions were attempted and documented prior to administration of an antipsychotic (class of medications used to treat a mental disorder characterized by a gross impairment testing) medication for Resident (R) 2, who had a diagnosis of dementia (a progressive mental disorder characterized by failing memory, confusion). This placed the resident at risk for unnecessary psychotropic (alters perception, mood, consciousness, cognition, or behavior) medications and related complications. Findings included: - R2's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of dementia, Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness)with Lewy body's, neurocognitive disorder (a type of progressive dementia that leads to a decline in thinking, reasoning, and independent function), psychotic disorder (a collection of symptoms that affect the mind, where there has been some loss of contact with reality), and hypertension (HTN-elevated blood pressure). The Significant Change in Status Minimum Data Set (MDS) dated [DATE] for R2 documented a Brief Interview of Mental Status (BIMS) score of zero. The MDS documented R2 received antipsychotic drugs during the observation period. R2's Psychotropic Drug Use Care Area Assessment (CAA) dated 04/01/2024 documented a psychotropic drug medication side effect screening on 03/15/24, and psychotropic drug use side effects will be part of the plan of care. R2's Care Plan dated 04/04/24 documented R2 took Seroquel (antipsychotic medication) for Parkinson's psychosis. Staff would monitor for potential side effects such as urinary retention, skin changes, slurred speech, mental status, and behavioral changes. Staff would report side effects to the charge nurse for further evaluation. The Physician's Order dated 12/18/23 directed to give Seroquel 50 milligram (mg) tablet once daily for psychotic disorder with delusions. R2's EMR lacked documentation or evidence of nonpharmacological symptom management interventions that were implemented and failed before starting Seroquel. On 05/08/24 at 09:41 AM Licensed Nurse (LN) G stated that antipsychotic medications were ok to give to a resident with a dementia diagnosis. She stated residents with a diagnosis of psychosis needed antipsychotic medication. LN G stated she would try nonpharmacological interventions first if that was possible. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/08/24 at 12:44 PM Administrative Nurse D stated a nonpharmacological approach would be the best approach. He stated he would do talk therapy, but he had no residents who needed the therapy yet. He stated residents came into the facility on an antipsychotic and the facility tried to get the residents to the lowest dose. Administrative Nurse D stated the facility worked closely with physicians and pharmacists to ensure the resident was on the lowest dose of each medication. The facility's Psychotropic Medication Use policy, revised on 07/22 documented that psychoactive medications will not be used for discipline or convenience and will not be used unless necessary to treat medical symptoms. Residents receiving psychoactive medications will be monitored and observed for improvement or decline in functional status, target behaviors, and side effects. For any of the types of antipsychotics, gradual dose reductions and behavioral interventions will be done per physician orders, unless clinically contraindicated in an effect to discontinue the medication or to reach the lowest effective dose. Psychotropic medications are given to treat a specific condition diagnosed and documented in eh clinical record. The facility failed to ensure nonpharmacological interventions were attempted prior to the administration of an antipsychotic medication for R2, who had a diagnosis of dementia. This placed the resident at risk for unnecessary psychotropic medications and related complications.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 35 residents. The sample included 12 residents with one resident reviewed for hospice. Based on observation, record review, and interviews, the facility failed to ensure a communication process was implemented, which included how the communication would be documented between the facility and the hospice provider. This deficient practice created a risk for missed or delayed services and impaired care for Resident (R)32. Findings included: - R32s Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), dementia (progressive mental disorder characterized by failing memory, confusion), hearing loss, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and dysphagia (swallowing difficulty). The Significant Change Minimum Data Set (MDS) dated [DATE] documented R32 had severely impaired cognition, and never or rarely made decisions. The MDS documented R32 was dependent on two staff assistants for all activities of daily living (ADLs). The MDS documented R32 received hospice services during the observation period. R32's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 04/15/24 documented R32 was unable to participate in a Brief Interview of Mental Status (BIMS) assessment; the causes included general decline, advanced age, dementia, and cognitive communication deficit. R32's risk factors include falls, agitation, behaviors, weight loss, and communication. R32's Care Plan dated 04/25/24 documented the facility would coordinate R32's care and services with the hospice provider. The plan of care directed the facility to communicate with hospice regarding R32's preferences, care concerns, and needs. The plan of care documented a nurse would visit weekly to assess for changes, symptoms management, pain, discomfort, dyspnea (difficulty breathing), air hunger, mobility, and skin and recommend and implement changes. The hospice aide was to have one-on-one visits with reading, music, personal hygiene, preventative skin care, eating, drinking, and toileting. A review of the communication binder provided by the hospice revealed R32 was admitted to hospice services on 04/15/24. The hospice communication binder lacked the plan of care for R32 and the physician-signed terminal diagnosis for admission to hospice. The last documentation of hospice care was dated 05/02/24. On 05/08/24 at 09:35 AM Certified Nursing Aide (CNA) P stated there were binders in the front halls by the nursing station that contained hospice information. CNA P stated the binders contained R32's care needs. CNA P stated he was unsure what to look for in the binder and stated there were tabs with different instructions for nursing staff. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/08/24 at 09:41 AM Licensed Nurse (LN) H stated all hospice binders were kept in the cabinet next to the nursing charting station. LN H stated the facility had its care plan for communication of care, and hospice also had a care plan for each resident. R32 ' s care would be found in both care plans. On 05/08/24 at 12:44 Administrated Nurse D stated the facility had care plans for everyone. He stated R32 ' s Care Plan was found in medical records; the document had been scanned into his file instead of being put in the hospice binder. Administrative Nurse D stated the facility collaborated with hospice through the care plans. He stated all hospice providers were welcome to attend the weekly care plan meetings. The facility was unable to provide a policy related to hospice services. The facility failed to ensure a communication process was implemented, which included how the communication would be documented between the facility and the hospice provider. This deficient practice created a risk for missed or delayed services and impaired care for R32.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 42966 The facility identified a census of 35 residents. The sample included 12 residents with five residents reviewed for pneumococcal (a disease that refers to a range of illnesses that affect various parts of the body and are caused by infection) vaccinations. Based on record review and interviews, the facility failed to obtain a signed consent or declination for pneumococcal vaccination Prevnar 20 (PCV20) for Resident (R) 2, R25, and R86. This deficient practice placed the residents at risk of acquiring, spreading, and experiencing complications from pneumococcal disease. Findings included: - R2's clinical record documented she received Prevnar 13 (pneumococcal vaccination used for the prevention of pneumococcal disease caused by 13 serotypes of Streptococcus pneumoniae [bacteria that causes pneumonia]) on 04/01/15 and Pneumovax 23 (pneumococcal vaccination used for the prevention of pneumococcal disease caused by 23 serotypes of Streptococcus pneumoniae) on 05/01/17. R2's clinical record lacked evidence she received Prevnar 20 (pneumococcal vaccination used for the prevention of pneumococcal disease caused by 20 serotypes of Streptococcus pneumoniae) or had a signed declination for Prevnar 20 vaccination. R25's clinical record documented she received Pneumovax 23 on 01/01/97 and Prevnar 13 on 01/01/16. R25's clinical record lacked evidence she received Prevnar 20 or had a signed declination for Prevnar 20 vaccination. R86's clinical record documented she received Pneumovax 23 on 01/01/07 and Prevnar 13 on 10/09/18. R86's clinical record lacked evidence she received Prevnar 20 or had a signed declination for Prevnar 20 vaccination. On 05/08/24 at 10:28 AM, Licensed Nurse (LN) H stated when a resident was admitted to the facility, she asked them about their immunizations and the dates they were immunized or reviewed their admission records for their immunization history. She stated that was all she did with immunizations on admission. On 05/08/24 at 10:31 AM, Administrative Nurse E stated when a resident was admitted to the facility, if they had received Pneumovax 23 but not the Prevnar 13 or Prevnar 20, the resident was asked if they wanted to receive the vaccination. She stated if a resident had not received Prevnar 20, staff called the physician for immunization verification or to get an order to give the vaccination. She stated the resident or their representative then signed the consent form. Administrative Nurse E stated if the resident or their representative refused the vaccination, they signed a declination. On 05/08/24 at 10:57 AM, Administrative Nurse E stated the facility received the guidance on Prevnar 20 last week but she had heard the guidance was happening, so she started looking at who needed Prevnar 20 in April. She stated the facility received an order for R25 to receive Prevnar 20 on 05/01/24. Administrative Nurse E stated R2 was receiving end-of-life care and the facility did not receive an order to give Prevnar 20 yet. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/08/24 at 01:00 PM, Administrative Nurse D stated Administrative Nurse F was in charge of immunizations. He stated the facility found out about four weeks ago that Prevnar 20 was important and they started working on it two weeks ago. Administrative Nurse D stated the pharmacy informed the facility of new immunization guidance and if corporate received new guidance, they sent it to the facility too. On 05/08/24 at 01:03 PM, Administrative Nurse F stated when a resident was admitted to the facility, she looked through their immunization record or obtained their records for their immunizations. She stated she reviewed for Prevnar 13 and Pneumovax 23 but the guidance just changed to include Prevnar 20. Administrative Nurse F stated if a resident received Prevnar 13 or Pneumovax 23 over five years ago, it was recommended the resident receive Prevnar 20 with a physician order and family approval. She stated she tried to get consent or declinations within a couple of weeks after admission. The facility's Immunization- Pneumococcal policy, last revised 01/31/22, directed residents were provided the opportunity and were encouraged to receive the pneumococcal vaccination(s). The policy directed the facility to provide educational material regarding risks and benefits to residents and obtained the resident's consent for, or refusal of, each pneumococcal vaccination(s). If vaccination status was unknown, the pneumococcal vaccinations were offered upon admission. The facility failed to obtain a signed consent or declination for the PCV 20 for R2, R25, and R86. This deficient practice placed the residents at risk of acquiring, spreading, and experiencing complications from pneumococcal disease.