

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175310	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/08/2026
NAME OF PROVIDER OR SUPPLIER Clay Center Presbyterian Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 924 8th Street Clay Center, KS 67432	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to serve food in a sanitary manner for the 29 residents who received food from the facility kitchen. Findings included:- On 07/06/2026 at 12:25 PM, observation revealed Certified Nurse Aide (CNA) M brought her ponytail to the front of her body and stroked it up and down with both hands approximately three times, then flung the ponytail to the back of her head and did not wash hands or use hand gel. Continued observation revealed CNA M delivered a resident plate of food to the table, then returned to the kitchenette and obtained another plate of food and delivered that plate to another resident. Continued observation revealed CNA M tied her scrub pants with both hands and did not wash hands or use hand gel and delivered a plate of food from the kitchenette, then returned to the kitchenette and got a small glass of thickened liquid and grabbed it by the top of the cup and touched the lip surface with her hand before she delivered the cup to the resident. CNA M grabbed a rolling stool and pushed it next to a resident and assisted her to eat a few bites of pureed food. Continued observation revealed at 12:40 PM, CNA M brought her ponytail to the front of her body and stroked it up and down with both hands approximately two times, then flung the ponytail to the back of her head and did not wash hands or use hand gel. She obtained a clothing protector and delivered it to another CNA to place on a resident before they ate their lunch. Continued observation of the meal service revealed CNA M did not wash her hands or use hand gel throughout the meal service. On 07/07/26 at 01:40 PM, Administrative Nurse D verified staff should not touch their hair or scrubs while assisting the residents with their meal service or while delivering plates of food to the table. Administrative Nurse D stated she would hold an in-service immediately regarding proper hand hygiene and servicing of meals. The facility's Serving Basic policy, undated, documented staff would ensure safe serving practices to prevent contamination, and all team members would follow safe serving practices. The policy documented staff would ensure clean hands and utensils are used during dining service, and staff would not touch the food contact surface, handle by the edges, handles, or bottom or middle of the service ware.		

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a 14-day stop date or a specified duration with rationale for Resident (R)3's ongoing as needed (PRN) antianxiety (class of medications that calm and relax people) medications. Findings include: - R3's Electronic Health Record (EHR) revealed diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, irrational fear) and hypertension (HTN-elevated blood pressure). R3's Significant Change Minimum Data Set (MDS) dated [DATE], recorded R3 had intact cognition. The MDS recorded that she required staff assistance with bed mobility and transfers. The MDS documented R3 received an antianxiety medication during the observation period. R3's Activities of Daily Living Care Plan, dated 06/26/2026, recorded R3 required assistance with activities of daily living (ADL) care. R's Psychotropic Drug Use Care Plan dated 06/26/26, dated 06/26/26, documented the resident received psychotropic medication with the potential for drug related complications related to pain and anxiety. The care plan documented R3 received Xanax (antianxiety medication) daily but lacked that she received a PRN dose, and the care plan lacked mention that R3 received lorazepam (antianxiety medication) as needed for anxiety. The care plan documented a pharmacy consultation would review R3's medications monthly. R3's Physician's Order, dated 06/15/2026, directed the staff to administer lorazepam 1.0 milliliters (ml) every eight hours as needed for anxiety PRN. The order lacked a stop date. R3's Physician's Order, dated 05/05/2026, directed staff to administer Xanax 0.25 milligrams (mg) every six hours as needed for anxiety PRN. The order lacked a stop date. R3's EMR lacked evidence of a specified duration, which included a physician's rationale for the extended use of the PRN lorazepam and the PRN Xanax. On 07/07/2026 at 08:00 AM, R3 sat up in her bed, and Certified Medication Aide (CMA) R administered the resident's morning medication, which included a scheduled Xanax. On 07/07/2026 at 01:30 PM, Administrative Nurse D verified the resident received lorazepam PRN, with a physician order date of 06/15/2026 and received a Xanax PRN, with a physician order date of 05/05/2026. Administrative Nurse D verified the facility failed to obtain the 14-day stop date or a reason for the continued use with the appropriate rational. The Psychoactive Psychopharmacological Medications, policy dated 04/15/2025, documented psychotropic medications would be used only when a practitioner determines that the medication is appropriate to treat a resident's specific diagnosed and documented condition and the medication(s) are beneficial to the resident as demonstrated by monitoring and documentation of the resident's response to the medication. Psychoactive medications would be monitored by an interdisciplinary team (IDT) through the care planning process. Benefits and side effects of these medications would be discussed with the Primary Care Provider (PCP), so drug selection and dosages are adjusted as necessary to provide the best therapeutic effect for residents. Individualized behavioral interventions would also be addressed through the care planning process and documented on the electronic health record. The policy documented psychotropic medications used on a PRN basis must have a diagnosed specific condition and indication for the PRN use documented in the resident's medical record and subject to the limitations as noted: PRN orders for psychotropic medications, excluding antipsychotics, shall be limited to no more than 14 days, unless the attending physician or prescribing practitioner believes it is appropriate to extend the order beyond 14 days. The medical record should include documentation from the physician or prescriber for the rationale for the extended time period and indicate a specific duration. PRN orders for antipsychotic medications only shall be limited to 14 (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	days with no exception. If the attending physician or prescribing practitioner believes it is appropriate to write a new order for the PRN antipsychotic, they must first evaluate the resident to determine if the new order for the PRN antipsychotic is appropriate. The policy documented a drug regimen review would be conducted and documented monthly by a licensed nurse, pharmacist, or PCP. Drug irregularities, discrepancies, or non-compliance with regulatory guidelines is brought to the attention of the director of nursing, medical director, and attending PCP.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a 14-day stop date or a specified duration with rationale for Resident (R)3's ongoing as needed (PRN) antianxiety (class of medications that calm and relax people) medications. Findings include:- R3's Electronic Health Record (EHR) revealed diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, irrational fear) and hypertension (HTN-elevated blood pressure). R3's Significant Change Minimum Data Set (MDS) dated [DATE], recorded R3 had intact cognition. The MDS recorded that she required staff assistance with bed mobility and transfers. The MDS documented R3 received an antianxiety medication during the observation period. R3's Activities of Daily Living Care Plan, dated 06/26/2026, recorded R3 required assistance with activities of daily living (ADL) care. R's Psychotropic Drug Use Care Plan dated 06/26/2026, documented the resident received psychotropic medication with the potential for drug related complications related to pain and anxiety. The care plan documented R3 received Xanax (antianxiety medication) daily but lacked that she received a PRN dose, and the care plan lacked mention that R3 received lorazepam (antianxiety medication) as needed for anxiety. The care plan documented a pharmacy consultation would review R3's medications monthly. R3's Physician's Order, dated 06/15/2026, directed the staff to administer lorazepam 1.0 milliliters (ml) every eight hours as needed for anxiety PRN. The order lacked a stop date. R3's Physician's Order, dated 05/05/2026, directed staff to administer Xanax 0.25 milligrams (mg) every six hours as needed for anxiety PRN. The order lacked a stop date. R3's EMR lacked evidence of a specified duration, which included a physician's rationale for the extended use of the PRN lorazepam and the PRN Xanax. The Consultant Pharmacist monthly review for R3 completed on 05/05/2026, 06/02/2026, and 07/02/2026 lacked evidence that the CP identified the PRN lorazepam with no stop date, or the PRN Xanax with no stop date. On 07/07/2026 at 08:00 AM, R3 sat up in her bed, and Certified Medication Aide (CMA) R administered the resident's morning medication, which included a scheduled Xanax. On 07/07/2026 at 01:30 PM, Administrative Nurse D verified the resident received lorazepam PRN, with a physician order date of 06/15/2026, and received a Xanax PRN, with a physician order date of 05/05/2026. Administrative Nurse D verified the facility failed to obtain the 14-day stop date or a reason for the continued use with the appropriate rational. Administrative Nurse D verified the Consultant Pharmacist had sent monthly reviews to the facility and lacked a recommendation for the 14 days stop date or rational for continued use of the medication. The Psychoactive Psychopharmacological Medications, policy dated 04/15/2025, documented psychotropic medications would be used only when a practitioner determines that the medication is appropriate to treat a resident's specific diagnosed and documented condition and the medication(s) are beneficial to the resident as demonstrated by monitoring and documentation of the resident's response to the medication. Psychoactive medications would be monitored by an interdisciplinary team (IDT) through the care planning process. Benefits and side effects of these medications would be discussed with the Primary Care Provider (PCP), so drug selection and dosages are adjusted as necessary to provide the best therapeutic effect for residents. Individualized behavioral interventions would also be addressed through the care planning process and documented on the electronic health record. The policy documented psychotropic medications used on a PRN basis must have a diagnosed specific condition and indication for the PRN use documented in the resident's medical record and subject to the limitations as noted: PRN orders for psychotropic medications, excluding (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	antipsychotics, shall be limited to no more than 14 days, unless the attending physician or prescribing practitioner believes it is appropriate to extend the order beyond 14 days. The medical record should include documentation from the physician or prescriber for the rationale for the extended time period and indicate a specific duration. PRN orders for antipsychotic medications only shall be limited to 14 days with no exception. If the attending physician or prescribing practitioner believes it is appropriate to write a new order for the PRN antipsychotic, they must first evaluate the resident to determine if the new order for the PRN antipsychotic is appropriate. The Drug Regimen Review, policy, dated 02/03/25, documented the resident's medication regimen would be reviewed monthly and as needed by a licensed pharmacist. A Drug Regimen Review (DRR) is completed at admission by clinical staff. DRR is a thorough evaluation of resident's medication in order to improve outcome and minimize adverse outcomes or risks. A DRR would be conducted by the Pharmacist on day of admission, monthly, and as needed. A DRR would include medication reconciliation, medication review of all current medications, and the medications would be reviewed to identify irregularities and to identify clinically significant risks and/or actual or potential adverse consequences which may result from or be associated with medications. The drug regimen would identify limitations of PRN prescriptions of psychotropic drugs, including anti-psychotic drugs for longer than 14 days.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, and interview, the facility failed to ensure a sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections when staff failed to store Resident (R)21 and R3's oxygen tubing and nasal cannula in a sanitary manner. Findings included:1. On 07/07/2026 at 03:02 PM, observation revealed R21's unbagged oxygen tubing and nasal cannula coiled up and placed on the back of her wheelchair, located in the hall by her room.On 07/07/2026 at 03:03 PM, Licensed Nurse (LN) G verified the above observation and stated staff was to place R21's oxygen tubing and nasal cannula in a plastic bag when not in use. 2. On 07/08/2026 at 09:35 AM, observation revealed R3's uncovered oxygen tubing coiled up and placed on the top of the resident's wheelchair back. On 07/08/2026 at 09:39 AM, Administrative Nurse D verified R2's uncovered oxygen tubing on R2's wheelchair back with the cannula and tubing touching the wheelchair. Administrative Nurse D stated she would expect staff to store the residents' oxygen tubing and nasal cannula in a plastic bag when not in use. The facility's Oxygen Therapy Policy, revised 02/03/2025, documented when the oxygen device is not in use, store in a plastic or other bag to keep the tubing and device off the floor. Label bag with resident name, date, time, and staff initial.		