

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175241	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2024
NAME OF PROVIDER OR SUPPLIER Sabetha Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1441 Oregon Street Sabetha, KS 66534	

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)
<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>32358</p> <p>The facility had a census of 25 residents. The sample included 12 residents with one reviewed for hospitalization . Based on observation, record review, and interview, the facility failed to provide a written notice for a facility-initiated transfer to Resident (R) 14, or her representative, when she was transferred to the hospital and failed to notify the Office of the Long-Term Care Ombudsman (LTCO-a public official who works to resolve resident issues in nursing facilities) of the discharge. This placed the resident at risk for uninformed care choices.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - R14's Electronic Medical Record (EMR) documented R14 had a diagnosis of chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). R14's Medicare Five Day Minimum Data Set (MDS) documented R14 had a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R14 required maximal to partial staff assistance with most activities of daily living (ADLs). R14's Care Plan, revised 12/21/23, documented R14 required continuous oxygen, and instructed staff to check R14's oxygen saturation every shift and as needed (PRN) and monitor for changes in R14's breathing patterns. The Progress Note, dated 02/05/2024 at 03:44 PM, documented R14 was admitted to the hospital. A review of R14's clinical record lacked evidence the resident or representative was provided written notice when he was transferred to the hospital. The facility was unable to provide evidence the LTCO was notified of the transfer. On 12/27/23 at 3:06 PM, observation revealed R14 sat in a recliner in her room with oxygen on per nasal cannula. <p>(continued on next page)</p>

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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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>03/20/24 at 09:35 AM, Social Service X stated she was unaware she was responsible for notifying the resident or representative in writing when R14 went to the hospital because she had not received training regarding providing the written notice. Social Service X verified R14's transfer to the hospital was also not sent to the LTCO due to it did not come up on her report in the computer notification. Social Service X said the notice of the transfer should have been sent to the LTCO.</p> <p>03/20/24 at 09:44 AM, Licensed Nurse (LN) H stated social service staff was responsible for providing transfer information to R14 or her representative when R14 was transferred to the hospital.</p> <p>The facility's Emergency Transfer Notification Policy, revised 09/2018, documented that when a resident is transferred on an emergency basis the resident and representative would be notified verbally as soon as is practicable and would be notified of transfer in writing by the SSD as soon as is practicable. a copy of this notification would be kept on file and documentation that this notification was completed would be placed in the medical record. The policy documented the facility would notify the resident, representative, and state ombudsman of emergency transfers.</p> <p>The facility failed to provide R14 or her representative written notice regarding R14's facility-initiated transfer to the hospital and failed to notify the LTCO of the transfer. This placed the resident and/or her representative at risk of uninformed care choices.</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>32358</p> <p>The facility had a census of 25 residents. The sample included 12 residents with one reviewed for hospitalization . Based on observation, record review, and interview, the facility failed to provide Resident (R)14 or his representative with written information regarding the facility bed hold policy when R14 was transferred to the hospital. This placed R14 at risk of not being permitted to return and resume residence in the nursing facility.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - R14's Electronic Medical Record (EMR) documented R14 had a diagnosis of chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). <p>R14's Medicare Five Day Minimum Data Set (MDS) documented R14 had a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R14 required maximal to partial staff assistance with most activities of daily living (ADLs).</p> <p>R14's Care Plan, revised 12/21/23, documented R14 required continuous oxygen, and instructed staff to check R14's oxygen saturation every shift and as needed (PRN) and monitor for changes in R14's breathing patterns.</p> <p>The Progress Note, dated 02/05/2024 at 03:44 PM, documented R14 was admitted to the hospital.</p> <p>A review of R14's clinical record lacked evidence the resident or representative was provided the facility's bed hold policy when R14 went to the hospital.</p> <p>On 12/27/23 at 3:06 PM, observation revealed R14 sat in a recliner in her room with oxygen on per nasal cannula.</p> <p>03/20/24 at 09:35 AM, Social Service X stated nursing was responsible for sending the bed hold policy and she was unaware the facility was supposed to have a signed copy from the resident or representative regarding they were notified.</p> <p>03/20/24 at 09:44 AM, Licensed Nurse (LN) H stated nursing was responsible for providing transfer information to R14 or her representative with the bed hold policy when R14 was transferred to the hospital. LN H stated she did not check to see if the signed bed hold policy came back to the facility.</p> <p>The facility's Bed Hold Policy, revised 11/2017, documented to ensure that residents are made aware of a facility's bed hold and reserve bed payment policy before and upon transfer to a hospital or when taking a therapeutic leave of absence from the facility. At the time of transfer, or in cases of emergency transfer, written notice must be provided to the resident and if applicable the resident's representative within 24 hours. Documentation of multiple attempts to reach the resident's representative would be retained in the medical record in cases where the facility was unable to notify the representative.</p> <p>(continued on next page)</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility failed to provide R14 or his representatives with the bed hold policy when R14 was transferred to the hospital. This placed the resident at risk of not being permitted to return and resume residence in the nursing facility.</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>32358</p> <p>The facility had a census of 25 residents. Based on observation, record review, and interview, the facility failed to provide Registered Nurse (RN) coverage eight consecutive hours a day, seven days a week and failed to employ a full-time Director of Nursing (DON) placing all residents who resided in the facility at risk for decreased quality of care.</p> <p>Findings included:</p> <p>- A review of the August, September, and October 2023 nursing schedule revealed there was not an RN for eight consecutive hours on the following dates: 08/07/23, 09/07/23, 09/13/23, 09/14/23, 09/16/23, 09/17/23, 09/20/23, 09/28/23, 10/03-5/23, 10/09/23, 10/10/23, and 10/11/23.</p> <p>On 03/13/24 at 09:00 AM, during the initial entrance conference Administrative Staff A verified the facility did not have a current DON but there was a Registered Nurse that had been at the facility for a long time that was in charge.</p> <p>On 03/18/24 at 11:50 AM, Administration Staff A brought in a handwritten list of dates from 08/07/23 to 09/20/23 and stated the hours were when the previous director of nursing served as the eight-consecutive-hour RN. Administrative Staff A was unable to provide any verifiable documentation for those dates. Administrative Staff A verified the lack of RN coverage on 09/28/23 and the October dates listed above.</p> <p>The facility's Nursing Services-Registered Nurse (RN) Policy, revised in February 2023, documented the facility would utilize the services of an RN for at least eight consecutive hours per day, seven days per week. The facility would designate an RN to serve as the Director of Nursing on a full-time basis.</p> <p>The facility failed to provide RN coverage eight consecutive hours a day, seven days a week and failed to employ a full-time DON placing the residents who resided in the facility at risk of decreased quality of care.</p>		

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p>32358</p> <p>The facility had a census of 25 residents. The sample included 12 residents and one kitchen. Based on observation, record review, and interview, the facility failed to employ a full-time certified dietary manager for the 25 residents who resided in the facility and received meals from the facility kitchen. This placed the residents at risk for inadequate nutrition.</p> <p>Findings included:</p> <p>- On 03/13/24 at 11:00 AM, the noon meal consisted of grilled sausage cuts, German potato salad, sauerkraut with bacon, and cookies.</p> <p>On 03/13/24 at 11:30 AM, observation revealed Dietary Staff BB in the kitchen preparing the noon meal.</p> <p>On 03/13/24 at 11:35 AM, Dietary Staff BB verified she was not a certified dietary manager. Dietary Staff BB stated she was on the last section of the dietary manager class.</p> <p>On 03/13/24 at 09:51 AM, Administrative Staff A verified Dietary Staff BB did not have a dietary manager certification.</p> <p>The facility's Dietary Services-Staffing Policy, revised February 2023, documented the facility would employ a qualified dietitian or other clinically qualified nutrition professional on a full-time, part-time, or consultant basis.</p> <p>The facility failed to employ a full time certified dietary manager for 25 residents who resided in the facility and received meals from the kitchen. This placed the residents at risk for inadequate nutrition.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>32358</p> <p>The facility had a census of 25 residents. The sample included 12 residents. Based on observation, record review, and interview the facility failed to check the food temperatures of pureed (an eating plan where all the foods have a soft, pudding-like consistency) foods and the regular breakfast food items before serving to ensure the appropriate food temperature for food safety and palatability. This placed the residents at risk for food-borne illness and impaired palatability.</p> <p>Findings included:</p> <p>- On 03/14/24 at 12:05 PM, Dietary Manager (DM) BB stated the facility had two residents on a fully pureed and one with pureed meat only. Observation revealed DM BB placed two 4-ounce scoops of sauerkraut into a blender, added one teaspoon (tsp) of chicken broth, and blended to the consistency of mashed potatoes. DM BB placed the sauerkraut on a plastic divided plate on the counter next to the microwave and covered it with a room tray lid. DM BB then ran the blender container through the dishwasher, brought it back to the counter, placed two 4-ounce scoops of German potato salad into the blender container, and then blended it. DM BB added chicken broth a little at a time until the potato salad was the consistency of pudding. Observation revealed DM BB placed the potato salad into a different section of the same plate the sauerkraut was on, then covered it with the lid. DM BB used the same procedure to clean the blender container and then placed three 4-ounce scoops of sausage pieces into the blender, added chicken broth, and blended to the consistency of mashed potatoes. DM BB then placed one scoop into a different section of each plate on the counter, with the other pureed food items. Further observation revealed at 12:11 PM, DM BB handed a dietary staff the pureed diet plate. After the survey team intervened and requested a temperature for the food items, the items were assessed, and the following inadequate temperatures were noted: pureed sausage at 120 degrees Fahrenheit (F), potatoes at 120 degrees F, and sauerkraut at 120 degrees F. DM BB stated she typically does not leave the food plate on the counter as she did during the observation but did not confirm whether she assessed food temperatures on pureed food items routinely before serving.</p> <p>The Food Temp Sheet, for January, February, and March 2024 revealed no food temperatures were assessed and recorded for breakfast food items every day. The sheet lacked pureed food temperatures for breakfast, lunch, and supper, every day.</p> <p>On 03/18/24 at 10:16 AM, DM BB stated dietary staff do not check breakfast food temperature because the food is made to order. DM BB said the sausage gravy was in the refrigerator, and the staff placed it in a microwave for about two minutes, and that made it hot. DM BB verified the above Food Temp Sheets lacked evidence that pureed food temperatures were assessed due to there being no column to record them.</p> <p>The facility's Record of Food Temperatures Policy, revised February 2023, documented food temperatures would be checked on all items prepared in the dietary department. Hot foods would be held at 135 degrees Fahrenheit or greater. Measure and record the temperatures for each food product and milk at all meals and record the temperature on the temperature log.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility dietary staff failed to measure, and record pureed and breakfast food item temperatures before serving them. This placed the residents at risk for foodborne illness and impaired palatability.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32358</p> <p>The facility had a census of 25 residents. Based on observation, record review, and interview, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety when staff stored unlabeled, undated, expired food in the refrigerators. This placed the 25 residents who received their meals from the facility's kitchen at risk for foodborne illness.</p> <p>Findings included:</p> <p>- On [DATE] at 09:00 AM, observation in the kitchen revealed the following:</p> <p>A white refrigerator/freezer had seven 4-ounce vanilla Mighty Shakes with an expiration date of [DATE].</p> <p>A two-door silver refrigerator had an unsealed package of yellow cheese slices.</p> <p>On [DATE] at 09:05 AM, Social Service X verified the above findings and discarded the food item in the trash.</p> <p>On [DATE] at 9:15 AM the white upright refrigerator /freezer, located in the dining room, had eight 7-ounce Ensure Plus high protein strawberry containers with an expiration date of [DATE] and three Ensure original 7-ounce containers with an expiration date of [DATE] in the freezer. Social Service X verified the Ensure products were expired and stated staff should discard expired food items. Social Service X discarded the items in the trash.</p> <p>On [DATE] at 10:48 AM, observation during a follow-up to the kitchen revealed:</p> <p>The mopboard around the edge of the kitchen had a black substance on it. Underneath the steam table in the outside corner, the mopboard was coming away from the wall approximately one-half inch (in) to 1 in.</p> <p>The edge of the oven hood had numerous areas of varying size where the paint was peeling.</p> <p>The bottom and top cabinets located across from the ovens had numerous areas with the top layer of wood missing.</p> <p>Three lower cabinet drawers below the toaster had eight screw holes with screws sunk inside of the hole.</p> <p>The three lower cabinet drawers to the left of the sink had nine screw holes with the same screws sunk inside.</p> <p>The cabinet below the coffee pot had a missing cupboard door and the bottom shelf inside the cabinet had a missing top layer of wood approximately 1.5 in by one-eighth in.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Underneath the ice machine were four plastic blue gowns in plastic packages, and a plastic cup lid.</p> <p>The legs underneath the counter where the dirty dishes go in were rusted from top to bottom,</p> <p>The pipe starting underneath the dishwasher to the garbage disposal, approximately 18 inches long, had numerous areas of brown substance.</p> <p>The board above the sink located across from the ovens, above the window, had an area of approximately 18 in. by 4.5 in with a missing top layer of wood.</p> <p>On [DATE] at 10:30 AM, Dietary Manager (DM) BB verified the above findings with the issues in the kitchen and stated she would notify maintenance about the oven hood and cupboard issues. DM BB said staff have a daily cleaning they should be doing, but the kitchen had been short-staffed.</p> <p>The facility's Dietary Cleaning Procedures Policy, undated, documented the facility would store, prepare, distribute, and serve food under sanitary conditions to ensure that proper sanitation and food handling practices to prevent the outbreak of foodborne illnesses. The procedure instructed staff on how and what cleaning to do in the kitchen.</p> <p>The facility kitchen staff failed to prepare, store, distribute, and serve food in accordance with professional standards for food service safety. This placed the 25 residents who received their food from the facility's kitchen at risk for foodborne illness.</p>

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<p>F 0851</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.</p> <p>32358</p> <p>The facility had a census of 25 residents. Based on observation, interview, and record review, the facility failed to submit complete and accurate staffing information through Payroll Based Journaling (PBJ) as required. This deficient practice placed the residents at risk for unidentified and ongoing inadequate nurse staffing.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - The PBJ report provided by the Centers for Medicare & Medicaid Services (CMS) for Fiscal Year (FY) 2023 Quarter 4 and FY 2024 Quarters 1 indicated the facility did not have licensed nurse coverage 24 hours a day, seven days a week on multiple (15) dates. <p>A review of the facility licensed nurse timeclock data for the dates listed on the PBJ revealed a licensed nurse was on duty for 24 hours a day seven days a week.</p> <p>On 03/20/24 AM, observation revealed a registered nurse on duty in the facility.</p> <p>On 03/18/24 at 11:50 AM, Consultant Nurse (CN) GG stated she helped with reporting data to CMS for the payroll-based data. CN GG said when she looked at her documentation regarding the information she reported it showed the information was reported correctly, so she was not sure why CMS records were different.</p> <p>The facility's Payroll-Based Journal Policy,' revised February 2023, documented the facility would electronically submit timely to Centers of Medicare/Medicaid Services (CMS) complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS.</p> <p>The facility failed to submit accurate PBJ data which placed the residents at risk for unidentified and ongoing inadequate staffing.</p>		

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<p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>29183</p> <p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>The facility had a census of 25 residents. The sample included 12 residents. Based on observation, record review and interview the facility failed to have the required members participate and attend Quality Assurance and Performance Improvement (QAPI) meetings at least quarterly for the quality assurance program. This placed the 25 residents who resided in the facility at risk for decreased quality of care.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - On 03/20/24 at 11:00 AM, the QAPI committee sign-in sheets for quarterly meetings lacked a Director of Nursing and Infection Preventionist on the committee on 03/07/24, 01/23/24, 11/28/23, and 09/26/23. <p>On 03/20/24 at 11:10 AM, Administrative Staff A verified the facility did not employ a full-time Director of Nursing or an Infection Preventionist.</p> <p>The facility's undated Quality Assurance and Performance Improvement Plan (QAPI) policy documented the facility's Quality Assurance Committee should consist of a Director of Nursing and an Infection Preventionist.</p> <p>The facility failed to have the required members attend and participate at least quarterly in the QAPI program. This placed the residents in the facility at risk for decreased quality of care.</p>

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<p>F 0882</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home.</p> <p>29183</p> <p>The facility had a census of 25 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to ensure the facility employed a designated staff person for the Infection Preventionist (IP) who was responsible for the facility's Infection Prevention and Control Program (IPCP) and who completed the specialized training in infection prevention and control. This placed the residents at increased risk for infections.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - On 03/13/24 at 09:00 AM, during the initial entrance conference Administrative Staff A verified the facility did not have an IP. <p>On 03/18/24 at 10:00 AM, Nurse Consultant GG verified she had been tracking infections, but the facility did not employ an onsite IP.</p> <p>The facility' Infection Preventionist undated policy, documented the facility will employ one or more qualified individuals with responsibility for implementing the facility's infection prevention and control program. The facility will ensure the Infection Preventionist is qualified by education, training, and certification. Develop and implement an ongoing infection prevention and control program to recognize and control the onset and spread of infections to provide safe, sanitary, and comfortable environment-wide systems for the prevention, identification, reporting, investigation, and control of infections and communicable diseases of residents, staff, and visitors. Oversight of and ensuring the requirements are met for the facility's antibiotic stewardship program. Review and or revise the facility's infection prevention and control program its standards, policies, and procedures annually and as needed for changes to the facility assessment to ensure they are effective and in accordance with current standards of practice for preventing and controlling infections. Provide infection control training for staff.</p> <p>The facility failed to employ a designated staff person as the Infection Preventionist who possessed the required certification, placing the residents at increased risk for infections.</p>