| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175241 | A. Building<br>B. Wing | 07/02/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Sabetha Manor | 1441 Oregon Street<br>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) |
|---|---|
| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42966<br><br>The facility identified a census of 29 residents. The sample included three residents. Based on observation, record review, and interviews, the facility failed to report an allegation of abuse between staff and Resident (R) 1 and an injury of unknown origin for R1 to the State Agency (SA) as required. This deficient practice placed R1 at risk for unidentified and ongoing abuse.<br><br>Findings included:<br><br>- R1's Electronic Medical Record (EMR) documented a diagnosis of dementia (a progressive mental disorder characterized by failing memory, and confusion) without behavioral disturbance.<br><br>The Significant Change Minimum Data Set (MDS) dated [DATE], documented R1 had a Brief Interview for Mental Status (BIMS) score of 13 which indicated intact cognition. R1 had no behaviors. R1 was dependent on staff assistance for activities of daily living (ADLs) except she required substantial/maximal assistance for upper body dressing. R1 received antiplatelet (medications that prevent platelets from sticking together and forming blood clots) medications.<br><br>The Functional Abilities Care Area Assessment (CAA) dated 03/18/24, documented R1 was dependent on staff assistance for all ADLs and mobility except upper body dressing.<br><br>R1's Care Plan, dated 05/24/16, documented an intervention, dated 06/27/23, that directed R1 wore arm-protecting sleeves that were applied when she woke up and were removed before she went to bed, R1 had bruising on both upper extremities due to thin skin and medications she took.<br><br>R1's Care Plan, dated 05/24/16, documented an intervention, last revised on 08/12/21, that directed R1 was unable to dress herself at times and preferred staff to assist her with all of her dressing needs.<br><br>In an undated Witness Statement, Certified Nurse Aide (CNA) M stated that on 06/21/24 around 07:00 AM, she checked on R1 to see if the resident wanted to get up for breakfast and R1 declined. Around 10:00 AM, R1's hospice nurse went to the nurse's station and asked about two big bruises on R1's left arm and if the staff knew how they got there. CNA M stated she told the hospice nurse she knew about the bruises on R1's right arm but not the ones on her left arm. CNA M stated she also told the hospice nurse that at times CNA N could be rough when transferring and rolling residents.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an undated Witness Statement, Licensed Nurse (LN) G stated on 06/21/24, R1's hospice nurse reported bruising on R1's left arm and asked LN G if R1 had a fall. According to R1's progress notes, she did not have a fall and the bruising was of unknown origin. LN G assessed R1's left arm and noted two large bruises with many smaller bruises present. The main bruises measured 7.5 centimeters (cm) by 4.5 cm and nine cm by 4. 5 cm.<br><br>The facility's investigation, dated 06/22/24, documented on 06/21/24 at approximately 11:17 AM, Administrative Staff A received a phone call from R1's hospice nurse who reported she noted increased bruising to R1's left arm and reported that a CNA stated the bruising may have been caused by CNA N being rough when turning R1. CNA N was immediately suspended, and the investigation was begun. On 06/20/24 at 02:35 PM, LN H noted scattered bruising on R1's arm. At approximately 10:00 AM on 06/21/24, the amount of bruising had increased on the left arm. As per R1's Care Plan, R1 was known to have scattered bruising on her arms. Regarding CNA M. who made a statement regarding CNA N, CNA M stated she was having a bad day and spouted off to the hospice nurse about CNA N but she had not witnessed CNA N being rough on 06/21/24. CNA N denied any rough handling of R1 and recited the proper interventions per R1's plan of care. There were no concerns noted regarding CNA N's treatment of residents. In an interview with CNA O, she stated that she and CNA P assisted R1 into the shower chair on 06/20/24 at 09:30 AM. CNA O stated R1 was leaning to the left while in the shower chair which was hard plastic and they attempted to correct the lean as much as possible using the lift sling. In an interview with CNA P, she stated she was called into the shower house by CNA O to assist with R1 who was leaning in her shower chair. CNA P stated R1 was leaning on her left arm on the shower chair, and they assisted R1 to off-load the left arm and correct R1's positioning in the shower chair. In conclusion, the investigation did not indicate concerns regarding abuse or neglect. The cause of the bruising was determined to be related to pressure from leaning on the shower chair combined with the fragile skin and long-term use of blood thinners. The investigation lacked evidence the facility reported the allegation of abuse to the SA.<br><br>R1's EMR revealed a Nurses Note on 06/21/24 at 10:49 AM that documented the hospice nurse reported bruising on R1's left arm. The bruising was of unknown origin and was a mix of black and purple. The main bruises were 7.5 cm by 4.5 cm and nine cm by 4.5 cm. The hospice nurse said she had to report bruising due to it being of unknown origin.<br><br>On 07/02/24 at 12:44 PM, R1 sat in her Broda chair (specialized wheelchair with the ability to tilt and recline) with Geri-sleeves (protective sleeves) in place. She stated she did not recall any bruising and felt safe in the facility.<br><br>On 07/02/24 at 11:29 AM, Administrative Staff A stated the facility did not find any abuse with R1 and did not report the allegation and bruising to the SA.<br><br>On 07/02/24 at 12:54 PM, CNA Q stated she reported any new bruising or injuries of unknown origin to the nurse immediately. She stated R1 mostly leans to her left side in her wheelchair.<br><br>On 07/02/24 at 12:57 PM, LN G stated for any new bruising she checked the charting for the bruising, asked around to see if anybody knew what happened, completed risk management, and notified Administrative Nurse D.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 07/02/24 at 01:01 PM, Administrative Nurse D stated she expected CNAs to notify the charge nurse if they found new bruising and she expected the charge nurse to assess the bruising and try to figure out how it happened then notify her of the bruising. She stated she notified Administrative Staff A to let her know what was going on and do an investigation if the bruising was of unknown origin. Administrative Nurse D stated the facility reported to the SA injuries of unknown origin if the investigation could not determine where the bruising or injury came from. She stated the timeframe for reporting to the SA was 24 hours or two hours depending on what it was. Administrative Nurse D stated if an allegation was brought to her, she made sure the resident was safe, suspended the staff if there was a name in the allegation, and started an investigation. Administrative Nurse D stated she would report abuse to the SA only if the investigation concluded there was possible abuse.<br><br>On 07/02/24 at 01:10 PM, Administrative Staff A stated she expected CNAs to tell the charge nurse of any new bruising or injuries of unknown origin who then notified her or Administrative Nurse D. She stated she then launched an investigation, if there was a suspicion of abuse, the employee was suspended pending investigation. She interviewed residents and staff and looked in the chart for any notes on when the bruising appeared. Administrative Staff A stated she reported to the SA if there was a finding of abuse or neglect. She stated the investigation on R1's bruising did not find any abuse, so it was not reported to the SA.<br><br>The facility's Abuse, Neglect, and Exploitation Policy and Procedure, updated 03/31/20, documented that any report of neglect or abuse made by a resident, family member, visitor, or employee was investigated within 24 hours. The Administrator, Director of Nursing (DON), or designee was notified immediately of the report. The investigation was conducted by the Administrator, DON, or any member of the administrative staff. The Administrator contacted the SA within 24 hours of the incident unless the incident met the definition of a crime against a person or resulted in serious bodily injury then the report was made directly to law enforcement and the SA no later than two hours after forming the suspicion. The investigation of the alleged or suspected violations was completed and submitted to the SA within five days.<br><br>The facility failed to report an allegation of abuse and an injury of unknown origin for R1 to the SA. This deficient practice placed R1 at risk for unresolved and ongoing abuse. |