STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175304	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2024

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 32358 The facility had a census of 48 residents, with three reviewed for the Center for Medicare and Medicaid Services (CMS) beneficiary liability notices. Based on record review and interview, the facility failed to provide a CMS Form 10055 which included the estimated costs for Resident (R) 32 and R41. This placed the residents at risk for uninformed decisions regarding skilled services. Findings included: - The Medicare Advance Beneficiary Notice (ABN) Form 10055 informed the beneficiaries that Medicare may not pay for future skilled therapy and did not provide an estimated cost to continue their services. The form included an option for the beneficiary to (1) receive specified services listed, and bill Medicare for an official decision on payment. I understand if Medicare does not pay, I will be responsible for payment, but can appeal to Medicare. (2) receive therapy listed, but do not bill Medicare, I am responsible for payment of services. (3) I do not want the listed services but lacked documentation regarding which option the residents choose. A review of the ABN Form 10055 provided to R32 (or their representative) lacked the estimated cost to continue services or which option R32 chose when the resident's skilled services ended on 04/09/24. A review of the ABN Form 10055 provided to R41 (or their representative) lacked the estimated cost to continue services and which option R41 chose when the resident's skilled services ended on 11/10/23. On 04/11/24 at 11:11 AM, Administrative Staff B stated she was responsible for providing the CMS Form 10055. Administrative Staff B verified the forms for R32 and R41 did not include the estimated cost to continue services or the option the residents or their representative chose. Administrative Staff B said she was unaware she was supposed to provide the estimated cost and said she must have missed the fact the residents or representatives had not chosen an option for the beneficiaries. On 04/11/24 at 11:11 AM, Administrative Staff A verified the facility lacked documentation staff provided the estimated cost on the ABN form. Upon request, the facility did not provide a policy regarding beneficiary notification. (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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to provide R32 and R41 with the estimated cost to continue services or the option chosen on the CMS Form 10055, placing the residents at risk for uninformed decisions regarding skilled services.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 32358 The facility had a census of 48 residents. The sample included 13 residents. Based on observation, record review, and interview the facility failed to provide a clean, comfortable, and homelike environment in Resident (R) 35's room. This placed the resident at risk for impaired comfort and dignity. Findings included: - On 04/09/24 at 08:10 AM, observation revealed R35 rested in bed with his eyes closed. There was an overwhelming urine odor in the room. R35's urinary catheter (a tube inserted into the bladder to drain the urine into a collection bag) was not visible. On 04/09/24 at 10:00 AM, R35's room door was open, and a strong urine odor was noted in the hall in front of R35's door to his room. Further observation revealed an approximately 12-inch (in) x 12-inch area of a yellowish wet spot visible on his sheet. R35 was not in his room. On 04/10/24 at 08:10 AM, observation revealed R35's door was closed, but an overwhelming urine odor was still evident by the entrance to his room. On 04/10/24 at 10:00 AM, observation revealed two maintenance staff cleaned R35's carpet and air-conditioner. There was a strong urine odor noted in the room. On 04/11/24 at 08:00 AM, R35's room door was closed, but a strong urine odor was noted by the door to his room. On 04/11/24 at 08:31 AM, observation revealed R35 sat up in bed with his glasses on. There was an overwhelming urine odor noted in the room. On 04/15/24 at 08;30 AM, observation revealed R35 rested in bed with his eyes open. There was a strong urine odor in the room. R35's clinical record including the plan of care lacked interventions or documentation regarding staff or facility efforts to decrease the urine odor in R35's room. On 04/11/24 at 01:17 PM, Licensed Nurse (LN) G) stated the urine odor in R35's room was from R35 emptying his urinary catheter bag. LN G said most of the time, the urine ended up on the floor. LN G said R35 refused to let staff assist him with emptying it. On 04/10/24 at 09:35 AM, Administrative Staff A verified the urine odor in R35's room and stated she was unaware of where the urine odor was coming from. Administrative Staff A said she would have maintenance clean the carpet and check the room out. On 04/10/24 at 10:16 AM, Administrative Nurse D stated R35 was fiercely independent and emptied his catheter bag himself. Administrative Nurse D said R35 frequently spilled urine on the carpet. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon request, the facility did not provide a room cleaning policy. The facility failed to provide a clean, comfortable, and homelike environment for R35. This placed the residents at risk for impaired comfort and dignity.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 41713 The facility identified a census of 48 residents. The facility had three medication carts. Based on observation, record review, and interview, the facility failed to ensure reconciliation of controlled medications (substances that have an accepted medical use, and have a potential for abuse, ranging from low to high, and may also lead to physical or psychological dependence) was completed consistently and per industry standards. This placed residents at risk of medication misappropriation. Findings included: - On 04/11/24 at 07:50 AM a review of the April 2024 Eight Hour Verification Controlled Substance Count sheet on the locked memory care unit revealed a missing signature either for the on-coming nurse signature or the off-going nurse signature on 13 of 62 opportunities. On 04/15/24 at 10:45 AM a review of the April 2024 Eight Hour Verification Controlled Substance Count sheet on the nurse's cart revealed a missing signature either for the on-coming nurse signature or the off-going nurse signature on four of 84 opportunities. On 04/15/24 at 10:50 AM a review of the April 2024 Eight Hour Verification Controlled Substance Count sheet on the medication aide's cart revealed a missing signature either for the on-coming nurse signature or the off-going nurse signature on 12 of 84 opportunities. On 04/11/24 at 07:50 AM Certified Medication Aide (CMA) R stated that the narcotic sign-on/off sheets should be signed by both the nurse and or medication aide when coming on shift or when going off shift after the narcotic count has been completed and reconciled by both staff. On 04/15/24 at 10:55 AM Licensed Nurse H stated that at the beginning or end of every shift, each staff member either coming on or going off their shift should be signing off that the count had been completed on the controlled narcotic medications. On 04/15/24 at 11:00 AM Administrative Nurse D stated she was aware that all the nursing staff passing medications had not been signing off and on for the narcotic counts as they should have been doing. Administrative Nurse D stated had just started a performance improvement project (PIP) to reconcile this issue. Administrative Nurse D stated the facility had not had an issue with controlled medications missing or the count being off on them. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Medication Storage-Controlled Meds policy last revised 10/08/21 documented that the nurse on duty who accepted the count would maintain possession of the key to the controlled medication storage areas at all times until the next count. The Count Reconciliation Log will be placed in front of each narcotic sign-out book. At the beginning of each narcotic count, count the number of medication accountability records to see that the number of count sheets matches the number on the reconciliation log. At each shift change, a physical inventory of controlled medications was to be conducted by two licensed/certified staff, one oncoming, and one offgoing, and was documented on the Eight Hour Verification Controlled Substances Count form. The Director of Nursing (DON) or designee should routinely complete an audit of controlled substances using the Weekly Narcotic Audit form. This audit was to ensure records were accurate and was a part of the community's Quality Assurance and Performance Improvement (QAPI) process. A record of the audit would be maintained in the quality assurance (QA) records. The facility failed to ensure an accurate reconciliation of controlled medications was completed. This placed residents at risk of medication misappropriation and diversion.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 32358 The facility had a census of 48 residents. The sample included 13 residents. Based on record review and interview, the facility failed to ensure the required members, including the infection preventionist, attended the Quality Assessment and Assurance (QAA) Committee meetings at least quarterly. This placed the residents who resided in the facility at risk for decreased quality of care. Findings included: - On 04/12/23, 07/19/23, 10/18/23, 01/24/24, the facility's Quarterly Quality Assurance Performance Improvement (QAPI) Meeting Attendance Sheets lacked evidence the designated infection preventionist attended the meetings. On 04/15/24 at 12:30 PM, Administrative Nurse D verified the lack of a designated infection preventionist signature on the quarterly meeting sign-in sheets and stated the facility had not employed an infection preventionist at the times of the quarterly meetings. The facility's Quality Assurance Process Improvement Plan (QAPI), revised 01/15/24 documented that the goal of the QAPI was to promote autonomy while maintaining safety and quality of care. The steering committee, comprised of department directors, would oversee the QAPI process and would meet monthly to prioritize and monitor the plans in place as well as new projects. The facility failed to ensure the required participants, including the infection preventionist, attended QAPI/QAA meetings at least quarterly. This placed residents at risk of decreased quality of care.