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	175304	A. BUILDING _____ B. WING _____	04/15/2024

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EMPORIA PRESBYTERIAN MANOR	2300 INDUSTRIAL ROAD EMPORIA, KS 66801

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #185446. The 2567 was sent electronically on 04/25/24.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.	F 582		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 04/25/2024

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(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.
(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.
This REQUIREMENT is not met as evidenced by:
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

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F 582	Continued From page 2	F 582		

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.

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F 582	Continued From page 3 Upon request, the facility did not provide a policy regarding beneficiary notification. 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.	F 582		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each	F 584		

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resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
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

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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.

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F 584	Continued From page 6 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. 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.	F 584		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F 755		

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§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
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.

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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.

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

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F 755	Continued From page 9 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.	F 755		
F 868 SS=F	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist.	F 868		

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§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:
(i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary.

§483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis.
This REQUIREMENT is not met as evidenced by:
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

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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.