STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175376	A. BUILDING _____ B. WING _____	12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APOSTOLIC CHRISTIAN HOME	511 PARAMOUNT STREET SABETHA, KS 66534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Compliant Investigation #166962 and #158621. The 2567 was electronically sent to the facility on 12/07/21.	F 000		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: The facility had a census of 65 residents. The sample included 16 residents. Based on observation, interview, and record review, the	F 761		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 12/07/2021

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.

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facility failed to label Resident (R) 6's, and R35's insulin (hormone which allows cells throughout the body to uptake glucose) pens with the date opened, expiration date and resident name in two of four medication carts.

Findings included:

- On 11/29/21 at 09:55 AM, observation of the North West medication cart, revealed R6's Humalog (a fast acting insulin that starts working faster and works for a shorter period of time than regular insulin) flex pen lacked a date opened, date of expiration, and resident name.

On 11/29/21 at 10:10 AM, observation of the South East medication cart, revealed R35's Levemir (a long acting insulin that can work for around 24 hours or longer) flex pen lacked a date opened, date of expiration, and resident name.

On 11/29/21 at 09:55 PM, Licensed Nurse (LN) G verified R6 received insulin daily, and the insulin flex pen lacked a date opened, a date of expiration, and/or a resident's name.

On 11/29/21 at 10:10 AM, LN H stated the nurses were to date the insulin pens/vials when opened, label with the resident's name, and discard expired medications.

The facility's "Pen Devices for Insulin Administration" policy, dated 01/11/21, documented staff would write on the label and the insulin flex pen date opened and the end date 28 days after opening.

The facility failed to label and date when opened, the expiration date and resident name, R6's

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F 761	Continued From page 2 Humalog flex insulin pen, and R35's Levemir flex pen, placing the residents at risk for receiving ineffective medications.	F 761		
F 801 SS=E	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he	F 801		

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F 801	Continued From page 3	F 801		

or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.
(iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.

§483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who-
(i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is:
(A) A certified dietary manager; or
(B) A certified food service manager; or
(C) Has similar national certification for food service management and safety from a national certifying body; or
D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and
(ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and
(iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional.
This REQUIREMENT is not met as evidenced by:

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F 801	Continued From page 4 The facility had a census of 65 residents. The sample included 16 residents. Based on observation, interview, and record review, the facility failed to employ a full time certified dietary manager for 43 residents who resided in the facility and received meals from the facility kitchen. Findings included: - On 11/29/21 at 10:00 AM, observation revealed Dietary Staff (DS) BB and DS CC serving food and preparing lunch for the residents. On 11/29/21 at 10:00 AM, DS BB and DS CC stated they were co-managers of dietary for the facility and verified neither was certified by the state as a certified dietary manager. On 12/02/21 at 03:30 PM, Administrative Staff A verified the facility should have a certified dietary manager. The facility's "Dietary Manager Certification" policy, dated January 2021, documented the facility required the dietary manager to be a full time employee and have either a Registered Dietician license or a Dietary Certification by the state of Kansas. The facility failed to employ a full time certified dietary manager for the 64 residents who resided in the facility and received meals from the facility kitchen, placing the residents at risk for receiving inadequate nutrition.	F 801		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		

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F 812	Continued From page 5 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: The facility had a census of 65 residents. The sample included 16 residents. Based on observation, interview, and record review, the facility failed to prepare and serve food in the facility kitchen under sanitary conditions. Findings included: - On 11/29/21 at 10:00 AM, observation in the facility kitchen revealed one large air unit above a food preparation area had blackish and gray substances on the air vents and the filter was full of blackish substance, with a small amount hanging down. Further observation revealed peeling ceiling paint around the air unit and a two-foot-long area of peeling paint over the bakery preparation area with an approximately 4-inch x 8-inch strip hanging down.	F 812		

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F 812	Continued From page 6 The "Kitchen Cleaning Schedule" documented the last staff entry dated 11/08/21. Review of the facility maintenance requests for the month of November 2021 revealed no requests for cleaning the vent in the kitchen or fixing the peeling paint. On 11/29/21 at 10:00 AM, Dietary Staff CC verified the dirty air vent and peeling paint areas in the kitchen and verified the last initialed entry on the cleaning schedule was 11/08/21. On 11/29/21 at 10:10 AM, Administrative Staff A verified the peeling paint and stated maintenance staff would clean the air unit. The facility's "Dietary Cleaning Procedures" policy, dated January 2021, documented staff were to report any defective equipment to the environmental department. Staff were to follow and document the Kitchen Cleaning Schedule Form. Staff members were responsible for checking the cleaning schedule daily to ensure tasks scheduled for that day are performed. Filters were to be cleaned monthly. The facility failed to prepare and serve food in a sanitary kitchen for the 64 residents who resided in the facility and received their meals from the facility kitchen, placing the residents at risk for food borne illness.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		

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infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and

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(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 65 residents. The sample included 16 residents. Based on observation, record review, and interview, the facility failed to prevent the development and transmission of infection when staff failed to properly store Resident (R)29 and R30's oxygen tubing and nasal cannula (a device used to deliver supplemental oxygen or increased airflow to a person in need of respiratory help).

Findings included:

- On 12/01/21 at 11:25 AM, observation revealed R29 and R30's oxygen tubing and nasal cannula,

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coiled up, unbagged, and placed under the handle of the oxygen concentrator in the East dining room.

On 12/02/21 at 11:00 AM, observation revealed R29 and R30's oxygen tubing and nasal cannula coiled up, unbagged, and placed under the handle of the oxygen concentrator in the East dining room.

On 12/02/21 at 11:10 AM, Administrative Nurse H stated R29 and R30 used their oxygen continuously and the facility had enough concentrators to place one in the resident's room and another concentrator was left in the dining room for the resident's use. Administrative Nurse H stated the staff should store the resident's nasal cannula and tubing in a plastic bag when not in use.

Upon request no policy was provide by the facility.

The facility failed to store R29 and R30's oxygen tubing and nasal cannula in a sanitary environment, placing the resident at risk for infection.