STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175241	A. Building B. Wing	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sabetha Manor	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)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility identified a census of 26 residents. The sample included four residents, with four residents reviewed for misappropriation of medications. Based on observations, record review, and interviews, the facility failed to ensure Resident (R) 1, R2, R3, and R4 remained free from misappropriation of medications. This deficient practice had the risk for missed medications and further misappropriation of medications for the affected residents.Findings included:- R1's Electronic Medical Record (EMR) documented an order with a start date of 05/24/25 for oxycodone (narcotic pain medication) five milligrams (mg) every 12 hours as needed (PRN) for breakthrough pain.R2's EMR documented an order with a start date of 02/24/25 for oxycodone five mg two times a day for pain.R3's EMR documented an order with a start date of 05/01/25 for fludrocortisone (corticosteroid medication used to treat pain and inflammation) 0.1 mg one time a day for hyperkalemia (high levels of potassium in the blood).R4's EMR documented an order with a start date of 11/26/24 for fludrocortisone 0.1 mg in the morning for corticosteroid.The facility's Investigation dated 06/03/25, documented on 05/26/25 around 06:35 PM, Licensed Nurse (LN) G and LN H completed narcotic count at change of shift and noted a small piece of tape on the back of the bubble pack. LN H notified Administrative Nurse D and Administrative Nurse E, who both arrived at the facility to investigate. Upon investigation, the facility noted a narcotic medication bubble pack had been tampered with, which involved a slit in the foil and a small piece of tape placed on the back of the bubble pack. R1's oxycodone was tampered with, and she missed eight tablets of oxycodone, which had been replaced with fludrocortisone tablets. R2's oxycodone was tampered with, and she missed 21 tablets of oxycodone, which had been replaced with fludrocortisone tablets. R3 was missing 16 tablets of fludrocortisone. R4 was missing eight tablets of fludrocortisone. The facility followed the narcotic count policy, but the minute change in the medication card was difficult to detect. The facility immediately started investigating, which included drug testing all staff who passed medications or were licensed nurses. The facility notified the police and immediately replaced the medications. The facility reviewed 24-hour video surveillance and noted suspicious footage of Certified Medication Aide (CMA) R. On 05/28/25, CMA R arrived for work, and the facility asked her to go to Administrative Staff A's office to meet with Administrative Staff A and Administrative Nurse D. The facility showed CMA R the video surveillance, and she offered no explanation of her actions on camera. The facility asked CMA R what she was doing in the video, and she responded that she did not know. The facility suspended CMA R pending investigation and later terminated her that day for refusing to provide information regarding the investigation.Upon request, the facility provided a timeline of the video surveillance, and Administrative Staff A confirmed on 07/24/25 at 02:18 PM that the video surveillance timeline only involved CMA R.The timeline documented on 05/21/25 at 11:37 AM, CMA R removed a medication card from the second drawer and popped medications out of the card. She moved the medical tape to the corner of the medication room, then retrieved something from the trash can. She put a new narcotic medication card into the narcotic box and retrieved a narcotic medication card from the narcotic box, and placed it on top of the medication cart. CMA R stood in the corner of the medication room with the medication card, then reopened the medication drawer and popped more medications out before returning the medication card in the corner. CMA R grabbed a spoon, put the medication card back in the drawer, grabbed a medication cup, then went to the bathroom. On 05/22/25 at 06:40 AM, CMA R opened the narcotic box in the medication cart and set a medication card on top of the medication cart. CMA R went into the corner of the medication room with the medication card then slipped a medication cup into her pocket. On 05/24/25 at 06:47 AM, CMA R opened the narcotic box and pulled a medication card out then went to the corner of the medication room. She grabbed a medication cup then put her cupped hand in her pocket and went to the bathroom. On 05/25/25 at 03:00 PM, CMA R grabbed a medication card from the second drawer and popped pills out with a spoon. She then taped the back of the card with medical tape and returned the card to the second drawer. On 05/26/25 at 06:40 AM, CMA R took a narcotic medication card out of the narcotic box and placed it on top of the medication cart. She retrieved something from the trash can then went to the bathroom. On 05/26/25 at 07:19 AM, CMA R retrieve a narcotic medication out of the narcotic box and popped the medication out of the bubble pack before returning the card to the narcotic drawer of the medication cart.On 07/17/25 at 01:08 PM, R4 laid in bed with her eyes closed.On 07/17/25 at 01:13 PM, R3 sat in her recliner in her room. She stated the facility told her that her medications had been taken, but she had no concerns from the incident. On 07/17/25 at 01:15 PM, R1 sat in her wheelchair in the day area and played bingo with other residents On