STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175264	A. BUILDING _____ B. WING _____	09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

(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 Facility Resurvey and investigation of complaint #151672, #164578, #162391,and #165215. This 2567 was elcetronically sent to the facility on 9/28/21.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the	F 561		

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

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F 561	Continued From page 1	F 561		

facility.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 30 residents with 15 residents sampled, including one resident reviewed for dignity. Based on observation, interview, and record review, the facility failed to provide dignity for one Resident (R)8, by failure to cover his indwelling urinary catheter bag (tube placed in the bladder to drain urine into a collection bag), leaving it exposed for others to see.

Findings included:

- The "Physician Order Sheet" (POS), dated 08/03/21, documented Resident (R)8 had a diagnosis of neuromuscular dysfunction of the bladder (bladder problems due to disease or injury of the central nervous system).

The annual "Minimum Data Set" (MDS), dated 01/07/21, documented the resident had a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. He required extensive assistance of two staff for toileting and had an indwelling urinary catheter.

The "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA), dated 01/07/21, documented the resident had a suprapubic catheter (catheter inserted directly into the bladder through the abdomen) for a diagnosis of neurogenic bladder.

The quarterly "MDS," dated 07/02/21, documented the resident had a BIMS score of 3, indicating severe cognitive impairment. He

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175264	A. BUILDING _____ B. WING _____	09/23/2021

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MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

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F 561	Continued From page 2	F 561		

required extensive assistance of two staff for toileting and had an indwelling urinary catheter.

The Activities of Daily Living (ADL) care plan, dated 07/02/21, instructed staff to perform catheter care every shift.

On 09/20/21 at 03:14 PM, the resident sat in his wheelchair in his room. His catheter collection bag hung underneath his wheelchair and lacked coverage with a dignity bag. The urine in the catheter collection bag was visible to anyone who walked past his room in the hallway.

On 09/21/21 at 08:30 AM, the resident sat in his wheelchair in the dining room eating breakfast. His catheter collection bag hung underneath his wheelchair and lacked coverage with a dignity bag. The urine in the catheter collection bag was visible to anyone in the dining room or in the hallway.

On 09/21/21 at 04:47 PM, the resident sat in his wheelchair in his room. His catheter collection bag hung underneath his wheelchair and lacked coverage with a dignity bag. The urine in the catheter collection bag was visible to anyone in the dining room or in the hallway.

On 09/21/21 at 04:47 PM, Certified Nurse Aide (CNA) O stated, staff would put the resident's catheter collection bag in the dignity bag when the resident was in bed. When the resident was up in his wheelchair, staff would hang the bag underneath his wheelchair without coverage of a dignity bag.

On 09/22/21 at 01:57 PM, Licensed Nurse (LN)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175264	A. BUILDING _____ B. WING _____	09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

(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 561	Continued From page 3 G stated, the resident's catheter collection bag should be kept in a dignity bag at all times. On 09/23/21 at 08:44 AM, Administrative Nurse D stated, it was the expectation for staff to put the catheter collection bag in a dignity bag at all times to protect the dignity of the resident. The facility lacked a policy regarding the use of dignity bags for indwelling catheter collection bags. The facility failed to provide dignity with coverage, for this dependent resident's urine in the indwelling urinary catheter collection bag.	F 561		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175264	A. BUILDING _____ B. WING _____	09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

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F 656	Continued From page 4	F 656		

(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 30 residents with 15 selected for review. Based on observation, interview and record review, the facility failed to ensure the development of an individualized comprehensive care plan for activities for three sampled residents (R)79, R 23 and R15.

Findings included:

- Review of R 79's "Physician Order Sheet," dated 09/08/21 revealed the resident admitted to the facility on 08/31/21, with diagnoses that included senile degeneration (progressive mental disorder characterized by failing memory, confusion), diabetes (when the body cannot use

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175264	A. BUILDING _____ B. WING _____	09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

(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 656	Continued From page 5	F 656		

glucose, not enough insulin made, or the body cannot respond to the insulin), and hypothyroidism (condition characterized by hyperactivity of the thyroid gland).

The "Admission Minimum Data Set" (MDS,) dated 09/06/21, assessed the resident with severe cognitive impairment, and verbal behavior directed toward others, on one to three days, of the seven day look back period. The resident required extensive assistance for mobility with impairment in functional range of motion in both sides of the lower extremities. The resident received five days of antipsychotic, and antianxiety medications during the seven day look back period.

The" Activity Care Area Assessment" (CAA), dated 09/06/21, assessed the resident with severe impaired cognitive function and a diagnosis of unspecified dementia the resident had a diagnosis of unspecified dementia (progressive mental disorder characterized by failing memory, confusion), with behaviors. The resident had clear speech and usually understood staff. The resident had agitation and anxiety and yelled at staff. One-on-one activities will be offered to the resident.

The "Care Plan," reviewed 09/16/21, instructed staff to encourage the resident to attend activities and become integrated and involved with life in the facility. Staff instructed to encourage the resident to visit with other residents and attend activities to keep busy. The care plan lacked individualized interventions for activities of interest for this resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175264	A. BUILDING _____ B. WING _____	09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

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F 656	Continued From page 6	F 656		

Observation, on 09/20/21 at 08:00 AM, revealed the resident positioned in his wheelchair in the common tv area, with his eye closed. The resident responded to his name by opening his eyes slowly.

Observation, on 09/20/21 at 10:00 AM, revealed the resident continued seated in his wheelchair in the common tv area with his eyes closed. The tv was playing a country western music advertising commercial.

Observation, on 09/21/21 at 12:10 PM, revealed the resident opened his eyes during the noon meal, but remained somnolent while CNA M fed the resident.

Interview, on 09/21/21 at 12:52 PM, with CNA N revealed she did not know what activity staff should provide to the resident.

Interview, on 09/21/21 at 04:00 PM with CNA P, revealed the resident had yelling behaviors when first admitted, but now was cooperative and sleepy most of the time. CNA P did not know what activities staff provided to the resident.

Interview on 09/23/21 at 09:15 AM, with Licensed Nurse (LN) G, revealed the resident had yelling behaviors when first admitted, but now was somnolent through the day. LN G did not know what activities staff provided to the resident as he did sit in his wheelchair in the common tv area but did not know if he listened to the tv.

Interview, on 09/23/21 at 10:45 AM, with Administrative Nurse D, revealed she would expect staff to provide activities to the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175264	A. BUILDING _____ B. WING _____	09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

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F 656	Continued From page 7	F 656		

Interview, on 09/23/21 at 9:00 AM with Administrative Nurse F, revealed staff should provide one on one activities for the resident, and the resident did not attend bingo or group activities. Administrative Nurse F stated staff developed the "Care Plan" for activities based on the MDS, CAA and family interview.

The facility used the RAI (resident assessment instrument) manual for the care plan development.

The facility failed to provide this dependent confused resident with a comprehensive individualized care plan for activities to enhance the quality of his life.

- Review of resident (R)23's "Physician Order Sheet," dated 09/10/21, revealed diagnoses included history of COVID-19, bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods) and dementia (a progressive mental disorder characterized by failing memory, confusion.)

The "Significant Change Minimum Data Set" (MDS), dated 08/19/21, assessed the resident with severe impairment of cognitive function. The resident's preferences per staff interview revealed the resident liked animals, music, groups, outdoor and religious activities. The resident required extensive assistance of two staff for transfer and bed mobility and was dependent of staff for locomotion.

The "Activities Care Area Assessment "(CAA),

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175264	A. BUILDING _____ B. WING _____	09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

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F 656	Continued From page 8	F 656		

dated 08/19/21, assessed the resident with severe impaired cognitive function with clear speech, usually understands and was usually understood. The resident required total assistance with activities of daily living and was on hospice services. Staff to offer one on one activities.

The "Care Plan," reviewed 09/13/21, instructed staff to remind the resident of activities and allow the resident to attend activities/participate at her choice. The resident likes to join the bingo and move and stretch activity. The care plan lacked activities for the significant change in the resident's status.

Observation, on 09/20/21 at 8:30 AM, revealed the resident seated in her wheelchair in the assistive feeding room. The resident attempted to hold her cup and drink out of it. The resident responded to Certified Nurse Aide (CNA) MM who assisted the resident to drink from her cup.

Observation, on 09/20/21, at 10:00 AM, revealed the resident seated in her wheelchair, in the common tv area. The resident's eyes were closed, and she dropped a stuffed puppy onto the floor. The activity bingo was taking place in the dining area.

Interview, on 09/21/21 at 03:00 PM, with CNA M revealed the resident does not attend activities and did not watch/listen to tv.

Interview, on 09/21/21 at 4:20 PM with CNA P, revealed staff got the resident out of bed for supper last, and returned her to bed first after the evening meal due to fall risk. CNA P did not know

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175264	A. BUILDING _____ B. WING _____	09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

(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 656	Continued From page 9	F 656		

what activities the staff should provide to the resident.

Interview, on 09/22/21 at 12:18 PM, with Activity Staff Z, revealed the resident did not talk much, and did hold onto a stuffed dog. The resident liked to look out a window and used to like looking at the birds in the cage in the dining room when she used to wait for bingo to start. Activity Staff Z revealed she did not provide an activity of watching the birds.

Interview, on 09/23/21 at 08:46 AM with Administrative Nurse D, revealed she would expect some activity for the resident and provide an appropriate care plan

Interview, on 09/23/21 at 9:00 AM with Administrative Nurse F, revealed staff should provide one on one activities for the resident, and the resident did not attend bingo or group activities since her significant change in status after COVID-19 illness. Administrative Nurse D confirmed the care plan for the significant change in status did not update to reflect the resident's current status.

The facility used the RAI (resident assessment instrument) manual for the care plan development.

The facility failed to provide this dependent confused resident with a comprehensive individualized activity care plan to enhance the quality of her life.

- Review of resident (R) 15's "Physician Order

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175264	A. BUILDING _____ B. WING _____	09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

(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 656	Continued From page 10	F 656		

Sheet," dated 09/22/21, revealed diagnoses included Alzheimer's dementia (progressive mental deterioration characterized by confusion and memory failure) traumatic brain injury and depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness.)

The "Admission Minimum Data Set" (MDS), dated 07/02/21, assessed the resident had severe cognitive impairment. Staff assessed the resident's activity preferences as listening to music and going outside, being around animals and groups of people and religious services.

The "Psychosocial Care Area Assessment" (CAA), dated 07/02/21, assessed the resident had clear speech at times and understood verbal communications.

The "Care Plan," reviewed 08/13/21, instructed staff the resident had cognitive loss that affected her memory and the resident needed to develop a trusting therapeutic relationship with others. Staff need to establish a regular daily schedule. The care plan lacked individualized activities for the resident.

Observation, on 09/20/21 at 10:00 AM, revealed the resident in her wheelchair in the common tv area. The resident made repetitive monotonal noises and did not focus on the television. Staff provided residents with bingo in the dining room at that time.

Observation, on 09/21/21 at 08:30 AM, revealed the resident seated in her wheelchair in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175264	A. BUILDING _____ B. WING _____	09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

(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 656	Continued From page 11 assisted dining room. The resident had word salad and had repetition of noises. The resident propelled herself around the table and touched objects on the table. Interview, on 09/22/21 at 12:15 PM with Activity Staff Z, revealed the resident was unable to verbalize activity preferences and could not complete an activity assessment as family did not come in to interview. Activity Staff Z stated the resident liked to hold a baby doll at times and thought staff provided laundry for the resident to fold, but she dropped the items on the floor. Activity Staff Z stated she thought about a keyboard for the resident. Interview on 09/23/21 at 08:46 AM, with Administrative Nurse D, revealed she would expect staff to provide activities to the resident. Interview, with Administrative Nursing staff E, revealed the care plan was developed after the MDS assessment completed and should include activities of interest for the resident. The facility used the RAI (resident assessment instrument) manual for the care plan development. The facility failed to provide a comprehensive care plan for individualized activities for this confused resident activities to enhance the quality of her life.	F 656		
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on	F 679		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175264	A. BUILDING _____ B. WING _____	09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

(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 679	Continued From page 12	F 679		

the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 30 residents with 15 residents sampled, including six residents reviewed for activities. Based on observation, interview, and record review, the facility failed to provide an ongoing program of individualized activities for five Residents (R)5, R 8, R 15, R 23, R 79, of the six sampled residents.

Findings included:

- The "Physician Order Sheet" (POS), dated 08/03/21, for Resident (R)5, documented diagnoses which included: anxiety (a feeling of worry, nervousness, or unease, typically about an imminent event or something with an uncertain outcome) and muscle weakness.

The annual "Minimum Data Set" (MDS), dated 03/28/21, documented the resident had a Brief Interview for Mental Status (BIMS) score of 7, indicating impaired cognition. It was somewhat important to do her favorite activities, go outside to get fresh air and participate in religious services. She required extensive assistance of one staff for locomotion on and off of the unit.

The "Activities Care Area Assessment" (CAA),

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175264	A. BUILDING _____ B. WING _____	09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

(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 679	Continued From page 13	F 679		

dated 03/28/21, documented the resident had a diagnosis of a cerebral infarct (stroke-damage to tissues in the brain due to a loss of oxygen to the area) and for staff to offer activities to the resident.

The quarterly "MDS," dated 06/24/21, documented the resident had a BIMS score of 7, indicating impaired cognition. She required total assistance of one staff on and off of the unit. She was always incontinent of bowel and bladder.

The care plan for activities, dated 06/18/21, instructed staff that the resident enjoyed talking with her family and 1:1 visits.

Review of the resident's electronic medical record (EMR), under the "Tasks" tab, revealed one time of a staff member having a conversation with the resident. No other activities were documented as provided for the resident from 08/23/21 through 09/29/21.

Review of the resident's "Activity Assessment", dated 09/15/21, located under the "Assessment" tab of the resident's EMR, included the resident enjoyed reading her bible, visiting, learning classes and entertainment. She enjoyed watching TV and listing to the radio.

On 09/21/21 at 10:51 AM, the resident sat in her wheelchair in her room. The TV was on, however, the resident was not watching it.

On 09/20/21 at 01:00 PM, an activity of "Book Reading" took place in the facility. Staff did not invite the resident to attend.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175264	A. BUILDING _____ B. WING _____	09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

(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 679	Continued From page 14	F 679		

On 09/22/21 at 10:00 AM, an activity of "Bingo" took place in the facility. Staff did not invite the resident to attend.

On 09/20/21 at 01:37 PM, Certified Nurse Aide (CNA) MM stated, the resident did not participate in activities.

On 09/20/21 at 01:37 PM, CNA Q stated, the resident did not participate in activities because she was not able to do much on her own.

On 09/21/21 at 04:20 PM, CNA O stated, the resident did not go to any activities in the facility.

On 09/22/21 at 12:07 PM, CNA NN stated, activities are all documented in the resident's EMR. She does as much 1:1 with the residents as she can. At this time, there are not many activities for residents who require assistance.

On 09/22/21 at 01:57 PM, Licensed Nurse (LN) G stated, the facility did not offer many activities for resident's who were unable to do things on their own.

On 09/23/21 at 08:44 AM, Administrative Nurse D stated, it was the expectation for dependent residents to have some type of stimulation.

The facility lacked an activities policy.

The facility failed to provide an ongoing program of individualized activities for this dependent resident.

- The "Physician Order Sheet" (POS), dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175264	A. BUILDING _____ B. WING _____	09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

(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 679	Continued From page 15	F 679		

08/03/21, documented Resident (R)8 had diagnoses which included: Parkinson's disease (slowly progressive neurological disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness) and schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought).

The annual "Minimum Data Set" (MDS), dated 01/07/21, documented the resident had a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. It was somewhat important for him to listen to music he liked, be around animals such as pets, to keep up with the news, and to go outside when the weather was good. He required total assistance of one staff for locomotion on and off of the unit.

The "Activities Care Area Assessment", dated 01/07/21, did not trigger.

The quarterly "MDS," dated 07/02/21, documented the resident had a BIMS score of 3, indicating severely impaired cognition. He required extensive assistance of one staff for locomotion on and off of the unit.

The activities care plan, dated 07/02/21, instructed staff to remind and encourage the resident to attend activities. Staff were to ensure the resident had an activity calendar in his room. Staff were to offer to visit with him 1:1 each day to encourage him to join in a group activity.

Review of the resident's electronic medical record (EMR), under the "Tasks" tab, revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175264	A. BUILDING _____ B. WING _____	09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

(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 679	Continued From page 16	F 679		

the resident participated in conversation with staff twice from 08/24/21 thorough 09/21/21. No other activities were documented as provided for the resident.

Review of the "Activity Assessment", located in the resident's electronic medical record (EMR), dated 07/06/21, included that the resident enjoyed church services, visiting with others, entertainment, country music and pet visits.

On 09/21/21, 09/22/21, and 09/23/20 at 10:00 AM, an activity of Bingo took place in the facility. Staff did not invite the resident to attend.

On 09/20/21 at 03:14 PM, the resident sat in his darkened room with his eyes open. The TV was turned off, no music was playing, no activity calendar was in his room.

On 09/21/21 at 04:47 PM, Certified Nurse Aide (CNA) O stated, the resident did not participate in activities.

On 09/22/21 at 12:07 PM, CNA NN stated, activities are all documented in the resident's EMR. Shee does as much 1:1 with the residents as she can. At this time, there are not many activities for residents who require assistance.

On 09/22/21 at 01:57 PM, Licensed Nurse (LN) G stated, in the past, the resident participated in activities all of the time, especially Bingo. Currently, there are not many activities available for resident's who aren't able to do things on their own.

On 09/23/21 at 08:44 AM, Administrative Nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175264	A. BUILDING _____ B. WING _____	09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

(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 679	Continued From page 17	F 679		

D stated, it was the expectation for dependent residents to have some type of stimulation.

The facility lacked an activities policy.

The facility failed to provide an ongoing program of individualized activities for this dependent resident.

- Review of R 79's "Physician Order Sheet," dated 09/08/21 revealed the resident admitted to the facility on 08/31/21, with diagnoses that included senile degeneration (progressive mental disorder characterized by failing memory, confusion), diabetes (when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin), and hypothyroidism (condition characterized by hyperactivity of the thyroid gland).

The "Admission Minimum Data Set" (MDS,) dated 09/06/21, assessed the resident with severe cognitive impairment, and verbal behavior directed toward others, on one to three days, of the seven day look back period. The resident required extensive assistance for mobility with impairment in functional range of motion in both sides of the lower extremities. The resident received five days of antipsychotic, and antianxiety medications during the seven day look back period.

The" Activity Care Area Assessment" (CAA), dated 09/06/21, assessed the resident with severe impaired cognitive function and a diagnosis of unspecified dementia the resident had a diagnosis of unspecified dementia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175264	A. BUILDING _____ B. WING _____	09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

(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 679	Continued From page 18	F 679		

(progressive mental disorder characterized by failing memory, confusion), with behaviors. The resident had clear speech and usually understood staff. The resident had agitation and anxiety and yelled at staff. One-on-one activities will be offered to the resident.

The "Care Plan," reviewed 09/16/21, instructed staff to encourage the resident to attend activities and become integrated and involved with life in the facility. Staff instructed to encourage the resident to visit with other residents and attend activities to keep busy.

Observation, on 09/20/21 at 08:00 AM, revealed the resident positioned in his wheelchair in the common tv area, with his eye closed. The resident responded to his name by opening his eyes slowly.

Observation, on 09/20/21 at 10:00 AM, revealed the resident continued seated in his wheelchair in the common tv area with his eyes closed. The tv was playing a country western music advertising commercial.

Observation, on 09/21/21 at 12:10 PM, revealed the resident opened his eyes during the noon meal, but remained somnolent while CNA M fed the resident.

Observation, on 09/21/21 at 12:52 PM, revealed CNA O and CNA N transferred the resident to bed with the mechanical lift. The resident remained somnolent. Interview with CNA N revealed she did not know what activity staff should provide to the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175264	A. BUILDING _____ B. WING _____	09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

(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 679	Continued From page 19	F 679		

Interview, on 09/21/21 at 04:00 PM with CNA P, revealed the resident had yelling behaviors when first admitted, but now was cooperative and sleepy most of the time.

Interview on 09/23/21 at 09:15 AM, with Licensed Nurse (LN) G, revealed the resident had yelling behaviors when first admitted, but now was somnolent through the day. LN G did not know what activities staff provided to the resident as he did sit in his wheelchair in the common tv area but did not know if he listened to the tv.

Interview, on 09/23/21 at 10:45 AM, with Administrative Nurse D, revealed she would expect staff to provide activities to the resident.

Interview, on 09/23/21 at 9:00 AM with Administrative Nurse F, revealed staff should provide one on one activities for the resident, and the resident did not attend bingo or group activities.

The facility did not provide a policy for activities.

The facility failed to provide this dependent resident with activity to enhance the quality of her life.

- Review of resident (R)23's "Physician Order Sheet," dated 09/10/21, revealed diagnoses included history of COVID-19, bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods) and dementia (a progressive mental disorder characterized by failing memory, confusion.)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175264	A. BUILDING _____ B. WING _____	09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

(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 679	Continued From page 20	F 679		

The "Significant Change Minimum Data Set" (MDS), dated 08/19/21, assessed the resident with severe impairment of cognitive function. The resident's preferences per staff interview revealed the resident liked animals, music, groups, outdoor and religious activities. The resident required extensive assistance of two staff for transfer and bed mobility and was dependent of staff for locomotion.

The "Activities Care Area Assessment "(CAA), dated 08/19/21, assessed the resident with severe impaired cognitive function with clear speech, usually understands and was usually understood. The resident required total assistance with activities of daily living and was on hospice services. Staff to offer one on one activities.

The "Care Plan," reviewed 09/13/21, instructed staff to remind the resident of activities and allow the resident to attend activities/participate at her choice. The resident likes to join the bingo and move and stretch activity.

Observation, on 09/20/21 at 8:30 AM, revealed the resident seated in her wheelchair in the assistive feeding room. The resident attempted to hold her cup and drink out of it. The resident responded to Certified Nurse Aide (CNA) MM who assisted the resident to drink from her cup.

Observation, on 09/20/21, at 10:00 AM, revealed the resident seated in her wheelchair, in the common tv area. The resident's eyes were closed, and she dropped a stuffed puppy onto the floor. The activity bingo was taking place in the dining area.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175264	A. BUILDING _____ B. WING _____	09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

(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 679	Continued From page 21 Interview, on 09/21/21 at 03:00 PM, with CNA M revealed the resident does not attend activities and did not watch/listen to tv. Interview, on 09/21/21 at 4:20 PM with CNA P, revealed staff got the resident out of bed for supper last, and returned her to bed first after the evening meal due to fall risk. Interview, on 09/22/21 at 12:18 PM, with Activity Staff Z, revealed the resident did not talk much, and did hold onto a stuffed dog. The resident liked to look out a window and used to like looking at the birds in the cage in the dining room when she used to wait for bingo to start. Activity Staff Z revealed she did not provide an activity of watching the birds. Interview, on 09/23/21 at 08:46 AM with Administrative Nurse D, revealed she would expect some activity for the resident. Interview, on 09/23/21 at 9:00 AM with Administrative Nurse F, revealed staff should provide one on one activities for the resident, and the resident did not attend bingo or group activities since her significant change in status after COVID-19 illness. The facility did not provide a policy for activities. The facility failed to provide this dependent resident with activity to enhance the quality of her life. - Review of resident (R) 15's "Physician Order	F 679		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175264	A. BUILDING _____ B. WING _____	09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

(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 679	Continued From page 22	F 679		

Sheet," dated 09/22/21, revealed diagnoses included Alzheimer's dementia (progressive mental deterioration characterized by confusion and memory failure) traumatic brain injury and depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness.)

The "Admission Minimum Data Set" (MDS), dated 07/02/21, assessed the resident had severe cognitive impairment. Staff assessed the resident's activity preferences as listening to music and going outside, being around animals and groups of people and religious services.

The "Psychosocial Care Area Assessment" (CAA), dated 07/02/21, assessed the resident had clear speech at times and understood verbal communications.

The "Care Plan," reviewed 08/13/21, instructed staff the resident had cognitive loss that affected her memory and the resident needed to develop a trusting therapeutic relationship with others. Staff need to establish a regular daily schedule. The care plan lacked specific activities for the resident.

Observation, on 09/20/21 at 10:00 AM, revealed the resident in her wheelchair in the common tv area. The resident made repetitive monotonal noises and did not focus on the television. Staff provided residents with bingo in the dining room at that time.

Observation, on 09/21/21 at 08:30 AM, revealed the resident seated in her wheelchair in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175264	A. BUILDING _____ B. WING _____	09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

(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 679	Continued From page 23 assisted dining room. The resident had word salad and had repetition of noises. The resident propelled herself around the table and touched objects on the table. Interview, on 09/22/21 at 12:15 PM with Activity Staff Z, revealed the resident was unable to verbalize activity preferences and could not complete an activity assessment as family did not come in to interview. Activity Staff Z stated the resident liked to hold a baby doll at times and thought staff provided laundry for the resident to fold, but she dropped the items on the floor. Activity Staff Z stated she thought about a keyboard for the resident. Interview on 09/23/21 at 08:46 AM, with Administrative Nurse D, revealed she would expect staff to provide activities to the resident. The facility did not provide a policy for activities. The facility failed to provide this confused resident with activity to enhance the quality of her life.	F 679		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175264	A. BUILDING _____ B. WING _____	09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

(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 690	Continued From page 24	F 690		

comprehensive assessment, the facility must ensure that-
(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;
(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and
(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 30 residents with 15 residents sampled, including two residents sampled for bowel and bladder incontinence. Based on observation, interview, and record review, the facility failed to provide appropriate peri-care (cleansing of genitals and anal area) to prevent urinary tract infections for one of the two sampled residents, Resident (R)5.

Findings included:

- The "Physician Order Sheet" (POS), dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175264	A. BUILDING _____ B. WING _____	09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

(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 690	Continued From page 25	F 690		

08/03/21, documented Resident (R)5 had a diagnosis of muscle weakness.

The annual "Minimum Data Set" (MDS), dated 03/28/21, documented the resident had a Brief Interview for Mental Status (BIMS) score of 7, indicating severe cognitive impairment. The resident required extensive assistance of two staff for toilet use and she was always incontinent of bowel.

The "Activities of Daily Living Functional/Rehabilitation Potential Care Area Assessment" (CAA), dated 03/28/21, documented the resident required staff assistance of two for toilet use.

The "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA), dated 03/28/21, documented the resident was incontinent of bowel and wore briefs for protection.

The care plan for incontinence, dated 06/18/21, instructed staff to provide peri-care as needed (PRN).

Review of the resident's electronic medical record (EMR), under the "Tasks" tab, included the resident had several incontinent bowel movements (BM) from 08/25/21 through 09/22/21 which required 1-2 staff for assistance with peri-care.

On 09/20/21 at 01:37 PM, Certified Nurse Aides (CNA) Q and MM, entered the resident's room to perform peri-care following a bowel incontinence episode. The staff removed the resident's brief,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175264	A. BUILDING _____ B. WING _____	09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

(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 690	Continued From page 26 dirty with a large amount of loose BM, and began to clean the resident. Both staff used one wipe for multiple swipes of the BM while cleaning the resident. Staff would wipe the resident from back to front during the hygiene cares. On 09/20/21 at 01:37 PM, CNA MM stated, he would use one wipe for multiple swipes when performing peri-care at times, depending on how much of a hurry he was in and also to conserve the wipes. CNA confirmed he had wiped the resident with a motion from the back through to the front a few times due to being in a hurry. On 09/20/21 at 01:37 PM, CNA O stated, she would swipe more than once with a wipe, but would fold the wipe in between swipes. On 09/22/21 at 01:57 PM, Licensed Nurse (LN) G stated, when doing peri-care staff should only use one wipe per one swipe. The facility does not have a shortage of supplies. There are plenty of wipes. On 09/23/21 at 08:44 AM, Administrative Nurse D stated, when doing peri-care staff are expected to wipe front to back and use one wipe for one swipe. Wipes should not be folded and reused. The facility does not have a shortage of supplies. The facility lacked a policy for peri-care. The facility failed to provide appropriate peri-care hygiene to prevent urinary tract infections, for this dependent resident with bowel incontinence.	F 690		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175264	A. BUILDING _____ B. WING _____	09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

(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 758	Continued From page 27	F 758		

§483.45(e) Psychotropic Drugs.
§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175264	A. BUILDING _____ B. WING _____	09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

(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 758	Continued From page 28	F 758		

rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
The reported a census of 30 resident with 15 selected for review, which included five residents reviewed for unnecessary medications. Based on observation, interview and record review, the facility failed to ensure monitoring and diagnoses for resident (R)79's antipsychotic and anxiolytic (medication used for anxiety) medication and failed to ensure one resident R80 received reevaluation for as needed doses of Ambien and Valium, which continued past the 14-day limitation as required, to ensure the residents did not received medications with adverse side effects.

Findings included:

- Review of R 79's "Physician Order Sheet," dated 09/08/21 revealed the resident admitted to the facility on 08/31/21, with diagnoses that included senile degeneration (progressive mental disorder characterized by failing memory, confusion), diabetes (when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin), and hypothyroidism (condition characterized by hyperactivity of the thyroid gland).

The "Admission Minimum Data Set" (MDS,)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175264	A. BUILDING _____ B. WING _____	09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

(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 758	Continued From page 29	F 758		

dated 09/06/21, assessed the resident with severe cognitive impairment, and verbal behavior directed toward others on one to three days of the seven day look back period. The resident required extensive assistance for mobility with impairment in functional range of motion in both sides of the lower extremities. The resident received five days of antipsychotic, and antianxiety medications during the seven day look back period.

The Cognitive Loss Care Area Assessment"" (CAA), dated 09/06/21, assessed the resident with a diagnosis of unspecified dementia with behaviors. The resident had agitation and anxiety and yells at staff.

The "Psychotropic Drug Use" CAA, dated 09/06/21, assessed the resident had Haloperidol (an antipsychotic medication used to treat schizophrenia [psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought] and when used with other medications may cause increased sedation), 2 milligrams (mg), three times a day, for agitation and also Lorazepam (a medication to decrease anxiety), 0.5 mg, every four hours, for agitation and anxiety.

The "Care Plan," revised 09/16/21, instructed staff the resident took multiple medications with a "Black Box Warning" (a warning by the Food and Drug Administration for certain medications that carry serious safety risks. Often these warnings communicate potential rare but dangerous side effects, or they may be used to communicate important instructions for safe use of the drug.)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175264	A. BUILDING _____ B. WING _____	09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

(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 758	Continued From page 30	F 758		

which placed him at potentially higher risk for adverse reactions. Staff instructed to observe/report any changes in mental status/mood/behavior caused by situational stressor. Staff instructed to provide a calm and safe environment to allow the resident to express feelings as needed, provide reassurance and monitor for psychosocial changes. Staff instructed to ask the resident why he wandered as he may want something that staff can help him with or reassure him and redirect him from exit seeking behavior. The resident may have pain, hunger or need to toilet.

The "Physician's Orders" revealed the following:

On 08/31/21, Haldol 1 milligram (mg) every (Q)8 hours (hr.) as needed (PRN) for delirium (sudden severe confusion, disorientation and restlessness) agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition) and hallucination (sensing things while awake that appear to be real, but the mind created). The resident received a total of four doses from 08/31/21 through 09/04/21.

On 08/31/21, Lorazepam (an antianxiety medication) 0.5 mg, every four hours for agitation. The resident received 10 doses from 08/31/21 through 09/08/21 and this order was discontinued on 09/08/21.

On 09/04/21, Haldol 2 mg, TID (three times a day) for agitation.

On, 09/09/21, Lorazepam 1 mg, every four hours, then discontinued one day later, on 09/10/21.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175264	A. BUILDING _____ B. WING _____	09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

(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 758	Continued From page 31	F 758		

On 09/10/21, Lorazepam 0.5 mg every four hours, then discontinued 13 days later, on 09/23/21.

On 09/23/21, Lorazepam 0.5 mg every six hours.

Review of the medical record revealed a lack of monitoring for extrapyramidal ((physical symptoms, including tremor, slurred speech, akathisia (inability to sit still constant movement), dystonia (involuntary muscle contractions that cause slow repetitive movements , anxiety, distress, paranoia (feeling persecuted), and bradyphrenia (slowed thinking and processing of information, that are primarily associated with improper dosing of or unusual reactions to neuroleptic (antipsychotic) medications) side effects of Haldol.

Review of the "Behavior Monitoring" in Point of Care electronic medical record, from 08/31/21 through 09/22/21, revealed one episode of yelling on 09/03/21 with no other behaviors documented.

Review of the "Progress Notes" from 08/31/21 through 09/21/21, in the electronic medical record, revealed a lack of notation of the resident's behaviors.

Observation, on 09/20/21 at 08:00 AM, revealed the resident positioned in his wheelchair in the common tv area, with his eye closed. The resident responded to his name by opening his eyes slowly.

Observation, on 09/21/21 at 7:56 AM, revealed the resident seated in his wheelchair in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175264	A. BUILDING _____ B. WING _____	09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

(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 758	Continued From page 32	F 758		

common tv area with his eye closed, moaning at times and sliding forward in his wheelchair. Certified Nurse Aide (CNA) O and Certified Medication Aide (CMA) R repositioned the resident in his wheelchair with the use of the lift sling. The resident minimally responded. CMA R stated the resident has had behaviors of yelling at the staff, but today the resident had no behaviors. The resident continued to remain seated in his wheelchair with his eyes closed. CMA R stated the medications made the resident sleepy.

Observation, on 09/21/21 at 09:00 AM, revealed CMA R propelled the resident to the dining room for breakfast. CNA M fed the resident his breakfast. CNA M stated at that time that the resident had aggressive behavior when he first admitted to the facility, but now was cooperative.

Observation, on 09/21/21 at 12:10 PM, revealed the resident opened his eyes during the noon meal, but remained somnolent while CNA M fed the resident.

Observation, on 09/21/21 at 12:52 PM, revealed CNA O and CNA N transferred the resident to bed with the mechanical lift. The resident remained somnolent. CMA R and CNA N provided incontinence care for urine and stool. The resident required assistance to turn and reposition.

Interview, on 09/21/21 at 12:52 PM, with CNA O, revealed when the resident first admitted he was very confused and wanted to go home and yelled at the staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175264	A. BUILDING _____ B. WING _____	09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

(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 758	Continued From page 33	F 758		

Interview, on 09/21/21 at 04:00 PM with CNA P, revealed the resident had yelling behaviors when first admitted, but now was cooperative and sleepy most of the time.

Interview on 09/23/21 at 09:15 AM, with Licensed Nurse (LN) G, revealed the resident had yelling behaviors when first admitted, but now was somnolent through the day.

Interview, on 09/23/21 at 10:45 AM, with Administrative Nurse D, revealed the resident should have the monitoring tool for extrapyramidal side effects upon admission to the facility and every quarter. Administrative Nurse E stated the resident's behaviors should be monitored and documented in the electronic record.

Interview, on 09/23/21 at 11:30 AM, with consulting pharmacy staff GG, revealed the resident should have monitoring for extrapyramidal side effects upon admission and quarterly. Consulting staff GG stated diagnoses for Haldol should include what type of agitation/behaviors the resident exhibited to justify the use of Haldol and Lorazepam.

The facility policy "Behavior Management and Psychotropic Medications" revised 12-2017, instructed staff to enhance the quality of life through behavioral interventions to minimize psychotropic medication use and monitor for adverse effects. AIMS (abnormal involuntary movement scale) or DISCUS (dyskinesia [inability to execute voluntary movements] identification system condensed user scale) are to be completed upon admission with initiation of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175264	A. BUILDING _____ B. WING _____	09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

(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 758	Continued From page 34	F 758		

antipsychotic medication. Staff were to monitor and document target behaviors every shift.

The facility failed to monitor for adverse extrapyramidal side effects of the antipsychotic Haldol and failed to document the behaviors the resident exhibited to justify the benefit verses the risk of continued use of Haldol and Lorazepam to prevent adverse side effects.

- Review of resident (R) 80's "Physician Order Sheet," dated 09/03/21, revealed the resident admitted to the facility on 09/03/21, with diagnoses that included anxiety disorder, major depressive disorder (major mood disorder) and insomnia (inability to sleep.)

The "Admission Minimum Data Set" (MDS), dated 09/09/21, assessed the resident with normal cognitive function, and received three days of antianxiety medications, six days of antidepressant and anticoagulant medications and 1 day of hypnotic medications during the seven day look back period.

The "Psychosocial Well-Bing Care Area Assessment "(CAA), dated 09/09/21, assessed the resident with normal cognitive status and had little pleasure in doing things. The resident had diagnosis of anxiety and major depressive disorder and received therapy with the goal to return home. The resident received venlafaxine (an antidepressant 100 mg (milligrams) 0.5 tablet twice a day, diazepam (an antianxiety medication) 5 mg 0.5 tablet every eight hours as needed and zolpidem 10 mg, 0.5 tablet at night for insomnia.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175264	A. BUILDING _____ B. WING _____	09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

(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 758	Continued From page 35	F 758		

The "Care Plan," dated 09/03/21, instructed staff the resident took medications with "Black Box Warnings" (a warning by the Food and Drug Administration for certain medications that carry serious safety risks. Often these warnings communicate potential rare but dangerous side effects, or they may be used to communicate important instructions for safe use of the drug.) Staff instructed to provide a calm, consistent, and matter of fact approach, encourage and praise the resident to participate in daily living activities. Staff instructed to encourage the resident to verbalize her feelings and thoughts.

The "Physician's Orders," dated 09/03/21, revealed the following medications of concern:

On 09/03/21, Diazepam 5 milligram (mg), give 0.5 tablet every eight hours as needed for anxiety.

On 09/03/21, Zolpidem 10 mg, give 0.5 tablet as needed for insomnia.

Review of the "Medication Administration Record" from 09/03/21 through 09/22/21, revealed the resident received 11 doses of Diazepam and eight doses of Zolpidem.

Observation, on 09/21/21 at 08:30 AM, revealed the resident sitting upright in her bed, asleep, with her breakfast on her over the bed table, uneaten.

Interview, on 09/21/21 at 03:30 PM, with the resident, revealed she received therapy to build up strength to return home.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175264	A. BUILDING _____ B. WING _____	09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

(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 758	Continued From page 36 Interview on 09/23/21 at 09:15 AM, with Licensed Nurse (LN) G, revealed the family members informed her that the resident routinely took the Zolpidem and Diazepam at home at night. Interview, on 09/23/21 at 10:45 AM, with Administrative Nurse D, confirmed the resident's family did inform the facility that the resident routinely took Zolpidem and Diazepam at home. Administrative Nurse D confirmed both medications continued past the 14-day limit for need for reevaluation for the continuation of the medications. Interview, on 09/23/21 at 11:30 AM, with Consulting Pharmacist GG, revealed he would expect the physician to reevaluate the Zolpidem and Diazepam after 14 days to reevaluate the medications for continued use. The facility policy "Behavior Management and Psychotropic Medications," revised 12-2017, lacked a policy for the 14-day reassessment of as needed psychotropic medications. The facility failed to reevaluate the continued, as needed, use of Zolpidem and Diazepam past the 14-day use limitation, as required, to prevent adverse side effects.	F 758		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §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.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175264	A. BUILDING _____ B. WING _____	09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

(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 812	Continued From page 37	F 812		

(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 reported a census of 30 residents. Based on observation and interview, the facility failed to ensure sanitary food preparation and storage for the residents of the facility.

Findings included:

- Observation of the initial kitchen tour, on 09/20/21 at 09:47 AM, revealed the following items of concern in the refrigerator:

Nine single serving containers of salsa dated 08/31/21 (20 days old).

Tomato soup in a quart container, half full, labeled 08/30/21 (21 days old).

Potato salad in a quart container, half full, labeled 08/30/21 (21 days old).

The walk-in refrigerator contained an opened box of individually packaged butter positioned directly

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175264	A. BUILDING _____ B. WING _____	09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

(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 812	Continued From page 38	F 812		

on the floor of the refrigerator.

Three packages of white bread, with best by dates of 09/16/21 and two with the date of 09/19/21.

One partial loaf of bread with best by date of 09/16/21.

Three packages of hot dog buns with best by dates of 08/26/21 and two with best by dates of 09/12/21.

Interview, on 09/20/21 at 09:57 AM, with dietary staff CC, confirmed the above refrigerated items should be stored three to five days after opening and confirmed the baked good items were past the best by date.

Environmental tour of the kitchen on 09/22/21 at 02:26 PM, with Dietary Staff BB, revealed the following areas of concern:

The deep fat fryer with dirt and grime on the fryer. Interview, at that time with Dietary Staff BB revealed it had not been used for approximately one month due to lack of cleaning/lack of staff.

The four shelved cart holding spices contained debris and dust on all four shelves and the wheels contained an accumulation of grime.

Three food service carts with beverages, tableware, and cooking implements contained shelves with dust/grime and wheels with accumulation of grime.

The stove contained seven control knobs with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175264	A. BUILDING _____ B. WING _____	09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

(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 812	Continued From page 39	F 812		

grime and dust accumulation and six burners with an accumulation of grime and grease.

Nine dish racks contained discolorations and scratches making sanitation difficult.

Interview, on 09/22/21 at 03:00 PM, with Dietary Staff BB, confirmed the above areas in need of cleaning for sanitation and reveled staff follow the cleaning schedule for the above areas of concern, but due to lack of dietary staff, some issues were missed. Dietary Staff BB confirmed the baked goods were past their best by date and the above noted refrigerated items were beyond their storage time for safe consumption.

The facility did not provide a policy for food storage.

The facility policy "Sanitation of Dining and Food Service Areas," dated 2016, instructed staff to uphold the sanitation in the dining areas according to a thorough,written schedule.

The "Cleaning Rotation," dated 2016, indicated stove top and food carts cleaned daily and shelves cleaned weekly.

The facility failed to store and prepare food in a sanitary manner to prevent food borne illness for the residents of the facility.