STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175275	A. BUILDING _____ B. WING _____	08/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES KINSLEY	620 WINCHESTER AVENUE KINSLEY, KS 67547

(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. The 2567 was electronically sent to the facility on 08/30/19.	F 000		
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: The facility identified a census of 27 residents. The sample included 12 residents. Based on observation, record review, and interview the facility failed to inform and provide R16 with the opportunity to make decisions regarding the alternative treatment option of having suprapubic catheter (urinary bladder catheter inserted through the skin).	F 552		

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
	175275	A. BUILDING _____ B. WING _____	08/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES KINSLEY	620 WINCHESTER AVENUE KINSLEY, KS 67547

(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 552	Continued From page 1	F 552		

Findings included:

- The facility's electronic medical record (EMR) diagnoses list for R16, last updated on 08/13/19, documented a diagnosis of Wegener's Granulomatosis, a rare disease of uncertain cause that is characterized by inflammation in various tissues, including blood vessels.

The "Minimum Data Set" (MDS) for significant change dated 04/12/19 documented R16 had no speech. The MDS indicated moderately impaired cognition and no issues were identified concerning short memory, long-term memory, or recall ability for R16.

The "Care Area Assessment" (CAA), dated 04/12/19, for Cognitive Loss/Dementia documented R16 was nonverbal and only able to answer yes or no questions with head nods. The CAA for Dehydration/Fluid Maintenance documented R16 was hospitalized and had an indwelling urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag) placed for urinary retention (lack of ability to urinate and empty the bladder) with a plan to follow up with a urologist (a physician who specializes in diseases of the urinary organs).

The "Care Plan" dated 07/12/19, documented R16 was nonverbal but received and understood verbal communication. The care plan documented R16 had a communication board in his room and instructed staff to encourage R16 to use gestures, pointing, facial expressions to convey messages. The care plan documented a diagnosis of urinary retention and R16 had an indwelling catheter related to residual urine after

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175275	A. BUILDING _____ B. WING _____	08/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES KINSLEY	620 WINCHESTER AVENUE KINSLEY, KS 67547

(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 552	Continued From page 2	F 552		

voiding.

The quarterly social service note dated 12/26/18 at 06:39 PM documented R16 understood conversation but was aphasic (condition with disordered or absent language function).

The social service progress note dated 05/2/2019 at 08:20 AM documented R16 had an appointment with urology for urinary retention.

The social service progress note dated 05/29/2019 at 03:18 PM documented R16 had a urodynamics study (tests that assess how the bladder and urethra are performing their job of storing and releasing urine) done.

Review of the progress notes lacked documentation regarding attempts to discuss with and encourage R16 to participate in future health care treatment options and alternatives regarding the urinary catheter.

An observation on 08/22/19 at 10:10 AM revealed R16 sat upright in his wheelchair in hallway near the nurse's station. R16 appeared alert, well-groomed, made eye-contact, and smiled as others greeted him as they passed by. R16 did not talk or make any vocal sounds.

An interview on 08/21/19 at 10:58 AM with unidentified resident representative stated the urologist recommended a suprapubic catheter due to deteriorating health and agreed; however, after discussion and response from the facility felt that the facility was against the suprapubic catheter due to past experiences of suprapubic catheters and their preferences. The unidentified resident representative stated no one discussed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175275	A. BUILDING _____ B. WING _____	08/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES KINSLEY	620 WINCHESTER AVENUE KINSLEY, KS 67547

(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 552	Continued From page 3	F 552		

the urologist's recommendations for a suprapubic catheter with R16 or provided R16 with the opportunity to choose what he preferred.

An interview on 08/27/19 at 11:52 AM with Certified Nurse Aide (CNA) G stated R16 did not talk but pointed or used yes or no gestures to answer questions. CNA G stated she knew how to care for residents when she referred to the resident's plan of care. CNA reviewed the plan of care and unable to verify whether or not R16 had possession of communication materials or picture boards that would facilitate communication and/or conversation with staff and others.

An interview 08/26/19 at 03:25 PM with CNA I and Certified Medication Aide (CMA) J stated R16 wore a pendent around his neck that he could push if he could not get to his call light. When asked CNA I and CMA J if R16 had a communication board or pictures, they were unable to confirm without checking the room for evidence and found a communication book that contained several pages with pictures and tools to facilitate communication.

An interview on 08/27/19 at 02:23 PM with Licensed Nurse (LN) C stated R16 was non-verbal, able to answer yes or no questions, had a communication book, and did better when he pointed at things. LN C stated she knew how to care for residents when she referred to the resident's care plan. LN C stated she assumed the guardian did not want R16 to have a suprapubic catheter since R16 still did not have a suprapubic catheter.

An interview on 08/27/19 at 12:39 PM with Social Service Designee (SSD) H stated R16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175275	A. BUILDING _____ B. WING _____	08/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES KINSLEY	620 WINCHESTER AVENUE KINSLEY, KS 67547

(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 552	Continued From page 4	F 552		

understood everything, answered yes or no questions, and used magazines and pictures to share interests with others. SSD H used laminated pages with words or sentences to assist R16 with answering MDS questions and believed R16 understood the sentences on the laminated pages. SSD H stated R16 did not have a communication or picture board to facilitate communication or conversation with others.

An interview on 08/27/19 at 03:30 PM with Administrative Nurse B stated R16 understood others, was cognitively intact, and had a communication board that facilitated communication when he pointed at the pictures, but nobody in the facility discussed healthcare options regarding the suprapubic catheter with R16. Administrative Nurse B reported the facility's physician was against it due to personal preference and the facility was waiting for the guardian to get a second opinion and make the decision on whether he/she wanted R16 to have the suprapubic catheter. When asked if anyone attempted to use the communication book or if anyone tried to discuss the option for a suprapubic catheter with R16, Administrative Nurse B replied, "Nobody has done that with him."

The facility did not provide a communication policy.

The facility's Admission Packet document titled, "Resident Rights," documented the resident "shall be allowed to obtain information concerning their total health status ..." and "shall be afforded the opportunity to refuse medication and/or treatment after being fully informed of and understanding the consequences of such actions."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175275	A. BUILDING _____ B. WING _____	08/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES KINSLEY	620 WINCHESTER AVENUE KINSLEY, KS 67547

(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 552	Continued From page 5 The facility failed to inform and provide R16 with the opportunity to make decisions regarding the alternative treatment option for a suprapubic catheter.	F 552		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs.	F 553		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175275	A. BUILDING _____ B. WING _____	08/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES KINSLEY	620 WINCHESTER AVENUE KINSLEY, KS 67547

(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 553	Continued From page 6	F 553		

(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 27 residents. The sample included 12 residents. Based on observation, record review, and interview the facility failed to ensure care plan meetings for R16 and/or the resident's representative.

Findings included:

- The facility's electronic medical record (EMR) diagnoses list for R16, last updated on 08/13/19, documented a diagnosis of Wegener's Granulomatosis, a rare disease of uncertain cause that is characterized by inflammation in various tissues, including blood vessels.

The "Minimum Data Set" (MDS) for significant change dated 04/12/19 documented R16 had no speech. The MDS indicated moderately impaired cognition and no issues were identified concerning short memory, long-term memory, or recall ability for R16.

The "Care Area Assessment" (CAA), dated 04/12/19, for Cognitive Loss/Dementia documented R16 was nonverbal and only able to answer yes or no questions with head nods.

The "Care Plan" dated 07/12/19, documented R16 was nonverbal but received and understood verbal communication. The care plan documented R16 had a communication board in his room and instructed staff to encourage R16 to use gestures, pointing, facial expressions to convey messages.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175275	A. BUILDING _____ B. WING _____	08/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES KINSLEY	620 WINCHESTER AVENUE KINSLEY, KS 67547

(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 553	Continued From page 7	F 553		

The quarterly social service note dated 12/26/18 at 06:39 PM documented R16 understood conversation but was aphasic (condition with disordered or absent language function).

Record review from 01/2018 to 07/2019 lacked documentation of care plan meetings with R16 and/or the resident representative.

An observation on 08/22/19 at 10:10 AM revealed R16 sat upright in his wheelchair in hallway near the nurse's station. R16 appeared alert, well-groomed, made eye-contact, and smiled as others greeted him as they passed by. R16 did not talk or make any vocal sounds.

An observation on 08/26/19 at 03:25 PM revealed communication picture book on night stand in R16's room. The communication book contained several pages with pictures and tools to facilitate communication.

An interview on 08/21/19 at 11:09 AM with unidentified resident representative reported he/she was not notified about a care plan meeting and received paperwork about it in the mail. The unidentified resident representative stated the care plan meetings were annual and not quarterly.

An interview on 08/27/19 at 11:52 AM with Certified Nurse Aide (CNA) G stated R16 did not talk but pointed or used yes or no gestures to answer questions.

An interview on 08/27/19 at 02:23 PM with Licensed Nurse (LN) C stated R16 was non-verbal, able to answer yes or no questions, had a communication book, and did better when

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175275	A. BUILDING _____ B. WING _____	08/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES KINSLEY	620 WINCHESTER AVENUE KINSLEY, KS 67547

(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 553	Continued From page 8	F 553		

he pointed at things.

An interview on 08/27/19 at 12:15 PM with Social Service Designee (SSD) H stated R16 understood everything, answered yes or no questions, and used magazines and pictures to share interests with others. SSD H used laminated pages with words or sentences to assist R16 with answering MDS questions and believed R16 understood the sentences on the laminated pages.
SSD H verified a care plan meeting was held with the resident representative via phone call on 07/08/19 and the resident representative was unable to attend the care plan meeting on 12/14/18. SSD H confirmed there were no other care plan meetings held between 12/2018 and 07/2019.

An interview on 08/27/19 at 12:26 PM with Administrative Nurse B stated care plan meetings occurred quarterly or every three months and confirmed there were no care plan meetings held for R16 between 12/2018 and 07/2019.

The facility's policy titled, "Electronic Care Plan," dated 12/2018, documented:

"To provide a guide to the Interdisciplinary Team, the resident and their responsible party to promote quality care and quality of life to attain highest practical level of independence and dignity to each resident by facility communication about the resident's barrier, strengths, voice, choice and needs."

The facility did not provide a care plan meeting policy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175275	A. BUILDING _____ B. WING _____	08/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES KINSLEY	620 WINCHESTER AVENUE KINSLEY, KS 67547

(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 553	Continued From page 9 The facility failed to ensure quarterly care plan meetings for R16 and/or the resident's representative.	F 553		
F 585 SS=F	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file	F 585		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175275	A. BUILDING _____ B. WING _____	08/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES KINSLEY	620 WINCHESTER AVENUE KINSLEY, KS 67547

(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 585	Continued From page 10	F 585		

grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175275	A. BUILDING _____ B. WING _____	08/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES KINSLEY	620 WINCHESTER AVENUE KINSLEY, KS 67547

(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 585	Continued From page 11	F 585		

the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and
(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 27 residents with 12 residents included in the sample. Based on observation, record review, and interview the facility failed to have a system in place for residents to file a grievance anonymously.

Findings included:

- Observations during survey dates 08/21/19 through 08/27/19 revealed the lack of accessible grievance forms and a designated location for residents to discretely file a grievance anonymously within the facility.

An interview on 08/22/19 at 01:15 PM with the resident council group stated there were no grievance forms and residents verbally informed staff of concerns. The resident council group

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175275	A. BUILDING _____ B. WING _____	08/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES KINSLEY	620 WINCHESTER AVENUE KINSLEY, KS 67547

(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 585	Continued From page 12	F 585		

stated there was no way to formally file a grievance anonymously within the facility.

An interview on 08/27/19 at 11:52 AM with Certified Nurse Aide (CNA) G stated she verbally communicated complaints and/or grievances regarding residents to the nursing and administrative staff.

An interview on 08/27/19 at 02:23 PM with Licensed Nurse (LN) C stated complaints and grievances regarding residents were handled verbally and she was unaware of any form designated for communicating and/or documenting grievances.

An interview on 08/27/19 at 12:15 PM with Social Service Designee (SSD) H stated she wrote up grievances that were reported to her and gave them to the grievance officer, Administrator A.

An interview on 08/27/19 at 12:55 PM with Administrative Staff A stated grievance forms were located at the nurse's station and residents would need to request a form from staff.

An interview on 08/27/19 at 03:57 PM with Administrative Staff A confirmed there was no system for residents to file grievances anonymously within the facility.

The facility's policy titled, "Grievance Policy & Procedure," dated 01/2017 documented, "The resident has the right to voice grievances anonymously." The policy documented that grievances, concerns or issues voiced by residents were recorded by facility personnel when the resident wished to remain anonymous. The policy lacked information and/or instruction

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175275	A. BUILDING _____ B. WING _____	08/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES KINSLEY	620 WINCHESTER AVENUE KINSLEY, KS 67547

(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 585	Continued From page 13 on how residents would file a grievance anonymously and without involving facility personnel. The facility failed to ensure the right of the residents to file a grievance anonymously.	F 585		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: The facility identified a census of 27 residents with 12 residents included in the sample. Based on observation, record review, and interview the facility failed to follow the care plan to date and/or change the oxygen tubing for Resident (R) 2, R10 and to utilize R16's communication book. Findings included: - The electronic medical record (EMR) diagnoses list for R2 documented a diagnosis on 07/01/15 of Chronic Obstructive Pulmonary Disease (COPD), a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing. The annual "Minimum Data Set" (MDS) dated 02/15/19 for R2 revealed a Brief Interview for Mental Status (BIMS) of 15, which indicated intact cognition. The resident required supplemental oxygen.	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175275	A. BUILDING _____ B. WING _____	08/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES KINSLEY	620 WINCHESTER AVENUE KINSLEY, KS 67547

(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 658	Continued From page 14	F 658		

The "Care Plan" for R2 dated 06/20/19, revealed R2 required the use of supplemental oxygen to assist with breathing when in her room or in bed and instructed nursing staff to change the resident's nasal cannula tubing every Friday.

Review of R2's "Physician Order" dated 07/05/19 ordered staff to change the resident's oxygen tubing every Friday.

An observation on 08/21/19 at 02:54 PM revealed R2 sitting in a chair in her room, wearing oxygen tubing that was labeled with a dated of 08/02/19.

An observation on 08/22/19 at 01:59 PM revealed the oxygen tubing for R2 was labeled with a date of 08/02/19.

An interview on 08/27/19 at 11:52 AM with Certified Nurse Aide (CNA) G stated CNA's did not do anything with resident's oxygen tubing and reported she thought the oxygen tubing was changed weekly. CNA G stated she knew how to care for residents when she referred to the resident's plan of care.

An interview on 08/27/19 at 02:23 PM with Licensed Nurse (LN) C revealed oxygen tubing and supplies were changed every Friday night by the night nurse. LN C stated the tubing was labeled with a date and reported she would replace the oxygen tubing if it was not labeled with a date. LN C stated the nurse documented on the treatment administration record (TAR) when the tubing was changed. LN C stated she knew how to care for residents when she referred to the resident's care plan.

An interview on 08/27/19 at 03:30 PM with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175275	A. BUILDING _____ B. WING _____	08/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES KINSLEY	620 WINCHESTER AVENUE KINSLEY, KS 67547

(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 658	Continued From page 15	F 658		

Administrative Nurse B stated nursing staff changed oxygen tubing weekly and labeled the oxygen tubing with the date. Administrative Nurse B stated nursing staff documented on the TAR when the oxygen tubing was changed. Administrative Nurse B stated she expected staff to follow the resident's care plan and outdated or undated oxygen tubing would be replaced by nursing personnel as soon as possible.

The facility's policy titled, "Electronic Care Plan," dated 12/2018 documented the resident's person-centered plan of care was an active working document that reflected the care needs of the resident.

The facility failed to follow the care plan to date and/or change R2's oxygen tubing.

- The facility's electronic medical record (EMR) diagnoses list for R10 included a diagnosis of Chronic Obstructive Pulmonary Disease (COPD), a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing.

The annual "Minimum Data Set" (MDS) dated 10/12/18 for R10 documented a Brief Interview for Mental Status (BIMS) score of 08, which indicated moderately impaired cognition. R10 required supplemental oxygen and respiratory therapy (RT) for at least 15 minutes per day for seven of the seven day look back period.

The "Care Plan" dated 06/19/19 revealed R10 required continuous use of supplemental oxygen to assist with breathing and instructed nursing staff to change the oxygen tubing every Friday.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175275	A. BUILDING _____ B. WING _____	08/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES KINSLEY	620 WINCHESTER AVENUE KINSLEY, KS 67547

(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 658	Continued From page 16	F 658		

Review of R10's "Physician Order" dated 07/05/19 ordered staff to change the resident's oxygen tubing every Friday.

Review of R10's "Physician Order" dated 07/31/18 revealed continuous oxygen every shift for increased airway related to COPD.

An observation on 08/21/19 at 12:34 PM revealed R10 in the dining room wearing undated oxygen tubing.

An interview on 08/27/19 at 11:52 AM with Certified Nurse Aide (CNA) G revealed CNAs did not do anything with oxygen tubing and reported she thought the oxygen tubing was changed weekly. CNA G stated she knew how to care for residents when she referred to the resident's plan of care.

An interview on 08/27/19 at 02:23 PM with Licensed Nurse (LN) C stated oxygen tubing and supplies were changed every Friday night by the night nurse. LN C stated the tubing was labeled with a date and reported she replaced undated oxygen tubing. LN C stated the nurse documented on the treatment administration record (TAR) when the tubing was changed. LN C stated she knew how to care for residents when she referred to the resident's care plan.

An interview on 08/27/19 at 03:30 PM with Administrative Nurse B revealed nursing staff changed oxygen tubing weekly and labeled the oxygen tubing with the date resident's initials. Administrative Nurse B stated she expected the staff to follow the resident's care plan and outdated or undated oxygen tubing was replaced soon as possible.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175275	A. BUILDING _____ B. WING _____	08/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES KINSLEY	620 WINCHESTER AVENUE KINSLEY, KS 67547

(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 658	Continued From page 17	F 658		

The facility's policy titled, "Electronic Care Plan," dated 12/2018 documented the resident's person-centered plan of care was an active working document that reflected the care needs of the resident.

The facility failed to follow the care plan to date and/or change R10's oxygen tubing.

- The facility's electronic medical record (EMR) diagnoses list for R16, last updated on 08/13/19, documented a diagnosis of Wegener's Granulomatosis, a rare disease of uncertain cause that is characterized by inflammation in various tissues, including blood vessels.

The "Minimum Data Set" (MDS) for significant change dated 04/12/19 documented R16 had no speech. The MDS indicated moderately impaired cognition and no issues were identified concerning short memory, long-term memory, or recall ability for R16.

The "Care Area Assessment" (CAA), dated 04/12/19, for Cognitive Loss/Dementia documented R16 was nonverbal and only able to answer yes or no questions with head nods.

The "Care Plan" dated 07/12/19, documented R16 was nonverbal but received and understood verbal communication. The care plan documented R16 had a communication board in his room and instructed staff to encourage R16 to use gestures, pointing, facial expressions to convey messages.

An observation on 08/22/19 10:10 AM revealed R16 sat upright in his wheelchair in hallway near

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175275	A. BUILDING _____ B. WING _____	08/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES KINSLEY	620 WINCHESTER AVENUE KINSLEY, KS 67547

(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 658	Continued From page 18	F 658		

the nurse's station. R16 appeared alert, well-groomed, made eye-contact and smiled as others greeted him as they passed by. R16 did not talk or make any vocal sounds.

An interview on 08/27/19 at 11:52 AM with Certified Nurse Aide (CNA) G stated R16 did not talk but pointed or used yes or no gestures to answer questions. CNA G stated she knew how to care for residents when she referred to the resident's plan of care. CNA was unable to verify that R16 had possession of communication materials or picture boards to facilitate communication and/or conversation with staff and others.

An interview 08/26/19 at 03:25 PM with CNA I and Certified Medication Aide (CMA) J stated R16 wore a pendent around his neck that he could push if he could not get to his call light. When asked CNA I and CMA J if R16 had a communication board or pictures, they were unable to confirm without checking the room for evidence and found a communication book that contained several pages with pictures and tools to facilitate communication.

An interview on 08/27/19 at 02:23 PM with Licensed Nurse (LN) C stated R16 was non-verbal, able to answer yes or no questions, had a communication book, and did better when he pointed at things. LN C stated she knew how to care for residents when she referred to the resident's care plan.

An interview on 08/27/19 at 12:39 PM with Social Service Designee (SSD) H stated R16 understood everything, answered yes or no questions, and used magazines and pictures to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175275	A. BUILDING _____ B. WING _____	08/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES KINSLEY	620 WINCHESTER AVENUE KINSLEY, KS 67547

(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 658	Continued From page 19 share interests with others. SSD H used laminated pages with words or sentences to assist R16 with answering MDS questions and believed R16 understood the sentences on the laminated pages. SSD H stated R16 did not have a communication or picture board to facilitate communication or conversation with others. An interview on 08/27/19 at 03:30 PM with Administrative Nurse B stated R16 understood others, was cognitively intact, and had a communication board that facilitated communication when he pointed at the pictures. Administrative Nurse B stated she expected staff to follow the resident's care plan. The facility's policy titled, "Electronic Care Plan," dated 12/2018 documented the resident's person-centered plan of care was an active working document that reflected the care needs of the resident. The facility failed to follow the care plan to utilize R16's communication book.	F 658		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility reported a census of 27 residents	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175275	A. BUILDING _____ B. WING _____	08/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES KINSLEY	620 WINCHESTER AVENUE KINSLEY, KS 67547

(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 689	Continued From page 20	F 689		

with five cognitively impaired, mobile residents who resided on the 300 Hall. Based on observation and interview the facility failed to provide an environment free from accident hazards when facility staff left chemicals in an unlocked cabinet of the soiled utility closet to which residents had access.

Findings included:

- During a follow-up environmental tour of the facility on 08/27/19 at 03:13 PM observation revealed a container of "PDI Sani-cloth Bleach Germicidal Disposable Wipe" (Orange top) in an unlocked cabinet in the unlocked soiled utility room on the 300 Hall. The product label noted the disposable wipe as a physical or chemical hazard for use on hard surfaces only- not a skin wipe.

During an interview on 08/27/19 at 03:29 PM, Environmental Services Manager (ESM) D stated the staff always kept the soiled utility closet on the 300 Hall unlocked. ESM D stated the germicidal wipes found in the unlocked cabinet have been stored in a locked room by the nurses' station. ESM D stated he did not know why the wipes were in the soiled utility closet and he removed the germicidal wipes.

A policy concerning chemical storage was requested on 08/27/19 but Administrative Nurse B stated there was not a policy for chemical storage.

The facility failed to provide an environment free from accident hazards when facility staff left chemicals in an unlocked cabinet of the soiled utility closet to which residents had access.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175275	A. BUILDING _____ B. WING _____	08/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES KINSLEY	620 WINCHESTER AVENUE KINSLEY, KS 67547

(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 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: The facility identified a census of 27 residents with 12 residents included in the sample. Based on observation, record review, and interview the facility failed to date and/or change the oxygen tubing for Resident (R) 2 and R10. Findings included: - The EMR (electronic medical record) diagnoses list for R2 documented a diagnosis on 07/01/15 of Chronic Obstructive Pulmonary Disease (COPD), a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing. The annual "Minimum Data Set" (MDS) dated 02/15/19 for R2 revealed a Brief Interview for Mental Status (BIMS) of 15, which indicated intact cognition. The resident required supplemental oxygen. The "Care Plan" for R2 dated 06/20/19, revealed R2 required the use of supplemental oxygen to assist with breathing when in her room or in bed and instructed nursing staff to change the resident's nasal cannula tubing every Friday.	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175275	A. BUILDING _____ B. WING _____	08/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES KINSLEY	620 WINCHESTER AVENUE KINSLEY, KS 67547

(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 695	Continued From page 22	F 695		

Review of R2's "Physician Order" dated 07/05/19 ordered staff to change the resident's oxygen tubing every Friday.
An observation on 08/21/19 at 02:54 PM revealed R2 sitting in a chair in her room, wearing oxygen tubing that was labeled with a dated of 08/02/19.

An observation on 08/22/19 at 01:59 PM revealed the oxygen tubing for R2 was labeled with a date of 08/02/19.

An interview on 08/27/19 at 11:52 AM with Certified Nurse Aide (CNA) G stated CNA's did not do anything with resident's oxygen tubing and reported she thought the oxygen tubing was changed weekly.

An interview on 08/27/19 at 02:23 PM with Licensed Nurse (LN) C revealed oxygen tubing and supplies were changed every Friday night by the night nurse. LN C stated the tubing was labeled with a date. LN C reported she would replace the oxygen tubing if it was not labeled with a date. LN C stated the nurse documented on the treatment administration record (TAR) when the tubing was changed.

An interview on 08/27/19 at 03:30 PM with Administrative Nurse B stated nursing staff changed oxygen tubing weekly and labeled the oxygen tubing with the date. Administrative Nurse B stated nursing staff documented on the TAR when the oxygen tubing was changed. Administrative Nurse B stated she expected staff to follow the resident's care plan and outdated or undated oxygen tubing would be replaced by nursing personnel as soon as possible.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175275	A. BUILDING _____ B. WING _____	08/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES KINSLEY	620 WINCHESTER AVENUE KINSLEY, KS 67547

(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 695	Continued From page 23	F 695		

The facility did not provide an oxygen policy.

The facility failed to date and/or change R2's oxygen tubing as ordered.

- The facility's electronic medical record (EMR) diagnoses list for R10 included a diagnosis of Chronic Obstructive Pulmonary Disease (COPD), a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing.

The annual "Minimum Data Set" (MDS) dated 10/12/18 for R10 documented a Brief Interview for Mental Status (BIMS) of 08, which indicated moderately impaired cognition. R10 required supplemental oxygen and respiratory therapy (RT) for at least 15 minutes per day for seven of the seven day look back period.

The "Care Plan" dated 06/19/19, revealed R10 required continuous use of supplemental oxygen to assist with breathing and instructed nursing to change the oxygen tubing every Friday.

Review of R10's "Physician Order" dated 07/05/19 ordered staff to change the resident's oxygen tubing every Friday.

Review of R10's "Physician Order" dated 07/31/18 revealed continuous oxygen every shift for increased airway related to COPD.

An observation on 08/21/19 at 12:34 PM revealed R10 in the dining room wearing undated oxygen tubing.

An interview on 08/27/19 at 11:52 AM with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175275	A. BUILDING _____ B. WING _____	08/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES KINSLEY	620 WINCHESTER AVENUE KINSLEY, KS 67547

(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 695	Continued From page 24 Certified Nurse Aide (CNA) G revealed CNAs did not do anything with oxygen tubing and reported she thought the oxygen tubing was changed weekly. An interview on 08/27/19 at 02:23 PM with Licensed Nurse (LN) C stated oxygen tubing and supplies were changed every Friday night by the night nurse. LN C stated the tubing was labeled with a date. LN C reported she replaced undated oxygen tubing. LN C stated the nurse documented on the treatment administration record (TAR) when the tubing was changed. An interview on 08/27/19 at 03:30 PM with Administrative Nurse B revealed nursing staff changed oxygen tubing weekly labeled the oxygen tubing with the date resident's initials. Administrative Nurse B stated she expected staff followed the resident's care plan and outdated or undated oxygen tubing was replaced soon as possible. The facility did not provide an oxygen policy. The facility failed to date and/or change R10's oxygen tubing as ordered.	F 695		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility	F 727		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175275	A. BUILDING _____ B. WING _____	08/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES KINSLEY	620 WINCHESTER AVENUE KINSLEY, KS 67547

(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 727	Continued From page 25 must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: The facility identified a census of 27 residents. The sample included 12 residents. Based on observation, record review, and interview the facility failed to utilize the services of a registered nurse (RN) for at least eight consecutive hours a day, seven days a week. Findings included: - Review of the daily nurse staffing hours and working staff schedule from 05/01/19 to 08/22/19 revealed there was no RN coverage for eight consecutive hours per day on 05/02/19, 06/08/19, 06/09/19, and 06/23/19. An interview on 08/22/19 at 01:00 PM with Administrator A confirmed there was no RN coverage on 05/02/19, 06/08/19, 06/09/19, and 06/23/19. The facility did not provide a staffing policy. The facility failed to utilize the services of a registered nurse (RN) for at least eight consecutive hours a day, seven days a week.	F 727		
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of	F 803		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175275	A. BUILDING _____ B. WING _____	08/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES KINSLEY	620 WINCHESTER AVENUE KINSLEY, KS 67547

(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 803	Continued From page 26	F 803		

residents in accordance with established national guidelines.;

§483.60(c)(2) Be prepared in advance;

§483.60(c)(3) Be followed;

§483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups;

§483.60(c)(5) Be updated periodically;

§483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and

§483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 27 residents with one main kitchen, which served two resident pureed diets. Based on observation, interviews, and record review the facility failed to prepare two pureed diets by methods that conserved nutritive value.

Findings included:

- Observation on 08/27/19 at 09:52 AM revealed Dietary Staff F placed four stuffed pasta shells (two servings) into a food processor and added tomato juice without first measuring the amount listed on the recipe (0.4 cups per two servings). Staff F then prepared pureed bread by removing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175275	A. BUILDING _____ B. WING _____	08/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES KINSLEY	620 WINCHESTER AVENUE KINSLEY, KS 67547

(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 803	Continued From page 27 three slices of bread from the package, placed the bread in the food processor, and added some milk and melted butter. Staff F failed to measure the milk or butter as directed by the recipe before he/she pureed the bread. Review of the facility provided recipe for pureed bread revealed staff would use two slices of bread per two servings, 2/3 cups of milk and 2 1/2 teaspoons of melted margarine. During an interview on 08/27/19 at 12:04 PM, dietary manager E stated she expected the cooks to follow the recipes as stated and not to eyeball the ingredients. Review of the "Pureed Food Preparation" policy dated 2016 revealed, "Standardized recipes will be used to prepare all pureed food..." The facility failed to follow the recipes for two residents with pureed diets.	F 803		
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. (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.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175275	A. BUILDING _____ B. WING _____	08/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES KINSLEY	620 WINCHESTER AVENUE KINSLEY, KS 67547

(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 28	F 812		

(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 27 residents with one main kitchen that served one dining room. Based on observation, interviews, and record review the facility failed to properly store food items placed in a refrigerator by the failure to ensure two dessert items were dated.

Findings included:

- During the follow-up environmental tour of the kitchen on 08/27/19 at approximately 12:00 PM, an undated large pan of what appeared to be a green gelatin dessert and a smaller undated pan of sliced bananas and orange gelatin dessert were found in a refrigerator.

During an interview on 08/27/19 at 10:37 PM, Dietary Manager (DM) E stated she expected the pans of dessert found in the refrigerator to be dated.

Review of the "Labeling and Dating Foods (Date Marking)" policy dated 2016 revealed, "All foods stored will be properly labeled..."

The facility failed to properly store food items placed in a refrigerator by not ensuring the food items were dated.