

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/25/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175135	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/11/2024
NAME OF PROVIDER OR SUPPLIER MEDICALODGES POST ACUTE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6500 GREELEY AVENUE KANSAS CITY, KS 66104		
(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	F 000			
F 609 SS=D	The following citations represent the findings of complaint investigations #KS00186388 and KS00186353. The 2567 was sent electronically on 03/25/24. Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F 609			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

03/25/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 609	Continued From page 1 by: The facility identified a census of 33 residents. The sample included three residents. Based on observation, record review, and interviews, the facility failed to report an allegation of resident-to-resident abuse between R1 and R2 to the State Agency (SA) within the mandated timeframe. This deficient practice placed R2 at risk for unresolved and ongoing abuse. Findings included: - The "Diagnoses" tab of R1's Electronic Medical Record (EMR) documented diagnoses of schizoaffective disorder (a mental disorder in which a person experiences a combination of symptoms of schizophrenia [psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought] and dementia progressive mental disorder characterized by failing memory, confusion) with other behavioral disturbance. The "Significant Change Minimum Data Set (MDS)" dated 10/09/23, documented R1 had a Brief Interview for Mental Status (BIMS) score of nine which indicated moderate cognitive impairment. R1 had hallucinations (sensing things while awake that appear to be real, but the mind created) and wandering behavior for one to three days in the assessment period. The "Quarterly MDS" dated 01/04/24, documented R1 had hallucinations and delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue) and had physical behaviors directed towards others one to three days in the assessment	F 609			

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F 609	Continued From page 2 period. The "Cognitive Loss/Dementia Care Area Assessment (CAA)" dated 10/11/23, documented R1 triggered for cognitive loss related to low BIMS and wandering. The "Behavioral Symptoms CAA" dated 10/12/23, documented R1 triggered for behavioral symptoms. R1's "Care Plan," last revised 06/04/21, documented R1 had difficulty keeping his hands to himself at times and documented an intervention, dated 01/05/24, that directed R1 had an increase in verbal and physical approaches to staff and staff were to cue R1 regarding appropriate requests to staff for needs given. In a "Report of Concern" dated 03/01/24, Certified Nurse Aide (CNA) M reported R1 was touching other residents sexually and inappropriately. The report alleged R1 was rubbing R2's private areas on 03/01/24 at 08:50 PM. CNA M's "Witness Statement" dated 03/06/24 documented that on 03/01/24, CNA M sat in a chair across from the nurse's station and at about 08:45 PM, R1 kept trying to get behind the nurse's station to CNA N and Licensed Nurse (LN) G. CNA M stated she stopped R1 from going behind the nurses station. At approximately 08:50 PM, R1 went around the nurse's station and over to R2. R1 started to touch R2's private areas and R2 told R1 to stop. CNA M stated she pushed R1 away. CNA N's undated "Witness Statement," stated on 03/01/24, CNA N saw R1 sitting by R2. CNA N	F 609			

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F 609	Continued From page 3 did not see R1 touch R2 but another staff member said R1 touched R2. CNA N stated she told R1 not to touch R2 and R1 moved away from R2. LN G's undated "Witness Statement," stated on 03/01/24, she was working as the nurse in charge on the night shift. She was notified of a potential resident-to-resident incident that occurred that day but she was not notified by any working staff member that shift. LN G stated to her knowledge, there were no known incidents. On 03/11/24 at 12:23 PM, R1 sat in his wheelchair at the dining table and ate lunch. On 03/11/24 at 11:54 AM, LN H stated she had not seen R1 being sexually inappropriate with any other residents. She stated if she saw any abuse or it was reported to her, she reported it immediately to Administrative Staff A or Administrative Nurse D. On 03/11/24 at 11:56 AM, LN I stated she had not seen R1 being sexually inappropriate with any other residents. She stated if she saw any abuse, she would intervene and then notify Administrative Staff A and Administrative Nurse D immediately. She stated the facility reported to the SA within 24 hours. On 03/11/24 at 11:59 AM, Administrative Staff A stated he was gone on 03/04/24 and 03/05/24 so when he came back on 03/06/24, he found the "Report of Concern" from CNA M. He stated it was already past five days, so he did not report the allegation to the SA. He stated he planned to complete the investigation and then report it to the SA. Administrative Staff A stated he reviewed	F 609			

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F 609	Continued From page 4 the cameras and R1 was observed poking R2 twice on the outside of her hip and never touched her genitals. He stated once he received the "Report of Concern," he started the investigation and got witness statements. Administrative Staff A stated CNA N and LN G did not see the incident. He stated CNA M called him on 03/02/24 to report she had issues with R1 herself but did not mention any incident with R1 and R2. Administrative Staff A stated he did not report the allegation because it was way out of the reportable window. He stated he expected if staff saw something, they would call him or Administrative Nurse D and he would report it to the SA and then investigate. Administrative Staff A stated he educated staff that a "Report of Concern" was not a timely report of an allegation and that staff had access to his phone number to call him directly. The facility's "Abuse, Neglect, and Exploitation" policy, revised October 2022, directed all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown sources were reported immediately to the administrator and/or their designated representative, the SA, and when applicable, law enforcement. Allegations were reported not later than two hours after the allegation was made if the allegation involved abuse or resulted in serious bodily injury or not later than 24 hours if the allegation did not involve abuse and did not result in serious bodily injury. The facility failed to report an allegation of abuse between R1 and R2 to the SA within the mandated timeframe. This deficient practice placed R2 at risk for unresolved and ongoing abuse.	F 609			

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