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 _____	02/10/2025

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 Resurvey and Complaint Investigation #192495. The 2567 was electronically sent on 2/20/25.	F 000		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: The facility reported a census of 29 residents with 15 residents selected for review. Based on observation, interview, and record review, the facility failed to accurately complete the Minium Data Set for three residents: Resident (R) 15 and R20 related to falls; R18 related to antidepressant medication. This placed the residents at risk for uncommunicated care needs. Findings included: - The Electronic Health Records (EHR) documented R15 had the following diagnoses that included cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), coronary artery disease (CAD- abnormal condition that may affect the flow of oxygen to the heart), hypertension (HTN-elevated blood pressure), muscle weakness, and depression (a	F 641		

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
	175264	A. BUILDING _____ B. WING _____	02/10/2025

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

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F 641	Continued From page 1	F 641		

mood disorder that causes a persistent feeling of sadness and loss of interest).

The 11/04/24 "Admission Minimum Data Set" (MDS) documented a brief interview for mental status (BIMS) of 13, which indicated intact cognition and one non-injury fall from 10/30/24 thru 11/04/24.

The 11/04/24 "Falls Care Area Assessment" (CAA) documented R15 was at risk for falls and received antidepressants for diagnosis of major depressive disorder. He has had one non injury fall since admission. He has not had a fall within the last year before admission. He is working with therapy to improve his strength and balance.

The 11/2/24 at 01:13 AM "Progress Note" revealed staff found R15 on the floor in his room leaning back against his closet. R15 stated he was looking for his pants.

The 11/2/24 at 11:10AM "Progress Note" revealed the nurse saw R15 in his room on the floor inside his door facing the door. He was unable to explain what happened.

During an observation on 02/05/25 at 01:58 PM, R15 sat in his recliner with no call light within reach, The nurse was not outside the room at the nurses' station.

During an interview on 02/10/25 at 11:20 AM, Administrative Nurse D confirmed that the MDS was incorrect.

The facility utilized the "Resident Assessment Instrument" (RAI) for the completion of MDSs.

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 _____	02/10/2025

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 641	Continued From page 2	F 641		

The facility failed to accurately complete the MDS for (R)15 related to falls. This placed the resident at risk for uncommunicated care needs.

- The Electronic Health Records (EHR) documented Resident (R) 1 had the following diagnoses that included spastic hemiplegia affecting left side (that causes muscle tightness and involuntary contractions in the limbs and extremities on one side of the body), bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), seizure (violent involuntary series of contractions of a group of muscles),

The 11/21/24 "Annual Minimum Data Set" (MDS) documented R1 had a brief interview for mental status (BIMS) of 12, which indicated intact cognition and was always incontinent of bowel and bladder also documented that he had a restorative program for amputation/prosthesis care and splint care six days out of the seven days in the look back period of 11/16/24 to 11/21/24.

The 11/21/24 "Incontinence Care Area Assessment" (CAA) documented R1 was always incontinent of bowel and bladder.

The 02/06/25 "Care Plan" documented a restorative program for an ankle-foot orthotic (AFO- a custom-made brace that supports the foot, ankle, and lower leg) to the left leg while awake and a left hand splint at night. Also, a passive range of motion program before staff put on the splint and after staff removed the splint. Staff documented R1 wore the leg brace every day in the last 30 days except 1/10/25, 1/11/24,

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 _____	02/10/2025

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 641	Continued From page 3	F 641		

1/12/25, 1/13/25, and 1/24/25.

The 02/06/25 "Care Plan" documented R1 was incontinent at times, he used a urinal and a bed pan.

The bowel and bladder task record for the time prior to the MDS documented R1 was continent of bladder six times and incontinence nine times from 11/15/24 to 11/21/24. It also documented that R1 was continent of bowel on 11/16/24 and 11/18/24,

The "Progress Notes" on 8/14/2024 at 11:30 AM documented that R1 needed a referral for an appointment at Progressive Prosthetics and Orthotics in Joplin, Mo for a new AFO brace and shoes as his brace did not fit him properly anymore.

The "Progress Notes" on 8/20/2024 at 01:34 PM documented Dr. Taylor saw R1 and was to send the referral to Progressive Prosthetics and Orthotics for R1 to see about a new AFO brace and shoes. No new orders received at this time.

The "Progress Notes" from 11/15/14 to 11/21/24 revealed R1 was sometimes continent of bowel and bladder during this time.

The 1/31/25 at 2:28 PM "Restorative Aide Note" documented a program of a left hand splint to be put on at night and off in the morning and left leg AFO to be worn daily- put on in morning and off at night. Restorative Aide documented that R1 was doing well with program, he was able to complete all task, and was wearing the splints as ordered. Also documented he participated actively, did not refuse.

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 _____	02/10/2025

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

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F 641	Continued From page 4	F 641		

During an observation on 02/05/25 at 02:08 PM, R1 sat in the dining area in his wheelchair and watched television, His legs were wrapped, and he had no brace or AFO on his left leg.

During an interview on 2/06/25 at 02:41 PM, Certified Medication Aide (CMA) S verified that R1 can be continent of bowel and bladder, but that he has urgency. She also stated that he had not worn his brace in a while because it was too small and he needed a new one. Unable to remember how long.

During an interview on 02/10/25 10:32 AM, CMA U confirmed that R1 did not have an amputation or prosthetic, and R1's AFO was too small for him and that they were to get a new one for him. Also confirmed that R1 could let you know that he has to toilet when he wanted to go.

During an interview on 02/10/25 at 11:20 AM, Administrative Nurse D confirmed that R1 was sometimes continent of bowel and bladder, and he did notify staff that he needed to go but had urgency so sometimes they didn't make it in time. Administrative Nurse D confirmed that R1 did not have an amputation or prosthetic, and R1's AFO was too small for him. They were working with insurance to get a new one. Confirmed that it should not have been documented that the program was done, because it couldn't be done. She took over as the MDS Coordinator and has been working on fixing thing.

The facility utilized the "Resident Assessment Instrument" (RAI) for the completion of MDSs.

The facility failed to accurately complete the 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 _____	02/10/2025

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 641	Continued From page 5	F 641		

for (R)1 related to continence status and restorative care. This placed the resident at risk for uncommunicated care needs.

- Review of Resident (R)18's electronic medical record (EMR) revealed a diagnosis of major depressive disorder (major mood disorder which causes persistent feelings pf sadness).

The "Admission Minimum Data Set" (MDS), dated 07/09/24, documented the resident had a Brief Interview for Mental Status (BIMS) score of four, indicating severe cognitive impairment. He received antipsychotic ((medications used to treat psychosis (any major mental disorder characterized by a gross impairment perception)), an antibiotic (medication used to treat infections) and an antiplatelet (medication used to prevent platelets from sticking together and decrease your body ' s ability to form blood clots) during the assessment period.

The "Psychotropic Drug Use Care Area Assessment" (CAA), documented the resident's physician would review and make adjustments to the resident's psychoactive medications, as needed.

The "Quarterly MDS," dated 01/02/25, documented the staff assessment for cognition revealed modified independence with daily decision making. He received antipsychotic, antidepressant, antiplatelet and anticonvulsant (medications used to treat seizures) medications during the assessment period.

The care plan, revised 09/27/24, instructed staff the resident took antidepressant medication due

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 _____	02/10/2025

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 641	Continued From page 6	F 641		

to being tearful at times. Staff were to allow the resident to express his feelings without judgement or criticism.

Review of the resident's EMR revealed the following physician's order:

Venlafaxine (an antidepressant medication), 75 milligrams (mg), by mouth (po), every day (QD), for MDD, ordered, 07/03/24.

On 02/10/25 at 12:30 PM, Administrative Nurse D stated the 07/09/24 MDS, which lacked documentation of an antidepressant medication being given during the assessment period, was inaccurate.

The facility utilized the "Resident Assessment Instrument" (RAI) for the completion of MDSs.

The facility failed to complete an accurate MDS for this dependent resident who received antidepressant medication.

- Review of Resident (R)20's electronic medical record (EMR) revealed a diagnosis of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) and Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness).

The "Significant Change Minimum Data Set" (MDS), dated 12/19/24, documented the resident had a Brief Interview for Mental Status (BIMS) score of zero, indicating severe cognitive impairment. She used a wheelchair for

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 _____	02/10/2025

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

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F 641	Continued From page 7	F 641		

locomotion and was dependent on staff for chair to bed to chair transfers. She had one injury fall (except major) since the prior assessment.

The "Functional Abilities Care Area Assessment" (CAA), dated 12/19/24, did not trigger.

The "Fall CAA," dated 12/19/24, documented the resident required staff assistance with all cares.

The "Annual MDS," dated 12/05/24, documented the resident had a BIMS score of one, indicating severe cognitive impairment. She used a wheelchair for locomotion and was dependent on staff for chair to bed to chair transfers. She had one injury fall (except major) since the prior assessment.

The care plan, revised 11/29/24, instructed staff to use two staff and a gait belt while transferring the resident.

Review of the resident's EMR, revealed the following Fall Assessments which placed the resident at a moderate risk for falls: 12/17/24 and 10/28/24.

Review of the resident's EMR, revealed the following Fall Assessments which placed the resident at a high risk or falls: 11/30/24 and 04/21/24.

Review of the resident's EMR, revealed the resident had an injury fall (except major) on 10/28/24, when she raised her electric recliner up and fell forward out of the chair. She received a reddened area to her mid, upper back.

The resident's EMR lacked documentation of a

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 _____	02/10/2025

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

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F 641	Continued From page 8 fall for this resident between the dates of 12/05/24 and 12/19/24. On 02/10/25 at 09:03 AM, Administrative Nurse D stated the 12/19/24 MDS was inaccurate as the resident did not have a fall after 10/28/24. The facility utilized the "Resident Assessment Instrument" (RAI) for the completion of MDSs. The facility failed to complete an accurate MDS for this dependent resident with falls.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §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). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR	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 _____	02/10/2025

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 9	F 656		

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.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 29 residents with 15 residents included in the sample. Based on observation, record review and interview, the facility failed to develop and implement a comprehensive person-centered care plan for one Resident (R)20, regarding the use of an electric recliner.

Findings included:

- Review of Resident (R)20's electronic medical record (EMR) revealed a diagnosis of Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness).

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 _____	02/10/2025

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		

The "Significant Change Minimum Data Set" (MDS), dated 12/19/24, documented the resident had a Brief Interview for Mental Status (BIMS) score of zero, indicating severe cognitive impairment. She was dependent on staff for chair-to-bed-to-chair transfers. The inaccurate MDS documented the resident had one injury (except major) fall since the prior assessment.

The "Functional Abilities Care Area Assessment" (CAA), dated 12/19/24, did not trigger.

The "Fall CAA," dated 12/19/24, documented the resident required staff assistance with cares.

The "Annual MDS," dated 12/05/24, documented the resident had a BIMS score of four, indicating severe cognitive impairment. She was dependent on staff for chair-to-bed-to-chair transfers. She had one injury (except major) fall since the prior assessment.

The comprehensive care plan, revised 11/29/24, lacked staff instruction regarding the resident's use of an electric recliner in her room.

Review of the resident's EMR revealed fall assessments, dated 10/28/24 and 12/17/24, which placed the resident at a moderate risk for falls. Fall assessments, dated 04/21/24 and 11/30/24, placed the resident at a high risk for falls.

Review of the resident's EMR, revealed the resident had an injury (except major) fall in her room from her recliner on 10/28/24. Staff informed the nurse the resident's electric lift chair with the lift chair in the upper most position and

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

(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	F 656		

the resident on the floor in front of the electric chair. Upon assessment, the resident had a reddened area to her spine. The resident had no further injuries, was able to move all of her extremities per her normal and her vital signs (VS) were within normal range (WNR). Staff initiated neurology checks (a medical assessment that evaluates the function of a patient's nervous system by testing their mental status, muscle strength, coordination, sensation, reflexes, and other neurological functions), which were all WNR. The interdisciplinary team (IDT) initiated a new intervention to keep the resident's lift chair unplugged when the resident was in the chair to prevent her from raising the chair on her own.

Review of the resident's EMR revealed an "Electric Recliner Assessment", dated 11/05/24, which documented the resident did not have the physical or cognitive ability to safely operate the electric recliner. No other "Electric Recliner Assessments" were available in the resident's EMR.

Review of the resident's EMR, from 01/12/25 through 02/09/25, revealed the resident required substantial/maximal to dependent staff assistance with chair to bed to chair transfers.

Review of the resident's EMR, from 01/12/25 through 02/09/25, revealed the resident required substantial/maximal to dependent staff assistance with going from sitting to standing.

On 02/06/25 at 09:35 AM, Certified Medication Aide (CMA) S transferred the resident from her wheelchair to her electric recliner with extensive assistance and the use of the gait belt. The resident was unable to bear weight during 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 _____	02/10/2025

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 12	F 656		

transfer. The electric recliner remained plugged in when the CMA left the room following cares. The controller to the electric recliner rested on the arm of the chair.

On 02/06/25 at 10:47 AM, the resident sat in her electric recliner in her room. The electric recliner remained plugged in and the controller to the recliner rested on the arm of the chair.

On 02/06/25 at 01:18 PM, Certified Nurse Aide (CNA) N and Licensed Nurse (LN) G transferred the resident from her wheelchair to her bed with extensive assistance and the use of a gait belt. The resident was unable to bear her full weight during the transfer.

On 02/06/25 at 09:39 AM, CMA S stated staff were not to unplug the resident's electric recliner. Staff were to use the chair plugged in at all times. CNA S stated the resident was able to bear some weight during transfers but was unable to bear her full weight.

On 02/06/25 at 01:18 PM, CNA N stated the resident could only bear minimal weight during transfers. Staff left the resident's electric recliner plugged in all of the time.

On 02/06/25 at 01:18 PM, LN G stated the resident was not able to fully bear weight during transfers. LN G was unsure if the resident's electric recliner was to be plugged in or not.

On 02/10/25 at 09:03 AM, Administrative Nurse D stated the facility did not complete an "Electric Recliner Assessment" for this dependent resident upon her admission to the facility. The only "Electric Recliner Assessment" the facility had

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 _____	02/10/2025

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 13 was the one completed on 11/05/24. Administrative Nurse D stated the "Electric Recliner Assessment" should have been completed upon the resident's admission and then quarterly and with significant changes, thereafter. The facility policy for "Assessments", revised 11/2024, included: The "Electric Recliner Assessment" shall be completed with use of the electric recliner initiation then quarterly, and as needed. The facility policy for "Electronic Care Plan", revised 12/2020, included: The resident's care plan shall promote quality care and quality of life to attain the highest practical level of independence and dignity to each resident by facilitating communication about the resident's barriers, strengths, voice, choice and needs. The facility failed to develop and implement a comprehensive person-centered care plan for this dependent resident who utilized an electric recliner in her room.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident.	F 657		

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 _____	02/10/2025

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 657	Continued From page 14	F 657		

(C) A nurse aide with responsibility for the resident.
(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident's representative(s).
An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 29 residents with 15 residents selected for review. Based on observation, interview, and record review, the facility failed to accurately revise Resident (R) 15's care plan after falls and failed to revise R 11's care plan for pressure ulcer care. This placed the residents at risk for uncommunicated care needs.

Findings included:

- The Electronic Health Records (EHR) documented R15 had the following diagnoses cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), muscle weakness, diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), coronary artery disease (CAD-

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 _____	02/10/2025

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 657	Continued From page 15	F 657		

abnormal condition that may affect the flow of oxygen to the heart), hypertension (HTN-elevated blood pressure), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).

The 11/04/24 "Admission Minimum Data Set" (MDS) documented a brief interview for mental status (BIMS) of 13, which indicated intact cognition and one non-injury fall from 10/30/24 thru 11/04/24.

The 11/04/24 "Falls Care Area Assessment" (CAA) documented R15 was at risk for falls and received antidepressants for diagnosis of major depressive disorder. He has had one non injury fall since admission. He has not had a fall within the last year before admission. He is working with therapy to improve his strength and balance.

The 1/19/25 Quarterly "MDS" documented a BIMS of 12, which indicated moderate cognitive impairment and two or more noninjury falls.

The 02/05/25"Care Plan" documented the following fall interventions:
11/2/24 ensure R15 had his call light within reach and encourage him to use it to ask for assistance.
11/2/24 move R15's room closer to the nurse's station.
11/10/24 transfer pole to be placed near R15's bed on his left side.
11/24/24 transfer bar and grab bars in resident's bathroom.
12/07/24 fall lacked an intervention on the care plan.
12/13/24 a handlebar next to resident's closet.
12/15/24 bed in the lowest position.

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 _____	02/10/2025

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

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F 657	Continued From page 16	F 657		

12/20/24 nonskid strips on the floor.
01/25/25 computed tomography scan (CT- a noninvasive medical imaging procedure that uses X-rays to create detailed pictures of the inside of the body) of his head in order received to check for suspected neuro deficit to determine if neuro consultation is needed. Record review revealed this had not been completed.

They "Fall Risk Assessment" documented R15 fluctuated between moderate to high risk for falls.

The "Progress Note" on 11/02/24 at 01:13 AM documented a non-injury fall. The "Fall Report" documented a root cause analysis that he lost his balance and an intervention of a call light within reach.

The "Progress Note" on 11/02/24 at 11:10 AM documented a non-injury fall. The "Fall Report" documented a root cause analysis confusion, post hospitalization and staff moved his room closer to the nurse's station.

The "Progress Note" on 11/10/24 at 06:32 AM documented a non-injury fall. The "Fall Report" documented a root cause analysis that he lost his balance with an intervention of a transfer pole.

The "Progress Note" on 11/24/24 at 03:43 AM documented a non-injury fall. The "Fall Report" documented a root cause analysis that he went to the bathroom unattended. with an intervention of a transfer pole and bar in the bathroom.

The "Progress Note" on 12/07/24 at 01:05 AM documented a non-injury fall. There was no "Fall Report" that documented a root cause analysis, and it lacked an intervention.

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 _____	02/10/2025

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 657	Continued From page 17	F 657		

The "Progress Note" on 12/13/24 at 05:30 PM documented a fall that sent him to the ER. The "Fall Report" documented a root cause analysis that he lost his balance with an intervention of nonskid strips and a fall mat.

The fall on 12/15/24 lacked a "Progress Note". The "Fall Report" documented no root cause analysis, but an intervention of bed in lowest position.

The "Progress Note" on 1/20/25 09:35 PM documented a non-injury fall. He was wearing slippery socks and got up to go to the bathroom. The "Fall Report" documented a root cause analysis that he lost his balance ant they put strips on the floor.

The "Progress Note" on 1/25/25 at 10:46 PM documented a non-injury fall. The "Fall Report" documented a root cause analysis of suspected nero deficit (an impairment or loss of function in the nervous system, affecting the brain, spinal cord, nerves, or muscles).

During an observation on 02/05/25 at 09:26 AM, R15 was lying in bed the call light was on his over bed table that was several feet out of reach. He was asked where it was, he stated the call light was down there somewhere and pointed toward the head of the bed. There was no transfer bar beside his bed.

During an observation on 02/05/25 at 01:58 PM, R15 sat in his recliner with no call light within reach.

During an interview on 02/10/25 at 10:19 AM,

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 _____	02/10/2025

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 657	Continued From page 18	F 657		

Certified Nurse Aide (CNA) M reported that she looked at the care plan to know how to care for a resident. She reported that R15 had a fall mat and they do frequent checks.

During an interview on 02/10/25 at 12:49 PM, Licensed Nurse (LN) G reported that interventions for falls was group effort. Confirmed there was not a transfer pole beside his bed in his room.

During an interview on 02/10/25 at 11:20 AM, Administrative Nurse D was notified that R15 did not have his call light, she reported he should have his call light. She would fix that. She confirmed that the transfer pole was not in his room, it is on back order, also confirmed that R15 did not have the CT scan yet. Administrative D confirmed that there must be an appropriate intervention for each fall to keep the resident safe.

The facility's "Falls Management" policy dated 12/2018, revised 12/2020 documented the plan of care was to address individualized resident focus, goals, and interventions directed towards reducing the resident's risk if injury and potential recurrence of falls. The resident's plan of care was to be reviewed and revised with each fall occurrence and a new intervention or interventions implemented.

The facility failed to revise R15's care plan after falls. This placed the resident at risk for uncommunicated care needs. This deficient practice had the potential to have a negative effect on the overall physical and psychosocial well-being of the resident in the facility.

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 _____	02/10/2025

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

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F 657	Continued From page 19	F 657		

- Resident (R)11's Electronic Health Record (EHR) revealed diagnoses included diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), morbid obesity (serious condition of excessive body weight that seriously impacts the health and well-being), and chronic kidney disease (CKD- a long-term condition where the kidneys gradually lose their ability to filter waste products and excess fluid from the blood).

The 04/25/24 "Annual Minimum Data Set (MDS)" documented a "Brief Interview for Mental Status" (BIMS) score of 14, which indicated intact cognition. R11's total severity score of zero, indicating no depression. R11 had a Foley catheter (tube inserted into the bladder to drain urine into a collection bag) in place and was always incontinent of bowel. R11 required set up assistance for oral care and eating. R11 was dependent on staff assistance with toileting hygiene, dressing, transfers, and extensive staff assistance with bed mobility. R11 had a chair cushion and a pressure reducing mattress. No pressure areas at that time.

The 04/25/24 "Pressure Ulcer/Injury Care Area Assessment" (CAA) documented R11 had a Foley catheter (tube inserted into the bladder to drain urine into a collection bag) in place and was always incontinent of bowel. He had a mild risk of developing a pressure wound. He had a low air loss mattress.

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 _____	02/10/2025

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 657	Continued From page 20	F 657		

The 02/05/25 "Care Plan" documented. R11 had a stage two pressure ulcer to his buttock and directed the following interventions:
Pressure reducing mattress.
Wheelchair cushion when in wheelchair.
Given multivitamin.
Follow treatment orders.
Registered dietician to consult.

The 01/25/25 "Physician Orders" included an order for wound care to evaluate and treat for a Keloid (an overgrown scar) to R11's buttocks.

The wound care provider note with a date of service 01/16/25, identified the wound a stage two pressure ulcer.

The 01/30/25 "Skin Condition Note" noted shearing to an area of scar tissue that had reoccured along with shearing to the inner right buttock.The assessment documented R11 had a low air loss mattress and a cushion in his recliner.

During an observation on 02/06/25 at 08:02 AM, R11 sat in his motorized scooter next to his room and waited to be assisted to bed. His motorized scooter, his recliner, and his manual high back wheelchair did not have a seat cushion.

During an interview on 02/10/25 11:08 AM, R11 reported he did not have a cushion for his recliner, wheelchair, or motorized scooter. He reported he tried a cushion a couple months ago for about an hour or an hour and a half and it did not work.

During an interview on 02/10/25 at 10:32 AM,

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 _____	02/10/2025

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 657	Continued From page 21	F 657		

Certified Medication Aide (CMA) U reported that R11 did not have a cushion and did not want a cushion.

During an interview on 02/10/25 at 12:49 PM, Licensed Nurse (LN) G reported that R11 did not have a cushion in his recliner.

During an interview on 02/11/24 at 8:31AM, Administrative Nurse D confirmed the care plan for R11 was incorrect, he did not have a cushion in his recliner, his high back wheelchair, or either of his motorized scooters,

The facility's "Wound Prevention and Management" policy last updated 12/2018, documented the purpose of the policy was to develop interventions to decrease the incidence of residents who develop pressure ulcers. The policy documented residents that utilize a wheelchair will have a pressure reducing cushion.

The facility's "Electronic Care Plans" policy revised 12/2020, documented that the facility was to develop a plan of care to attain and maintain the highest practical level of physical, psychological, emotional, and social wellbeing for each resident in the facility. The resident's person-centered plan of care was an active working document that reflects the care needs and resident's voice.

The facility failed to revise R11's care plan to reflect the care need for the pressure area. This placed the resident at risk for uncommunicated care needs. This deficient practice had the potential to have a negative effect on the overall physical and psychosocial well-being of the resident in the facility.

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 _____	02/10/2025

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

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F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: The facility reported a census of 29 residents with 15 residents sampled, including two residents reviewed for skin issues. Based on observation, interview and record review, the facility failed to leave the shoes off one Resident (R)13, regarding the resident having abrasions (process of scraping or wearing something away) on the second toe of the right foot and the second and third toe of the left foot. Findings included: - Review of Resident (R)13's electronic medical record (EMR) revealed the following diagnoses: Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) and peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel). The "Annual Minimum Data Set" (MDS), dated 09/19/24, documented the resident had a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impairment. He required substantial to maximal staff assistance with	F 684		

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 _____	02/10/2025

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 684	Continued From page 23	F 684		

putting on and taking off his footwear.

The "Functional Abilities Care Area Assessment" (CAA), dated 09/19/24, documented the resident worked with restorative and required staff assistance with "Activities of Daily Living" (ADL) cares, at times.

The "Pressure Ulcer CAA," dated 09/19/24, documented staff would perform skin assessments per facility protocol.

The "Medicare Five-Day MDS," dated 01/05/25, documented the resident had a BIMS score of 12, indicating moderately impaired cognition. He required supervision to touching assistance of staff with lying to sitting to standing and walking 150 feet.

The care plan for skin, revised 01/05/25, instructed staff the resident had skin abrasions (process of scraping or wearing something away) to his second and third toe of his left foot and the second toe of his right foot. Staff were to leave the resident's shoes off and only have him wear non-skid socks until the abrasions were healed.

Review of the resident's EMR revealed the following physician's orders:

Apply skin preparation (a skin disinfectant) to the resident's bilateral (both sides) toes, twice daily (BID), until healed, ordered 01/05/25.

Resident to only wear non-skid socks until bilateral toe abrasions are healed, ordered 01/05/25.

Review of the resident's EMR revealed a nursing

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 _____	02/10/2025

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 684	Continued From page 24	F 684		

note which documented: red abrasions to bilateral toes with a new order in place. Intervention for resident to only wear non-skid socks until healed. Staff are aware of the new intervention.

On 02/05/25 at 09:03 AM, the resident sat in his wheelchair in the commons area. The resident wore white Velcro tennis shoes.

On 02/05/25 at 02:31 PM, the resident sat in the recliner in his room. The resident wore white Velcro tennis shoes.

On 02/06/25 at 08:05 AM, the resident sat at the dining room table and wore his white Velcro tennis shoes.

On 02/10/25 at 10:07 AM, the resident sat in the recliner in his room and wore his white Velcro tennis shoes.

On 02/10/25 at 11:19 AM, Licensed Nurse (LN) H entered the resident's room to administer the ordered treatment to the resident bilateral toes. LN H removed the resident's Velcro tennis shoes and socks to reveal his right foot, second toe wound measured 0.5 by 0.4 centimeters (cm), and had a tannish scab (a dry, rough protective crust that forms over a cut or wound during healing) covering the entire wound bed. The left foot second toe wound measured 1.0 by 0.5 cm and had a dark red scab covering the entire wound bed. The left foot third toe wound measured 0.3 by 0.2 cm and had a reddish colored scab covering the entire wound bed. The resident tolerated the treatment without signs or symptoms of pain or discomfort.

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 _____	02/10/2025

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 684	Continued From page 25 On 02/06/25 at 03:37 PM, Certified Medication Aide (CMA) T stated the resident wore his shoes every day. On 02/06/25 at 03:39 PM, Certified Nurse Aide (CNA) S stated the resident currently had abrasions on some of his toes, but he was able to wear shoes. On 02/10/25 at 10:09 AM, CNA M stated the resident was not to wear tennis shoes due to abrasions on his toes. Staff were to only put non-skid socks on him. On 02/10/25 at 10:17 AM, Licensed Nurse (LN) H stated the resident was not to wear shoes due to the abrasions on his toes. On 02/10/25 at 10:40 AM, Administrative Nurse D stated the abrasions on the resident's toes were caused by ill-fitting shoes which have been removed from the facility by family. It was the expectation for staff to not put shoes on him until the areas to his toes were healed. The facility policy for "wound Prevention and Management", revised 12/2018, included: If identified at risk or with actual alterations in skin integrity of feet, footwear will be addressed for appropriateness. The facility failed to leave the shoes off Resident (R)13 as ordered due to the abrasions on the second toe of the right foot and the second and third toe of the left foot.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686		

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 _____	02/10/2025

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 686	Continued From page 26 §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: The facility reported a census of 29 residents with 15 residents sampled, including four residents reviewed for pressure ulcers (PU). Based on interview, record review and observation, the facility failed to care and services to promote the healing of an existing PU for one Resident (R)13, regarding a stage II (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed) PU behind the left ear and R 11, for failure of ensuring the resident had a pressure reducing cushion to his wheelchair. Findings included: - Review of Resident (R)13's electronic medical record (EMR) revealed a diagnosis of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure). The "Annual Minimum Data Set" (MDS), dated 09/19/24, documented the resident had a Brief Interview for Mental Status (BIMS) score of 12,	F 686		

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 _____	02/10/2025

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 686	Continued From page 27	F 686		

indicating moderately impaired cognition. He used a walker and a wheelchair for locomotion. He was at risk for the development of pressure ulcers (PU) with no unhealed PUs at the time of the assessment.

The "Pressure Ulcer Care Area Assessment" (CAA), dated 09/19/24, documented the resident had a mild risk for the development of PUs.

The "Medicare Five-Day MDS," dated 01/05/25, documented the resident had da BIMS score of 12, indicating moderately impaired cognition. He required supervision to touching assistance of staff to ambulate 150 feet. He was at risk for the development of PUs with no unhealed PUs at the time of the assessment.

The skin care plan, revised 12/13/24, instructed staff the resident was at risk for skin breakdown and had a stage II ((partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed) PU to his left ear.

Review of the resident's EMR revealed BRADEN assessments (a tool used to assess a patient's risk of developing pressure ulcers), which placed the resident at a moderate risk for the development of PUs completed on, 12/15/24 and 12/30/24.

Review of the resident's EMR revealed the following physician's orders:

Cleanse the PU behind the left ear with hypochlorous acid (a disinfective and sanitizer), apply Triple Antibiotic Ointment (TAO-a medicated ointment), and cover the wound with a gauze pad (a thin, loosely woven fabric pad),

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 _____	02/10/2025

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 686	Continued From page 28	F 686		

every day (QD), until healed, ordered 01/22/25.

Pad the earpiece of resident's glasses and oxygen tubing, every day, related to PU behind left ear, ordered 01/22/25.

On 02/06/25 at 08:05 AM, the resident sat in his wheelchair at the dining room table. The resident wore his glasses, but lacked padding behind his left ear, as ordered.

On 02/06/25 at 10:09 AM, Licensed Nurse (LN) G entered the resident's room to do the PU treatment to the resident's left ear. The resident wore his glasses, but lacked padding behind his left ear, as ordered.

On 02/10/25 at 10:07 AM, the resident sat in the recliner in his room. The resident wore his glasses, but lacked padding behind his left ear, as ordered.

On 02/06/25 at 03:37 PM, Certified Medication Aide (CMA) T the resident was to have padding behind his left ear due to a PU. CMA T stated she was unsure why the padding was not in place.

On 02/06/25 at 03:39 PM, CMA S stated the resident was to have padding behind his left year, but the padding was in place at that time.

On 02/10/25 at 10:09 AM, Certified Nurse Aide (CNA) M confirmed the padding to the resident's glasses was not in place.

On 02/06/25 at 10:09 AM, Licensed Nurse (LN) G stated the PU to the back of the resident's left ear was caused by oxygen tubing and his glasses.

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 _____	02/10/2025

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 686	Continued From page 29	F 686		

The resident no longer used the oxygen but continued to wear his glasses. The resident was to have padding behind his left ear while wearing his glasses but confirmed the padding was not always in place.

On 02/10/25 at 10:40 AM, Administrative Nurse D stated it was the expectation for the staff to have the padding in place to the resident's left ear until the wound healed.

The facility policy for "wound Prevention and Management", revised 12/2018, included: The facility shall develop interventions to decrease the incidence of residents who develop pressure ulcers. The plan of care will address problems, goals, and interventions directed towards prevention of pressure ulcers and/or skin integrity concerns identified.

The facility failed to provide care and services to promote the healing of an existing PU, regarding padding to the back of this resident's left ear.
- Resident (R)11's Electronic Health Record (EHR) revealed diagnoses included diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), morbid obesity (serious condition of excessive body weight that seriously impacts the health and well-being), and chronic kidney disease (CKD- a long-term condition where the kidneys gradually lose their ability to filter waste products and excess fluid from the blood).

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 _____	02/10/2025

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 686	Continued From page 30	F 686		

The 04/25/24 "Annual Minimum Data Set (MDS)" documented a "Brief Interview for Mental Status" (BIMS) score of 14, which indicated intact cognition. R11's total severity score of zero, indicating no depression. R11 had a Foley catheter (tube inserted into the bladder to drain urine into a collection bag) in place and was always incontinent of bowel. R11 required set up assistance for oral care and eating. R11 was dependent on staff assistance with toileting hygiene, dressing, transfers, and extensive staff assistance with bed mobility. R11 had chair cushion and a pressure reducing mattress. No pressure areas at that time.

The 04/25/24 "Pressure Ulcer/Injury Care Area Assessment" (CAA) documented R11 had a Foley catheter (tube inserted into the bladder to drain urine into a collection bag) in place and was always incontinent of bowel. He had a mild risk of developing a pressure wound. He had a low air loss mattress.

The 02/05/25 "Care Plan" documented. R11 had a stage two pressure ulcer to his buttock and directed the following interventions:
Pressure reducing mattress.
Wheelchair cushion when in wheelchair.
Give multivitamin.
Follow treatment orders.
Registered dietician to consult.

The 01/15/25 "Physician Orders" included an order for wound care to evaluate and treat for a Keloid to R11's buttocks.

The 01/16/25, wound care provider note identified the wound on his buttock as a stage two

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 _____	02/10/2025

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 686	Continued From page 31	F 686		

pressure ulcer.

The "Wellness Meeting Note" dated 1/16/2025 at 02:25 PM, documented R11 was working with Wound Care Plus to assess his skin flap area on buttock that he has had for years to see if there was anything else to relieve pressure/pain to that area.

The 01/30/25 "Skin Condition Note" an area of scar tissue to the right buttock that had shearing was reoccurring. Also had shearing to inner buttock. Assessment documented a low air loss mattress and a cushion in his recliner.

During an observation on 02/06/25 at 08:02 AM, R11 sat in his motorized scooter next to his room and waited to be assisted to bed. His motorized scooter, his recliner, and his manual high back wheelchair did not have a seat cushion.

During an interview on 02/10/25 11:08 AM, R11 reported he did not have a cushion for his recliner, wheelchair, or motorized scooter. He reported he tried a cushion a couple months ago for about an hour or an hour and a half and it did not work.

During an interview on 02/10/25 at 10:32 AM, Certified Medication Aide (CMA) U reported that R11 did not have a cushion and did not want a cushion.

During an interview on 02/10/25 at 11:20 AM, Administrative Nurse D acknowledged that wound measurements had not been done and wound tracking and measuring was not up to standards, she was taking over wounds and was working on getting it in 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 _____	02/10/2025

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 686	Continued From page 32 During an interview on 02/10/25 at 12:49 PM, Licensed Nurse (LN) G reported that R11 does not have a cushion in his recliner. During an interview on 02/11/24 at 8:31AM, Administrative Nurse D confirmed the care plan for R11 was incorrect, he did not have a cushion in his recliner, his high back wheelchair, or either of his motorized scooters. The facility's "Wound Prevention and Management" policy last updated 12/2018, documented the purpose of the policy was to develop interventions to decrease the incidence of residents who develop pressure ulcers. The policy documented residents that utilize a wheelchair will have a pressure reducing cushion. The facility's "Electronic Care Plans" policy revised 12/2020, documented that the facility was to develop a plan of care to attain and maintain the highest practical level of physical, psychological, emotional, and social wellbeing for each resident in the facility. The resident's person-centered plan of care was an active working document that reflects the care needs and resident's voice. The facility failed to properly assess the pressure ulcer and revise R11's care plan to reflect the care need for the pressure area. This placed the resident at risk for uncommunicated care needs.	F 686		
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 -	F 689		

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 _____	02/10/2025

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 689	Continued From page 33	F 689		

§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 29 residents with 15 residents selected for review. Based on observation, interview, and record review, the facility failed to identify, implement, and reevaluate fall prevention interventions to prevent falls including failing to provide a call light within reach for Resident (R) 15, when staff preformed unsafe transfers and failed to follow the care plan for R20, and failed to follow the care plan by failing to provide the call light within reach R17 and R18. This placed the residents at risk for falls with injury.

Findings included:

- The Electronic Health Records (EHR) documented R15 had the following diagnoses that included cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), muscle weakness, diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), coronary artery disease (CAD-abnormal condition that may affect the flow of oxygen to the heart), hypertension (HTN-elevated blood pressure), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).

The 11/04/24 "Admission Minimum Data Set"

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 _____	02/10/2025

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 689	Continued From page 34	F 689		

(MDS) documented a brief interview for mental status (BIMS) of 13, which indicated intact cognition and one non-injury fall from 10/30/24 thru 11/04/24.

The 11/04/24 "Falls Care Area Assessment" (CAA) documented R15 was at risk for falls and received antidepressants for diagnosis of major depressive disorder. He has had one non injury fall since admission. He has not had a fall within the last year before admission. He is working with therapy to improve his strength and balance.

The 1/19/25 Quarterly "MDS" documented a BIMS of 12, which indicated moderate cognitive impairment and two or more noninjury falls.

The 02/05/25 "Care Plan" documented the following interventions:
11/2/24 ensure R15 had his call light within reach and encourage him to use it to ask for assistance.
11/2/24 move R15's room closer to the nurse's station.
11/10/24 transfer pole to be placed near R15's bed on his left side.
11/24/24 transfer bar and grab bars in resident's bathroom.
12/07/24 fall lacked an intervention on the care plan.
12/13/24 handlebar next to resident's closet.
12/15/24 his bed in the lowest position.
12/20/24 nonskid strips on the floor.
01/25/25 computed tomography scan (CT- a noninvasive medical imaging procedure that uses X-rays to create detailed pictures of the inside of the body) of his head in order received to check for suspected neuro deficit to determine if neuro consultation is needed.

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 _____	02/10/2025

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 689	Continued From page 35	F 689		

The "Fall Risk Assessment" for R15 documented between 11/02/24 and 02/08/25 documented scores between 9 and 22. Which indicated R15 was moderate to high risk for falls.

The "Progress Note" on 11/02/24 at 01:13 AM documented a non-injury fall. The "Fall Report" documented a root cause analysis that he lost his balance and an intervention of a call light within reach.

The "Progress Note" on 11/02/24 at 11:10 AM documented a non-injury fall. The "Fall Report" documented a root cause analysis confusion, post hospitalization and staff moved his room closer to the nurse's station.

The "Progress Note" on 11/10/24 at 06:32 AM documented a non-injury fall. The "Fall Report" documented a root cause analysis that he lost his balance with an intervention of a transfer pole.

The "Progress Note" on 11/24/24 at 03:43 AM documented a non-injury fall. The "Fall Report" documented a root cause analysis that he went to the bathroom unattended. with an intervention of a transfer pole and bar in the bathroom.

The "Progress Note" on 12/07/24 at 01:05 AM documented a non-injury fall. There was no "Fall Report" that documented a root cause analysis, and it lacked an intervention.

The "Progress Note" on 12/13/24 at 05:30 PM documented a fall that sent him to the ER. The "Fall Report" documented a root cause analysis that he lost his balance with an intervention of nonskid strips and a fall mat.

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 _____	02/10/2025

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 689	Continued From page 36	F 689		

The fall on 12/15/24 lacked a "Progress Note". The "Fall Report" documented no root cause analysis, but an intervention of bed in lowest position.

The "Progress Note" on 1/20/25 09:35 PM documented a non-injury fall. He was wearing slippery socks and got up to go to the bathroom. The "Fall Report" documented a root cause analysis that he lost his balance ant they put strips on the floor.

The "Progress Note" on 1/25/25 at 10:46 PM documented a non-injury fall. The "Fall Report" documented a root cause analysis of suspected nero deficit (an impairment or loss of function in the nervous system, affecting the brain, spinal cord, nerves, or muscles).

During an observation on 02/05/25 at 09:26 AM, R15 was lying bed, the call light was on his over bed table that was several feet out of reach. He was asked where it was, he stated the call light was down there somewhere and pointed toward the head of the bed. There was no transfer bar beside his bed.

During an observation on 02/05/25 at 01:58 PM, R15 sat in his recliner with no call light within reach.

During an interview on 02/10/25 at 10:19 AM, Certified Nurse Aide (CNA) M reported that she looked at the care plan to know how to care for a resident. She reported that R15 had a fall mat, and they do frequent checks.

During an interview on 02/10/25 at 12:49 PM, Licensed Nurse (LN) G reported that

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 _____	02/10/2025

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 689	Continued From page 37	F 689		

interventions for falls was group effort. Confirmed there was not a transfer pole beside his bed in his room.

During an interview on 02/10/25 at 11:20 AM, Administrative Nurse D was notified that R15 did not have his call light, she reported he should have his call light and she would fix that. She confirmed that the transfer pole was not in his room, it is on back order, also confirmed that R15 did not have the head CT yet even though it was the intervention for the fall on 01/25/25. Administrative D confirmed that there must be an appropriate intervention for each fall to keep the resident safe.

The facility's "Falls Management" policy dated 12/2018, revised 12/2020 documented the plan of care was to address individualized resident focus, goals, and interventions directed towards reducing the resident's risk if injury and potential recurrence of falls. The resident's plan of care was to be reviewed and revised with each fall occurrence and a new intervention or interventions implemented.

The facility failed to implement new interventions to prevent falls after several falls. This deficient practice placing her at risk for further falls.

- Resident (R) 17's Electronic Health Record (EHR) revealed diagnoses, which included: dementia (progressive mental disorder characterized by failing memory, confusion), muscle weakness, reduced mobility, abnormal gait (manner or style of walking), osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), osteoarthritis (degenerative changes to one or

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 _____	02/10/2025

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 689	Continued From page 38	F 689		

many joints characterized by swelling and pain), and diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin).

The 01/16/25 "Annual Minimum Data Set" (MDS) documented a "Brief Interview for Mental Status" (BIMS) score of five, which indicated severely impaired cognition. R17 required supervision or touch assistance with activities of daily living (ADL) to include dressing, toileting hygiene, footwear, personal hygiene and standing. The MDS documented R17 had one injury fall since the prior assessment.

The 01/16/25 "Falls Care Area Assessment" (CAA) documented R17 had a fall with a head laceration that required staples. The CAA revealed therapy worked with R17 to improve her strength and balance. The CAA noted the resident was a fall risk and staff were to assist her as needed.

The 01/16/25 "Cognitive Loss/Dementia" CAA documented R17 had a BIMS score of five. The CAA noted R17 usually understood others, others usually understood her, and staff were to assist with her cares as needed.

The 02/06/25 "Care Plan" documented the following fall prevention interventions including to keep the call light with the resident's reach and educate the resident to use the call light.

The "Fall Risk Evaluation" for R17, documented the resident was at moderate to high risk for falls.

The "Progress Note" on 06/18/24 at 11:21 PM revealed R17 experienced a non-injury fall, where

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 _____	02/10/2025

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 689	Continued From page 39	F 689		

R17 said she sat down on the arm of her chair and slid off.

The "Progress Note" on 09/19/24 at 06:03 AM revealed R17 experienced a non-injury fall, where R17 said she raised her electric chair too high and slid out.

The "Progress Note" on 11/05/24 at 04:04 PM revealed R17 lost her balance, fell, hit her head, and was taken to the hospital by EMS, where she required staples to close the laceration.

During an observation on 02/06/25 at 09:07 AM Maintenance Supervisor V checked the call lights in R17's room, with the surveyor. The call light in R17's room was activated by Maintenance Supervisor V but did not display on the computer monitor or alert to the staffs pager. The call light for R17's bathroom did not activate either.

During an interview on 02/06/25 at 02:41 PM, CMA S stated the call lights and pagers worked most of the time. CMA S stated the CNAs in the past did not carry the pagers and the residents got used to nobody answering them. CMA S said the facility implemented a pager sign out book to get staff to grab a pager, a couple of months ago, and wrote staff up if they did not have a pager. CMA S said as far as she was aware, this fixed the problem.

During an interview on 02/06/25 at 11:30 AM, Administrative Staff A was notified of the call lights that were not working. Administrative Staff A said Administrative Nurse D and Maintenance Staff V looked at the call lights about a week prior and they were working. Administrative Staff A stated that R17 preferred the hand bell. 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 _____	02/10/2025

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 689	Continued From page 40	F 689		

surveyor informed her the handbell was not within R17's reach..

During an interview on 02/06/25 at 12:00 PM, Administrative Nurse D said she was aware some of the call lights got stuck on and would not reset. Administrative Nurse D stated Maintenance Saff V checked all of the call lights within the last month, and they were all working. Administrative Nurse D said some of the call lights needed batteries at that time.

During an observation and interview on 02/06/25 at 02:26 PM, R17 sat in her recliner with her call light and hand bell out of her reach. The call light cord was loosely wound on the floor under the call light box. The surveyor handed the resident the call light, and R17 pushed the call light button. When asked, R17 reported she used the call light and she had used the hand bell a couple of times. R17 continued to push the call light button and said, "It doesn't work right. You have to keep pushing the button" and she continued to push it. At 02:58 PM on 02/06/25, no staff had responded to answer R17's call light. R17 kept pushing the call light button and said the staff will come eventually. The staff did stop by R17's room but not in response to the light. R17 stated, "See. I told you."

The call light display monitor did not show the call light was activated for R17.

The facility policy "Electronic Care Plan" dated 12/2020, documented the resident's person-centered plan of care is an active working document that reflects the care needs and the resident's voice.

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 _____	02/10/2025

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 689	Continued From page 41	F 689		

The facility failed to follow the fall prevention interventions to prevent falls for cognitively impaired R17, who had a history of falls at facility, when the facility staff did not ensure R17's call light was within reach and functioning. This deficient practice placed R17 at risk for further falls with injury.

- Review of Resident (R)20's electronic medical record (EMR) revealed a diagnosis of Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness).

The "Significant Change Minimum Data Set" (MDS), dated 12/19/24, documented the resident had a Brief Interview for Mental Status (BIMS) score of zero, indicating severe cognitive impairment. She was dependent on staff for chair-to-bed-to-chair transfers. The inaccurate MDS documented the resident had one injury (except major) fall since the prior assessment.

The "Functional Abilities Care Area Assessment" (CAA), dated 12/19/24, did not trigger.

The "Fall CAA," dated 12/19/24, documented the resident required staff assistance with cares.

The "Annual MDS," dated 12/05/24, documented the resident had a BIMS score of four, indicating severe cognitive impairment. She was dependent on staff for chair-to-bed-to-chair transfers. She had one injury (except major) fall since the prior assessment.

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 _____	02/10/2025

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 689	Continued From page 42	F 689		

The fall care plan, revised 11/29/24, instructed staff the resident required one to two staff assistance with transfers and the use of a gait belt. The staff were to ensure the resident's call light was within reach at all times while she was in her room.

Review of the resident's EMR revealed fall assessments, dated 10/28/24 and 12/17/24, which placed the resident at a moderate risk for falls. Fall assessments, dated 04/21/24 and 11/30/24, placed the resident at a high risk for falls.

Review of the resident's EMR, revealed the resident had an injury (except major) fall in her room from her recliner on 10/28/24. Staff informed the nurse the resident's electric lift chair with the lift chair in the upper most position and the resident on the floor in front of the electric chair. Upon assessment, the resident had a reddened area to her spine. The resident had no further injuries, was able to move all of her extremities per her normal and her vital signs (VS) were within normal range (WNR). Staff initiated neurology checks (a medical assessment that evaluates the function of a patient's nervous system by testing their mental status, muscle strength, coordination, sensation, reflexes, and other neurological functions), which were all WNR. The interdisciplinary team (IDT) initiated a new intervention to keep the resident's lift chair unplugged when the resident was in the chair to prevent her from raising the chair on her own.

Review of the resident's EMR revealed an "Electric Recliner Assessment", dated 11/05/24, which documented the resident did not have the physical or cognitive ability to safely operate 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 _____	02/10/2025

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 689	Continued From page 43	F 689		

electric recliner.

No other "Electric Recliner Assessments" were available in the resident's EMR.

Review of the resident's EMR, from 01/12/25 through 02/09/25, revealed the resident required substantial/maximal to dependent staff assistance with chair to bed to chair transfers.

Review of the resident's EMR, from 01/12/25 through 02/09/25, revealed the resident required substantial/maximal to dependent staff assistance with going from sitting to standing.

On 02/06/25 at 09:35 AM, Certified Medication Aide (CMA) S transferred the resident from her wheelchair to her electric recliner with extensive assistance and the use of the gait belt. The resident was unable to bear weight during the transfer. The electric recliner remained plugged in when the CMA left the room following cares. The controller to the electric recliner rested on the arm of the chair.

On 02/06/25 at 10:47 AM, the resident sat in her electric recliner in her room. The electric recliner remained plugged in and the controller to the recliner rested on the arm of the chair.

On 02/06/25 at 01:18 PM, Certified Nurse Aide (CNA) N and Licensed Nurse (LN) G transferred the resident from her wheelchair to her bed with extensive assistance and the use of a gait belt. The resident was unable to bear her full weight during the transfer.

On 02/06/25 at 09:39 AM, CMA S stated staff were not to unplug the resident's electric recliner.

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 _____	02/10/2025

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 689	Continued From page 44	F 689		

Staff were to use the chair plugged in at all times. CNA S stated the resident was able to bear some weight during transfers but was unable to bear her full weight.

On 02/06/25 at 01:18 PM, CNA N stated the resident could only bear minimal weight during transfers. Staff left the resident's electric recliner plugged in all of the time.

On 02/06/25 at 01:18 PM, LN G stated the resident was not able to fully bear weight during transfers. LN G was unsure if the resident's electric recliner was to be plugged in or not.

On 02/10/25 at 09:03 AM, Administrative Nurse D stated the intervention for the fall on 10/28/24 was to keep the lift chair unplugged when the resident sat in the chair. Administrative Nurse D stated a resident should be able to bear weight during a transfer for the transfer to be considered safe. The facility would possibly need to utilize the full body lift with the resident. Administrative Nurse D stated the 11/05/24 "Electric Recliner Assessment", was the only assessment available.

The facility policy for "Falls Management", revised 12/2022, included: The plan of care shall address individualized resident focus, goals, and interventions directed towards reducing the resident's risk of injury and potential reoccurrence of falls.

The facility policy for "Assessments", revised 11/2024, included: The "Electric Recliner Assessment" shall be completed with use of the electric recliner initiation then quarterly, and as needed.

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 _____	02/10/2025

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 689	Continued From page 45	F 689		

The facility failed to practice safe transfers for this dependent resident who was unable to bear weight during transfers. Furthermore, the facility failed to complete an "Electric Recliner Assessment" for this confused resident who was found to be physically and cognitively unable to safely operate the electric lift chair.

- Review of Resident (R)18's electronic medical record (EMR) revealed a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion).

The "Admission Minimum Data Set" (MDS), dated 07/09/24, documented the resident had a Brief Interview for Mental Status (BIMS) score of four, indicating severe cognitive impairment. The resident had no limitation in range of motion (ROM). He used a walker for mobility. He required substantial/maximal assistance of staff for lying to sitting to the side of the bed, sit to stand and chair/bed-to-chair transfers. The resident had no falls since the prior assessment.

The "Cognitive Loss/Dementia Care Area Assessment" (CAA), dated 07/09/24, documented the resident had a diagnosis of dementia and had the potential for falls.

The "Quarterly MDS," dated 01/02/25, documented the staff assessment for cognition revealed modified independence with daily decision making. He had limited ROM on one side of his lower extremity (LE) and used a walker and a wheelchair. He required substantial/maximal assistance of staff for lying to sitting to the side of the bed, sit to stand and chair/bed-to-chair transfers. The resident had two

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 _____	02/10/2025

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 689	Continued From page 46	F 689		

or more non-injury falls since the prior assessment.

The fall care plan, revised 12/24/24, instructed staff to ensure the call light was within reach of the resident and to encourage him to use it for assistance. Staff were to keep a non-skid substance in the resident's recliner to prevent him from sliding and to install a transfer pole between his bed and recliner.

Review of the resident's EMR revealed "Fall Assessments" dated 07/03/24, 12/15/24 and 12/24/24, which placed the resident at a high risk for falls.

Review of the resident's EMR revealed a "Fall Assessment" dated 09/28/24, which placed the resident at a moderate risk for falls.

Review of the resident's EMR revealed the resident had a non-injury fall in his room on 12/15/24 when he slid off his recliner seat and landed on the floor on his buttocks in front of his recliner.

Review of the resident's EMR revealed the resident had a non-injury fall in his room on 12/25/24 when he fell to the floor while attempting to get out of bed unassisted.

On 02/06/25 at 07:31 AM, the resident rested in bed. His call light was not within the resident's reach.

On 02/06/25 at 01:29 PM, the resident rested in bed. His call light was not within the resident's reach.

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 _____	02/10/2025

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 689	Continued From page 47 On 02/06/25 at 12:00 PM, Administrative Nurse D stated she knew some of the call lights would not turn off but was unaware there were so many call lights that did not work. The facility lacked a policy for call lights. The facility failed to ensure this dependent resident had a call light within reach for him to utilize to call for staff assistance.	F 689		
F 730 SS=F	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: The facility reported a census of 29 residents. Based on interview and record review, the facility failed to complete an annual performance review at least once every 12 months for two of the five Certified Nurse Aides (CNA) reviewed, CNA M and O, to ensure adequate appropriate cares and services provided to the residents of the facility. Findings included: - Review of five employee personnel files, employed by the facility for greater than one year, revealed the following concerns: 1. Certified Nurse Aide (CNA) M, hired 11/04/22, lacked an annual performance review in her	F 730		

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 _____	02/10/2025

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 730	Continued From page 48 personnel file. 2. CNA O, hired 11/27/23, lacked an annual performance review in her personnel file. On 02/10/25 at 10:03 AM, Administrative Nurse D confirmed the facility lacked annual evaluations for the two CNAs. The facility "Employee Handbook" included: Supervisors are to conduct performance evaluations of all full-time and part-time employees on an annual basis. The facility failed to complete an annual performance review at least every 12 months for these two CNAs, employed great than one year, to ensure appropriate cares and services were provided to the residents of the facility.	F 730		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse	F 757		

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 _____	02/10/2025

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 757	Continued From page 49	F 757		

consequences which indicate the dose should be reduced or discontinued; or

§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 29 residents with 15 residents selected for review. Based on observation, interview, and record review, the facility failed to keep the residents free from unnecessary drugs when they gave an excessive dose of a medication without provider notification that medications were held, this caused adverse complications for resident (R) 17 and R134. This placed the residents at risk for future adverse complications.

- Resident (R) 17's Electronic Health Record (EHR) revealed diagnoses, which included hypertension (HTN-elevated blood pressure) and dementia (progressive mental disorder characterized by failing memory, confusion).

The 01/16/25 "Annual Minimum Data Set (MDS)" documented a "Brief Interview for Mental Status" (BIMS) score of five, which indicated severely impaired cognition. R17 required set up assistance for eating and required supervision or touching assistance with activities of daily living (ADLs) to include dressing, toileting hygiene, footwear, personal hygiene and standing. R17 had one injury fall.

Review of the 02/06/24 "Care Plan" documented antihypertensive (class of medication used to treat high blood pressure) medications had a BBW.

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 _____	02/10/2025

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 757	Continued From page 50	F 757		

Review of the "Physician Orders" on 02/06/25 documented the following medications:
Metoprolol Succinate (medication that treats high blood pressure) extended release 100 mg one tablet by mouth one time a day for hypertension. Start date 05/03/23.
Clonidine HCl (medication that treats high blood pressure) Oral Tablet 0.1 MG one tablet by mouth three times a day hypertension. Start date 05/05/23. End date 01/21/25. Instructions to hold for systolic blood pressure (SBP- top number, the force your heart exerts on the walls of your arteries each time it beats) < (less than)130.
Diltiazem HCl (medication that treats high blood pressure) extended-release tablet 120 mg. Give 1 tablet by mouth one time a day for hypertension. Start date 01/18/24. Instructions to hold for pulse < 60.
Lisinopril (medication that treats high blood pressure) 20 mg one tablet by mouth one time a day for hypertension. Start date 05/21/24. Instructions to hold for SBP < 130.
Clonidine HCl oral tablet 0.1 mg one tablet by mouth two times a day for hypertension. Start date 01/21/25.

Review of the EMAR revealed:
Diltiazem was held two times in August without provider notification.
Diltiazem was held four times in October 2024 without provider notification.
Diltiazem was held four times in November 2024 without provider notification.
Diltiazem was held three times in December 2024 without provider notification.
Diltiazem was held three times in January 2025 without provider notification.

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 _____	02/10/2025

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 757	Continued From page 51	F 757		

Lisinopril was held one time in October 2024 without provider notification.
Lisinopril was held four times in November 2024 without provider notification.

Metoprolol was held two times in August 2024 without provider notification.
Metoprolol was held three times in October 2024 without provider notification.
Metoprolol was held four times in November 2024 without provider notification.
Metoprolol was held three times in December 2024 without provider notification.
Metoprolol was held three times in January 2025 without provider notification.

Clonidine HCl 0.1 mg three times a day was held 54 times in August without provider notification.
Clonidine HCl 0.1 mg three times a day was held 37 times in September without provider notification.
Clonidine HCl 0.1 mg three times a day was held 53 times in October 2024 without provider notification.
Clonidine HCl 0.1 mg three times a day was held 56 times in November 2024 without provider notification.
Clonidine HCl 0.1 mg three times a day was held 56 times in December 2024 without provider notification.
Clonidine HCl 0.1 mg three times a day was held 30 times in January 2025. It was decreased to Clonidine HCl 0.1 mg two times a day on 01/21/25 and was held five more times in January without provider notification.

The September EMAR had B/P documented from 94/67 to 187/103 without a documented assessment or provider notification.

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 _____	02/10/2025

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

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F 757	Continued From page 52	F 757		

The October EMAR had B/P documented from 91/47 to 172/83.
The November EMAR had B/P documented from 101/54 to 173/99.
The December EMAR had B/P documented from 90/42 to 176/84.
The January EMAR had B/P documented as low as 99/49 to 180/81.

Review of "Progress note" from 08/01/24 to 02/06/25 revealed documentation of the following B/P with no documentation of assessment or physician notification.
On 08/05/24 at 04:29 PM a "Progress Note" documented a B/P of 93/48.
On 08/06/24 at 02:27 PM a "Progress Note" documented a B/P of 92/57.
On 08/11/24 at 01:19 PM a "Progress Note" documented a B/P of 87/41.
On 09/03/24 at 01:34 PM a "Progress Note" documented a B/P of 90/57.
On 10/07/24 at 02:06 PM a "Progress Note" documented a B/P of 93/46.
On 10/20/24 at 02:32 PM a "Progress Note" documented a B/P of 93/49.
On 11/07/24 at 01:28 PM a "Progress Note" documented a B/P of 97/45.
On 11/14/24 at 01:39 PM a "Progress Note" documented a B/P of 94/81.
On 11/15/24 at 01:17 PM a "Progress Note" documented a B/P of 98/79.
On 11/17/24 at 07:58 AM a "Progress Note" documented a B/P of 91/54.
On 11/17/24 at 11:20 AM a "Progress Note" documented a B/P of 97/47.
On 11/20/24 at 01:16 PM a "Progress Note" documented a B/P of 94/56
On 11/26/24 at 07:16 PM a "Progress Note" documented a B/P of 91/50.

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 _____	02/10/2025

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 757	Continued From page 53	F 757		

On 11/27/24 at 07:08 Pm a "Progress Note" documented a B/P of 93/76.
On 11/29/24 at 02:02 PM a "Progress Note" documented a B/P of 95/54.
On 11/30/24 at 07:23 PM a "Progress Note" documented a B/P of 96/53.
On 12/06/24 at 07:09 PM a "Progress Note" documented a B/P of 92/44.
On 12/10/24 at 02:02 PM a "Progress Note" documented a B/P of 91/63.
On 12/19/24 at 01:05 PM a "Progress Note" documented a B/P of 90/56.
On 12/23/24 at 01:09 PM a "Progress Note" documented a B/P of 79/51.
On 01/07/25 at 01:32 PM a "Progress Note" documented a B/P of 93/52.
On 01/12/25 at 03:17 PM a "Progress Note" documented a B/P of 90/54.
On 01/20/25 at 11:58 AM a "Progress Note" documented a B/P of 98/57.

On 01/21/25 at 01:02 PM a "Progress Note" documented a new order from the provider to decrease Clonidine to BID (with same parameters) due to med being held so often.

During an interview on 02/10/25 at 12:39 PM, Administrative Nurse D revealed it was her expectation that staff would notify the provider if a medication was held or not given for any reason and that staff would document provider notification in the EHR.

During an interview on 02/10/25 at 12:49 PM, Licensed Nurse (LN) G stated she notified the provider every time she held a medication and documented it in the EHR. When a medication is held, the provider should always be notified,

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 _____	02/10/2025

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 757	Continued From page 54	F 757		

During an interview on 02/10/25 at 03:58 PM, LN H stated he would notify the physician every time he held a medication and document it in the EHR.

The facility lacked a policy on physician notification.

The failed to keep the residents free from unnecessary drugs when they gave an excessive dose of an
antihypertensive medication without notifying the provider of holding medications, this caused adverse complications for resident (R) 17. This placed the resident at risk for future adverse complications.

- Resident (R) 134's Electronic Health Record (EHR) revealed diagnoses, which included diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin)
The "Admission Minimum Data Set (MDS)" was not completed.
Review of the 02/06/24 "Care Plan" documented R134 had a risk for hypoglycemia and hyperglycemia.
Review of the "Physician Orders" on 02/06/25 documented the following medications:
Lantus Subcutaneous Solution 100 units/ml (Insulin Glargine) (medication to lower blood sugar levels) 40 units subcutaneously two times a day related to diabetes. Started on 02/04/25.
Novolog Flex Pen Subcutaneous Solution Pen-injector 100 units/ml (Insulin Aspart) (medication to lower blood sugar levels) 10 units subcutaneously before meals related to diabetes type two. Start date 02/04/25. Instructions to hold if R134 did not eat or if blood sugar was less than 110.

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 _____	02/10/2025

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 757	Continued From page 55	F 757		

Review of the EMAR revealed Novolog was held on the days and time following times:
On 02/04/25 the morning dose was held for a blood sugar level of 90.
On 02/05/25 the morning dose was held for a blood sugar level of 63.
On 02/05/25 the supper dose was held for a blood sugar level of 88.
On 02/06/25 the morning dose was held for a blood sugar level of 87.
On 02/07/25 the supper dose was held for a blood sugar level of 99.
On 02/08/25 the morning dose was held for a blood sugar level of 86.
On 02/09/25 the morning dose was held for a blood sugar level of 68.
On 02/09/25 the supper dose was held for a blood sugar level of 94.
On 02/10/25 the morning dose was held for a blood sugar level of 72.
Review of "Progress note" from 02/03/25 to 02/06/25 revealed the provider was notified only on the 02/05/25 that the insulin dose was held.
During an interview on 02/10/25 at 12:39 PM, Administrative Nurse D revealed it was her expectation that staff would notify the provider if a medication was held or not given for any reason and that staff would document provider notification in the EHR.
During an interview on 02/10/25 at 12:49 PM, Licensed Nurse (LN) G stated she notified the provider every time she held a medication and documented it in the EHR. When a medication is held, the provider should always be notified.
During an interview on 02/10/25 at 03:58 PM, LN H stated he would notify the physician every time he held a medication and document it in the EHR.
The facility lacked a policy on physician notification.

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 _____	02/10/2025

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 757	Continued From page 56 The failed to keep the residents free from unnecessary drugs when they failed to notify the provider that insulin required to be held nine times in ten days, this had the risk for adverse complications for resident (R) 17. This placed the resident at risk for future adverse complications.	F 757		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §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	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 _____	02/10/2025

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 57	F 758		

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 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 facility reported a census of 29 residents with 15 residents sampled including five residents reviewed for unnecessary medications. Based on observation, record review and interview, the facility failed to monitor four Residents (R)12, R 17, R 18, and R 30, for use of antipsychotic medications (drugs used to treat psychosis-related conditions and symptoms), regarding the facility's failure to complete informed consents for the use of psychotropic (medications used to treat mental illnesses by affecting the chemical makeup of the brain and nervous system) and antipsychotic medications. Furthermore, the facility failed to monitor the use of an antianxiety (a class of medications used to treat anxiety disorders and related symptoms like excessive worry, fear, and tension) medication.

Findings included:

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 _____	02/10/2025

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 58	F 758		

- Review of Resident (R)12's electronic medical record (EMR) revealed diagnoses which included: depression (a mood disorder that causes a persistent feeling of sadness and loss of interest) and anxiety (an emotion characterized by feelings of worry, unease, or fear, often in anticipation of a future threat or event).

The "Annual Minimum Data Set" (MDS), dated 10/10/24, documented the resident had a Brief Interview for Mental Status (BIMS) score of two, indicating severe cognitive impairment. She received antianxiety medication (a class of medications used to treat anxiety disorders and related symptoms like excessive worry, fear, and tension) and antidepressant medication (medications used to treat mental illnesses by affecting the chemical makeup of the brain and nervous system) during the assessment period.

The "Psychotropic Drug Use Care Area Assessment" (CAA), dated 10/10/24, documented the resident received antidepressant and antianxiety medications.

The "Quarterly MDS," dated 01/09/25, documented the resident had a BIMS score of two, indicating severe cognitive impairment. She received antianxiety and antidepressant medications during the assessment period.

The psychotropic medications care plan, revised 01/03/25, instructed staff to monitor and document any side effects of the resident's antianxiety and antidepressant medications and to notify the physician of any adverse reactions.

Review of the resident's EMR revealed the following physician's orders:

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 _____	02/10/2025

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 59	F 758		

Prozac (an antidepressant medication), 10 milligrams (mg), by mouth (po), every day (QD), for a diagnosis of depression, ordered 11/02/20.

Xanax (an antianxiety medication), 0.25 mg, po, at bedtime (HS), for a diagnosis of anxiety, ordered 03/13/24.

Review of the resident's "Medication Administration Record" (MAR) from 01/01/25 through 02/06/25, revealed the resident received the medications, as ordered.

Review of the resident's EMR revealed the facility lacked a signed and dated "Informed Consent" for the use of psychotropic medications.

On 02/05/25 at 12:12 PM, the resident sat at the dining table in her wheelchair. No indication of tearfulness or anxiety.

On 02/06/25 at 07:39 AM, Certified Medication Aide (CMA) U combed and styled the resident's hair before breakfast. The resident chatted and interacted with the CMA during her cares. No obvious outward evidence of depression or anxiety displayed at that time.

On 02/11/25 at 11:05 AM, Administrative Nurse D stated the "Informed Consent" forms were not completed and signed for the residents who received psychotropic medications.

The facility policy for "Behavior Management and Psychotropic Medications", revised 11/2024, included: An informed consent will be completed for the use of psychotropic medications that affect brain activity for the residents prior to initial

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 _____	02/10/2025

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 60	F 758		

administration of the medication.

The facility failed to complete an "Informed Consent" for this dependent resident who received psychotropic medications.

- Review of Resident (R)18's electronic medical record (EMR) revealed the following diagnoses: dementia (progressive mental disorder characterized by failing memory, confusion) and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).

The "Admission Minimum Data Set" (MDS, dated 07/09/24, documented the resident had a Brief Interview for Mental Status (BIMS) score of four, indicating severe cognitive impairment. She received antipsychotic medication during the assessment period. (This inaccurate) MDS failed to document the resident received antidepressant medications throughout the assessment period.)

The "Psychotropic Drug Use Care Area Assessment" (CAA), dated 07/09/24, documented the resident's medications would be reviewed by the pharmacy consultant and adjustments completed, as needed (PRN).

The "Quarterly MDS," dated 01/02/25, documented the staff assessment for cognition revealed modified independence for daily decision making. She received antipsychotic and antidepressant medications during the assessment period.

The care plan for psychotropic medications, revised 09/27/24, instructed staff the resident took antidepressant medications for tearfulness

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 _____	02/10/2025

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 61	F 758		

and an antipsychotic medication for agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition).

Review of the resident's EMR revealed the following physician's orders:

Venlafaxine (an antidepressant medication), 75 milligrams (mg), by mouth (po), every day (QD), for a diagnosis of depression, ordered 07/03/24.

Seroquel (an antipsychotic medication) 25 mg, po, twice daily (BID), for a diagnosis of depression, ordered 07/03/24.

Review of the residents "Medication Administration Record" (MAR) from 01/01/25 through 02/06/25, revealed the resident received the medications, as ordered.

Review of the resident's EMR revealed the facility lacked a signed and dated "Informed Consent" for the use of psychotropic medications.

On 02/05/25 at 11:57 AM, Certified Medication Aide (CMA) U propelled the resident in his wheelchair to the dining room for lunch. The resident had no obvious outward indications of tearfulness or agitation.

On 02/11/25 at 11:05 AM, Administrative Nurse D stated the "Informed Consent" forms were not completed and signed for the residents who received psychotropic medications.

The facility policy for "Behavior Management and Psychotropic Medications", revised 11/2024, included: An informed consent will be completed for the use of psychotropic medications that affect

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 _____	02/10/2025

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 62	F 758		

brain activity for the residents prior to initial administration of the medication.

The facility failed to complete an "Informed Consent" for this dependent resident who received psychotropic medications.

- Review of Resident (R)17's electronic medical record (EMR) revealed the following diagnoses: major depressive disorder (MDD-major mood disorder which causes persistent feelings pf sadness) and anxiety (emotion characterized by feelings of worry, unease, or fear, often in anticipation of a future threat or event).

The "Annual Minimum Data Set" (MDS), dated 01/16/25, documented the resident had a Brief Interview for Mental Status (BIMS) score of five, indicating severe cognitive impairment. She received antidepressant medication (medications used to treat mental illnesses by affecting the chemical makeup of the brain and nervous system) during the assessment period.

The "Psychotropic Drug Use Care Area Assessment" (CAA), dated 01/16/25, documented the resident received antidepressant medication for a diagnosis of MDD.

The "Quarterly MDS," dated 10/24/24, documented the resident had a BIMS score of five, indicating severe cognitive impairment. She received an antidepressant medication during the assessment period.

Review of the resident's EMR revealed the following physician's 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 _____	02/10/2025

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 63	F 758		

Fluoxetine (an antidepressant medication), 60 milligrams (mg) one-half tablet, by mouth (po), every day (QD), for a diagnosis of MDD, ordered 1/14/23.

Review of the resident's "Medication Administration Record" (MAR) from 01/01/25 through 02/06/25, revealed the resident received the medications, as ordered.

Review of the resident's EMR revealed the facility lacked a signed and dated "Informed Consent" for the use of psychotropic medications.

On 02/11/25 at 11:05 AM, Administrative Nurse D stated the "Informed Consent" forms were not completed and signed for the residents who received psychotropic medications.

The facility policy for "Behavior Management and Psychotropic Medications", revised 11/2024, included: An informed consent will be completed for the use of psychotropic medications that affect brain activity for the residents prior to initial administration of the medication.

The facility failed to complete an "Informed Consent" for this dependent resident who received psychotropic medications.

- Review of Resident (R)30's electronic medical record (EMR) revealed the following diagnoses: anxiety (emotion characterized by feelings of worry, unease, or fear, often in anticipation of a future threat or event) and major depressive disorder (MDD-major mood disorder which causes persistent feelings of sadness) and insomnia (the inability to sleep).

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 _____	02/10/2025

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 64	F 758		

The "Annual Minimum Data Set" (MDS), dated 12/16/24, documented the resident admitted to the facility on 12/09/24 and had a Brief Interview for Mental Status (BIMS) score of five, indicating severe cognitive impairment. He received antidepressant (a class of medications used to treat mood disorders) and antianxiety medications (a class of medications that calm and relax people) during the assessment period.

The "Psychotropic Drug Use Care Area Assessment" (CAA), dated 12/16/24, documented the resident received antidepressant and antianxiety medications.

The care plan for psychotropic medications instructed staff the resident took an antidepressant for insomnia and an antianxiety medication for agitation.

Review of the resident's EMR revealed the following physician's order:

Lorazepam (a class of medications that calm and relax people), 05 milligrams (mg), by mouth (po), every six hours, as needed (PRN), for a diagnosis of anxiety, ordered 12/09/24.

Mirtazapine (class of medications used to treat mood disorders), 15 mg, po, at bedtime (HS), for a diagnosis of insomnia, ordered 12/10/24.

Review of the resident's "Medication Administration Record" (MAR) from 12/09/24 through 02/06/25, revealed the resident's Mirtazapine medication was given as ordered.

Review of the resident's "Medication

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 _____	02/10/2025

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 65 Administration Record" (MAR) from 12/09/24 through 02/06/25, revealed the resident's Lorazepam was given 14 times with effective results. However, documentation failed to document any behaviors at the time of the antianxiety medication administration. Review of the resident's EMR revealed the facility lacked a signed and dated "Informed Consent" for the use of psychotropic medications. On 02/11/25 at 11:05 AM, Administrative Nurse D stated the "Informed Consent" forms were not completed and signed for the residents who received psychotropic medications. The facility policy for "Behavior Management and Psychotropic Medications", revised 11/2024, included: An informed consent will be completed for the use of psychotropic medications that affect brain activity for the residents prior to initial administration of the medication. The facility failed to complete an "Informed Consent" for this dependent resident who received psychotropic medications.	F 758		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880		

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 _____	02/10/2025

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 880	Continued From page 66	F 880		

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

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct

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 _____	02/10/2025

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

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F 880	Continued From page 67	F 880		

contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

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

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

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 29 residents. The sample included 15 residents. Based on observation, interview, and record review, the facility failed to maintain an effective infection control program related to the staff improper hand hygiene with wound dressing changes and catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) care. The facility failed to follow enhanced barrier precautions (a set of infection control measures that use gowns and gloves to reduce the spread of multidrug-resistant organisms (MDROs) in nursing homes) (EBP). This deficient practice had the potential to spread possible infections to the residents in the facility.

Findings included:

On 02/06/25 at 08:12 AM, Certified Medication Aide (CMA) U, Certified Nurse Aide (CNA) N, and

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F 880	Continued From page 68	F 880		

Licensed Nurse (LN) G entered R11's room to transfer him and change the leg bag on the foley catheter to a full-sized bedside bag. The staff undressed him and changed out his catheter bag. They removed their gloves, but failed to preform proper hand hygiene before the put on new gloves and continued to dress R11 and got him ready to rest in bed.

During an interview on 02/06/25 at 08:22 AM (CMA) U and (CNA) N revealed they forgot to put on the gown for EBP. Also discussed that they failed to preform hand hygiene after removing their gloves. CMA U stated they used to have hand sanitizer in the room on the shelf, but it was no longer there.

On 02/06/25 at 10:09 AM, Licensed Nurse (LN) G performed a treatment and dressing change on R13. LN G washed hands with soap and water and dried with clean paper towels. Cleansed area with a gauze pad. LN G failed to peroform hand hygiene and change gloves prior to placing the clean dressing.

On 02/10/25 at 12:46 PM, CNA P, was observed removing dirty sheets off R11's bed. CNA P confirmed she had just given R11 a bed bath and transferred him to his recliner, she did not wear the proper PPE.

During an interview on 2/06/25 at 02:41 PM, CMA S stated that staff was required to use PPE when they cared for R11, and anyone that had a catheter or a wound and required EBP. CMA S stated that hand hygiene should always be done after gloves were removed.

During an interview on 02/10/25 at 10:19 AM,

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F 880	Continued From page 69 CNA M reported that staff gown up and glove up every time they provided care for a resident with wounds or a catheter. CNA M reported that they were to always preform hand hygiene every time before they put on cloves and when they removed their gloves. During an interview on 02/10/25 at 11:20 AM, Administrative Nurse D confirmed that it was her expectation that all staff follow EBP and gown up when they completed care for a person with a catheter or an open wound. It was her expectation that all staff preform hand hygiene prior to putting on gloves and when they took them off and other times according to the policy, The facility failed to maintain an effective infection control program related to improper hand hygiene after removal of soiled gloves and failed to wear the proper PPE when staff cared for residents on EBP to prevent cross contamination in the facility.	F 880		
F 919 SS=F	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: The facility reported a census of 29 residents. The sample included 15 residents. Based on observation, interview, and record review the	F 919		

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F 919	Continued From page 70	F 919		

facility failed to maintain a functional emergency call system, which allowed residents to call for staff assistance from each resident's room, bedside, bathroom area, and/or bathing facilities and alarmed at a centralized staff work area.

Findings included:

- On 02/05/25 at 09:02 AM, Resident (R) 11 sat in his recliner with his emergency call light laying on the floor behind the table beside him. The emergency call light sat out of his reach. The resident reported he used his phone to call for assistance when his emergency call light did not work.

On 02/05/25 at 09:26 AM, R15's emergency call light sat on the over-bed table and out of the resident's reach.

On 02/05/25 at 10:16 AM, R16 stated the facility emergency call system did not always work and the resident reported using the phone to call for staff assistance at times.

On 02/06/25 at 07:52 AM Licensed Nurse (LN) G and Certified Medication Aide (CMA) U reported they did not have pagers on them, which indicated a resident activated their emergency call light. CMA U stated there was a computer monitor, concealed by a curtain, which alerted staff a resident's emergency call light was activated and noted it could be seen in the commons area.

On 02/06/25 at 07:57 AM CMA R stated she forgot to grab a pager to monitor resident emergency call lights.

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F 919	Continued From page 71	F 919		

On 02/06/25 at 08:53 AM, during a call light observation with Maintenance Staff V to check the functionality of resident emergency lights revealed one resident room had a call light that only activated after three attempts and the shower room had two call lights, which did not work.

Observation of call lights on 02/06/25 from 08:56 AM through 10:04 AM revealed 16 resident emergency call lights that malfunctioned by continuing to sound once deactivated, never activated on staff pagers, never activated on the facility computer, and/or did not activate at all. The observations included both resident rooms and bathrooms.

During an interview on 02/06/25 at 10:06 AM, Maintenance Staff V stated he checked all of the staff pagers and call lights monthly. Maintenance Staff V completed a random weekly audit in addition to his monthly call light review. He reported in November or December he was notified of the resident emergency call lights not working and stated the facility immediately fixed the problem. Maintenance Staff V reported staff were taking the batteries out of the pagers and did not use them because "they did not want to carry them."

During an interview on 02/06/25 at approximately 11:30 AM, Administrative Staff A stated she was not aware of any current issues with the resident emergency call light system Administrative Staff A stated Administrative Nurse D and Maintenance Staff V checked all of the call lights about a week prior and everything was working properly. Administrative Staff A further stated she did not hear anything about staff choosing not to use

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F 919	Continued From page 72 their pagers. During an interview on 02/06/25 at 02:41 PM, CMA S stated the call lights and pagers worked most of the time. She stated the CNAs in the past did not carry the pagers and the residents got used to nobody answering them. The facility failed to provide a policy for the use of emergency call lights. The facility failed to maintain an emergency call system, which allowed residents to call for staff assistance from each resident's room, bedside, bathroom area, and/or bathing facilities and alarmed at a centralized staff work area.	F 919		