STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175275	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/02/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The following citations represent the findings of complaint investigation KS00195955. 2567 was sent electronically on 07.17.25	F0000		
F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: The facility reported a census of 24 residents, with four residents reviewed for abuse. Based on observation, interview, and record review, the facility failed to ensure Resident (R) 1 remained free from verbal abuse and mistreatment. This deficient practice placed the resident at risk for fear and decreased quality of life. Findings included: - R1's Electronic Health Record (EHR) documented diagnoses that included unspecified dementia (a progressive mental disorder characterized by failing memory and confusion).	F0600		

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175275	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/02/2025

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F0600 SS = D	Continued from page 1 R1's 12/13/24 "Significant Change Minimum Data Set" (MDS) documented a Brief Interview of Mental Status (BIMS) score of seven, which indicated severely impaired cognition. The assessment documented R1 utilized a wheelchair for locomotion and was dependent on staff for shower/bathing and toileting hygiene. R1 required substantial/maximal assistance for all other cares except eating, which was performed independently. The assessment documented R1 was frequently incontinent of bowel and bladder. The 12/13/24 "Delirium CAA" documented R1 was unable to focus attention and had disorganized thoughts. The 12/13/24 "ADL Functional / Rehabilitation Potential CAA" documented R1 needed assistance from staff. R1's 03/14/25 "Quarterly MDS" documented a BIMS score of 99 which indicated the assessment could not be completed. Staff assessed R1 to have memory problems with moderately impaired cognition. The assessment documented R1 was dependent on staff for shower/bathing and toileting hygiene. R1 required substantial/maximal assistance for all other cares except eating, which required setup/cleanup assistance. R1 was frequently incontinent of bowel and bladder. The EHR "Progress Notes" tab reviewed from 06/04/25 to 07/02/25 lacked documentation of the incident on 06/08/25. The facility's investigation documented on 06/08/25 at approximately 01:30 AM, Certified Nurse Aide (CNA) M and CNA O provided incontinence care to R1. R1 had feces on one hand, and when CNA O attempted to clean R1's hand, R1 reached for CNA M. CNA O reported that CNA M threatened R1 with physical violence if he touched her. CNA O informed CNA M that the speech was inappropriate and asked CNA M to leave the room. CNA O's undated and unnotarized "Witness Statement" documented on (the night of) 06/07/25, R1 had a loose bowel movement in bed, and CNA M and CNA O went into R1's room to clean him up. CNA O documented that CNA M was assisting R1 with standing so CNA O could clean the bed and the resident. CNA O documented CNA M said, "If you touch me with that hand, I will head butt you" to R1. CNA O documented that she informed CNA M that she could not say that to a resident. The facility did not obtain a witness statement from CNA M. During an observation on 07/02/25 at 11:40 AM, R1	F0600		

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F0600 SS = D	Continued from page 2 self-propelled in his wheelchair in the front lobby of the building without an apparent destination. During an interview on 07/02/25 at 11:40 AM, R1 was unable to answer questions, responding with rambling speech. He indicated he wanted to go fishing after attending religious services. On 07/02/25 at 11:00 AM, CNA O was unavailable for interview, and no contact information was provided by the facility. During an interview on 07/02/25 at 11:30, CNA N revealed if she observed another staff member saying or doing anything inappropriate to a resident, she would intervene and ensure resident was safe then immediately report to the charge nurse, Administrative Staff A or Administrative Nurse D. CNA N confirmed education was provided by leadership staff since the incident that occurred on 06/08/25. During an interview on 07/02/25 at 11:42 AM, Certified Medication Aide (CMA) R revealed if they observed another staff saying or doing anything inappropriate to a resident, they would intervene and ensure the resident remained safe and then immediately report to the charge nurse, Administrative Nurse D or Administrative Staff A. CMA R confirmed education was provided by leadership since the incident that occurred 06/08/25. During an interview on 07/02/25 at 11:45 AM, Maintenance U revealed if another staff member was observed saying or doing anything inappropriate to a resident, he would intervene and ensure the resident was safe, then immediately report to Administrative Staff A. Maintenance U confirmed education had been provided by leadership since the incident that occurred on 06/08/25. During an interview on 07/02/25 at 11:50 AM, Dietary BB revealed if another staff was observed saying or doing anything inappropriate to a resident, their immediate reaction depended on what happened and would report the concern immediately to her supervisor and/or Administrative Staff A. Dietary BB revealed that no education had been provided by leadership since the incident on 06/08/25. During an interview on 07/02/25 at 11:55 AM, Dietary CC revealed if she witnessed anything she suspected was inappropriate, she would immediately report the situation to her supervisor and/or Administrative Staff A. Dietary CC revealed no education had been provided	F0600		

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F0600 SS = D	Continued from page 3 by leadership since the incident on 06/08/25. During an interview on 07/02/25 at 11:56 AM, Laundry W revealed if she saw or heard anything that she thought was inappropriate towards a resident, she would immediately report the situation to her supervisor or Administrative Staff A. Laundry W revealed no education was provided by leadership since the incident on 06/08/25 During an interview on 07/02/25 at 12:00 PM, Administrative Staff A revealed on 06/11/25 at approximately 02:00 PM, Administrative Nurse D and a group of CNA staff had a meeting where CNA O revealed the statements made by CNA M to R1 on 06/08/25. Administrative Nurse D immediately notified Administrative Staff A, who initiated an investigation. Administrative Staff A revealed CNA M was telephoned and informed not to return to the facility as her employment was terminated due to the result of the investigation, as well as other concerns. Administrative Staff A reported that staff education was only provided to direct care staff, as the allegation of abuse was a nursing matter. The facility's 10/2022 "Abuse, Neglect and Exploitation" policy documented that the resident has the right to be free from verbal, sexual, physical, and mental abuse and involuntary seclusion. The policy defined verbal abuse as oral language and provided an example of threats of harm.	F0600		
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term	F0609		

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F0609 SS = D	Continued from page 4 care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: The facility reported a census of 24 residents, with four residents reviewed for abuse. Based on observation, interview and record review, the facility failed to report an allegation of abuse for one resident, Resident (R) 1 when on 06/08/24 at approximately 01:30 AM, Certified Nurse Aide (CNA) M verbally threatened R1 with physical violence was witnessed by CNA O, however the incident was not reported to Administrative Nurse D until 06/11/25 at approximately 02:00 PM. This deficient practice allowed CNA M to work an additional three shifts, which had the potential to have a negative psychosocial impact for the residents in the facility. Findings included: - R1's Electronic Health Record (EHR) documented diagnoses that included unspecified dementia (a progressive mental disorder characterized by failing memory and confusion). R1's 12/13/24 "Significant Change Minimum Data Set" (MDS) documented a Brief Interview of Mental Status (BIMS) score of seven, which indicated severely impaired cognition. The assessment documented R1 utilized a wheelchair for locomotion and was dependent on staff for shower/bathing and toileting hygiene. R1 required substantial/maximal assistance for all other cares except eating, which was performed independently. The assessment documented R1 was frequently incontinent of bowel and bladder. The 12/13/24 "Delirium CAA" documented R1 was unable to focus attention and had disorganized thoughts. The 12/13/24 "ADL Functional / Rehabilitation Potential CAA" documented R1 needed assistance from staff. R1's 03/14/25 "Quarterly MDS" documented a BIMS score of 99, which indicated the assessment could not be	F0609		

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F0609 SS = D	Continued from page 5 completed. Staff assessed R1 to have memory problems with moderately impaired cognition. The assessment documented R1 was dependent on staff for shower/bathing and toileting hygiene. R1 required substantial/maximal assistance for all other cares except eating, which required setup/cleanup assistance. R1 was frequently incontinent of bowel and bladder. The EHR "Progress Notes" tab reviewed from 06/04/25 to 07/02/25 lacked documentation of the incident on 06/08/25. The facility's investigation documented on 06/08/25 at approximately 01:30 AM, Certified Nurse Aide (CNA) M and CNA O provided incontinence care to R1. R1 had feces on one hand, and when CNA O attempted to clean R1's hand, R1 reached for CNA M. CNA O reported that CNA M threatened R1 with physical violence if he touched her. CNA O informed CNA M the speech was inappropriate and asked CNA M to leave the room. CNA O's undated and unnotarized "Witness Statement" documented on (the night of) 06/07/25, R1 had a loose bowel movement in bed, and CNA M and CNA O went into R1's room to clean him up. CNA O documented that CNA M was assisting R1 with standing so CNA O could clean the bed and the resident. CNA O documented CNA M said, "If you touch me with that hand, I will head butt you" to R1. CNA O documented she informed CNA M that she could not say that to a resident. The facility did not obtain a witness statement from CNA M. Review of the facility's staffing schedule revealed CNA M worked 06/07/25, 06/08/25, 06/09/25, and 06/10/25. During an observation on 07/02/25 at 11:40 AM, R1 self-propelled in his wheelchair in the front lobby of the building without an apparent destination. During an interview on 07/02/25 at 11:40 AM, R1 was unable to answer questions, responding with rambling speech. He indicated he wanted to go fishing after attending religious services. On 07/02/25 at 11:00 AM, CNA O was unavailable for interview, and no contact information was provided by the facility. During an interview on 07/02/25 at 11:30 AM, CNA N revealed if she observed another staff member saying or doing anything inappropriate to a resident, she would intervene and ensure resident was safe then immediately	F0609		

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F0609 SS = D	Continued from page 6 report to the charge nurse, Administrative Staff A or Administrative Nurse D. CNA N confirmed education was provided by leadership staff since the incident that occurred on 06/08/25. During an interview on 07/02/25 at 11:42 AM, Certified Medication Aide (CMA) R revealed if they observed another staff saying or doing anything inappropriate to a resident, they would intervene and ensure the resident remained safe and then immediately report to the charge nurse, Administrative Nurse D or Administrative Staff A. CMA R confirmed education was provided by leadership since the incident that occurred 06/08/25. During an interview on 07/02/25 at 11:45 AM, Maintenance U revealed if another staff member was observed saying or doing anything inappropriate to a resident, he would intervene and ensure the resident was safe, then immediately report to Administrative Staff A. Maintenance U confirmed education had been provided by leadership since the incident that occurred on 06/08/25. During an interview on 07/02/25 at 11:50 AM, Dietary BB revealed if another staff was observed saying or doing anything that is inappropriate to a resident, their immediate reaction depended on what happened and would report the concern immediately to her supervisor and/or Administrative Staff A. Dietary BB revealed no education had been provided by leadership since the incident on 06/08/25. During an interview on 07/02/25 at 11:55 AM, Dietary CC revealed if she witnessed anything she suspected was inappropriate, she would immediately report the situation to her supervisor and/or Administrative Staff A. Dietary CC revealed no education had been provided by leadership since the incident on 06/08/25. During an interview on 07/02/25 at 11:56 AM, Laundry W revealed if she saw or heard anything that she thought was inappropriate towards a resident, she would immediately report the situation to her supervisor or Administrative Staff A. Laundry W revealed no education was provided by leadership since the incident on 06/08/25 During an interview on 07/02/25 at 12:00 PM, Administrative Staff A revealed on 06/11/25 at approximately 02:00 PM, Administrative Nurse D and a group of CNA staff had a meeting where CNA O revealed the statements made by CNA M to R1 on 06/08/25. Administrative Nurse D immediately notified	F0609		

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F0609 SS = D	Continued from page 7 Administrative Staff A, who initiated an investigation. Administrative Staff A revealed CNA M was telephoned and informed not to return to the facility as her employment was terminated due to the result of the investigation, as well as other concerns. Administrative Staff A reported CNA O said the concern was not immediately reported to the nurse on duty because CNA O did not think it was abuse since nothing physical happened. Administrative Staff A reported that staff education was only provided to direct care staff, as the allegation of abuse was a nursing matter. The facility's 10/2022 "Abuse, Neglect and Exploitation" policy documented that the resident has the right to be free from verbal, sexual, physical, and mental abuse and involuntary seclusion. Additionally, the policy documented that every employee of the facility was responsible to report any abuse or allegations of abuse to the facility's administrator and/or the administrator's designee, the appropriate State Agency (SA), and, when applicable, law enforcement (LE). All allegations should be reported within two hours after the allegation is made if the allegation involves abuse or resulted in serious bodily injury.	F0609		