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 10/14/2026

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 a Health Recertification Survey and complaint survey regarding allegations in 3726307, 3186852, 3159242, 3152834, and 3024035. The census was 21. The sample included 12 residents.	F0000		
F0730 SS = F	Nurse Aide Perform Review – 12Hr/Year 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: Based on observation, interview, and record review, the facility failed to ensure that the required annual performance reviews were completed for four randomly selected nurse aides. Findings included: -A review of the facility nurse aide performance evaluation revealed that Certified Nurse Aide (CNA) O, with an employment date of 07/31/2018, lacked an annual performance review. The facility provided the last performance review with a date of 10/21/2022. On 10/14/2026 at 08:37 AM, Administrative Staff A reported that CNA O was an as-needed employee, and the previous Director of Nursing was responsible for performance evaluations. Upon request, the facility failed to provide a “Nurse Aide Performance Evaluation” policy.	F0730		

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

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F0761 SS = F	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the facility failed to store insulin appropriately and failed to list open date on insulin pens that were used. Additionally, the facility failed to discard Purified Protein Derivative vial (PPD is a diagnostic skin test solution used to detect a tuberculosis (TB) infection) with an open date of 08/21/2026. The facility failed to secure medications in a locked medication storage room; Resident (R) 1 and R9 had unsecured medications in their rooms. Findings included: 1. 10/12/2026 at 08:06 AM, R1 had a bottle of Flonase (an over-the-counter and prescription-strength nasal spray used for nasal congestion) on his nightstand. On 10/12/2026 at 09:28 AM, R1 was seated in his wheelchair in his room. He reported that he administered his own Flonase, and he was going to have his wife bring him another nasal spray.	F0761		

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F0761 SS = F	Continued from page 2 On 10/13/2026 at 09:58 AM, R1 was in his chair, and the Flonase remained on the nightstand. R1's electronic medical record (EMR), reviewed from 07/31/2026 through 10/13/2026, lacked a current or discontinued order for Flonase in the physician orders. 2. On 10/12/2026 at 09:51 AM, R19 was seated in his room in his recliner. An albuterol inhaler was on his table next to his recliner on the second shelf. R19 reported that he used the inhaler when he was short of air. On 10/13/2026 at 08:13 AM, R19 was seated in his recliner; the albuterol inhaler remained on his table as Licensed Nurse (LN) G administered his morning medications. On 10/13/2026 at 03:34 PM, LN G reported that if a resident had a medication at bedside, they would have an order, and they should have a self-medication assessment completed. He reported that he could not recall any resident at this time who had medications in their room. On 10/14/2026 at 11:20 AM, Administrative Nurse D reported that she expected residents to not have medications left in their room unless there was a provider order and self-medication assessment completed. She reported that R1 and R19 did not have orders for bedside medications and thought that R19 was given his inhaler when he went out with his wife recently, and he kept the inhaler. 3. 10/13/2026 at 08:04 AM, LN G prepared R19's morning medications. The Novolog flex pen (rapid-acting insulin) 100 units/milliliters had R19's name on it and a label that the pen was removed from the emergency kit, the pen lacked an open date or the discard date. On 10/13/2026 at 8:17 AM, LN G reported that all insulin pens were to be labeled when opened and labeled with the expiration date. On 10/13/2026 at 08:19 AM, the medication storage contained four insulin pens that lacked an open date or the discard date: R3's Novolog flex pen and Lantus flex pen (long-acting insulin), R19's Lantus flex pen, R7's Lantus flex pen. On 10/13/2026 at 8:22 AM, LN G picked up all the insulin pens and placed them in one basket in the	F0761		

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F0761 SS = F	Continued from page 3 medication cart drawer. LN G reported that they were stored together. 4. On 10/13/2026 at 08:12 AM, LN G left the medication cart storage room open that contained a box of medication blister packs with medications in them that laid on the floor. On 10/13/2026 at 08:40 AM, LN G prepared R9's medications and left the medication cart storage room open with a box of medications on the floor. On 10/13/2026 at 08:55 AM, LN G reported that he should have shut the door and made sure it was locked when he left the room, and reported that the facility had residents who wandered and said that he had to do two jobs as he had no Certified Medication Aide (CMA). 5. On 10/13/2026 at 08:48 AM, the medication room had an open vial of purified protein derivative with a date opened of 08/21/2026. LN G reported that he did not know how long the vial of PPD was good for once opened and reported that Administrative Nurse D took care of the PPD's. The Centers for Disease Control and Prevention (CDC is the nation's leading science-based, data-driven, service organization that protects the public's health), dated 03/2003, documented that PPD had been open more than 30 days or the expiration date had passed, the vial should be thrown away and a new vial used. On 10/14/2026 at 11:20 AM, Administrative Nurse D reported that she expected all medications to be secured and locked when not in the sight of the staff; she expected the insulin pens to be labeled when opened and discarded 28 days after they were opened. She also said that she expected the insulin pens to be stored separately for each resident. Administrative Nurse D reported that she expected the outdated PPD solution to be discarded. The facility's policy "Medication Storage" dated 01/2024 documented that medications and biologicals are stored properly, following manufacturers or provider pharmacy recommendations, to keep their integrity and to support safe, effective drug administration. The medication supply shall be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. To limit access to prescription medications, only licensed nurses, pharmacy staff,	F0761		

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F0761 SS = F	Continued from page 4 and those lawfully authorized to administer medications are allowed access to medication carts. Medication rooms, cabinets, and medication supplies should remain locked when not in use or attended to by persons with authorized access. Insulin products should be stored in the refrigerator until opened. Note the date on the label for insulin vials and pens when first used. Outdated medications are immediately removed from stock.	F0761		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to store, prepare, and serve food in a sanitary manner for the residents who reside in the facility and receive meals from the facility kitchen. Findings included: - On 10/13/2026, during the tour of the facility's kitchen, staff were preparing and serving the noon meal; observation revealed: The dry storage room contained 18 4-ounce cans of sweetened condensed milk with a use-by date of	F0812		

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F0812 SS = F	Continued from page 5 08/27/2026. The American Chemical System Precision Chlorine Test paper strips lacked an expiration date, and the Hydrion QT 40 paper strips had an expiration date of 05/16/2026. The drawer containing different sizes of knives had debris in the white storage baskets and the bottom of the drawer. The convection oven top and the tubing housing underneath had grey/brown thick fuzzy material. The wooden cabinets and tile-like backsplash directly located in front of the convection oven were sticky to the touch and also had brownish debris speckled on them. The metal shelving throughout the kitchen had rust staining and grey/brown sticky-to-the-touch debris also. The flooring throughout the kitchen lacked a finish and had brown/blacking material along the baseboards. The flooring under equipment and worktables also had rust stains. The flooring behind the ice machine had built-up blackish-grey material along the length of the ice machine. The flooring under the dishwasher also had dark staining and rust present. Dietary Staff (DS) DD wore a purple threaded bracelet on her left wrist with round beads which dangled over the wrist portion of her gloves. DS CC wore open-toe and open-heel shoes while in the kitchen. DS CC and DS BB verified the areas of concern and reported trying to clean some areas but could not get the debris cleaned off. DS BB reported that the facility's owner company had plans for new cabinets, painting, and work on the dishwashing area. DS BB reported DS BB should not wear jewelry that dangles. DS BB reported wearing open-toe and open-heel footwear due to working in her office. The facility's "Cleaning Rotation" policy, dated the 2011 edition, documented that equipment and utensils will be cleaned according to the following	F0812		

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F0812 SS = F	Continued from page 6 schedule. Items cleaned daily included the exterior of large appliances and kitchen and dining room floors; items cleaned weekly included drawers and shelves; items cleaned monthly included ice machines, walls, and windows; and items cleaned annually included walls and windows.	F0812		
F0880 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 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:	F0880		

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F0880 SS = F	Continued from page 7 (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 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: Based on interviews, observation and record review, the facility failed to utilize Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high-contact care) and hand hygiene while providing direct care to Resident (R) 1. The facility failed to implement adequate infection control practices related to urinary catheter (a tube inserted into the bladder to drain the urine into a collection bag) care for R4. Additionally, the facility failed to follow appropriate infection control practices related to hand hygiene when ice water was delivered and failed to use sanitary storage for respiratory equipment. Findings included: - 1. On 10/12/2026 at 08:13 AM, R10’s oxygen nasal cannula lay on the wooden chair that was connected to the oxygen concentrator.	F0880		

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F0880 SS = F	Continued from page 8 On 10/12/2026 at 09:49 AM, R4's oxygen nasal cannula was wrapped around and laid directly on top of the oxygen concentrator. On 10/13/2026 at 01:44 PM, R10's oxygen nasal cannula laid on the floor when Licensed Nurse (LN) G was in R10's room to administer R10's breathing treatment. LN G reported that the nasal cannula was to be placed in the bag attached to the oxygen concentrator. LN G then took the oxygen tubing off the floor and placed the nasal cannula in a bag. On 10/14/2026 at 11:38 AM, Administrative Nurse D reported that she expected clean oxygen tubing to be placed in a bag when not in use. 2. On 10/12/2026 at 11:32 AM, LN G performed hand hygiene and applied gloves; LN G did not apply a gown. LN G placed several disposable gloves that laid directly on a television tray stand that had other resident personal care items on it. LN G removed R1's dressings from his lower right leg. R1 had several open areas on his right lower leg; the dressings had a large amount of serosanguineous (semi-thick blood-tinged drainage). LN G removed his gloves, and no hand hygiene was performed. LN G applied new gloves, cleansed R1's wound areas, then removed his gloves, did not perform hand hygiene, applied new gloves, then dried off the areas. LN G removed his gloves; hand hygiene was not performed, and he applied new gloves. LN G opened a cotton tip applicator and applied Vaseline around the wound perimeter on the front of his right leg that had a dark brown wound base and then LN G removed his gloves, no hand hygiene performed, he then applied new gloves and opened a cotton tip applicator and applied Vaseline to the back of R1's right leg. LN G removed his gloves and did not perform hand hygiene. LN G stood up, grabbed the bathroom doorknob, grabbed a handful of gloves, and placed the gloves on the television tray table. LN G applied new gloves and repeated the Vaseline application to the other area on the right side of R1's leg. LN G removed his gloves, with no hand hygiene performed, and applied new gloves. LN G then opened four non-stick dressings from the package and held the dressing in his right hand like a fist, then removed each dressing from its package and applied them to the remaining areas on R1's lower right leg and wrapped the lower right leg. No EBP signage or personal protective equipment (PPE-gowns, face shields and/or eyeglasses/goggles, and gloves) was observed in R1's room or outside of his room.	F0880		

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F0880 SS = F	Continued from page 9 On 10/12/2026 at 12:44 PM, LN G reported that he did not need to wash his hands when he removed his gloves; he reported that it was a clean technique and it would be difficult to keep washing his hands or using hand sanitizer between glove changes to get the new gloves on. LN G reported that R1's dressing was not a sterile dressing. LN G reported that if a resident had to be on EBP, they would have a cart for the personal protective equipment (PPE-gowns, face shields and/or eyeglasses/goggles, and gloves) and a sign on the door. LN G reported that he was unsure what EBP was. On 10/12/2026 at 02:20 PM, Certified Nurse Aide (CNA) N and CNA P sat at the nurse station. CNA N reported that she did not remember what EBP was. CNA P reported that the facility had three residents that required EBP, that included R1 because he had wounds on his lower right leg, she reported that the PPE should be on the back of the inside of his door and could not recall if he had a EBP sign on his door. On 10/13/2026 at 02:58 PM, R1 was in the shower room and sat on the toilet naked when CNA M entered the shower room to assist CNA N, who called for assistance from the shower room. CNA N had gloves on and no gown worn. CNA M applied gloves and assisted CNA N in transferring R1 off the toilet and onto the shower chair. On 10/13/2026 at 04:21 PM, CNA N reported that she had forgotten that R1 was on EBP and did not have any PPE in the shower to use. CNA N reported that she should have had the correct PPE on when she provided hands-on care. On 10/14/2026 at 11:38 AM, Administrative Nurse D reported that she expected all staff to perform hand hygiene after they removed gloves. Administrative Nurse D reported that she expected all staff to wear the required PPE for all residents who have EBP. 3. On 10/13/2026 at 08:02 AM, R4 was dressed and sat in the commons area in her wheelchair. R4 had a privacy bag for the urinary drainage bag underneath the seat of her wheelchair; the urinary catheter tube was touching the floor. On 10/13/2026 at 03:07 PM, R4 sat in her wheelchair in the dining room for an activity. R4's urinary catheter tubing lay directly on the floor under her wheelchair. On 10/14/2026 at 02:10 PM, CNA Q and CNA M	F0880		

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F0880 SS = F	Continued from page 10 provided catheter care and a brief change to R4. CNA Q did not change her gloves after she provided R4 peri care. CNA Q then placed a clean brief and adjusted her clothes with the same gloves she used to cleanse R4's peri area. CNA Q reported she should have changed her gloves after cleansing the peri area. On 10/14/2026 at 02:20 PM, LN G reported that the staff should have changed their gloves and the urinary catheter tubing should not have been on the floor. On 10/14/2026 at 02:26 PM, Administrative Nurse D reported that she expected the staff to change gloves after peri care was completed and the urinary catheter tubing should not have been on the floor. 4. On 10/13/2026 at 02:48 PM, CNA M delivered ice water to several residents' rooms in the 300 hallways. CNA M performed no hand hygiene between the residents' rooms. CNA M delivered a new cup of ice water into the resident's room and picked up the used water cup. CNA M opened the bathroom door, emptied the water from the used cup, exited the resident's room, placed the resident's used cup on the bottom shelf of the cart, removed a new cup from the top shelf, entered another resident's room, and repeated that four times with no hand hygiene performed. On 10/13/2026 at 02:57 PM, CNA M reported that she should have sanitized her hands between residents' rooms when she passed the new ice water. On 10/14/2026 at 11:38 AM, Administrative Nurse D reported that she expected staff to perform some type of hand hygiene between residents' rooms when ice water was delivered. 5. On 10/14/2026 at 11:38 AM, Administrative Nurse D reported that she was not the Infection Preventionist (IP); she had just signed up for the education. Administrative Staff A reported that she was going to be the IP and assist Administrative Nurse D. Administrative Staff A reported that she was certified and was an LN too. Administrative Nurse D and Administrative Staff A reported that the infection surveillance was completed on the computer program, but they had no access to the surveillance logs from the past six months. Administrative Staff A reported that the previous Director of Nursing (DON) had completed that task and reported to QAPI the previous month's results.	F0880		

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F0880 SS = F	Continued from page 11 On 10/14/2026 at 12:20 PM, Administrative Staff A provided a handout of the last 6 months of infection surveillance reports. The reports were reviewed, and R1, R4, R3, and R25's antibiotics and the reason why the antibiotics were ordered were not documented on the report. On 10/14/2026 at 01:00 PM, Administrative Staff confirmed that R1, R4, R3, and R25's antibiotics were not documented in the report and said that staff was required to input that information into the report, and it was not completed as required. She expected all the antibiotics, the reason why they were ordered, signs and symptoms, and the status of how the resident responded to the treatment to be documented in the report. The facility's policy "Enhanced Barrier Precautions in Nursing Homes," dated 03/24/2024, documented that EBP were used in conjunction with standard precautions and expanded the use of PPE to donning a gown and gloves during high-contact resident care activities that provide opportunities for transfer of multiple drug-resistant organisms (MDRO-common bacteria that have developed resistance to multiple types of antibiotics) to staff hands and clothing. For residents for whom EBP is indicated, EBP is employed when performing the following high-contact resident care activities that include showering, transferring, and wound care. The facility's policy "Hand Hygiene," dated 05/2017, is documented to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Hand hygiene to be completed by staff included between glove changes during care or procedures. The facility's policy "Infection Control Surveillance," dated 11/2025, is documented to prevent, identify, monitor, analyze, and report infections in the facility. Antibiotic usage is to be tracked on the Infection Control Surveillance and Analysis log. The type of infection, location, resident, antibiotic, and lab results are to be documented in the Infection Control module. Analysis is to be completed routinely to determine trends, clusters, and/or outbreaks in the facility. Interventions and/or education are to be initiated with identified trends, clusters, and/or outbreaks. Interventions and/or education provided are to be based on analysis and documented. The facility did not provide a policy for urinary catheters.	F0880		

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F0557 SS = D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure residents were treated with respect and dignity. Facility staff referred to residents that required assistance with dining as “feeders” in the dining room. Findings included: - On 10/12/2026 at 08:32 AM, Resident (R) 20 and R4 were seated at the back table in the dining room; neither resident had food. Dietary Staff EE asked Dietary Staff CC about room trays as they stood in the dining room. Dietary Staff EE then pointed to the table that R20 and R4 were seated at. Dietary Staff CC commented out loud that that was the feeder table. There were several other residents in the dining room at that time eating their breakfast. On 10/13/2026 at 02:51 PM, Certified Nurse Aide (CNA) M reported that R20 and R4 required assistance with eating their food for all their meals. On 10/14/2026 at 08:51 AM, Dietary Staff CC reported that she always said that those residents were feeders. She reported that she did not know that would be a concern. On 10/14/2026 at 01:43 PM, Administrative Staff A reported she was concerned that staff called residents’ feeders and she had been working with staff addressing that concern. She reported that she expected the staff not to say that. The facility did not provide a policy on “Dignity or Respect.”	F0557		
F0637 SS = D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii)	F0637		

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F0637 SS = D	Continued from page 13 §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the facility failed to complete the required "Significant Change Minimum Data Set" (MDS) for Resident (R) 4 upon the initiation of hospice services (a program that gives special care to people who are near the end of life) as required. Findings included: - R4's Electronic Medical Record (EMR) included diagnoses of Alzheimer's disease, muscle weakness, pain, cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), depression, urinary tract infection, and neuropathic bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying). R4's "Quarterly" MDS dated 06/26/2026 documented that the resident had severe cognitive impairment and was dependent on toileting, bathing, dressing, personal hygiene, and mobility. R4 had intermittent catheterizations (a tube placed in the bladder to drain urine), was frequently incontinent of urine, and occasionally of bowel. The MDS further documented that R4 received scheduled pain medication, an antidepressant (a class of medications used to treat mood disorders), an antihypertensive (a class of medications used to treat high blood pressure), a diuretic (a medication to promote the formation and excretion of urine), an opioid (a class of medications used to treat severe pain), an antiplatelet (a medication used to prevent blood clots), and an anticonvulsant. The "Quarterly Minimum Data Set" (MDS) dated 09/25/2026 documented R4 had severe cognitive impairment and was dependent on staff for upper and lower body dressing, personal hygiene, toileting, and mobility. R4 had an indwelling urinary catheter	F0637		

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F0637 SS = D	Continued from page 14 (tube placed in the bladder to drain urine into a collection bag) and received scheduled pain medication, an antidepressant, antihypertensive, diuretic, opioid, antiplatelet, and anticonvulsant. The MDS further documented R4 had a condition or chronic disease that may result in a life expectancy of less than six months, received hospice care, and received oxygen therapy. The “Care Plan” dated 08/26/2026 documented R4 was on hospice services related to terminal illness. The Care Plan directed staff to coordinate care and services with hospice and communicate with hospice care for ongoing treatment plans. The Care Plan also directed staff to administer medications as ordered and manage pain. The Care Plan lacked specifics related to the hospice agency’s phone number, address, frequency of disciplinary visits, supplies, equipment, and medication provided to the facility and resident. The “Progress Note” dated 08/14/2026, at 04:47 PM, documented that R4’s family member would like to start hospice services. The physician was notified and signed the order. The “Progress Note” dated 08/18/2026 at 04:19 PM showed the family signed consent for hospice services. On 10/13/2026 at 08:02 AM, R4 was dressed and sitting in a wheelchair in the commons area, covered with a blanket, reporting she was cold and glad she had a blanket. On 10/14/2026 at 01:12 PM, Administrative Nurse D verified that a “Significant Change” MDS should have been initiated following R4’s admission to hospice services. The Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument Manual (RIA) 3.0 criteria for Significant Change in Status (SCSA) are required within 14 days when a resident receives hospice services.	F0637		
F0655 SS = D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement	F0655		

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F0655 SS = D	Continued from page 15 a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is NOT MET as evidenced by:	F0655		

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F0655 SS = D	Continued from page 16 Based on observation, interview, and record review, the facility failed to provide a written baseline care plan to Resident (R) 2, and R15. Additionally, the facility failed to complete a baseline care plan within 48 hours of admission for R15. Findings include: 1. R2's electronic medical record (EMR) lacked documentation that a written baseline care plan was given to or reviewed by R2 or a representative since she was admitted on 09/17/2026. 2. R15's EMR lacked documentation that a written baseline care plan was given or reviewed by R15 or a representative since he admitted on 09/25/2026. R15's EMR documented that her care plan was started on 09/30/2026, five days after she admitted. On 10/12/2026 at 11:00 AM, R2 laid in her bed with her eyes closed; R15 was seated in R2's recliner with her rolling walker in front of her. R15 reported that R2 was her mother and she was R2's durable power of attorney (DPOA- a legal document that names a person to make healthcare decisions when the resident is no longer able to). R15 reported that R2 was admitted a week before she was, and the plan was to go home, as she and her mother had lived together for three years. R15 reported that she and R2 did not have any care plan meetings with the facility; only a care assessment was completed. R15 could not recall a baseline care plan reviewed or offered for herself or for R2. On 10/13/2026 at 03:34 PM, Licensed Nurse (LN) G reported that when a resident was admitted the care plan on the EMR was opened and completed by Administrative Nurse D. LN G reported there were no paper care plans and there was no baseline care plan in the EMR for the charge nurse to complete. On 10/14/2026 at 11:20 AM, Administrative Nurse D reported that she expected the baseline care plan to be completed within 48 hours and confirmed that R2 did not have a baseline care plan reviewed with her or the DPOA. Administrative Nurse D reported that R2 or R15 was not offered a copy of the baseline care plan. Additionally, Administrative Nurse D confirmed that R15's baseline care plan was not started until 09/30/2026. The facility's policy "Electronic Care Plan," dated 12/2020, documented that the facility is to develop a plan of care to attain and maintain the highest	F0655		

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F0655 SS = D	Continued from page 17 practical level of physical, psychological, emotional, and social well-being for each resident in the facility. The interdisciplinary team was to develop a Baseline Care Plan within forty-eight hours of admission in EMR. The policy lacked if a written baseline care plan was to be given to or reviewed resident or representative.	F0655		
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the facility failed to ensure residents received assistance with activities of daily living (ADL) including nail care for Resident (R) 9. Findings included: - R9’s electronic medical record (EMR) documented a diagnosis of acute cerebral insufficiency (a sudden drop in blood and oxygen supply to the brain, caused by low systemic blood pressure, cardiac output failure, or the blockage of a cerebral artery). R9’s 01/30/2026 "Annual Minimum Data Set" (MDS) documented a Brief Interview for Mental Status (BIMS) score of eight, which indicated moderately impaired cognition. R9’s MDS documented that he required moderate assistance with personal hygiene. R9's 02/11/2026 " Functional Abilities (Self-Care and Mobility) Care Area Assessment" (CAA) documented that R9 required partial to substantial assistance with ADLs. He could communicate his needs and usually understood others. R9’s "Care Plan" dated 02/06/2024 instructed staff that R9 required assistance of one staff member for personal care. On 10/12/2026 at 09:21 AM, R9 was in his room, and he had long fingernails on both of his hands, and he reported that he could not trim them. On 10/13/2026 at 08:41 AM, R9 was in his room coloring in his book; his fingernails remained long. On 10/14/2026 at 09:01 AM, R9 was seated in his	F0677		

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F0677 SS = D	Continued from page 18 wheelchair in his room. He reported that he received a shower yesterday; his nails remained long, and he reported he did not like them long. On 10/13/2026 at 02:51 PM, Certified Nurse Aide (CNA) M reported that R9 did not refuse care, and the staff was expected to trim and clean fingernails on shower days and as needed. On 10/13/2026 at 03:34 PM, Licensed Nurse (LN) reported that he expected the staff to trim and clean fingernails as needed and offer trimming on shower days; he reported that the nurse was to trim diabetic fingernails. He reported that R9 was not diabetic. On 10/14/2026 at 11:20 AM, Administrative Nurse D reported that she expected the staff to check fingernails weekly or at the resident's preference to trim and clean their nails, and she expected the staff to assist residents who could not complete this task. The facility did not provide a policy for ADL assistance.	F0677		
F0684 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: Based on observation, interview, and record review the facility failed to provide treatment and care within the professional standards of practice when staff did not complete a weekly skin assessment for Resident (R) 26. Findings included: - R26's electronic medical record (EMR) documented diagnoses of dementia and vitamin D deficiency. R26's 07/03/2026 "Annual Minimum Data Set" (MDS) documented that staff were unable to interview R26 for a Brief Interview for Mental Status	F0684		

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F0684 SS = D	Continued from page 19 (BIMS) as she rarely or never understood. The assessment documented R26 had severely impaired cognition. R26's MDS documented she had no behaviors, falls, or skin issues. R26's 07/10/2026 "Pressure Ulcer/ Injury Care Area Assessment" (CAA) documented R26 was incontinent of bowel and bladder. R26 was dependent on staff for most of her activities of daily living (ADLs). R26 was on one-to-one (1:1) care, and her family was involved in the care planning. R26's 04/03/2026 "Quarterly MDS" documented that staff were unable to interview R26 for a BIMS score as she was rarely understood. The assessment documented she had severely impaired cognition. The MDS documented R26 had no behaviors, falls, or skin issues. R26's 07/23/2025 "Care Plan" instructed staff that R26 was to be a 1:1 and family would help complete the 1:1 when they visited. R26's 05/22/2026 "Care Plan" instructed staff to monitor her bruise for changes and assess for pain. R26's 06/04/2026 "Care Plan" instructed staff to provide skin assessments as indicated. R26's "Skin Condition Note," dated 12/10/2025 at 12:42 AM, documented no new skin issues. R26's EMR "Skin Condition Note," lacked documented skin notes from 12/11/2025 through 02/02/2026. R26's "Skin Condition Note," dated 02/03/2026 at 02:26 PM, documented that her skin was within normal limits, not applicable for new skin conditions. R26's "Skin Condition Note," dated 02/10/2026 at 02:09 PM, documented that R26 continued to have a scab on the anterior left scalp. R26's "Skin Condition Note," dated 02/18/2026 at 05:19 PM, documented that R26 continued to have a scab on her head and no other skin issues. R26's "Skin Condition Note," dated 02/23/2026 at 01:14 PM, documented that she continued to have a scab on her head. R26 had old bruising on her right forehead, top of her left breast, and a small area on the back of her scapula. It was documented that all three bruises appeared old and were yellow and fading.	F0684		

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F0684 SS = D	Continued from page 20 R26's "Skin Condition Note," dated 03/03/2026, 03/10/2026, 03/28/2026, and 04/07/2026, documented a scab area on her head and no other skin issues. R26's "Skin Condition Note," dated 04/28/2026 at 10:36 AM, documented no new skin issues, and R26 always required 1:1 care. R26's EMR "Skin Condition Note," lacked documented skin notes from 04/28/2026 through 06/01/2026. R26's "Skin Condition Note," dated 06/02/2026 at 05:51 PM, documented that R26 had a fading bruise above her right eyebrow. R26's "Physician's Orders" documented that a skin condition note was to be completed every day shift, on every Tuesday for health maintenance, ordered 01/06/2026. R26's "Progress Note," dated 07/23/2026 at 02:49 PM, documented that R26 would be discharged on 07/24/2026. Review of the "Facility's Reportable Incident," dated 05/22/2026, documented that, on 05/22/2026 at 08:10 AM, Certified Nurse Aide (CNA) R reported to Licensed Nurse (LN) G that R26 had a bruise on her right eyebrow. The area appeared to be light blue/purple in color and measured two centimeters (cm) by one cm. CNA R had been with R26 since 06:00 AM and reported that nothing had occurred in R26's room and CNA R had not noticed the bruise in R26's room as the room was dim. R26 was observed ambulating in the hallways unaccompanied on the morning of 05/21/2026. R26's family member visited on 05/21/2026 in the afternoon and did not report any incidents or concerns. The staff sat with R26 that evening and did not report any injury. The staff witness statements documented that R26 remained 1:1, and no staff reported that any incident occurred or that they noticed the bruise until 05/22/2026 at 08:10 AM. On 10/13/2026 at 04:18 PM, Social Service Designee (SSD) X reported that R26 was a 1:1 the entire time she lived at the facility because she would wander into other residents' rooms and remove their belongings. SSD X reported that staff stayed next to her the entire time because she liked to walk. SSD X reported that when R26 was in her room, the staff would sit with her when she sat up or slept. SSD X reported that if she found a bruise or skin issue, she	F0684		

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F0684 SS = D	Continued from page 21 would report it to the nurse immediately. SSD X reported that the staff did not document 1:1 in the EMR or on paper. On 10/13/2026 at 04:21 PM, CNA N reported that R26 was 1:1 the entire time she lived at the facility because she would wander into other residents' rooms and remove their belongings. CNA N reported that staff stayed next to her the entire time. CNA N reported that when R26 was in her room, the staff would sit with her when she sat up or slept. She reported that R26 was not combative with her when she completed the 1:1. CNA N reported that the staff documented everything in the EMR. On 10/13/2026 at 04:32 PM, CNA M reported that R26 was always 1:1 and the staff would stay right with her unless her family was at the facility; then they would do the 1:1. She said that R26 liked to walk a lot and that the staff would change assignment every two hours so it was not the same staff member with her. CNA M reported that all the documentation would be completed in the EMR and could not recall if the 1:1 was in the EMR to document on. On 10/13/2026 at 04:38 PM, LN G reported that R26 was always 1:1 because she would wander around the facility. LN G reported that the staff was with her constantly, and if she was in her room, the staff member would sit in her room, and if the family was there, then they would do the 1:1. LN G reported that he did not know how R26 received a bruise on her right eye. LN G reported that the nurse was responsible for documenting weekly in the resident's EMR in a skin condition note. On 10/13/2026 at 08:30 AM, Administrative Nurse D reported that she expected the staff to complete a weekly skin note for each resident. She reported that R26 was a 1:1 resident 24 hours a day, seven days a week. Administrative Nurse D reported that the staff would be by her side when she was out of the room, and they would also sit in her room with her. The facility's policy "Wound Prevention and Monitoring," dated 12/2018, documented that a licensed nurse would be responsible for weekly assessment of skin for all residents and document findings in the EMR in a skin condition note.	F0684		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F0689		

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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
F0689 SS = D	Continued from page 22 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure Resident (R) 9 remained free from accident hazards when staff failed to investigate a fall and failed to maintain his bed equipment in a safe condition, resulting in a loose and unstable bed rail attached to his bed frame. Findings included: - R9's electronic medical record (EMR) documented a diagnosis of acute cerebral insufficiency (a sudden drop in blood and oxygen supply to the brain, caused by low systemic blood pressure, cardiac output failure, or the blockage of a cerebral artery). R9's 01/30/2026 "Annual Minimum Data Set" (MDS) documented a Brief Interview for Mental Status (BIMS) score of eight, which indicated moderately impaired cognition. R9's MDS documented that he required moderate assistance with standing and transfers. R9's 02/11/2026 "Falls Care Area Assessment" (CAA) documented that R9 was a risk for falls related to high-risk medications. R9 had no behavioral symptoms and was pleasant and cooperative with staff. He required partial to substantial assistance with activities of daily living (ADLs). R9 used a wheelchair for mobility and had no falls. R9's "Care Plan," dated 02/06/2024, instructed staff that R9 required assistance of one staff member for transfers, and that he required his commonly used items within his reach. R9's "Care Plan," dated 02/07/2024, instructed staff that R9 required his bed to be in the lowest position and a fall mat placed by his bed. R9's "Care Plan," dated 10/13/2026, lacked documentation for a fall that occurred on 11/25/2026 and lacked documentation for the bed rail on his	F0689		

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F0689 SS = D	Continued from page 23 bed. R9's "Fall Risk Evaluation," dated 12/30/2025, 01/24/2026. 04/16/2026, and 09/29/206 documented R9's fall risk was moderate. R9's "Fall Risk Evaluation," dated 04/22/2026 and 07/08/2026, documented R9's fall risk was high. R9's "Progress Note," dated 11/25/2025 at 06:20 PM, documented that staff found R9 on his floor in his room. R9 was in a seated position on the cushioned floor mat. R9 indicated that he slid down while transferring himself to his bed. No signs of injury, no changes to range of motion, and vitals within normal limits. On 10/12/2026 at 09:21 AM, R9 was in his room seated in his wheelchair. He had a fall mat next to his bed on his right side and a loose half side rail on the right side of the bed. R9 reported that he does not get himself up. On 10/12/2026 at 03:20 PM, R9 was seated in his wheelchair in his room watching TV. His side rail remained loose on the bed. On 10/13/2026 at 08:41 AM, R9 was in his room coloring in his book; the side rail on his bed remained loose. On 10/14/2026 at 09:01 AM, R9 was seated in his wheelchair in his room; the side rail remained loose on his bed. On 10/13/2026 at 02:51 PM, Certified Nurse Aide (CNA) M reported that if a resident's positioning rail on their bed was loose, the staff were expected to let the maintenance man know via a link on the computer that would go to his email. CNA M reported that R9 does not usually use the rail on his bed when he is transferred in or out of it. On 10/13/2026 at 03:34 PM, Licensed Nurse (LN) G reported that if a resident needed any repair in their room, the staff were to communicate on the computer program so the maintenance department would receive an email. On 10/14/2026 at 09:59 AM, Administrative Staff A reported that there was no fall investigation for R9's fall that occurred 11/25/2025. Administrative Staff A reported that she was not made aware of the fall and she reported that it occurred with a nurse working at the time that was no longer employed at the facility. Administrative Staff A reported that she expected the	F0689		

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F0689 SS = D	Continued from page 24 nurses to complete a report in the EMR and to call the provider, administrator, and director of nursing. She reported that she expected staff to investigate the root cause of the fall and to complete an intervention to prevent further falls. On 10/14/2026 at 10:10 AM, Maintenance Director U reported that he completed a monthly check on the rails on the beds. Maintenance Director U reported that the report did not document which rooms were checked, as he checked all the beds. Maintenance Director U checked R9's side rail in his room and reported it was loose and that was how it always was and could not get the side rail from having the loose wiggled to it. Maintenance Director U explained how the side rail was attached to the bed frame; as he tried to tighten the rail, he reported that it was just clamped on the frame and that he was not sure if that side rail was made for that bed. He reported that he had not received a request on the computer for any loose side rails. The facility's policy "Falls Management" dated 12/2022 documented that the facility strives to minimize the risk for resident falls and to reduce injuries associated with resident falls. After a fall occurs, the licensed nurse is to initiate the risk management event reporting process. This process includes fall occurrences are to be documented in the clinical record including environmental, situational, or psychological and situational factors, location, time found, position, adaptive equipment, actions taken, and new intervention implemented. The resident's plan of care is to be reviewed and revised with each fall occurrence and new intervention(s) implemented.	F0689		
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an	F0690		

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F0690 SS = D	Continued from page 25 indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to provide Resident (R) 4 with sanitary indwelling urinary catheter (tube placed in the bladder to drain urine into a collection bag) care, who had frequent urinary tract infections (UTIs- an infection in any part of the urinary system) and a frequent need for antibiotic (a class of medications to treat infections) treatment. Findings included: -R4's Electronic Medical Record (EMR) included diagnoses of Alzheimer's disease, muscle weakness, pain, cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), depression, urinary tract infection, and neuropathic bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying). The "Quarterly Minimum Data Set" (MDS) dated 09/25/2026 documented R 4 had severe cognitive impairment and was dependent on staff for upper and lower body dressing, personal hygiene, toileting, and mobility. R4 had an indwelling urinary catheter (tube placed in the bladder to drain urine into a collection bag) and received scheduled pain medication, an antidepressant (a class of medications used to treat mood disorders), antihypertensive (a class of medication used to treat	F0690		

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F0690 SS = D	Continued from page 26 high blood pressure), diuretic (a medication to promote the formation and excretion of urine), opioid (a class of medications used to treat severe pain), antiplatelet (medication used to prevent blood clots), and anticonvulsant. The MDS further documented R4 had a condition or chronic disease that may result in a life expectancy of less than six months, received hospice care, and received oxygen therapy. The “Care Plan” dated 07/13/2026 documented that R4 had an indwelling catheter and directed staff to change the catheter as ordered, monitor output every shift, and report signs or symptoms of infection to the provider. The “Progress Note” dated 05/04/2026 at 01:25 PM documented that the physician ordered Bactrim (an antibiotic) DS (Double Strength) 800 milligrams (mgs)-160 mgs tablet twice a day for 10 days for UTI. The “Progress Note” dated 07/01/2026 at 09:29 PM documented a new order from the physician for urinary catheter insertion for neurogenic bladder. The “Progress Note” dated 07/06/2026 at 12:15 PM documented R4 returning to the facility by ambulance with a discharge diagnosis of UTI and altered mental status. New order of Macrobid (an antibiotic) 100 mgs twice a day for nine doses. The “Progress Note” dated 07/17/2026 at 04:21 PM documented that the physician ordered Rocephin (an antibiotic) intramuscularly (IM-injected into muscle tissue) daily for seven days and to repeat a urine analysis (UA) three days after the antibiotic treatment. On 10/13/2026 at 08:02 AM, R4 was dressed and sitting in a wheelchair in the commons area around the nurses' station. R4 had a privacy bag fastened to the underside of the wheelchair, with clear tubing touching the floor with light yellow urine. On 10/13/2026 at 08:59 AM, R4 was sitting in the dining room, receiving assistance with eating. The privacy bag remained under the wheelchair, and the tubing continued to rest on the floor. On 10/13/2026 at 03:07 PM, R4 was participating in an activity in the dining room. The privacy bag remained under the wheelchair, and the tubing continued to rest on the floor. On 10/14/2026 at 02:10 PM, Certified Nurse Aide (CNA) Q provided R4 with catheter care. CNA Q gloved and gowned before starting care. CNA Q	F0690		

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F0690 SS = D	Continued from page 27 provided peri/catheter care. CNA Q finished without changing gloves, placed a clean brief on the resident, and adjusted bedding and clothing when finished. CNA Q emptied the measuring device, rinsed it out with soap and water, then placed the measuring device on the back of the toilet, unbagged. R4 had a shared bathroom with a resident next door. CNA Q verified she should have changed gloves after providing peri-hygiene care and placing a clean brief on the resident. On 10/14/2026 at 02:20 PM, Licensed Nurse (LN) G verified staff should change gloves after cleansing the catheter area and that the tubing should not touch the floor. On 10/14/2026 at 02:26 PM, Administrative Nurse D reported that gloves should be changed following cleaning of the peri-hygiene area and before placing a clean brief and adjusting clothing and blankets. Upon request, the facility failed to provide a catheter care/UTI prevention policy, stating the use of standards of practice.	F0690		
F0700 SS = D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.	F0700		

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F0700 SS = D	Continued from page 28 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that informed consent was obtained prior to the installation and use of a side rail for Resident (R) 9. Findings included: - R9's electronic medical record (EMR) documented a diagnosis of acute cerebral insufficiency (a sudden drop in blood and oxygen supply to the brain, caused by low systemic blood pressure, cardiac output failure, or the blockage of a cerebral artery). R9's 01/30/2026 "Annual Minimum Data Set" (MDS) documented a Brief Interview for Mental Status (BIMS) score of eight, which indicated moderately impaired cognition. The MDS documented that he required moderate assistance with standing and transfers. R9's 02/11/2026 "Falls Care Area Assessment" (CAA) documented that he was at risk for falls related to high-risk medications. R9 had no behavioral symptoms and was pleasant and cooperative with staff. He required partial to substantial assistance with activities of daily living (ADLs). R9 used a wheelchair for mobility and had no falls. R9's "Care Plan," dated 10/13/2026, lacked documentation for the bed rail on his bed. R9's "Siderail/Restraint Reviews," dated 10/25/2026, 01/24/2026, 04/16/2026, 04/22/2026, 07/08/2026, and 09/29/2026, lacked an area for informed consent for the bed assist device to be completed. On 10/12/2026 at 09:21 AM, R9 was in his room seated in his wheelchair. He had a fall mat next to his bed on his right side and a loose half side rail noted on the right side of the bed. R9 reported that he does not get himself up. On 10/13/2026 at 03:34 PM, Licensed Nurse (LN) G reported that the nurse would complete the side rail review at least quarterly in the EMR. LN G reported that the review did not include a section for informed consent to be completed. On 10/14/2026 at 12:13 PM, Administrative Nurse D reported that she was unsure if the facility completed an informed consent for a bed assist device on any resident's bed and would find that	F0700		

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F0700 SS = D	Continued from page 29 information. On 10/14/2026 at 12:35 PM, Administrative Nurse D reported that the facility did not complete informed consent for a bed assist device because it was used for positioning. The facility did not provide a policy for bed rails.	F0700		
F0849 SS = D	Hospice Services CFR(s): 483.70(n)(1)-(4) §483.70(n) Hospice services. §483.70(n)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(n)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care.	F0849		

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F0849 SS = D	Continued from page 30 (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical	F0849		

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F0849 SS = D	Continued from page 31 abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(n)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient.	F0849		

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F0849 SS = D	Continued from page 32 (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure collaboration/integration between the facility and hospice, which included a hospice (a program that gives special care to people who are near the end of life) service visit frequency, medications, medical equipment, and the resident representative's preference for Resident (R) 4. Findings included: - R4's Electronic Medical Record (EMR) included diagnoses of Alzheimer's disease, muscle weakness, pain, cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), depression, urinary tract infection, and neuropathic bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying). The "Quarterly Minimum Data Set" (MDS) dated 09/25/2026 documented R 4 had severe cognitive impairment and was dependent on staff for upper and lower body dressing, personal hygiene, toileting, and mobility. R4 had an indwelling urinary catheter (tube placed in the bladder to drain urine into a	F0849		

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MEDICALODGES KINSLEY	**620 WINCHESTER AVENUE , KINSLEY, Kansas, 67547**

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F0849 SS = D	Continued from page 33 collection bag) and received scheduled pain medication, an antidepressant (a class of medications used to treat mood disorders), antihypertensive (a class of medication used to treat high blood pressure), diuretic (a medication to promote the formation and excretion of urine), opioid (a class of medications used to treat severe pain), antiplatelet (medication used to prevent blood clots), and anticonvulsant. The MDS further documented R4 had a condition or chronic disease that may result in a life expectancy of less than six months, received hospice care, and received oxygen therapy. The “Care Plan” dated 08/26/2026 documented R4 was on hospice services related to terminal illness. The Care Plan directed staff to coordinate care and services with hospice and communicate with hospice care for ongoing treatment plans. The Care Plan also directed staff to administer medications as ordered and manage pain. The Care Plan lacked specifics related to the hospice agency’s phone number, address, frequency of disciplinary visits, supplies, equipment, and medication provided to the facility and resident. The “Progress Note” dated 08/14/2026, at 04:47 PM, documented that R4’s family member would like to start hospice services. The physician was notified and signed the order. In the “Progress Note” dated 08/18/2026 at 04:19 PM, the family signed consent for hospice services. On 10/13/2026 at 08:02 AM, R4 was dressed and sitting in a wheelchair in the commons area, covered with a blanket, reporting she was cold and glad she had a blanket. On 10/14/2026 at 2:10 PM, Certified Nurse Aide (CNA) M and CNA Q reported they thought the hospice nurse and hospice CNA came twice a week. They reported that hospice supplied some incontinence supplies, such as briefs, wipes, and disposable pads. Both CNA M and CNA Q reported not having knowledge of what the hospice provider was responsible for supplies or other care needs. On 10/14/2026 at 01:12 PM, Administrative Nurse D reported the information provided from the hospice agency was scanned into R4’s EMR. Administrative Nurse D stated that she was unsure what was included in the care plan and what specifics the hospice agency and facility were responsible for. Administrative Nurse G stated the previous administrative nurse had been responsible for the care plan interventions and shared information	F0849		

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 10/14/2026

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

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F0849 SS = D	Continued from page 34 between the facility and agency. The facility “Nursing Home and Hospice Services Agreement” dated 05/15/2021 documented that the “Hospice Plan” is a written document that will include a detailed description of the scope and frequency of hospice services and supplies needed to meet the needs. The hospice plan will specify which services and supplies are related to reasonable, and medically necessary for the patient's terminal illness. The individual’s hospice plan calls for nursing/aide/homemaker, social work, counseling, chaplaincy, physician, or other services related to the management of the terminal illness.	F0849		