| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 175313 | A. BUILDING _____ B. WING _____ | C 08/16/2023 |

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| MEDICALODGES ARKANSAS CITY | 203 E OSAGE AVENUE ARKANSAS CITY, KS 67005 |

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| F 000 | INITIAL COMMENTS<br><br>The following citations represent the findings of complaint investigation #KS00182064, #KS00182065, and #KS00182069.<br><br>This 2567 was electronically sent to the facility on 08/22/23. | F 000 | | |
| F 609 SS=D | Reporting of Alleged Violations<br>CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.<br><br>§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. | F 609 | | |

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

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This REQUIREMENT is not met as evidenced by:
The facility reported a census of 35 residents. Based on observation, record review, and interview, the facility failed to report allegations of abuse to the State Survey Agency when an allegation came to the corporate compliance hotline regarding a facility staff member being rough, when facility staff failed to report an allegation of staff to resident abuse to Resident (R)2 to the administrator and/or designee, and when facility administration failed to report allegation of staff to resident abuse to R9.

Findings included:

- On 08/14/23 at 11:15 AM the surveyor provided Administrative Staff B a list of items needed which included a request for a list of allegations of abuse or neglect reported to administration in the past 60 days, regardless of if the allegation occurred or not.

On 08/14/23 at 12:30 PM Administrative Nurse D stated no allegation of abuse or neglect were reported by staff in the past 60 days.

On 08/15/23 at 01:33 PM Consultant Staff GG stated a compliance complaint was made anonymously about Certified Medication Aide (CMA) R being "rough", but no specific complaints were made. A discussion occurred with Administrative Staff A and Administrative Nurse D at the time, who said they spoke with CMA R, found staff were not using gait belts properly and stated the facility corrected the concerns. Consultant Staff GG stated the concern with CMA R was not using a gait belt, and the anonymous caller probably thought when

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they called, they could get "someone fired."

On 08/15/23 at 04:50 PM Consultant Staff GG stated CMA R was the only staff member named in the complaint and there was not anything tied to a direct resident for abuse other than "just being rough." Consultant Staff GG stated the allegation was not reported to the state, and the allegation occurred on 07/31/23.

The facility policy "Abuse, Neglect and Exploitation" revised October 2022 revealed the Administrator and Director of Nursing were responsible for the investigation of alleged violations and reporting the results of the investigation to the proper authorities. All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property were to be reported immediately to the Administrator and/or their designated representative, the appropriate state agency and when applicable law enforcement not later than 24 hours if the allegation did not involve abuse and did not result in serious bodily injury.

The facility failed to report the allegation of abuse to the State Survey Agency.

- The "Medical Diagnosis" tab for Resident (R)2 included diagnoses of blindness of the right and left eye, stiffness of right and left hip and left knee, and bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods).

The "Annual Minimum Data Set" (MDS) dated 08/18/22 assessed R2 with severely impaired

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vision, a recall deficit with short and long-term memory, and moderately impaired decision making. R2 rejected care daily and had verbal behaviors four to six days of the observation period. He required extensive assistance of two or more staff for bed mobility, extensive assistance of one or more staff for toilet use, and was always incontinent of bowel and bladder. R2 had no impairment to his upper extremity range of motion, however, had impairment to both lower extremities.

The "ADL [activities of daily living] Functional/Rehabilitation Potential Care Area Assessment" (CAA) dated 08/23/22 revealed R2 showed overall decline, needing more assist with ADL needs, becoming more incontinent, and increased cognitive loss.

The "Behavioral Symptoms CAA" dated 08/13/22 revealed R2 often would refuse care and yell out at caregivers.

The "Urinary Incontinence and Indwelling Catheter CAA" dated 08/13/22 revealed R2 was incontinent of bowel and bladder and often rejected help from staff.

The "Quarterly MDS" dated 05/11/23 revealed no changes to R2's vision and assessed him with a "Brief Interview of Mental Status" (BIMS) score of nine, indicating moderately impaired cognition. R2 had physical behaviors one to three days, verbal behaviors four to six days, and rejected care four to six days of the observation period. He required extensive assistance of two or more staff for bed mobility and toilet use and had no change to his range of motion or bowel and bladder function.

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The "Care Plan" dated 08/15/23 revealed R2 could not see anything but darkness and at times could see movement in peripheral vision, he frequently refused cares and the staff were to attempt cares again if combative. R2 may grab, kick, grab clothing, and/or sing arms at staff while performing cares on the resident. The staff were to tell him the task they were doing before they began. The staff were to be patient with R2, get assistance, or return later. R2 required extensive assistance of staff with toileting and needed to be checked by the staff for incontinence.

On 08/14/23 at 03:52 PM Certified Medication Aide (CMA) S stated on Monday 08/07/23 around 08:00 PM she asked Certified Nurse Aide (CNA) P for assistance changing R2 due to him having a bowel movement, which was all over him and he had a little agitation. CNA P stated she would get CNA M to assist her. CMA S stated CNA P threw a blanket over R2's upper body and head and then proceeded to lay on him so he would not move. CMA S stated she did not say anything due to seeing CNA M starting rumors about other employees and treating them bad. CMA S stated then on Friday, 08/11/23, CNA M said to R2's ear "this is [explicit word] around and find out you are going to let me change you." CMA S stated she spoke with Administrative Staff A before and was told any nursing related issues needed to be told to Administrative Nurse D because that is who he would tell anyway. CMA S stated she did not go to Administrative Nurse D because he was friends with CNA M who has retaliated before against "those speaking up." CMA S did not report the above two instances to the facility staff.

On 08/15/23 at 11:19 AM CNA M denied placing a blanket over the resident's upper body and head

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and holding him down.

On 08/15/23 at 03:35 PM R2 rested in bed with his eyes closed, head off of pillow, and a blanket covering his body but not his head.

On 08/15/23 at 03:36 PM R2 denied staff being rough with him during cares, denied staff placing a blanket over his upper body and head and/or holding his arms down while doing cares, saying anything mean to him, or saying any curse words to him. R2 stated the staff were good to him, he knew when his bowels needed to move and he did not use the toilet, the staff would change his brief.

On 08/15/23 at 06:08 PM CNA P stated R2 was always incontinent of bowel, only preferred "some staff" to take care of him and stated he would get aggressive verbally. CNA P stated she could take care of him by herself and further stated he did well for her. CNA P stated last Wednesday, 08/09/23, CMA S asked for help changing R 2 and CNA P told CMA S to leave R2 and she would get to him. CMA S stated CNA M passed her in the hallway and said she could get R2 when she was done, noting R2 would let her change him, and she came back out later and said he was done. CNA P stated she was not in the area when CMA S cared for R2 and was not sure if she provided cares with CMA S or not. CNA P stated she went back after CMA S left, around 10:15 PM which was about 20 minutes after she asked for help. CNA P stated he had a small bowel movement or was not properly cleaned after the fact. CNA P stated R2 stated to her why do they have to be so rough, however, he would say that all the time when staff were not rough with him.

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The "Complaint Investigation Witness Statement" dated 08/15/23 by CMA S revealed on 08/09/23 she was doing her last rounds and was going to change R2, but he did not want her to. CMA S stated she waited and did rounds on a few others and then went back to R2 and he was still a little agitated so she asked CNA P for help and CNA P told her she would get CNA M to help as she could always get R2 to let the staff change him. CMA S stated herself and CNA M went to change R2 and as CMA S was in the process of getting R2 "cleaned up". CNA M took R2's blanket and "threw if over the upper part of his body and head then proceeded to lay on him" while CMA S finished putting on R2's brief. Then, on 08/11/23 while doing final rounds CMA S asked R2 a few times if he would let her put a dry brief on him and he said no, so at the end of her rounds she asked for help. CMA S stated CNA M came to help her and said she changed him the night before then proceeded to say in R2's ear [explicit word]around and find out remember" and kept repeating that to him as she held his hands/arms. CMA S stated she did not feel comfortable reporting to Administrative Nurse D as he was friends with CMA S and was going to report to the state on 08/14/23, however, state was in the building.

On 08/16/23 at 11:12 AM CNA P stated she recalled helping CMA S with R2 one day, could not remember the specific day. CNA P stated R2 was always incontinent and could not recall him having bowel movement all over him. CNA P denied placing a blanket over his body and head and stated R2 liked to have a blanket over his head. CNA P stated she would just adjust the blanket so R2 could be changed and has never

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said any curse words or threats to him during cares.

The facility policy "Abuse, Neglect and Exploitation" revised October 2022 revealed the Administrator and Director of Nursing were responsible for the investigation of alleged violations and reporting the results of the investigation to the proper authorities. All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property were to be reported immediately to the Administrator and/or their designated representative, the appropriate state agency and when applicable law enforcement not later than 24 hours if the allegation did not involve abuse and did not result in serious bodily injury.

The facility failed to report abuse allegations to R2 to the facility staff at time of occurrences.

- The "Medical Diagnosis" tab for R9 included diagnoses of morbid obesity, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder, and dermatomyositis (disease that causes muscle weakness and skin rash).

The "Annual Minimum Data Set" (MDS) dated 04/29/23 assessed R9 with a "Brief Interview of Mental Status" (BIMS) score of 15, indicating intact cognition and required application of ointments/medications other than to feet.

The "Pressure Ulcer/Injury Care Area Assessment" dated 05/08/23 revealed R9 had slight redness under her abdominal folds and

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groin area and treated with Nystatin (treats fungal or yeast infection) powder.

The "Care Plan" dated 08/01/23 lacked information regarding redness or Nystatin treatment.

The "Orders" tab included an order dated 10/07/22 for Nystatin powder, 100,000 units per gram, apply to affected areas, topically, every shift, related to tinea cruris (fungal infection) and dermatomyositis.

The "Treatment Administration Record" dated August 2023 revealed the Nystatin treatment completed on the night shift on 08/12/23 and 08/13/23.

The facility nursing "Daily Schedule" dated 08/10/23 through 08/16/23 revealed Licensed Nurse (LN) G on duty on 08/13/23 from 06:00 PM to 06:00 AM.

On 08/15/23 at 09:05 AM R9 stated the other night there was a male nurse from an agency worked and when he applied powder to R9's skin (he was "applying hard" and it felt uncomfortable. R9 stated she said, "ow ow that hurts," and "he did not stop or say sorry" and he "did that twice". R9 identified the first name of the agency nurse, which matched the name on the "Daily Schedule" as LN G. R9 stated she told Social Service Staff X and told Administrative Nurse D she did not want LN G to take care of her anymore.

On 08/16/23 at 08:31 AM Administrative Nurse D stated R9 said something about the weekend night nurse and further said he hurt her when putting on the powder. Administrative Nurse D

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| F 609 | Continued From page 9<br>stated he was an agency nurse and "won't be back" because the facility hired another nurse to fill the position. Administrative Nurse D stated R9 exaggerates, and he did not see any marks on her when looking. Administrative D stated he did not report the allegation or talk to LN G about the allegation.<br><br>The facility policy "Abuse, Neglect and Exploitation" revised October 2022 revealed the Administrator and Director of Nursing were responsible for the investigation of alleged violations and reporting the results of the investigation to the proper authorities. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property were to be reported immediately to the Administrator and/or their designated representative, the appropriate state agency and when applicable law enforcement not later than 24 hours if the allegation did not involve abuse and did not result in serious bodily injury.<br><br>The facility failed to report R9's abuse allegations to the state agency. | F 609 | | |
| F 610 SS=D | Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.<br><br>§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the | F 610 | | |

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investigation is in progress.

§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 35 residents. Based on observation, record review, and interview, the facility failed to investigate allegations of abuse when an allegation came to the corporate compliance hotline regarding a facility staff member being rough, when facility staff reported allegation of verbal abuse to R8 by a staff member, and when R9 reported an allegation of abuse to facility staff.

Findings included:

- On 08/15/23 at 01:33 PM Consultant Staff GG stated a compliance complaint was made anonymously about Certified Medication Aide (CMA) R being "rough", no specific complaints were made. A discussion occurred with Administrative Staff A and Administrative Nurse D at the time, who said they spoke with CMA R, found staff were not using gait belts properly and stated the facility corrected the concerns. Consultant Staff GG stated the concern with CMA R was not using a gait belt, and the anonymous caller probably thought when they called, they could get "someone fired."

On 08/15/23 at 04:50 PM Consultant Staff GG stated CMA R was the only staff member named

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in the complaint and there was not anything tied to a direct resident for abuse, other than "just being rough." Consultant Staff GG stated the allegation occurred on 07/31/23 and the facility did not suspend CMA R when the allegation received, and it was deemed "no later" than 08/03/23 to be unsubstantiated.

The facility nursing "Daily Schedule" dated 07/27/23 through 08/02/23 revealed CMA R worked 02:00 PM as a Certified Nurse Aide (CNA) until 08/01/23 at 08:00 AM, again on 08/02/23 at 06:00 AM until 08/02/23 at 10:00 PM. The schedule dated 08/03/23 through 08/09/23 revealed CMA R worked on 08/03/23 at 02:00 PM until 08/04/23 at 06:00 AM. The facility failed to suspend CMA R pending investigation when the allegation received.

On 08/16/223 at 09:55 AM Consultant Staff GG stated he did not have a written investigation of the event due to it contained a lot of other false, malicious allegations "to get people in trouble."

The facility policy "Abuse, Neglect and Exploitation" revised October 2022 revealed the Administrator and Director of Nursing (DON) were responsible for the investigation of alleged violations and reporting the results of the investigation to the proper authorities. All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property were to be reported immediately to the Administrator and/or their designated representative, the appropriate state agency and when applicable law enforcement not later than 24 hours if the allegation did not involve abuse and did not result in serious bodily injury. All

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reported and/or suspected incidents of abuse, neglect, or exploitation of personal property shall result in an investigation. Any time a report of possible abuse, neglect, or exploitation is made against an employee, that employee should be immediately sent home and suspended until a thorough investigation can be conducted by the DON/Administrator. The resident involved shall be immediately assessed for injury, assured of protection from further harm, and monitored closely with both medical and social service intervention as indicated.

The facility failed to suspend CMA R pending investigation and failed to conduct a thorough investigation of the allegation, placing residents at risk for possible staff to resident abuse.

- The "Medical Diagnosis" tab for R9 included diagnoses of morbid obesity, anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) disorder, and dermatomyositis (disease that causes muscle weakness and skin rash).

The "Annual Minimum Data Set" (MDS) dated 04/29/23 assessed R9 with a "Brief Interview of Mental Status" (BIMS) score of 15 indicating intact cognition and required application of ointments/medications other than to feet.

The "Pressure Ulcer/Injury Care Area Assessment" dated 05/08/23 revealed R9 had slight redness under her abdominal folds and groin area and treated with Nystatin (treats fungal or yeast infection) powder.

The "Care Plan" dated 08/01/23 lacked

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information regarding redness or Nystatin treatment.

The "Orders" tab included an order dated 10/07/22 for Nystatin powder, 100,000 units per gram, apply to affected areas, topically, every shift, related to tinea cruris (fungal infection) and dermatomyositis.

The "Treatment Administration Record" dated August 2023 revealed the Nystatin treatment completed on the night shift on 08/12/23 and 08/13/23.

The facility nursing "Daily Schedule" dated 08/10/23 through 08/16/23 revealed Licensed Nurse (LN) G on duty on 08/13/23 from 06:00 PM to 06:00 AM.

On 08/15/23 at 09:05 AM R9 stated the other night a male nurse from an agency that was working and when he applied powder to R9's skin he was "applying hard" and it felt uncomfortable. R9 stated she had said "ow ow that hurts," and "he did not stop or say sorry" and he "did that twice". R9 identified the first name of the agency nurse, which matched the name on the "Daily Schedule" as LN G. R9 stated she told Social Service Staff X and told Administrative Nurse D she did not want LN G to take care of her anymore.

On 08/16/23 at 08:31 AM Administrative Nurse D stated R9 had said something about the weekend night nurse and further said said he hurt her when putting on the powder. Administrative Nurse D stated he was an agency nurse and "won't be back" because the facility hired another nurse to fill the position. Administrative Nurse D stated R9

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exaggerates, and he did not see any marks on her when looking. Administrative D stated he did not talk to LN G about the allegation or conduct an investigation.

The facility policy "Abuse, Neglect and Exploitation" revised October 2022 revealed the Administrator and Director of Nursing (DON) were responsible for the investigation of alleged violations and reporting the results of the investigation to the proper authorities. All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property were to be reported immediately to the Administrator and/or their designated representative, the appropriate state agency and when applicable law enforcement not later than 24 hours if the allegation did not involve abuse and did not result in serious bodily injury. All reported and/or suspected incidents of abuse, neglect, or exploitation of personal property shall result in an investigation. Any time a report of possible abuse, neglect, or exploitation is made against an employee, that employee should be immediately sent home and suspended until a thorough investigation can be conducted by the DON/Administrator. The resident involved shall be immediately assessed for injury, assured of protection from further harm, and monitored closely with both medical and social service intervention as indicated.

The facility failed to investigate the staff to resident abuse allegations from R9, increasing the risk of potential abuse to other residents.

- The "Medical Diagnosis" tab for R8 included

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diagnoses of need for assistance with personal care, muscle weakness, arthritis (inflammation of a joint characterized by pain, swelling, heat, redness, and limitation of movement), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder, presence of left artificial hip joint, and fracture (broken bone) around the left hip joint.

The "Annual Minimum Data Set" (MDS) dated 05/28/23 assessed R8 with a "Brief Interview of Mental Status" (BIMS) score of 13, indicating intact cognition. R8 required extensive assistance of two or more staff for transfers. R8 did not reject cares and had impaired range of motion to one side of her lower extremities.

The "Activities of Daily Living [ADL] Functional/Rehabilitation Potential Care Area Assessment" dated 05/31/23 revealed R8 had weakness and impaired mobility and required assist with her ADL's.

The "Quarterly MDS" dated 08/12/23 assessed R8 with a BIMS score of 14, indicating intact cognition and noted R8 did not reject care. R8 required total dependence on two or more staff for transfers and R8 had no change to her lower extremity range of motion.

The "Care Plan" dated 08/15/23 revealed R8 could use the call light and required two staff to assist with transfers using the total lift.

The facility "Report of Concern" filled out on 08/16/23 with a date of concern received of 08/15/23 revealed when Social Service Staff X was visiting with R8 and her family member, a few days ago a staff member (included a

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description) entered R8's room, which had the call light on, took the lift out of the room, and told R8 and the family member she had to lay other residents down and would return. They voiced concern with the staff members attitude and tone of voice. The staff member did not return for 30 minutes, and they told Social Service Staff X they did not like this aide.

On 08/14/23 at 01:27 PM R8 rested in bed in her room.

On 08/14/23 at 01:28 PM R8 stated about three weeks ago one of the staff members "scolded her like a child" and told R8 she had to wait her turn to get into bed. R9 stated she turned her light on again after waiting and the same staff member came in her room and "bursted out" because I had my light on again and said, "I told you that you had to wait your turn, when do you learn?" R9 stated she did not know the staff members name, some of the staff told her not to come back in my room, and did not tell anyone at that time, but decided to tell someone later. R9 stated no other facility staff asked her about the situation.

On 08/15/23 at 06:32 PM CNA N stated he witnessed CMA S being "rude" to R8 in the past week or two. CNA N stated R8 wanted to go to bed, and CMA S would tell her to "wait" and we are not supposed to do that, we are supposed to help them, it was "uncalled for" and CNA N stated he reported CMA S's behavior to Administrative Nurse D.

On 08/16/23 at 08:28 AM Administrative Nurse D stated there was a staff member who reported to him that R8 did not want CMA S to take care of her and he was not sure why. Administrative

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Nurse D stated if nobody else could take care of R8 then CMA S could. Administrative Nurse D then stated he heard CMA S was "rude" to R8 and did not investigate or talk to CMA S about the situation. Administrative Nurse D stated "I think the other aides said they would take care of her" referring to R8. Administrative Nurse D failed to investigate R8's concerns.

On 08/16/23 at 08:38 AM R8 stated she did not feel safe if CMA S were to take care of her and she had been in her room once since the incident, but she had another staff with her. R8 stated "I won't let her in my room alone." R8 stated Administrative Nurse D talked to her about it and one of the ladies in the office talked to her yesterday about it.

On 08/16/23 at 08:42 AM R8's family member entered R8's room and joined the conversation, stating they talked to Social Service Staff X yesterday about a situation that happened a few weeks ago with one of the girls telling R8 she was getting in a big hurry and needed to wait her turn, and seemed like she was being bossy. The family member stated R8 did not tolerate sitting up for very long due to her fracture and the lift used to move her was in the room, the girl took it out to go help others and was not back for around 30 minutes.

On 08/16/23 at 08:53 AM Social Service Staff X stated she was visiting with R8 and her family member yesterday about financial matters when they reported a girl, and provided a description that matched CMA S, had came into room when R8 had her call light on. They reported the lift was in the room, and she grabbed the lift and said she would be back as soon as they laid

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these other people down and it was 30 minutes before she returned. Social Service Staff X stated R8 seemed "put off" by it and she was not pleasant or attentive or cordial. Social Service Staff X stated it was the end of the day and she had not filled out a grievance form but intended to.

On 08/15/23 at 09:55 AM Consultant Staff GG stated if a resident complained of staff being rude and did not want that staff member in the room. Consultant Staff GG stated there should have been education with staff on customer service and they should have separated the two individuals, because sometimes it is just approach and not everybody gets along with everyone. Consultant Staff GG stated he would have expected Administrative Nurse D to talk to R8 and find out about the situation to see if R8 perceived the situation as short or rude.

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| F 610 | Continued From page 19<br>possible abuse, neglect, or exploitation is made against an employee, that employee should be immediately sent home and suspended until a thorough investigation can be conducted by the DON/Administrator. The resident involved shall be immediately assessed for injury, assured of protection from further harm, and monitored closely with both medical and social service intervention as indicated.<br><br>The facility failed to investigate the allegation by R8 and reported by CNA N regarding CMA S, increasing the risk of further potential for abuse to other residents. | F 610 | | |