

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175162	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2025
NAME OF PROVIDER OR SUPPLIER Medicalodges Leavenworth		STREET ADDRESS, CITY, STATE, ZIP CODE 1503 Ohio Street Leavenworth, KS 66048	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0602</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 37 residents, with three residents reviewed for misappropriation of resident property (a form of Abuse). Based on record review, observations, and interviews, the facility failed to protect one cognitively impaired resident (R1) from misappropriation of funds. On 07/21/25, it was discovered that Administrative Staff C downloaded R1's credit card account information to their cell phone to make purchases for R1. Administrative Staff C later admitted to purchasing items on R1's card account for themselves. This deficient practice placed R1, a cognitively impaired resident, in immediate Jeopardy, causing R1 emotional distress and a monetary loss of approximately \$6000.00. Findings included:- R1's Electronic Medical Record (EMR) documented R1 had a diagnosis of Alzheimer's disease (a common form of dementia characterized by gradual loss of memory, thinking, and reasoning skills).R1's Quarterly Minimum Data Set (MDS) dated [DATE] recorded a Brief Interview for Mental Status (BIMS) score of 3, which indicated R1 had severely impaired cognition. R1 used a wheelchair for ambulation and required some staff assistance with most activities of daily living (ADL), due to physical limitations. R1's Cognition Care Area Assessment (CAA) dated 01/03/25, recorded R1 could not always tell the difference between what was real and what was a hallucination. When this happened, staff were to stay with the resident and reassure R1 the staff would keep R1 safe.R1's Care Plan, revised 07/14/25, documented R1 had a potential for increased memory loss, due to visual and auditory hallucinations, and other medical conditions. A facility reported incident received on 7/21/25 at 02:19 PM recorded a facility staff member (Administrative Staff C) informed Administrative Staff A, that she [Administrative Staff C] had attached R1's credit card/debit information to her [Administrative Staff C] phone to make purchases for R1, but forgot to remove the card from her phone, which resulted in a charge to R1's account the next time Administrative Staff C used the card for a personal purchase. The report documented Administrative Staff A reviewed R1's bank account statement and discovered several suspicious charges. Administrative Staff A suspended Administrative Staff C and directed her to leave the building and notified law enforcement. The facility investigation lacked documentation regarding the amount of money charged to R1's account. The report also lacked documentation regarding when the personal charges began. A review of R1's account revealed suspicious charges exceeding \$5,987.14 noted since February 2025, with most occurring in July 2025. A non-notarized Witness Statement, documented Social Services X delivered R1's mail, and R1 asked Social Services X to open it (a bank statement), because R1 wanted to know the amount in the account. Looking at the account, Social Services X noticed several transactions that did not look like R1's; several were from another town (the town in which Administrative Staff C resided) and Administrative Staff C had R1's credit card in her office. Social Services X asked Administrative Staff C if she used R1's card. Administrative Staff C told Social Services X R1's card info was on her phone, and stated she might have accidentally used it a few times. Social Services X told Administrative Staff C there were more than a few times noted on the</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0602</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>immediate corrective action up to and including termination. On 07/29/25 at 04:14 PM, Administrative Staff A was provided the IJ template and notified of the facility's failure to protect a cognitively impaired resident from misappropriation of funds and financial which caused R1 to suffer emotional distress and financial loss of approximately \$6000.00, placing R1 in immediate jeopardy. The facility implemented immediate corrective actions, which included the following: On 07/21/25, Administrative Staff C was immediately suspended and subsequently terminated. On 07/21/25, an audit of all resident accounts was performed, and no other concerns were noted. On 07/21/25, a meeting with R1 was held wherein the matter was discussed and the facility offered, and R1 accepted counseling to cope with feelings of betrayal and loss of trust. On 07/21/25, the door code was changed to Administrative Staff C's office, and all keys were reclaimed from Administrative Staff C. R1's credit card was returned to him, and the facility took R1 to his bank, where a new, uncorrupted card was issued to him. On 07/21/25, the facility conducted an all-staff in-service regarding the facility ANE policy, timely reporting (of incidents) policy, and review of the Elder Justice Act, with employee signatures of attendance. On 07/22/25, the facility notified law enforcement, who responded and met with R1, and an ongoing criminal investigation began. On 07/25/25, the facility held an impromptu resident council meeting to inform residents there was no gifting of, or sharing of, sensitive information. Due to the corrective actions completed on 07/25/25, before the onsite survey, the citation was deemed past noncompliance at a J scope and severity.</p>		