STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175413	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Paola	501 Assembly Lane Paola, KS 66071

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)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility reported a census of 63 residents. Based on observation, interview and record review, the facility failed to maintain a clean, comfortable, and homelike environment in four of 23 resident rooms on the south hall placing the residents at risk of an uncomfortable and unhomelike environment. Findings included:- During an initial environmental tour of the south hall on 07/26/25 at 08:00 AM, the following issues were noted: 1. Resident (R)38's room had a build-up of a black substance around the base of the toilet. The wall beneath the sink had a large area that had been cut out and not repaired. 2. R13's room had areas of cove base several feet long that had separated from the wall. A build-up of a black substance had built up in the gap between the cove base and the wall. 3. R19's room had an area of cove base that had separated from the wall. A build-up of a black substance had built up in the gap between the cove base and the wall. The base of the window lacked paint in several areas. The bathroom door had multiple areas of missing paint. 4. R24's room had multiple areas on the wall at the head of the bed, which had been repaired but lacked paint. The bathroom had a build-up of a black substance around the base of the toilet. On 07/29/25 at 08:45 AM, Maintenance Staff U confirmed the areas were in need of repair. The facility did not provide a policy for housekeeping and maintenance of resident rooms.

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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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. The facility reported a census of 63 residents. Based on observation, interview, and record review, the facility failed to ensure the posted daily nurse staffing sheets included accurate and identifiable information to include the daily licensed and unlicensed staff hours, and daily census as required. Findings included:-Observed on 07/27/25 at 09:00 AM, the posted daily staffing sheet only had the first shift staffing information filled out; the second and third shift information was not included, nor were the actual hours worked filled out.Observed on 07/28/25 at 08:00 AM, the posted daily staffing sheet only had the first shift staffing information filled out; the second and third shift information was not included, nor were the actual hours worked filled out.Observed on 07/29/25 at 09:07, the posted staffing sheet only had the first shift information filled out; staffing hours and actual hours were not posted.Review of the daily staffing sheets from 07/29/25, 07/28/25, 07/27/25, 06/22/25, 06/21/25, 06/19/25, 06/16/25, 06/15/25, 06/07/25, 06/02/25, 05/29/25, 05/26/25 revealed they lacked all required information to be posted, including the total number and actual hours worked or daily census. On 07/28/25 at 08:00 AM, Administrative Staff B reported that the charge nurse for each shift, along with Administrative Nurse E, filled out the shift information on the staffing sheet for that shift. Administrative Staff B reported that she, by herself, then completed the actual hours worked for the staff once she verified their clock-in/out.On 07/28/25 at 12:12 PM, Administrative Nurse D stated that the daily staff sheet was filled out and posted by the morning charge nurse and Administrative Nurse E. Administrative Nurse D also stated that the daily staffing sheet was supposed to include facility name, date, staff number working that day, and total hours staff are scheduled to work, along with RN coverage and what shift, and the daily census. Administrative Nurse D further stated that the business office completed the actual hours staff worked, as verified by when staff clocked in/out of their shift. On 07/29/25 at 10:34 AM, Administrative Staff A reported that the posted staffing sheet was to be filled out by the charge nurse on each shift, by that shift, and then posted.The facility did not provide a policy related to sufficient staffing.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. The facility identified a census of 63 residents. The sample included 17 residents including five residents reviewed for unnecessary medications. Based on record review, interview and observation, the facility failed to act upon blood pressure monitoring for Resident (R) 50 and administer a hypertensive (high blood pressure) medication per the physician orders. This placed the resident at risk for complications related to high blood pressure and ineffective medication regimen.Findings included:- R50's Electronic Health Record (EHR) revealed a diagnosis of hypertension (HTN-elevated blood pressure).R50's 06/27/25 Quarterly Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) of 15, indicating intact cognition. The MDS recorded R50 had an active diagnosis of hypertension.R50's Care Plan dated 07/27/25 documented he had hypertension. The plan instructed staff to direct R50 to report complaints of headaches, dizziness, vision changes, chest pain, or palpitations. The plan noted R50 received Lisinopril (an antihypertensive medication) and Metoprolol (an antihypertensive medication) for HTN. It directed staff to monitor R50's blood pressure as ordered.R50's Physician's Order noted an order for amlodipine besylate (medication used to lower blood pressure and treat coronary artery disease), five milligrams (mg); give one tablet by mouth (PO) related to hypertension; ordered on 09/25/24. R50's Physician's Order noted an order for propranolol HCl (medication used to treat hypertension and chest pain) 10 mg PO three times a day related to drug-induced tremor; ordered on 08/16/24.R50's Physician's Order noted an order for metoprolol succinate extended release 24 hour (medication used to treat lower blood pressure and treat chest pain) 100mg; take one tablet PO one time a day for HTN; ordered on 08/16/24.R50's Physician's Order noted an order for lisinopril (a medication used to treat HTN) 40 mg every day for HTN ordered 08/16/24.R50's Physician's Order noted an order for clonidine (a medication to lower blood pressure.) 0.1 mg; give one-half tablet as needed (PRN) for systolic blood pressure (SBP- top number, the force your heart exerts on the walls of your arteries each time it beats) that is greater than 160 millimeters (mm) of Mercury (hg), related to HTN. Give for SBP greater than 160 mmHg. Recheck in one hour. May repeat one time in each 24-hour period. Ordered on 03/01/24.R50's EHR revealed the following dates when R50's SBP exceeded 160 mmHg, but the clonidine was not administered:11/01/24 at 07:26 PM, R50 had a blood pressure (BP) of 254 / 94 mmHg. The clonidine was not given as ordered. There was no progress note addressing the blood pressure.03/17/25 at 08:00 AM, R50 had a BP of 165 / 96 mmHg. The clonidine was not given as ordered. There was no progress note addressing the blood pressure.03/31/25 at 08:04 AM, R50 had a BP of 176 / 100 mmHg. The clonidine was not given as ordered. There was no progress note addressing the blood pressure.04/21/25 at 08:04 AM, R50 had a BP of 185 / 106 mmHg. The clonidine was not given as ordered. There was no progress note addressing the blood pressure.06/23/25 at 07:56 AM, R50 had a BP of 170 / 105 mmHg. The clonidine was not given as ordered. There was no progress note addressing the blood pressure.R50's Electronic Medication Administration Record (EMAR) documented that the clonidine was not given since the start of the order.During an observation on 07/29/25 at 09:18 AM, R50 walked in the hall without any concerns. R50 said that sometimes, when he bent down and then stood up too fast, he got lightheaded. He said he did not think he had any concerns with high blood pressure, but he was unsure.On 07/28/25 at 09:51 AM, Certified Medication Aide (CMA) S stated the CMA staff measure R50's blood pressures weekly as ordered. She did not know if he had PRN blood pressure medication orders. CMA S said the nurse gives any PRN medications, and the CMA staff cannot see the PRN orders. CMA S said she would notify the nurse if R50's blood pressure was high, the SBP was 190 or above, she would take it again, then notify the nurse if it was still high. CMA S said that anything less than 190, she would not notify the nurse for R50.On 07/28/25 at 10:58 AM, Licensed Nurse (LN) I stated the CMA gets (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the blood pressures. LN I said the CMA would notify her if it is high, and she would notify the doctor. LN I said she was unaware if R50 had any PRN blood pressure medications.On 07/28/25 at 12:35 PM, Administrative Nurse E stated R50's clonidine order was a weird order because the facility staff were not monitoring blood pressure. Administrative Nurse E verified R50's clonidine was not given when it should have been given on the above-mentioned dates. Administrative Nurse E said she monitors the blood pressures in the morning meeting and feels R50's blood pressure on 11/01/24 at 07:26 PM for 254 / 94 mmHg was probably a mistake.The facility did not provide a policy.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. The facility reported a census of 63 residents and one kitchen. Based on observation, record review, and interview, the facility failed to prepare and serve food under sanitary conditions, to the residents of the facility appropriately to prevent the potential for food borne bacteria placing them at risk of food-related illness.Findings included: - During an initial tour of the kitchen on 07/27/25 at 10:51 AM, the following areas of concern were noted:1. The hand-washing sink had a build-up of dirt and grime.2. The trash can next to the hand-washing sink had dried on food and fluid.3. Three large plastic containers holding dried milk, flour, and sugar had a build-up of dust and a sticky substance on the lids.4. Four cutting boards had deep grooves, making them unsanitizable.5. Several drawers containing cutting boards, cooking utensils, and hot pads had food debris in the bottom.6. A corner cabinet used to hold sandwich bags, plastic wrap, and plastic containers had food debris throughout.7. The fronts of several cabinet doors had a build-up of dried-on food and liquid substance.8. Two preparation tables used to hold pots, pans, clean trays, and plates had food debris on the lowest shelf.9. Two two-door reach-in freezers and one three-door reach-in refrigerator had food debris on the bottom shelf. 10. Several of the wire racks in the reach-in refrigerators had worn off protective plastic coatings, making the racks unsanitizable.11. The splashback behind the sink at the preparation counter had a large crack in the vinyl covering.On 07/29/25 at 09:01 AM, Dietary Staff BB confirmed the areas of concern needed to be corrected.The facility policy for Sanitation of Dining and Food Service Areas, dated 2016, included: The Dining Services staff will uphold sanitation of the dining areas according to the cleaning schedule set forth by the Dining Service Manager. The stationery can opener, worktables, and counters shall be cleaned following each use. The hand-washing sink shall be cleaned daily. Trash barrels and drawers shall be cleaned weekly, and refrigerators, freezers, and food containers shall be cleaned monthly.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. The facility reported a census of 63 residents. The sample included 17 residents. Based on interviews, record reviews and observation, the facility staff failed to implement 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) for Resident (R)8 and for R21 who had wounds and received wound care. This deficient practice placed the residents at increased risk for infections. Findings included:- Observed on 07/27/25 at 09:50 AM, there was no EBP personal protective equipment (PPE) or signage set-up in or around R8's room.Observed on 07/27/25 at 11:57 AM, R21 had no EBP personal protective equipment (PPE) or signage set up in or around his room.Observed on 07/28/25 at 09:00 AM, there was no EBP PPE or signage set up in or around R8's room.Observed on 07/29/25 at 08:35 AM, Licensed Nurse (LN) G opened the door after she finished R21's treatment. LN G stated the incision was closed, but there were two open areas they were debriding (medical removal of dead, damaged, or infected tissue to improve the healing potential for the remaining healthy tissue) with Silvadene (a topical antibiotic used in partial-thickness and full-thickness wounds to prevent infection). There were gloves in the trash can, but no gown. LN G stated they did not wear gowns to provide care which included dressing changes. Observed on 07/29/25 at 09:13 AM, there was no EBP PPE or signage set-up in or around R8's room.On 07/27/25 at 09:50 AM, R8 reported she had wounds on her abdominal folds area that was caused by her briefs that were being treated.On 07/27/25 at 09:50 AM, LN G reported that R8's wounds were open and treated with silver alginate (absorbent dressing material) and an ABD pad. On 07/29/25 at 09:19 AM, LN H reported that R8's abdominal fold wounds were open but not weeping or draining, and when she provided treatment and dressing changes, she would wear gloves only. LN H also stated that EBP PPE was only used if there was a chance of getting bodily fluid on one's person. On 07/29/25 at 09:38 AM, Administrative Nurse E stated that EBP PPE would be utilized along with standard precautions if there were a positive culture colonization, in-dwelling medical devices, or if there were wounds that had a multi-drug-resistant organism that could not be contained.On 07/29/25 at 10:43 AM, Administrative Staff A stated that EBP PPE was expected to be in place whenever a resident had any type of infection.On 07/29/25 at 11:32 AM, Administrative Nurse E stated that R21 should have EPB. The facility's Infection Management Process dated 11/2023 documented that PPE will be available for all staff and that signage would be posted to direct staff and visitors on what PPE is required.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. The facility reported a census of 63 residents. Based on interview, and record review, the facility failed to ensure the mandatory 12-hours of education were completed for one Certified Nurse Aide (CNA) as required. This placed the residents at risk for decreased quality of care.Findings included:- Review of CNA N's personnel and training records revealed CNA N was hired on 01/20/20. CNA N's files lacked evidence that he had completed any of the mandatory 12 hours of education for the last 12 months.On 07/28/25 at 02:26 PM, Certified Medication Aide (CMA) S stated that required education was performed online through Relias. On 07/29/25 at 10:19 AM, Administrative Nurse D reported that staff were expected to complete mandatory online training, which included the required 12 hours of mandatory training, periodically each month.On 07/29/2025 at 10:39 AM, Administrative Staff A stated that the required and mandatory 12 hours of education had to be done; there was no excuse for it not to be completed in a 12-month period. Administrative Staff A further stated that there was a monitoring system that linked to the annual evaluation of the staff and indicated if the education was complete.The facility's Certified Nursing Assistant Job Summary, dated 10/2014, documented that part of the CNA's responsibility included understanding and complying with Medicalodges' policies and procedures, as well as state and federal requirements.