STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175464	A. Building B. Wing	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Independence	1000 Mulberry Independence, KS 67301

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 43 residents; the sample included 14 residents. Based on observation, interview, and record review, the facility failed to verify advanced directives (legal documents in which a person specifies what actions should be taken for their health if they are no longer able to make decisions for themselves) to ensure the outside of hospital Do Not Resuscitate Directive form (DNR- or no code, a legal document or order that means the person does not desire cardiopulmonary resuscitation [CPR] in the event of cardiac arrest) were accurate and legal to reflect Resident (R) 4, R27, and R40's advance directives. This deficient practice placed the residents at risk for impaired rights related to end-of-life care. Findings included: - R4's Electronic Health Record (EHR) included diagnoses of morbid obesity (a serious medical condition characterized by excessive body fat accumulation, significantly impacting health and potentially shortening lifespan), chronic kidney disease (a condition where the kidneys are damaged and lose the ability to filter waste and fluid from the blood), atrial fibrillation (rapid, irregular heartbeat), hyperkalemia (greater than normal amount of potassium in the blood), heart failure (a condition where the heart cannot pump enough blood to meet the body's needs, leading to fluid buildup in the lungs, legs, and other areas), and essential hypertension (high blood pressure). R4's Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) of 14, which indicated intact cognition. R4's Quarterly MDS dated [DATE] documented a BIMS of 14. R4's Care Plan dated [DATE] documented R4 wished to be a DNR. R4's Physician Orders revealed an order for DNR dated [DATE]. R4's EHR Home tab documented R4's code status (full code or DNR) as DNR. R4's EHR, under the scanned documents section, revealed a Do-Not-Resuscitate Directive signed by the resident, with an illegible date. The directive was not signed by the physician. On [DATE] at 08:22 AM, Licensed Nurse (LN) G stated that DNR and full code status were verified in the resident's EHR and by their paper chart. LN G also stated that a DNR should have been signed by the resident and/or their legal representative and the physician. LN G further stated that if a (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident left the facility for any appointment or outing a packet was sent with them that included their face sheet indicating code status and their DNR if applicable. On [DATE] at 08:38 AM Administrative Staff A and Administrative Nurse D stated that an advanced directive and/or DNR should have had the resident's signature and physician's signature if resident was cognitively intact or the resident's legal representative's signature and this was done when the resident entered that facility. The staff said the residents also had the ability to enact a DNR once they were moved into the facility. On [DATE] at 08:51 AM, Administrative Nurse D stated that R4's DNR was not signed by a physician so it was not legal. The facility policy Advance Directives, dated 04/2018 stated that indicated that residents have the right to accept or refuse medical or surgical treatment including formulating an advance directive. This policy also indicated that complete copies of the resident's advance directive would be provided and maintained in their clinical record. The policy further indicated that if a resident requested to be a Do Not Resuscitate (DNR), a physician order would be obtained and the advance directive would be reviewed quarterly, with any significant change and upon the resident's request, and the reviews would be documented in their clinical record. The facility policy Advance Directive-Code Status, dated 12/2017 indicated that the policy was to identify and honor the resident's preference regarding advance directives and code status.

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	175464	A. Building B. Wing	06/18/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. The facility reported a census of 43 residents. The sample included 14 residents. Based on interview, observation, and record review, the facility failed to protect and promote the privacy, including during telephone use, for Resident (R) 145, R19 and R44. This deficient practice placed the residents at risk for negative psychosocial effects due to impaired privacy. Findings included: - Observation on 06/17/25 at 09:59 AM, Housekeeping V entered R145's room to perform housekeeping duties without knocking and announcing her presence. R145 was resting on his bed at that time. Observation on 06/17/25 at 10:03 AM, Maintenance U knocked once on R19's door, and without waiting for R19 to respond, walked in and turned the light on, R19 was resting in her bead at that time. On 06/16/25 at 09:20 AM, R4 reported that when she was on the phone, staff would just enter her room and loiter until she was off the phone. On 06/17/25 at 10:09 AM, Certified Nurse Aide (CNA) M stated she would knock and introduce herself and await acknowledgment from the resident before entering the room. CNA M said, if the resident was on the phone she would not enter until they were off the phone or acknowledged it was ok. On 06/17/25 at 10:11 AM, Housekeeping V stated that if there was a resident in the room she planned to work in, she would knock, announce herself, and once acknowledged she would enter the room. Housekeeping V said if the resident was asleep, she quietly entered and quickly performed her tasks. Housekeeping V also stated that if a resident was on the phone, she would just go in and complete her tasks while the resident remained on the phone. On 06/17/25 at 10:27 AM, Licensed Nurse (LN) G stated that before entering a resident's room, she knocked, introduced herself, and announced the reason she was there; she awaited acknowledgment. She said if a resident was on the phone, she would let them know that she would come back later. On 06/17/25 at 11:20 AM, Administrative Staff A reported that if care were performed the curtain would be pulled and doors closed; all staff were to knock, announce themselves, await a response, and re-knock if no response was received before entering the resident's room. Administrative Staff A stated that if the resident were on the phone, then staff should have come back later to allow the resident to have privacy. Administrative Staff A further stated that it was not appropriate to perform housekeeping duties or other resident care duties while the resident was sleeping unless the resident had previously approved of the actions. On 06/17/25 at 11:30 AM, Administrative Nurse D stated that staff were to knock and await permission before they entered a resident's room. Administrative Staff D also stated that if the resident was on the phone, then staff should have come back at a later time unless the resident said it was okay to come in. On 06/17/25 at 04:35 PM, Administrative Staff A reported that the facility did not have a specific policy for resident's rights or privacy, the facility followed the regulations. The facility did not provide a policy related to resident rights and privacy.

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	175464	A. Building B. Wing	06/18/2025

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. The facility had a census of 43 residents. The sample included 14 residents with one resident reviewed for hospitalization. Based on interview and record review, the facility failed to issue written notification as soon as practicable for transfer for Resident (R) 2. The facility additionally failed to notify the Office of the Long Term Care Ombudsman (LTCO). This placed the resident at risk for impaired rights related to returning to the facility. Findings included: - R2's Electronic Health Record (EHR) revealed diagnoses of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), paroxysmal atrial fibrillation (rapid, irregular heartbeat), atrioventricular block (a condition where the electrical signals that control the heartbeat are partially or completely blocked from traveling between the atria and ventricles), and the presence of cardiac pacemaker (implanted device to regulate the beating of the heart). R2's Discharge with Expected Return Minimum Data Set (MDS) dated 03/01/25 documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact memory. R2's Quarterly MDS dated 05/22/25 documented a BIMS score of 15 and indicated yes for shortness of breath when lying flat for health conditions. R2's Care Plan documented on 05/23/25 that R2 was at risk for potential complications and discomfort related to congestive heart failure. The care plan interventions included the administration of medications as ordered and directed staff to monitor for effectiveness and side effects of the medications. The plan also directed staff to report to the provider any shortness of breath decreased urine output or elevated blood pressure. The Progress Notes dated 03/01/25 at 09:07 AM documented R2 had complaints of chest pain and tightness that radiated down her left arm and neck; she appeared pale in color and displayed shortness of breath. R2 went to the emergency room (ER) for further evaluation. The Progress Notes dated 03/02/25 at 12:25 PM documented that R2 returned to the facility from the hospital. R2's EHR lacked evidence the facility provided written notification of the transfer to R2 and/or her representative. The facility was unable to provide evidence of notification to the LTCO for R2's transfer. On 06/17/25 at 01:25 PM, Administrative Staff A stated that the Ombudsman was provided notification monthly about resident transfers and/or discharges. Administrative Staff A said that the resident and/or legal representative received verbal notification and provided consent via a phone call. Administrative Staff A further stated that transfer packets were sent with the resident whenever they were transferred out, but the documents were never returned by EMS or the hospital. On 06/17/25 at 01:57 PM, Administrative Staff C stated that the LTCO was not been notified because (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2 had only transferred out for one day. Administrative Staff C also stated that R2 had not been provided written notification of her transfer by the facility. The facility did not provide a policy related to written notification of resident transfers or discharge to residents and the LTCO.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. The facility identified a census of 43 residents. The sample included 14 residents with five residents sampled for quality of care. Based on observation, interview, and record review, the facility failed to provide care and services to monitor medications for Resident (R) 11 when staff failed to monitor for effectiveness and side effects of an antibiotic and failed to follow instructions to discontinue mediations that had potential for increased adverse effects due to the antibiotic. This deficient practice placed R11 at risk for prolonged infection and adverse side effects. Findings: - R11's Electronic Medical Record (EMR) revealed the following diagnoses: end-stage renal disease (ESRD-a terminal disease of the kidneys), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), and infected wounds. R11's 04/20/25 admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) of 15, indicating intact cognition. The MDS recorded R11 had dialysis (a procedure where impurities or wastes are removed from the blood)and several wounds. The MDS noted R11 had two unstageable pressure ulcers (the depth of the wound is unknown due to the wound bed being covered by a thick layer of other tissue and pus), one deep tissue injury (DTI- purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear) and three venous ulcers (a stasis wound due to poor circulations). The 04/20/25 Nutritional Status Care Area Assessment (CAA) documented R11 was alert and oriented with intermittent confusion. He had diagnoses of ESRD, diabetes mellitus, and chronic wounds. R11's Care Plan dated 06/16/25 documented R11 was on an antibiotic and had an infection related to wounds. The plan directed staff to administer antibiotics as ordered; monitor for adverse reactions from the antibiotic treatment and continued signs and symptoms of infection; monitor for signs and symptoms of dehydration such and lethargy (extreme weakness), increased weakness, and decreased urine output. R11's Physician's Orders documented an order for atorvastatin (a medication used to lower cholesterol) 40 milligrams (mg) by mouth at bedtime for high cholesterol. R11's Wound Note dated 06/12/25 documented R11 was to start ciprofloxacin (an antibiotic) 250 milligrams (mg) by mouth once a day for 10 days. The note directed to hold while taking the ciprofloxacin. The note directed to start Augmentin 500-125 mg (an antibiotic) one tablet a day for a wound infection for 10 days and directed to take a second tablet after dialysis treatments. R11's Physician's Orders noted an order for ciprofloxacin 250 milligrams (mg) by mouth once a day for 10 days ordered on 06/12/25 for wound infection. R11's Physician's Orders noted an order for Augmentin 500-125 mg, take one tablet a day for a wound infection for 10 days ordered on 06/12/25. Also take one tablet on Monday, Wednesday, and Friday after dialysis. R11's June 2025 Medication Administration Record (MAR) documented atorvastatin calcium 40 mg was given for high cholesterol while he took the ciprofloxacin 250 milligrams on 06/14/25, 06/15/25, (continued on next page)

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	175464	A. Building B. Wing	06/18/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	06/16/25, and 06/17/25. R11's clinical record including Progress Notes lacked documentation of routine monitoring of adverse reactions or effectiveness of the antibiotic medications. On 06/18/25 at 09:37 AM, Licensed Nurse (LN) G stated staff should monitor adverse reactions and effectiveness of antibiotics and document every shift for every resident that was taking antibiotics. LN G stated that she was not documenting on R11 but was not surprised there was no documentation of monitoring for R11. LN G said she was not aware that R11's atorvastatin was supposed to be held and said the nurse that was working, or the wound nurse, should have put in the orders. On 06/18/25 at 10:39 AM, Administrative Nurse D stated all residents on antibiotics should be monitored every shift for effectiveness and any adverse reaction to antibiotics. Administrative Nurse D verified the order to hold R11's atorvastatin should have been followed. The Medication Management policy dated 01/2024 documented that each resident's drug regimen is reviewed to ensure it is free from unnecessary drugs. This included any drug without adequate monitoring. In order to optimize the therapeutic benefit of medication therapy and minimize or prevent potential adverse consequences. The facility staff, their physician, and the consultant pharmacist perform ongoing monitoring for appropriate, effective, and safe medication use.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. The facility identified a census of 43 residents. The sample included 14 residents with one resident reviewed for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). Based on observations, interviews, and record reviews, the facility failed to provide ordered treatments to prevent pressure ulcers and promote healing for Resident (R) 16. This deficient practice placed the resident at risk of developing pressure injuries and delayed wound healing. Findings included: - R16 's Electronic Health Record (EHR) revealed a diagnosis of chronic renal failure (inability of the kidneys to excrete wastes, concentrate urine, and conserve electrolytes). R16's 03/21/25 admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) of 12, indicating moderate cognitive impairment. The MDS documented R16 had no pressure ulcers but was at risk for pressure injuries. R16's 03/21/25 Pressure Ulcer Care Area Assessment (CAA) documented R16 had no pressure injuries or skin breakdown. He required significant to maximum assistance for bed mobility. R16 was dependent on staff for toileting hygiene and used a wheelchair with staff assistance. The CAA noted R16 had a Braden score 12 which indicated he was at high risk for pressure areas. He had poor intake. R16's 05/29/25 Significant Change MDS documented a BIMS score of four, indicating severely impaired cognition. R16 started hospice services. He had a significant weight loss. R16 had one Stage 1 (pressure wound which appears reddened, does not blanche, and may be painful but is not open) pressure ulcer and one deep tissue injury (DTI- purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear). R16's 05/29/25 Pressure Ulcer CAA documented R16 had a decline in cognition and activities of daily living since admission. His family had elected to implement comfort care provided by the facility in lieu of Hospice. He had two facility-acquired pressure injuries to the bottom of his right foot. R16 triggered for significant weight loss of 38 pounds. He utilized heel protectors. Staff applied Skin-prep (liquid skin protectant) to the pressure injuries. He required two staff to turn and reposition him in bed. He was at risk for further skin breakdown and pressure injuries. R16's Care Plan documented a DTI on his right foot. On 05/06/25 staff were instructed to apply Skin-prep to the ball of R16's right foot. The plan directed staff to apply heel pillow boots to both feet and a padded footboard to R16's bed. On 05/27/25, the plan directed staff to apply Skin-prep to a deep tissue injury on the bottom of the right foot and cover it with border foam dressing. The plan directed staff to apply Skin-prep to the Stage I pressure injury on the bottom of the right foot, and cover with a border foam dressing. The plan directed staff to apply Skin-prep to R16's buttocks and cover the area with a border foam dressing for prevention. R16's Braden Scale for Pressure Ulcer Risk V1.0- - V 1 dated 05/27/25 documented R16 had a pressure risk score of nine which indicated a severe risk for pressure areas. R16's Physician Order noted an order to apply Skin-prep to R16's buttocks and cover with a border foam dressing on Monday, Wednesday, and Friday for prevention; ordered 05/28/25. (continued on next page)

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	175464	A. Building B. Wing	06/18/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R16's Physician Order noted an order to apply Skin-prep to R16's right foot and cover with a border foam dressing on Monday, Wednesday, and Friday for deep tissue injury; ordered 05/28/25. R16's Physician Order noted an order for heel protector boots for both feet every shift; ordered 05/28/25. R16's Physician Order noted an order to apply Skin-prep to R16's right foot and cover it with a border foam dressing on Monday, Wednesday, and Friday for a second deep tissue injury; ordered 06/10/25. R16's 06/10/25 Skin/Wound Condition Assessment documented two right plantar foot suspected DTI areas 1.5 centimeters (cm) x 1.5 cm and a second one 1.5cm x 0.5 cm. The oldest pressure area was identified on 04/09/25. On 06/17/25 at 08:57 AM, R16 lay in bed with his boots applied. There was no dressing applied to his feet. On 06/17/25 at 11:35 AM, Certified Nurse Aide (CNA) N and CNA O changed R16's brief. Observation revealed R16's buttock was discolored; he had no dressing on his buttock as ordered. Further observation revealed R16 had no dressing to his feet either. On 06/17/25 at 02:31 PM, Licensed Nurse (LN) G attained the supplies to apply R16's dressings. LN G measured the deep tissue injury wounds on the bottom of R16's feet. The top one was 2.3 cm x 1.8 cm and dark bluish-purple. LN G stated it looked a bit bigger. The bottom wound measured 1.8cm x 0.5 cm and was dark bluish-purple. At 02:51 PM, LN H assisted LN G with the dressing on R16's buttocks. On 06/17/25 at 09:12 AM, CNA N stated that sometimes the dressings were on R16's feet and sometimes there were no dressings applied. On 06/17/25 at 09:14 AM, LN G stated the dressings should be applied to R16's foot and buttocks as ordered. LN G said she would apply the dressings when she was able. On 06/17/25 at 11:35 AM, CNA O stated R16 had not had a treatment or dressing on his buttock for a long time. CNA O said R16 occasionally had a dressing on his feet. On 06/18/25 at 10:39 AM, Administrative Nurse D stated that R16's dressings should have been in place. Administrative Nurse D stated she expected staff to follow treatment orders to prevent further decline. The Wound Prevention and Management Policy dated 12/2018 documented that the purpose of the policy is to identify residents at risk for skin breakdown and develop interventions to decrease the pressure areas and promote healing for residents with identified skin alterations.

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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. - R21's Electronic Health Record (EHR) revealed a diagnosis of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin). R21's 04/17/25 Significant Change Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) of 15, indicating intact cognition. R21 consumed a therapeutic, regular textured diet. R21 received insulin (a hormone that lowers the level of glucose in the blood) daily. R21's Care Plan documented on 02/08/25 she was at risk for hyperglycemia (high blood sugar) and hypoglycemia (low blood sugar) related to a diabetes diagnosis and the use of insulin. The plan documented R21 needed to have her insulin administered per physician orders. R21's Physician's Order noted an order for Admelog SoloStar (fast-acting insulin). Inject four units subcutaneously (beneath the skin) before meals related to diabetes. Hold for a blood sugar (BS) of less than 100 milligrams (mg) per deciliter (dL); ordered on 02/08/25. R21's EHR revealed a consultant pharmacist medication review dated 05/23/25 that documented R21 received Admelog outside the ordered parameters on the following dates: 05/01/25 when the BS was 75mg/dL; 05/04/25 when the BS was 93mg/dL; 05/12/25 when the BS was 96mg/dL; and 05/17/25 when the BS was 75 mg/dL. The pharmacist requested that staff ensure the medication was administered per physician's order and that responsible staff received education. A review of staff education provided by Administrative Nurse D revealed that Licensed Nurse (LN) H and LN I received education on 05/27/25 regarding following parameters on insulin. R21's May and June 2025 Medication Administration Record/Treatment Administration Record (MAR/TAR) documented the Admelog was administered on 05/30/25 when the BS was 84 mg/dL, and on 06/12/25 when the BS was 94 mg/dL. On 06/01/25 there was no documentation to indicate if it was given or if the BS was obtained. On 06/18/25 at 09:37 AM, Licensed Nurse (LN) G stated that staff were always supposed to look at the medication parameters before giving medications. LN G said that staff had received some training on following medication parameters. On 06/18/25 at 10:39 AM, Administrative Nurse D stated that she expected staff to read and follow parameters when administering any medications. Administrative Nurse D said that education was completed only for the staff that were identified during the pharmacy review for incorrectly administering medications outside of the ordered medication parameters. On 06/18/25 at 10:43 AM, Administrative Nurse E reported that parameter medications were monitored through the medication orders and not care planned, but hyperglycemia (high blood sugar level) and hypoglycemia (low blood sugar) measures were care planned. The Medication Management policy dated 01/2024 documented that each resident's drug regimen was reviewed to ensure it was free from unnecessary drugs. This included any drug without adequate monitoring, in the presence of adverse consequences which indicated the dose should be reduced or the drug eliminated. It further documented that to optimize the therapeutic benefit of medication therapy and (continued on next page)

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	175464	A. Building B. Wing	06/18/2025

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	minimize or prevent potential adverse consequences, the facility staff, their physician, and the consultant pharmacist would perform ongoing monitoring for appropriate, effective, and safe medication use. The facility reported a census of 43. The sample included 14 residents with five residents reviewed for unnecessary medications. Based on observation, interview, and record review, the facility failed to ensure medications were administered within the physician-ordered parameters for Resident (R) 25 and R21. This deficient practice placed the affected residents at risk for adverse medication reactions. Findings include: - R25's Electronic Health Record (EHR) revealed diagnoses of unspecified sequelae of 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), essential hypertension (high blood pressure), obstructive sleep apnea (a disorder of sleep characterized by periods without respirations), and renovascular hypertension (a type of high blood pressure caused by narrowing of the arteries that supply blood to the kidneys). R25's admission Minimum Data Set (MDS) dated 09/24/24 documented a Brief Interview of Mental Status (BIMS) of 15, which indicated intact cognition. The Fall Care Area Assessment CAA, dated 09/24/24, documented R25 had a fall within one month before admission and a fall recently since admission; she received high-risk medications. R25's Quarterly MDS dated 03/20/25 documented a BIMS score of 15. R25's Care Plan documented on 06/19/25 that R25 was at risk for falls. The interventions included medications that had a Black Box Warning (BBW- highest safety-related warning that medications can be assigned by the Food and Drug Administration) or had nursing considerations that needed to be monitored. The plan directed staff to monitor and report any concerns to the physician immediately. R25's EHR documented a Physician's Order for amlodipine 10 mg one time a day. Hold the medication if the systolic blood pressure (SBP- top number, the force the heart exerts on the walls of the arteries each time it beats) is less than 100 millimeters (mm) of mercury (Hg), diastolic blood pressure (DBP-minimum level of blood pressure measured between contractions of the heart; the bottom number of a blood pressure reading) is less than 60 mmHg or the heart rate (HR) is less than 60 beats per minute (BPM) R25's EHR documented a Physician's Order for metoprolol extended release 50 mg two times a day with instructions to hold the medication if the SBP is less than 100 mmHg, the DBP is less than 60 mmHg or the HR is less than 60 BPM. R25's EHR revealed a consultant pharmacist medication review dated 01/30/25 that documented R25 received amlodipine and metoprolol outside ordered parameters in January 2025. A review of staff education provided by Administrative Nurse D revealed that Certified Medication Aide (CMA) R and CMA S received education on 01/27/25 regarding following blood pressure (BP) parameters for amlodipine and metoprolol. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175464	A. Building B. Wing	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Independence	1000 Mulberry Independence, KS 67301

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R25's Medication Administration Record (MAR), reviewed from March 2025 through June 2025, recorded R25 received amlodipine and/or metoprolol outside ordered parameters for the following dates: 03/04/25 R25's morning BP was 124/56 mmHg and staff administered amlodipine and metoprolol. 04/05/25 R25's morning BP was 151/56 mmHg and staff administered amlodipine and metoprolol. 04/12/25 R25's evening BP was 137/54 mmHg and staff administered metoprolol. 04/30/25 R25's morning BP was 153/57 mmHg and staff administered the morning amlodipine and metoprolol. 05/18/25 R25's morning BP was 105/58 mmHg and staff administered the morning amlodipine and metoprolol. On 06/18/25 at 09:37 AM, Licensed Nurse (LN) G stated that staff were always supposed to look at the medication parameters before giving medications. LN G said that staff had received some training on following medication parameters. On 06/18/25 at 10:39 AM, Administrative Nurse D stated that she expected staff to read and follow parameters when administering any medications. Administrative Nurse D said that education was completed only for the staff that were identified during the pharmacy review for incorrectly administering medications outside of the ordered medication parameters. On 06/18/25 at 10:43 AM, Administrative Nurse E reported that medications with ordered parameters were monitored through the medication orders. The Medication Management policy dated 01/2024 documented that each resident's drug regimen was reviewed to ensure it was free from unnecessary drugs. This included any drug without adequate monitoring, in the presence of adverse consequences which indicated the dose should be reduced or the drug eliminated. It further documented that to optimize the therapeutic benefit of medication therapy and minimize or prevent potential adverse consequences, the facility staff, their physician, and the consultant pharmacist would perform ongoing monitoring for appropriate, effective, and safe medication use.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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 43 residents. Based on observation, record review, and interview, the facility failed to prepare and serve food under sanitary conditions, to prevent the potential for food borne bacteria in one of one kitchen and one of one kitchenettes. This placed the residents of the facility at risk for food borne illness. Findings included: - During a tour of the kitchen on 06/16/25 at 08:49 AM, the following areas of concern were noted: 1. The inside of the hand-washing sink had visible dirt and debris. The trash can next to the hand-washing sink had dried food debris stuck on the outside of the plastic can. 2. One three-tiered metal cart, used to transport resident snacks, had multiple areas of rust on the legs as well as a build-up of ground-on food on the wheels. 3. The inside of the three-doored freezer had food debris on the bottom shelf. 4. Two silver-colored skillets hanging by the stove contained multiple scratches in the protective coating causing the skillets to be unsanitizable. 5. The front vent of the three-door reach-in refrigerator had dried-on liquid and the inside of one door contained a long hair stuck to the door by the condensation. 6. Approximately 50 percent (%) of the rubber seal on one door of the three-doored reach-in refrigerator hung loosely. The rubber seal on all three doors contained a thick build-up of food debris. 7. The inside of the three-doored reach-in refrigerator had a copious amount of food debris on the bottom shelf. 8. Two plastic trash cans used in the kitchen had a build-up of dried-on food and liquid. During a tour of the kitchenette refrigerator, on one end of the dining room directly outside of the kitchen, on 06/16/25 at 09:15 AM, the following areas of concern were noted: 1. There was an opened gallon of vanilla ice cream in the refrigerator, unlabeled and undated. 2. There was a paper cup of a frozen solid shake from a local ice cream store, unlabeled and undated. 3. The refrigerator contained an opened container of cottage cheese which was unlabeled and undated. 4. The refrigerator contained a premade salad from a local restaurant which was unlabeled and undated. 5. The refrigerator contained a quart container of butter which was opened and undated. (continued on next page)

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	175464	A. Building B. Wing	06/18/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	6. The freezer contained an open box of pizza rolls which was unlabeled and undated. On 06/16/25 at 12:49 PM, Dietary Staff CC confirmed the above concerns needed to be addressed. The Cleaning Rotation guide, revised in 2016, included that microwave ovens, hand-washing sinks and food carts shall be cleaned daily. Trash barrels shall be cleaned weekly. Refrigerators and freezers shall be cleaned monthly.