STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175070	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Pittsburg	2520 S Rouse Street Pittsburg, KS 66762

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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34056 The facility reported a census of 29 residents with 14 residents sampled for review. Based on observation, interview, and record review, the facility failed to complete an accurate Significant Change Minimum Data Set (MDS), dated [DATE], as required, for Resident (R)83, regarding falls. Findings included: - Review of Resident (R)83's electronic medical record (EMR) included a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion). The Significant Change Minimum Data Set (MDS), dated [DATE], documented the staff assessment for cognition revealed severe impairment. The resident had no limitation in functional range of motion (ROM), used a wheelchair for mobility and had one non-injury fall and one injury (except major) fall since the prior assessment. The Fall Care Area Assessment (CAA), dated 01/25/24, lacked information regarding the resident's falls. The Modification of Significant Change MDS, dated [DATE], documented the staff assessment for cognition revealed severe impairment. He was dependent on staff for mobility, had no limitation in ROM, and had two non-injury falls and one injury (except major) fall since the prior assessment. The care plan, revised 01/02/24, instructed staff the resident could be impulsive. Staff were to ensure his room was free from clutter and not leave him alone in the wheelchair while in his room. Staff were to ensure he wore geri-sleeves (a protective covering on his arms) to help prevent injuries. Review of the resident's EMR revealed multiple Fall Assessments which placed the resident at a high risk for falls, dated: 01/22/24, 01/07/24, 12/28/23 and 12/08/23. On 09/19/24 at 11:36 AM, Administrative Nurse D confirmed the falls CAA for this resident lacked fall information. The facility used the Resident Assessment Instrument (RAI) for the accurate completion of MDSs. The facility failed to complete an accurate Significant Change MDS, dated [DATE], for this resident with a history of falls.

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28560 The facility reported a census of 29 residents with 14 residents selected for review which included one resident reviewed for accidents. Based on observation, interview, and record review, the facility failed to ensure adequate supervision and a safe and secure environment to prevent the elopement (when a cognitive impaired resident leaves the facility without the knowledge or supervision of staff) of cognitively impaired Resident (R)31. On 08/29/24 at 10:05 AM, R31, who the facility assessed as at high elopement risk, had dementia and poor safety awareness, exited the facility unsupervised and without staff knowledge. R31 ambulated approximately 248 feet, across a lawn, two parking lots, and a two-way egress street, to arrive at a dentist office. The staff from the dentist office phoned the facility at 10:15 AM to inquire if R31 was a resident of the facility. This deficient practice placed this resident in immediate jeopardy. Findings included: - Review of Resident (R)31's medical record revealed diagnoses that included Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) and major depressive disorder (major mood disorder with severe psychotic symptoms (any major mental disorder characterized by a gross impairment in reality testing). The Admission Minimum Data Set (MDS), dated [DATE], assessed the resident with a Brief Interview for Mental Status (BIMS) score of 00, which indicated severe cognitive impairment. The MDS documented the resident had continuous inattention and disorganized thinking and verbal behaviors directed toward others. The MDS included R133 wandered daily which put the resident at risk for wandering into potentially dangerous places. The resident received antipsychotic (class of medications used to treat psychosis and other mental emotional conditions) and antidepressant medication (class of medications used to treat mood disorders and relieve symptoms of depression). The Falls Care Area Assessment (CAA), dated 11/27/23, assessed the resident with dementia (progressive mental disorder characterized by failing memory, confusion) and impaired cognition which put him at risk for falls and injury. The resident had wandering behaviors and inattention and difficulty following verbal commands with impairment to recall and communication. The Quarterly MDS, dated [DATE], assessed the resident with a BIMS score of 00, with fluctuating inattention, and disorganized thinking and daily wandering. The Quarterly MDS dated [DATE], assessed the resident with daily wandering and continuous inattention and disorganized thinking. The Care Plan reviewed 05/30/24, instructed staff to evaluate the resident for exit seeking behaviors and determine the resident needs (looking for bathroom, hunger, boredom), redirect him from exit seeking behavior, and place the resident on safety checks if needed. Staff were to encourage the resident to attend activities to keep busy and review behaviors to determine triggers for exit seeking behavior. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Clinical Health Review dated 11/21/23, assessed the resident with an elopement score of 24 (a score over 13 indicated high risk). The Clinical Health Review dated 05/22/24, assessed the resident with an elopement score of 13. The Clinical Health Review dated 08/24/24, assessed the resident with an elopement score of 21. On 08/29/24 at 10:15 AM, a Nurse's Note revealed Licensed Nurse (LN) G received a phone call from a dentist office to inquire if the facility had a missing resident and described the resident. LN G instructed staff to start a building search and LN G went to the dentist office and brought the resident back to the facility. LN G evaluated the resident and found no injury. LN G instructed maintenance staff to check the doors and alarms. Wunderground.com documented the temperature on 08/29/24 at 10:05 AM was 88 degrees Fahrenheit with no precipitation and approximately nine mile per hour wind speed from the south. During an observation of the area on 09/17/24 at 09:30 AM, revealed all doors which would have included the exit door R133 possibly exited from, revealed R31 would have to walk across lawns, two parking lots and a two-way egress street to reach the dentist office. The facility is bordered on two sides by four lane roads with a 35 mph (mile per hour) speed limit. During an interview on 09/17/24 at 09:00 AM, CNA O stated the resident would wander about the facility but never exited the door, prior. CNA O stated the resident often sat in a recliner near the front door. During an interview on 09/17/24 at 08:30 AM, LN G revealed staff did not know which door the resident exited, as no alarm sounded. LN G stated R31 often went to exit doors and looked out, but never had left the facility. LN G stated the exit doors have a touch pad key code and alarm when held open. LN G stated she did not hear an alarm go off when R31 exited the building and Certified Nurse Aide (CNA) N reported she saw the resident seated in the recliner near the front door at approximately 10:05 AM. During an interview on 09/17/24 at 08:00 AM, Maintenance Staff U revealed he checked all the facility exit doors on 08/29/24. Maintenance Staff U found the alarm on the exit door, by the staff break room, alarmed after approximately one minute of opening. This door led to a patio area where staff smoked, and staff used the exit to take trash out to a dumpster. The adjacent area contained grass, and eventually a parking lot. Maintenance Staff U stated the other doors alarmed after approximately 15-30 seconds upon opening and functional checks were performed weekly. Maintenance Staff U stated on 08/29/24 after the elopement, the door alarm company inspected all the doors to ensure they were working properly and set the doors with a 5 to 15-second alarm time upon opening. Maintenance Staff U stated signs were posted to ensure the door closed completely upon exiting the facility. During an interview on 09/17/24 at 08:30 AM, Administrative Nurse D revealed the resident probably exited the building from the door by the back patio, which maintenance found had an approximate one-minute delay in the alarm sounding. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility Resident Elopement Policy and Procedure revised 12/2022, instructed staff to identify residents at risk and develop an individualized care plan based on the risk. Staff were to investigate and report instances of potential elopement and have a process to monitor security of the premises on a routine basis. The facility failed to ensure R31 remained free of accident hazards when the resident exited the facility, walked approximately 248 feet, across two parking lots and a two-lane egress street, in 88-degree Fahrenheit weather. The facility did not know the resident exited the building for approximately 10 minutes, when a dentist office notified the facility of the presence of R133 in their office. On 09/17/24 at 05:52 PM, Administrative Staff A was provided a copy of the immediate jeopardy (IJ) template and informed the failure to ensure the safety of R31 when he left the facility, unsupervised and without staff knowledge, placed R31 in immediate jeopardy. The immediate jeopardy first existed on 08/29/24 at 10:15 AM, when R 31 left the facility unsupervised and without staff knowledge. The facility identified and implemented the following corrective actions following R31's return to the facility: On 08/29/24 at 10:30 AM, LN G completed a full body assessment of R31 upon return to facility. On 08/29/24 at 10:30 AM, resident placed on 1:1 (one staff assigned to monitor the resident continuously) monitoring for the remainder of the investigation. On 08/29/24, maintenance and door alarm company provide door alarm testing. On 08/29/24, LN G notified R31's responsible party and his physician of his elopement. On 08/29/24 at 02:44 PM, Administrative Nurse D documented an alert in the electronic software of any care plan changes. On 08/29/24 at 02:45 PM, Administrative Nurse D notified the State Agency via email of the elopement. On 08/29/24, Administrative Nurse D reviewed the Medication Administration Record and progress notes 24-72 hours that led up to R31 leaving unsupervised and without staff knowledge, to determine if other risk factors were present. On 08/29/24 at 04:00 PM, Administrative Nurse D reviewed all residents for elopement risk, for accuracy, and updated the elopement book and care plans as needed. On 08/29/24, the facility provided Mandatory Elopement Policy training to all staff. On 09/03/24, Quality Assurance Performance Improvement (QAPI) meeting held with the medical director regarding the elopement. On 09/03/24 at 02:00 PM, all staff completed the mandatory Elopement Policy Training. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The surveyor validated the implementation of the above corrective measures completed on 09/03/24 at 02:00 PM, prior to entrance of the Health Resurvey. Therefore, the deficient practice was deemed past noncompliance at a J scope and severity.