STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175290	A. Building B. Wing	09/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Coffeyville on Midland	2921 W 1st Street Coffeyville, KS 67337

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41121 The facility reported a census of 72 residents with four residents sampled and one resident reviewed for neglect. Based on observation, interview, and record review, the facility failed to prevent the neglect of cognitively impaired Resident (R)2, who displayed a recent increase in behaviors. On 08/26/24 at 10:12 PM, Licensed Nurse (LN) G completed a skin assessment on R2 and documented her skin as clean, dry, intact, and without new skin conditions. On 08/27/24 at 10:45 AM, staff observed blood on a tissue after wiping R2 and failed to notify the LN in charge of R2's care. On 08/27/24 at 11:15 AM, Social Service Staff X and Administrative Staff B took R2 out of town to a senior behavioral unit. Upon arrival to the emergency room , R2 expressed the need to use the bathroom and when assisted by facility staff, R2's brief had two dime size spots of blood in it, and she had blood at the front of her peri-area. On 08/27/24 at 02:45 PM, hospital staff began a skin assessment on R2 after she arrived at the behavioral intake area from the emergency room . The assessment revealed R2 had multiple areas of bruising, bleeding, and genital trauma (possible indicators of sexual assault). On 08/27/24 at 08:30 PM, Consultant Staff GG performed a sexual assault examination, which revealed R2 had possible sexual and genital trauma, was having a bloody discharge, had evidence of abrasions to her major and minor labia, evidence of possible penetration, and vaginal edema. Prior to 08/27/24, R2 had increased behaviors, however, the multiple areas of bruising, bleeding, and genital trauma (possible indicators of sexual assault) for R2 were not discovered until they were observed by the hospital staff on 08/27/24, one day after the LN documented no skin issues. This deficient practice placed R2 in immediate jeopardy for neglect and a negative psychosocial impact to R2's sense of safety, protection, health, and well-being. Findings included: - The Medical Diagnosis tab for R2 included diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), cognitive communication deficit, muscle weakness, major depressive disorder (major mood disorder which causes persistent feelings of sadness), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). (continued on next page)

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Admission Minimum Data Set, dated dated dated [DATE], assessed R2 with a Brief Interview for Mental Status score of five, indicating severe cognitive impairment. She did not reject cares and had behaviors symptoms directed towards others that did not interfere with care or put her at risk for significant illness or injury for one to three days of the assessment period. R2 used a walker for mobility and required partial/moderate staff assistance for walking up to 50 feet, transfers, lower body dressing/undressing, and setup assistance for upper body dressing/undressing. R2 was frequently incontinent of urine, occasionally incontinent of bowel, and she did not have any skin issues. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 07/03/24, revealed R2 had recall deficits with a contributing factor of dementia and risk factors, which included self-care deficits, falls, injuries, incontinence, decreased socialization, and skin breakdown. The Functional Abilities CAA dated 07/03/24, revealed R2 required assistance with her activities of daily living (ADLs) with contributing factors of generalized weakness and decreased safety awareness with risk factors of further ADL decline, falls, incontinence, and skin breakdown. The Urinary Incontinence and Indwelling Catheter CAA dated 07/03/24, revealed R2 had incontinent episodes and required assistance with toileting. The Behavioral Symptoms CAA dated 07/03/24, revealed R2 had dementia and wandered with risk factors of injuring self/others, decreased socialization, and anxiety. The Pressure Ulcer/Injury CAA dated 07/03/24, revealed a LN was to assess R2's skin each week and put in proper interventions to prevent skin breakdown., Caregivers were to assess R2's skin with each bath and when dressing her. The staff were to notify the physician of any abnormal findings. The Care Plan dated 07/03/24, revealed R2 required staff assistance with ADLs related to physical limitations. R2 required psychotropic (alters mood or thought) medications, which included an antianxiety (class of medications that calm and relax people) for restlessness, and an antidepressant (class of medications used to treat mood disorders) for self-isolation. On 08/09/24, the facility added R2 often made statements about the building burning down or some other emergency occurring. On 08/23/24, the facility added R2 required an antipsychotic (class of medications used to treat major mental conditions which cause a break from reality) for behaviors of continuous screaming or yelling, negative delusions, and extreme fear. The Licensed Medication Administration Record (MAR) for August 2024, revealed R2's physician order for as needed (PRN) Ativan (antianxiety medication) changed from every 24 hours to every four hours as needed for anxiety on 08/11/24. R2 continued to have an order for scheduled Ativan twice daily. The Progress Notes dated 08/12/24 at 01:40 AM, by LN I revealed R2 attempted to rise from a sitting position in a recliner with the footrest extended, leaned forward, and fell to the floor. The fall note lacked documentation noting any injuries that occurred from the fall. The Skin Condition Note dated 08/19/24 at 02:42 PM, by LN L revealed R2's skin was clean, dry, intact, and the resident had no new skin issues. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Progress Notes dated 08/20/24, revealed Consultant Staff II saw R2 in the facility due to frequent behaviors and anxiety related to her dementia. Consultant Staff II ordered Aricept (medication used for treatment of dementia), 10 milligrams (mg), daily. The Progress Notes dated 08/23/24 at 02:45 PM, revealed R2 received a new physician order for Seroquel (antipsychotic medication), 25 mg, three times a day. The Progress Notes dated 08/26/24 at 11:22 AM, revealed R2 had a referral for geriatric-psych to evaluate and treat. The Skin Condition Note dated 08/26/24 at 10:12 PM, by LN G revealed R2's skin was clean, dry, intact, and she had no new skin conditions. The Task tab for skin observations every shift, dated 08/06/24 through 08/27/24, revealed documentation of none of the above observed or not applicable for any scratched, red areas, discoloration, skin tears, or open areas. The Progress Notes dated 08/27/24 at 05:09 PM, by Social Service Staff X revealed at 11:00 AM, she left with R2 and Administrative Staff B to a behavior unit. Review of the progress notes for 08/27/24 lacked any documentation of R2 having any redness, bruising, abrasions, or bleeding. The behavioral health Admission Note which lacked a date, but included a time of 02:45 PM, revealed R2 was brought to the unit from the emergency room and a patient assessment was started. R2 had swelling with a knot on her right cheek, bruising to her left forearm and left hand, bruising and redness under her right breast, redness between both inner thigh creases, purple/black/blue bruising with open cut on both labia with blood present and a foul odor, redness near anus and on coccyx area, bruising on both knees, and right and left great toe had bruising. Additionally, R2 had blood present inside of her vaginal opening, which was slightly spilling out and bright red blood present in her brief. The vaginal blood was discovered when Consultant Staff JJ performed a straight catheter to obtain a urine sample, Consultant Staff KK and Consultant Staff LL were also present at that time. The staff notified Consultant Staff GG of findings who approved to continue with the straight catheter procedure. The Sexual Assault Physician Exam dated 08/27/24 at 08:30 PM, for R2 revealed the reason for the exam was suspected sexual encounter of a nursing home patient. R2 had possible sexual and genital trauma upon evaluation of a straight catheter procedure for urinalysis per protocol in the senior behavioral unit. R2 had bloody discharge and evidence of abrasions of her labia, both major and minor, and evidence of possible penetration. Two vaginal swabs were obtained and due to R2 having so much atrophy and edema from injury a vaginal exam was not able to be performed. Consultant Staff GG completed the sexual assault kit to the best of her ability and gave it to one of the three chaperones present during the examination to transport to county law enforcement with jurisdiction of the facility, since suspected the event occurred at the facility prior to arrival and a male nurse cared for R2 during the night shift. The facility Nurses Schedule dated 08/08/24 through 09/04/24 revealed a male LN staff on was on duty on 08/26/24 from 06:00 PM to 06:00 AM. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility CNA Schedule dated 08/08/24 through 09/04/24 revealed no male staff on duty on 08/26/24 from 10:00 PM to 06:00 AM. The facility Witness Statement dated 09/03/24, by CNA M, revealed on 08/27/24, CNA N and CNA M assisted R2 to the bathroom around 10:45 AM. When CNA M wiped R2, she observed blood so she reported to the nurse (lacked name) who came in and observed R2, stating it may be her hemorrhoids on her rectum. The facility Witness Statement undated, by LN H revealed on 08/27/24 the staff (lacked name) called her into the bathroom and reported when they wiped R2 they witnessed some blood. LN H assessed R2's rectum and observed what appeared to be a hemorrhoid and LN H did not see any blood at that time. The facility Witness Statement undated, by Administrative Staff B, revealed on 08/27/24, she assisted R2 with Social Service Staff X in the restroom, noticed a small amount of blood in her brief, assisted with wiping once R2 had finished, and discovered red blood. Administrative Staff B asked Social Service Staff X to trade places so she could do a skin assessment to see if R2 had any sores or open areas and Social Service Staff X noted blood, but no sores or wounds. After cleaning R2 up, Administrative Staff B and Social Service Staff X informed behavioral unit Consultant Staff MM of the discovery. The facility Witness Statement undated, by Social Service Staff X, revealed on 08/27/24 upon arrival to the emergency room (lacked time) for R2's admission to the behavioral unit, R2 was assisted to the bathroom per her request by Social Service Staff X and Administrative Staff A. When changing R2's brief, there were two small blood spots in her brief. Social Service Staff X looked for any sore spots on R2 and found none. R2 had a small amount of blood dripping from her vaginal area, and they passed that information on to behavioral unit Consultant Staff MM. Observation, on 09/03/24 at 11:32 AM, revealed R2's room to be located approximately 25 feet from the nurse's station, her bed was made, and a wheelchair was parked next to the bed. R2 had a roommate according to signage by the room door. No residents were in the room at this time. R2 had not returned to the facility. On 09/03/24 at 02:54 PM, Consultant Staff JJ stated R2 came from the emergency room to the intake area at 02:45 PM, and when she started to do a skin assessment, she noticed some bruising. Consultant Staff JJ stated she found redness and bruising to R2's right breast, redness in between her inner thigh creases, purple/black/blue bruising on her labia, redness near her anus, bruising to her right and left great toes, swelling and a knot to her right cheek, and bruising to both knees. Consultant Staff JJ stated when emergency room staff pulled down R2's pants to perform a straight catheter, there was bright red blood in R2's brief and a smell I cannot describe so Consultant Staff JJ started looking for wounds. R2 had what appeared to be an open wound on the right labia and she did not touch the area until Consultant Staff GG could examine. Consultant Staff JJ stated when she received report from the facility nurse taking care of R2 (could not recall who), it was reported R2 had no skin issues. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 09/04/24 at 12:18 PM, CNA M stated on 08/27/24 around 10:45 AM, her and CNA N toileted R2, who was on their unit because R2 was going to be leaving. CNA M stated when standing R2 up, R2's pants were wet, so she had another staff member bring a dry pair of pants and R2 voided in the toilet. CNA M stated when wiping R2, there was red blood on the tissue, however she did not see any on R2's brief. CNA M stated LN H came in to examine R2, CNA M wiped R2 again, but there was no blood. CNA M stated LN H looked at R2 and said it was probably just hemorrhoids. On 09/04/24 at 02:45 PM, Social Service Staff X stated on 08/27/24 she arrived to get R2 to take her out of the facility and the nurse (LN H) reported R2 had just been toileted. Social Service Staff X stated LN H did not mention R2 having any blood present when wiped and she left with her and Administrative Staff B around 11:15 AM. Social Service Staff X stated when they arrived at the hospital, R2 needed to use the bathroom and they noted two dime size spots of blood in R2's brief and blood coming from the front of R2's peri-area. Social Service Staff X stated they reported to Consultant Staff MM about the blood and that they did not know anything about it, so assumed that was something new. On 09/04/24 at 03:06 PM, LN G stated she thought R2's skin was intact when she did her skin assessment on 08/26/24, and thought she performed the assessment when staff went to change her. LN G stated she tried to look at her breast and under the best she could, but it was hard to get a good view, she did not see anything wrong with R2's toes and was not able to see her peri-area. LN G stated she could only see R2's bottom and belly, the bigger more seen areas and it was difficult to get a good assessment of R2. LN G stated she could not recall if R2 had any hemorrhoids or not, however, she had some redness to her bottom, possibly from sitting up all day, but not any bruising. On 09/04/24 at 03:26 PM, LN H stated on 08/27/24 staff informed her R2 had blood they did not know where it was coming from and asked LN H to take a look, so LN H went in the bathroom. LN H stated she did not see any blood anywhere, observed possible hemorrhoids, and thought maybe that was what caused the bleeding. LN H stated she did not get a chance to tell the charge nurse responsible for R2 that day because she hurried down the hall to finish her work and Social Service Staff X came up to her and said they were taking R2. On 09/04/24 at 04:16 PM, LN L stated she was the charge nurse for R2 on 08/27/24 and did not receive any reports of blood in R2's brief or when staff wiped her. LN L stated she called the behavior unit to give report on R2, which included her recent behaviors and no skin issues. LN L stated one of R2's several falls resulted in bruising to one of her knees, and typically bruises would not be in the skin condition note because it was in a previous assessment. On 09/05/24 at 08:54 AM, Administrative Nurse D stated if the staff were unable to complete a full skin assessment due to behaviors or other reasons, the LN should document that in the skin condition notes. If a bruise was previously identified, the bruise should be included in the skin condition note, not as a new injury, but documented somewhere in the note. On 09/15/24 at 09:14 AM, attempts to interview Consultant Staff GG were unsuccessful. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility policy Abuse, Neglect and Exploitation dated October 2022 revealed it was the policy of the facility to keep residents free from abuse and neglect. The resident had the right to be free from verbal, sexual, physical and mental abuse. Sexual abuse included, but was not limited to, sexual harassment, sexual coercion, or sexual assault. The policy documented neglect was the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Neglect occurs on an individual basis when a resident receives lack of care in one or more areas. The facility failed to prevent the neglect of cognitively impaired R2 who had multiple areas of bruising and redness, bleeding, and genital trauma observed and discovered by hospital staff on 08/27/24, less than 17 hours after the facility LN documented no skin issues for R2. The presence of R2's bruising, bleeding, and genital trauma prompted completion of a sexual assault kit by the hospital staff. This deficient practice placed R2 in immediate jeopardy. On 09/05/24 at 04:28 PM, Administrative Staff A was provided a copy of the Immediate Jeopardy template and notified of the facility's failure to prevent neglect of R2 when hospital staff observed and identified multiple areas of bruising and redness, bleeding and genital trauma on 08/27/24 at 02:45 PM, less than 17 hours after the facility assessed R2's skin to be clean, dry, intact, and with no new skin issues. The facility provided an acceptable plan for removal of the immediacy on 09/05/24 at 06:43 PM which included the following: 1. R2 admitted to the hospital on 08/27/24. 2. R2's responsible party contacted on 09/03/24 at 11:52 AM and had already been made aware by the police department. 3. The facility contacted R2's physician on 09/03/24 at 10:05 AM. 4. The facility began interviewing staff and residents on 09/03/24 for any indications of abuse and neglect. 5. Staff in-service began on 09/03/24 on abuse, neglect and exploitation and education completed on 09/05/24 by 05:00 PM. 6. On 09/03/24 the facility held a quality assurance performance improvement (QAPI) meeting. 7. Starting on 09/05/24 at 05:30 PM, the facility educated staff to provide care in pairs for all residents until further notice and initiated immediately. 8. A skin sweep of all residents in the building initiated on 09/05/24 with care plans revised and physician and responsible party notified with any findings from assessments. 9. R2's responsible party informed the facility on 09/05/24 that R2 would not be returning. 10. On 09/05/24 the facility held a resident council meeting to review abuse, neglect, and exploitation. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The onsite surveyor verified the implementation of the above corrective actions on 09/09/24 at 04:10 PM and the deficient practice remained at a G scope and severity.