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	07/24/2025

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide and implement an infection prevention and control program. (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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The facility identified a census of 29 residents and 12 residents with impaired respiratory function. The sample included seven residents. Based on observation, interview, and record review the facility failed to take immediate actions to safely relocate residents from contaminated areas and failed to decontaminate facility areas populated by residents and used by residents, staff, and visitors after identification of potentially pathogenic organic material (mold) in residents' rooms, common areas, bathing areas, the kitchen, and other areas of the facility. On the morning of 07/21/25, Resident (R)1 complained to Social Services X about an unknown substance on her walls. Upon inspection, Social Services X identified areas of black discoloration on the wall and inside the closet. R1 moved to another room, but further inspection of other areas of the facility over the course of 07/21/25-07/23/25 revealed extensive growth of black, white, and green organic substances, which the facility identified as mold. The facility began moving residents to different rooms, though as of 07/23/25 at 03:55 PM, the facility had 29 residents and only 10 usable rooms and had not initiated decontamination procedures nor had the facility initiated an evacuation plan to mitigate the risk to the residents from the hazardous and potentially infectious mold. This deficient practice placed all 29 residents in the facility in immediate jeopardy. Findings included:- An environmental tour on 07/23/25 at 08:20 AM with Administrative Staff A, Maintenance U, and Housekeeping V revealed a pervasive musty odor in all four halls of the building, all containing resident rooms. Observation revealed multiple areas in the rooms and the hallway on the southwest hall which had an organic black, white, yellow and/or green substances/growths on the walls, floors, and ceilings, and on surfaces that included tile, drywall (a porous material), partially rotted wooden (a porous material) framework in areas where the drywall was removed, carpeted (a porous material) areas on the walls and cinder blocks (a porous material) behind baseboard materials. On the southwest hall, the doorway to one room had an area approximately three feet long and over six inches wide where the wallpaper had detached from the drywall, and a black and yellow discolored area was visible on the drywall where the wall met the ceiling. In one room on the southwest hall, the closet doors had an organic white substance resembling mold/mildew on the lower two feet portion of the door panels on. In one room on the northeast hall, observation revealed multiple small areas of a black substances on the horizontal window blinds, between the slats. In multiple rooms on all hallways, the carpeting on the walls was discolored, and in the rooms where the carpeting on the walls was removed, observation revealed multiple areas of white and yellow substances on the walls in a growth type pattern and not consistent with adhesive placement. In one room on the southeast hallway, observation revealed the linoleum floor covering in the bathroom was detached from the wall in the corner and a black substance was visible in the area in which the flooring was detached. Additionally, where the toilet water supply line came through the wall, the plumbing was covered with an unknown black and yellow substance. Observation of multiple areas in the hallways with partially carpeted walls revealed discoloration in the carpet itself, which looked like fuzzy growth distinct from the carpet color and tuft. Administrative Staff A identified the discoloration and organic substances to be consistent with the appearance of mold. During an additional environmental tour on 07/23/25 at 10:40 AM with Administrative Staff A, Administrative Nurse D, Maintenance U, and Housekeeping V, the room with the water heaters had multiple areas of black substances on the walls, floor, and ceiling. The laundry area had an approximate two square foot portion of the ceiling that bowed downward approximately one quarter of an inch with a slight bowl shape where the drywall appeared to have detached from the support structure and had several yellow and black spots in random and linear patterns. The area on the ceiling also contained linear cracks where the drywall had separated. Additionally, one area of the floor was misshapen in a round bowl-shape with what appeared to be where the flooring material and the sub-floor were no longer attached with multiple black and dark yellow spots. Another area on the floor in the laundry area where the flooring transitioned from the soiled laundry area to the room with the washing machines, the flooring material was separated along the seam with multiple black, brown and grey discolorations. In the room with the air handlers, the ceiling had multiple areas with yellow and black discoloration, and a large duct for carrying air had multiple areas of black and grey discoloration. In the kitchen, the doorway that led from the kitchen to the dry storage had a metal door jamb that was misshapen with altered structural integrity that appeared to be long-term exposure to water at the base and had multiple areas of black, brown and rust colored discoloration. Additionally, in a small storage area off the kitchen, there was standing water on the floor with multiple black areas on the nearby

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. The facility reported a census of 29 residents. Based on the observation, interview, and record review, the facility failed to ensure a safe environment at the front entrance of the facility and failed to ensure a sanitary environment in staff and visitor areas throughout the facility. This deficient practice had the risk of impaired health and safety.Findings included: - On 07/23/25 at 08:15 AM, the front door entrance to the facility revealed a large, rubberized rug covering the sloped walkway from the parking lot to the entrance of the facility. On 07/23/25 at 08:20 AM, an environmental tour with Administrative Staff A, Maintenance Staff U, and Housekeeping V revealed multiple areas throughout the facility of a black, white, yellow, and/or green substance on the walls, floors, and ceilings, including the following areas:The public restroom on the Southwest wing.The soiled and clean laundry area on the Northwest wing.,The central corridor included the kitchen area.The smoking lounge and medical records storage area are on the Southeast wing. On 07/23/25 at 10:40 AM, an additional tour of the facility service area with Administrative Staff A, Administrative Nurse D, Maintenance U, and Housekeeping V revealed multiple areas of the substance in the boiler room, laundry, and HVAC room. On 07/24/25 at 01:30 PM, the surveyor stumbled on the large rubberized rug upon leaving the building with Administrative Staff A. Administrative Staff A pulled back the large rubberized rug to reveal a large hole in the underlying cement and commented that was the reason why the rug was there, to cover the hole so residents, staff, and visitors did not trip and fall due to the crumbling cement at the entrance to the facility. On 07/23/25 at 12:10 PM, Licensed Nurse (LN) G said the floors in the records room had black spots for months. He reported that a lot of staff have complained of headaches and sore throats for weeks. On 07/23/25 12:35 PM, Certified Nurse Aide (CNA) N reported that in the recent past, there was a leak in the ceiling on the southwest hallway while it was raining outside, and there was a bucket placed underneath to catch the water. She reported a musty smell from the back hallway. On 07/23/25 03:55 PM, Administrative Staff A said that the decision to evacuate residents and restrict visitors and staff from areas within the facility would have to be made by corporate. He confirmed the above findings and stated that the environmental staff systematically cleaned all visible surfaces of all the affected and unaffected rooms and inspected for additional mold growth. On 07/24/25 at 12:30 PM, Administrative Staff A confirmed the above findings and reported that facility staff inspected the facility and identified all the rooms on the Southwest hallway, all of the rooms but one on the Northwest hallway, all the rooms but two on the Southeast hallway, and one room on the Northeast hallway were contaminated with mold. Administrative Staff A said he informed Consultant GG on 07/21/25 about the environmental concern and was told not to test the substance to verify presence or absence of mold due to the facility's obligation to treat if testing was positive for mold. Administrative Staff A said the leadership team held a tabletop exercise related to emergency preparedness and identified the best course of action was to evacuate the residents until the environmental concern could be appropriately treated. Administrative Staff A said on the evening of 07/21/25, Consultant GG toured the facility with Administrative Staff A, and Administrative Staff A pointed out the areas of concern in the hallways. Administrative Staff A said he presented the decision by the leadership team to evacuate the residents to Consultant GG and reported he was instructed by Consultant GG to instruct other members of the leadership team to stay in their lane and resume their assigned jobs. Administrative Staff reported that on the morning of 07/22/25, the leadership team met but had not received additional instructions from Consultant GG to evacuate the residents and instead received instructions to have the housekeeping staff spray all visible surfaces with Virex. Administrative Staff A further stated that 15 of the staff reported not feeling well in the days leading up to the discovery of the mold. The facility policy Infection Management Process, dated 11/2023, did not address mold treatment and or removal.