STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175135	A. Building B. Wing	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Post Acute Care Center	6500 Greeley Avenue Kansas City, KS 66104

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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39752 The facility identified a census of 36 residents with three residents reviewed for abuse and neglect. Based on record review, observation, and interview the facility failed to ensure staff identified and reported an allegation of physical abuse immediately to the Administrator as required. On 02/09/24 between 10:30 PM to 11:00 PM, Certified Nurse Aide (CNA) N and CNA M provided peri-care to Resident (R)1, a severely cognitively impaired resident who was dependent on staff for assistance with activities of daily living (ADL). As staff rolled R1 towards CNA M, R1 hit CNA M. CNA M allegedly became upset and smacked R1 on the hand. CNA N attempted to report the abuse to Licensed Nurse (LN) G, but CNA M approached, so CNA N ended the conversation and walked away. CNA N mentioned it later to another CNA on shift but did not report it to the Administrator. On 02/12/24, over three days later, CNA N wrote a Report of Concern and left it in Administrative Staff A's box. On 02/13/24 at 07:45 AM, Administrative Staff A received the Report of Concern and was informed of the allegation of abuse. The facility failed to ensure staff identified a situation of physical abuse and/or mistreatment and reported it immediately to the Administrator. CNA M worked in the facility again on 02/12/24. This placed R1 in immediate jeopardy. Findings included: - R1's Electronic Medical Record (EMR), under the Diagnosis tab recorded diagnoses of dysphagia (swallowing difficulty), abnormal posture, and hemiplegia (paralysis of one side of the body) affecting the left nondominant side. The Significant Change Minimum Data Set (MDS) dated [DATE] documented per staff interview that R1 had short and long-term memory problems but was able to recall staff names and faces. The Cognitive Loss Care Area Assessment (CAA) dated 02/01/24 documented R1 used gestures and noise to make needs known to staff. Staff anticipated R1's routine and understood R1's wants when R1 pointed or made gestures. The Communication CAA dated 02/01/24 documented R1 was deaf but communicated with gestures and noises and focused on staff facial areas. R1 understood information by reading the staff's lips. The Behavioral CAA dated 02/01/24 documented R1 was non-verbal and deaf, but communicated her likes and dislikes through slapping, pinching, and verbal noises. (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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NAME OF PROVIDER OR SUPPLIER Medicalodges Post Acute Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6500 Greeley Avenue Kansas City, KS 66104	

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's Care Plan dated 12/07/22 directed staff to tell R1 before starting a task of what was going to happen and to look at R1's facial expressions and eye movements and observe what R1 pointed at during interactions. R1's Care Plan directed staff to report any changes noted in R1's behaviors, or cognitive status. Interventions dated 07/10/23 directed staff to make eye contact and explained what was going to be done to R1 before beginning care. Interventions dated 01/19/24 documented R1 communicated mostly with hand gestures, facial expressions, hitting, scratching, or pinching and directed staff to approach slowly, smiling, gently, and calmly. The Report of Concern dated 02/12/24 documented CNA N arrived at work early on 02/09/24 and proceeded to take over R1's hall. CNA N documented she checked on R1 with CNA M. R1 hit CNA M and CNA M popped R1 on the hand. CNA N's undated Witness Statement, documented on 02/09/24 CNA N came in early and rounded with CNA M. CNA N entered R1's room to help CNA M with care. CNA N stood on one side of the bed, with CNA M on the other side. They rolled R1 towards CNA M and R1 started to hit CNA M. CNA M got upset and smacked R1's hand. CNA N started to report the incident to LN G, but CNA M walked up, so CNA N stopped talking and walked away. CNA N documented she also mentioned it to CNA O. CNA O told CNA N she needed to report it. LN G's undated Witness Statement, documented on 02/09/24, no incidents were reported to him. CNA O's undated Witness Statement, documented on 02/09/24 CNA O worked on R1's hall but did not witness abuse. The Nurse's Note dated 02/14/24 at 12:49 PM documented R1 had a skin assessment completed related to a staff-to-resident interaction. R1 showed no anxiety or unwanted behaviors towards current staff. R1's EMR lacked further documentation of the event which included any follow-up assessments to monitor R1's ongoing psychosocial wellbeing after the alleged abuse. A review of the facility's Investigation dated 02/19/24 documented Administrative Staff A was informed on 02/13/24 at 07:45 AM by a Report of Concern written by CNA N that CNA M hit R1 on the hand after R1 hit CNA M. The incident occurred on 02/09/24 between the hours of 10:30 PM and 11:00 PM. CNA N claimed she informed CNA O and LN G, but the witness statements written by CNA O and LN G documented they did not know about the event. CNA M was suspended pending investigation, and CNA N received a write-up for not reporting timely. The Investigation documented cognitive residents on R1's hall would be interviewed to rule out other possible abuse, neglect, or exploitation, and immediate abuse, neglect, and exploitation training for staff which would be completed by the end of day on 02/19/24. The Investigation lacked evidence the facility attempted to obtain a statement of events from the alleged perpetrator, CNA M. CNA O's notarized Witness Statement dated 02/20/24 documented CNA M offered to change R1's incontinence brief on the evening of 02/09/24. CNA O documented she was doing other rounds (providing care to other residents) at 10:00 PM when CNA M offered to help with R1. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 02/20/24 at 11:10 AM R1 laid in bed on her left side with a blanket pulled up to her chest. Her leg was out with her right hand cupping her right thigh although, in that position, visualization of the resident's hands for bruising was not possible. R1 did not respond to her name being called and her eyes were barely open. On 02/20/24 at 11:15 AM CNA P stated if she witnessed abuse towards any resident, she would report the concern as quickly as possible to Administrative Staff A and/or Administrative Nurse D. CNA P stated she would keep the resident safe. On 02/20/24 at 11:25 AM LN H stated if he saw or heard of any abuse, he would immediately report the abuse and remove the individual who was the source of the abuse. On 02/20/24 at 02:15 PM Administrative Staff A stated he arrived at work on 02/13/24 and found the Report of Concern from CNA N in the box by his office door. On 02/20/24 at 02:18 PM, CNA M said CNA N came in for the overnight shift and CNA M gave her report on what tasks were already completed on the assigned hall and that was all. CNA M went on to say she rarely worked on R1's hall and would not be the main person over there. CNA M stated she never gave a witness statement regarding the event and the facility never asked her to. CNA M stated the facility called her and told her she was suspended while the facility investigated an abuse allegation and once it was completed CNA M would be contacted and told if CNA M could come back to work. CNA M stated on 02/09/24 she was not assigned to R1's hall and went on to say she could not remember when she last worked with R1. CNA M said Administrative Staff A was aware on 02/09/24 but would not say who had reported something had happened. CNA M stated she worked with CNA N before 02/09/24 and she felt CNA N did not like her. CNA M talked about a night she had a headache and went home early and went on to say that CNA N went and reported to Administration about everything. CNA M said she knew staff were double briefing the residents and she told CNA N not to do that. CNA M said she never had to be physical with R1. CNA M stated other staff said that R1 hit and bit people, but R1 was never mean to her. CNA M stated she received a text from Administrative Staff A that stated she was cleared and scheduled to come back to work on 02/17/24. CNA M said she told Administrative Staff A that she already made plans and could not work on 02/17/24. On 02/20/23 at 02:23 PM CNA N was unavailable for interview. On 02/20/24 at 02:43 PM Administrative Nurse D stated she received text messages from CNA N on 02/09/24 throughout CNA N's shift, but CNA N never reported any concerns with R1 or abuse. On 02/20/24 at 04:18 PM Administrative Staff A stated he wondered about the delay in reporting being a concern because it was several days. The facility's policy Abuse, Neglect and Exploitation revised 10/22 documented the resident has the right to be free from verbal, sexual, physical, and mental abuse and involuntary seclusion. The policy directed that there were steps to be followed to ensure that all staff were knowledgeable in identifying other residents and staff who have the situational, recognized the potential to be abusive; as well as what to do should an incident occur. Training included reporting of suspected abuse, neglect, mistreatment of residents, and/or misappropriation of personal property. What to report and who to report to, and to report immediately to the administrator and/or their designated representative. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility failed to ensure staff identified a situation of physical abuse and/or mistreatment and reported immediately to the Administrator. This placed R1 in immediate jeopardy. The facility completed the following corrective actions by 02/19/24: CNA M was suspended via text message on 02/13/24 at 12:29 PM. All staff received Abuse, Neglect, and Exploitation training that started on 02/13/24, completed on 02/19/24. CNA N's employment was terminated on 02/19/24. The corrective actions were completed before the onsite survey therefore the citation was issued as past noncompliance at the scope and severity of J.