STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175226	A. Building B. Wing	05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Iola	600 E Garfield Street Iola, KS 66749

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 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 36 residents with four residents sampled. Based on observation, record review, and interview, the facility failed to prevent the physical abuse and neglect of R2. On 03/21/24, R2 reported Certified Nurse Aide (CNA) M was rough with her when assisting her to bed around 06:30 PM to 07:00 PM. R2 stated CNA M threw her into her bed by having a hold of her legs and swung her on the bed, while in the lift sling, during the transfer from the wheelchair to her bed. Afterwards, R2 experienced dizziness, nausea, and difficulty breathing due lying flat as the head of the bed was flat. R2 activated her call light and when nobody responded to the call light, R2 started yelling out. When CNA M responded to R2, she did so by yelling at R2 from the hallway saying R2 was not the only resident left to take care of. R2's bed remained flat and R2 lacked application of her supplemental oxygen for 3 to 3.5 hours, until CNA N arrived for the 10:00 PM shift. While rounding, R2 hollered out CNA N's name and before she could respond, CNA M yelled from approximately 34 feet away That's enough [R2]! CNA N responded to R2 and found the resident crying and upset. CNA N reported the concerns to Licensed Nurse (LN) G at 10:10 PM. CNA N and LN G failed to report the abuse and neglect to Administrative Staff A immediately. CNA M remained on duty until 06:00 AM on 03/22/24, working the last eight hours of her scheduled 12-hour shift on the other side of the facility. This deficient practice placed R2 in immediate jeopardy and other residents who resided in the facility at risk for abuse and neglect. Findings included: - The Medical Diagnosis tab located in the electronic medical record (EMR) for R2 included diagnoses of muscle weakness, anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). The Annual Minimum Data Set (MDS) dated [DATE], assessed R2 with a Brief Interview of Mental Status (BIMS) score of 15, indicating intact cognition. R2 required oxygen. R2 had a range of motion impairment to her upper extremity on one side, was dependent on staff to roll left and right and return to back when in bed, when moving from lying to sitting on the side of the bed, and transfers in and out of the bed. (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

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Functional Abilities Care Area assessment dated [DATE], revealed R2 had limited use of her right arm, used the call light when she needed assistance, and required total assistance from two staff for transfers with the full body lift. The Quarterly MDS dated [DATE], assessed R2 with a BIMS score of 14, indicating intact cognition. R2 required oxygen and continued to have impairment to one side of her upper extremity range of motion. R2 required substantial/maximum assistance from staff for rolling left-to-right and to back when in bed, moving from lying to sitting on the side of the bed, and transfers to/from the bed. The Care Plan dated 01/16/24 revealed R2 required extensive assistance of two staff with bed mobility and transfers with the full body lift. R2 wore oxygen at night to assist with her breathing to keep her oxygen saturations above 90 percent. The User Learning education log dated 05/02/24 revealed CNA M completed education on abuse/neglect/exploitation on 12/05/23 and 02/17/24. The Physician Order tab located in the EMR revealed R2 had an order dated 04/22/22 for oxygen at two liters at bedtime to keep oxygen saturations above 90 percent. The facility Assignment Sheet dated 03/21/24 revealed CNA M was scheduled for 06:00 PM to 10:00 PM on R2's side of the facility and the other side of the facility for the night shift. From 04:00 PM to 08:00 PM, CNA O scheduled on R2' s side of the facility and LN G scheduled the second half of the evening shift on R2's side of the facility, then on night shift was the charge nurse for both sides of the facility. CMA S scheduled for medications on the evening shift and CNA N scheduled on the night shift on R2's side of the facility. The facility Report of Concern dated 03/21/24 by CNA N, revealed when CNA N first walked in to get report R2 was in her room crying and said when she was put to bed, the unidentified staff left her head down flat, and it made her feel dizzy and sick. R2 had put her call light on to ask for help but nobody ever answered her light so then she yelled for help and when CNA M came in, she told R2 she needed to wait and left without helping her. CNA N was getting report from CNA M when R2 yelled CNA N's name from her room and CNA M yelled back at her That's enough [R2] then continued talking. CNA N went to room and R2 was telling her about what had happened and spend the next 30 to 40 minutes crying on and off in her room. CNA N stated R2 was very upset about the situation. The facility Report of Concern dated 03/21/24 by LN G, revealed at 10:10 PM CNA M told her she had been in R2's room and R2 was crying and upset that CNA M and CNA O had put her to bed, CNA M was rude to her, etc. LN G had talked to R2 at 06:00 PM when sitting in her wheelchair next to the television room and she was smiling and happy and stated she had a good day. LN G stated when trying to talk to her later about what happened, R2 got upset and had a difficult time explaining. R2 did stated they just plopped her into bed and left, she put on her call light and after 20 minutes, they had not answered her light, so she called out with her voice. CNA M came in and was rude to her. LN G did not push the issue further with R2 as it caused her to get upset again. LN G explained R2 had not done anything wrong, and LN G would try to investigate the manner. (continued on next page)

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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	The facility investigation revealed an interview with R2 stating she called out for help to put her to bed, she had rung the call light, and nobody came for 30 minutes or longer. When CNA M responded she stated she could not do it alone and she was the only one here, but R2 said CNA O was also on this side. R2 stated CNA M basically threw her in bed and she was sideways with her head towards the window and her feet towards the door with her head all the way down and lacked her oxygen. R2 started getting really dizzy and sick and used the call light and no one came, so she started yelling out and CNA M yelled from the hall that R2 was not the only resident they had to take care of and left. R2 stated her legs were all twisted in her blankets so she could not move herself and she kept getting dizzier, so she started yelling for help. R2 asked for help to untangle her legs so she could maybe get herself straightened up in bed, but nobody came. R2 stated CNA M was really rough with her and basically threw her in bed and she never sleeps with her bed flat because she cannot breathe. R2 was yelling for them to come back and finish and nobody ever came until the night shift got there, and CNA N came in. CNA N applied R2's oxygen first thing then helped R2 to get straight and elevate the head of her bed, then R2's dizziness stopped. R2 stated one time in her room CNA M yelled at her from the hallway and told her she needed to be quiet, or she was going to wake everyone up. R2 said all she wanted was for the CNA to help her, put her oxygen on, and raise the head of the bed up. The investigation included when Administrative Staff A and Administrative Nurse D interviewed CNA M and asked if she did all the things reported, CNA M answered yes. When asked if she felt like anything she had done was considered abuse, CNA M answered yes. The facility Witness Statement dated 03/22/24 by CNA Q, revealed on 03/21/24 she witnessed CNA M, after CNA O left, having multiple call lights on while CNA M remained sitting at the nurse's desk eating her food. The facility Witness Statement dated 03/22/24 by CNA N, revealed on 03/21/24 when first arriving for her shift, CNA M asked for help to pull R2 up in the bed. When walking in R2's room she was crying and would not respond to CNA N when trying to talk to her. CNA N then stated they left her room so CNA M could give CNA N report, and while talking, R2 started yelling CNA N's name and CNA M instead of checking on her yelled back at her down the hallway That's enough [R2] and went back to talking. CNA N went in to check on R2 and to ask what was wrong. While crying R2 said when she was put to bed, the staff had left her head down flat making her feel dizzy and sick. R2 told CNA N she pressed her call light to ask for help and waited but no one answered her light, so she then tried yelling for help. CNA M then came in and told her she needed to wait and left without helping R2. CNA N stated R2 continued crying on and off for the next 30 minutes or so and seemed to be very upset. CNA N told LN G and then filled out a Report of Concern form. The facility Witness Statement dated 03/22/24 by CNA M, revealed on 03/21/24 she arrived at the facility at 06:00 PM. Towards the end of the night close to 10:00 PM while charting R2's light came on and she called asking to be lifted up and CNA M told R2 she was going to need to wait a second for CNA N to get there to help. R2 stated she can't, and CNA N told her she was sorry and did not know what else she could do right then, and R2 seemed okay with the answer. CNA N came in and CNA M started giving report when R2 started to call out/holler and CNA M stated [R2] that's enough and asked CNA N to help lift R2 up. The statement lacked what occurred when assisting R2 to bed and any interactions after that until the request to be pulled up close to 10:00 PM. (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 Witness Statement dated 03/21/24 by LN G, revealed at approximately 10:10 PM CNA M, who came in at 10:00 PM, told LN G she had been in R2's room and R2 was crying and very upset. R2 had told CNA N that CNA M and CNA O put R2 to bed and they were rude to her and etc. LN G had seen her at 06:00 PM sitting in her wheelchair next to the television room smiling and happy and stated she had a very good day. When LN G tried to talk to her later to get an explanation of what happened to get her so upset, but R2 became upset again and had a hard time explaining with words. R2 did say they plopped her down into bed and left. R2 told LN G she put her call light back on and after 20 minutes no one answered her light, so she called out with her voice then CNA M came back into R2's room, was very rude to her, and then left the room. LN G did not push the issue with R2 any further as it was causing her great upset to recall the issue. LN G explained to R2 that R2 did not do anything wrong, and LN G would try to investigate the matter. The Licensed Medication Administration Record dated March 2024, revealed on 03/21/24 at hour of sleep, LN G documented R2's oxygen saturation level as 85 percent. All other days of the month R2's oxygen level was 93 percent or better except on 03/28/24 and 03/29/24 documented not applicable. The Vital Signs tab in the EMR revealed on 03/21/24 at 10:18 PM, LN G assessed R2's oxygen saturation level at 85 percent, eight minutes after CNA N reported R2's concerns to LN G. The Progress Note dated 03/22/24 at 02:00 PM revealed R2 alleged that an unidentified CNA on night shift last night was rough and spoke to her inappropriately. The facility Employee Warning Notice dated 03/25/24 revealed LN G did not follow the ANE (Abuse, Neglect, Exploitation) Policy - did not report ANE immediately. Observation on 05/06/24 at 08:57 AM, revealed R2 sat up in a wheelchair in the activity area with a lift sling under her. Her room was located approximately 34 feet from the east side of the nurse's desk. An unidentified staff member assisted her to her room for the interview. In R2's room, an oxygen concentrator was next to the head of the bed and a full body lift stored in her room. During an interview on 05/06/24 at 08:59 AM, R2 stated she thought on 03/21/24 at approximately 06:30 to 07:00 PM, CNA M and CNA O assisted her to bed using the lift and CNA M had a hold of her and just threw me into bed. R2 stated CNA M did not have a hold of the lift sling, she had a hold of her feet and slung me in there. R2 could not recall if she was crossways in the bed or not and stated both staff walked out after putting her to bed. R2 stated she has to have the head of the bed up; the staff lay it flat when she gets in to bed and then they put it up and she gets really dizzy if she lays flat. R2 stated she turned on her light to get help as she cannot run the bed controls due to her right side messed up and the staff run the controls. R2 stated her feet were all tangled up and everything. R2 stated she hollered out to get help and CNA M stated [R2] that is enough and stated CNA M was always nasty. R2 stated she was dizzy waiting for someone to help her and was nauseated too. R2 stated she was crying, and CNA N came to help her and put her head up. R2 stated she wears oxygen at night. R2 stated CNA O was nice to her that night and always is. On 05/06/24 at 09:24 AM, an attempt to reach CNA O for interview was unsuccessful. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/06/24 at 09:25 AM, LN G reported she thought it was around 08:00 PM when R2 received assistance to go to bed and did not hear anything until 10:00 PM or a little later when CNA N came in. LN G stated CNA N reported to her she had just been in the room with R2, and she was crying and when they put her to bed, they just plopped her down and walked out. LN G stated that was basically all CNA N said, but thought it was important to know R2 was upset. LN G stated she went back into R2's room to talk to her, she was crying again and had a hard time getting anything out, R2 said they (did not specify who) came in there and plopped her on the bed and left and her call light had been on, and they did not come back. LN G stated R2 did not tell her about her head being flat, but she was breaking up when talking and she could not recall if R2 had told her anything that CNA M said to R2. LN G stated she did not report anything at that time to Administrative Staff A and she filled out a report of concern form and placed it under Administrative Staff A's office door. LN G stated when R2 talked to her it really did not sound like anything, she could not spit it out, and she was upset. On 05/06/24 at 10:09 AM, CNA N stated on 03/21/24 when she first walked in, CNA M immediately came up to her and asked if staff could help pull R2 up in the bed. CNA N stated she was in the breakroom dropping off her things before she came to the desk. CNA N stated when entering R2's room she was crying, avoiding eye contact, sniffling, and rubbing her face. CNA N stated it was unusual for R2 to cry. CNA N stated she could not recall if R2 had oxygen on at that time, CNA N stated they then left the room, CNA M started giving her report, they were standing in front of the desk and had just finished rounds and R2 started yelling CNA N's name. CNA M stated before she had a chance to say anything, CNA M stated That's enough [R2] and kept talking like nothing happened and walked off to the other side of the facility. CNA N went to go talk to R2, who was hysterically crying when she walked in and had said a lot about not being able to breathe, would not answer the call light and come help, and CNA M should know better. CNA N left the room and LN G was at the cart, so she went straight to her and told her about it. CNA N stated she filled out a report of concern form and left it under Administrative Staff A's door. CNA N stated she did not contact Administrative Staff A nor Administrative Nurse D as she knew LN G was writing her report and assumed she was going to notify them. On 05/06/24 at 10:48 AM, CNA M stated she worked 06:00 PM to 10:00 PM on R2's side of the building. CNA M stated it was around 06:30 to 07:00 PM when assisting R2 to bed. CNA M denied having a hold of R2's feet or legs during the lift transfer to bed and stated she guided the lift as CNA O was not to run the lift and helped her put R2 to bed. CNA M denied swinging R2 into bed and stated they placed R2 over the bed and lowered her and moved her up in the bed. CNA M could not recall if she or CNA O put R2's oxygen in place and stated R2 had them put her head up a little bit but not too much. CNA M stated R2 had her call light on a few times after that, one for her teeth and one for her drink, and then shortly after that to be pulled up. CNA M stated she had forgotten to take care of her teeth when they laid R2 down so she went and ahead and took care of that. CNA M stated around 09:30 PM or closer to 10:00 PM, R2 wanted to be pulled up. CNA M stated R2 was hollering, she had put her call light on a few minutes before CNA N arrived and had told R2 that the nurse was busy, and CNA N was not here yet so it would be a few minutes before pulling her up. CNA M stated R2 did not like that answer and started crying and she told R2 she would have to wait, it would be a few minutes and as soon as R2 heard CNA N, she started hollering out into hallway screaming, while we were in the middle of giving report. CNA M said she raised her voice at R2 and said [R2] that is enough while standing at the desk. CNA M admitted she had gotten loud with R2 and after getting her situated she went over to the other side of the facility and worked until 06:00 AM on 03/22/24. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/06/24 at 11:20 AM Administrative Staff A stated on 03/22/24 there was a report of concern from LN G and CNA N under her door that she got to a few hours after arriving to the facility, which was usually 08:00 AM. Administrative Staff A stated she was not aware of R2's concerns prior to that and had she known, she would have suspended CNA M and if the staff truly felt CNA M yelled at R2 they should have called her. Administrative Staff A stated the staff were to call her immediately for allegations of abuse or neglect. On 05/06/24 at 01:14 PM Administrative Staff A stated she had interviewed CNA O and she did not hear or see anything that would be classified as abuse and did not collect a statement from her. The facility's policy for Abuse, Neglect, and Exploitation dated October 2022, revealed the resident has the right to be free from verbal, sexual, physical, and mental abuse and involuntary seclusion. The facility policy was to treat each resident with respect, kindness, dignity, and care, to keep them free form abuse and neglect, and to take swift and immediate action to investigate and adjudicate alleged resident abuse and neglect. All alleged violations involving abuse, neglect, exploitation, or mistreatment are to be reported immediately to the Administrator and/or their designated representative. Any time a report of possible abuse, neglect, or exploitation was made against an employee, that employee should be immediately sent home and suspended without by the person in charge until a thorough investigation could be conducted by the Director of Nursing/Administrator. The facility failed to prevent physical and verbal abuse and neglect to R2 on 03/21/24 by CNA M and allowed her to continue her shift for eight more hours placing other residents in the facility for abuse and neglect. On 05/06/24 at 04:33 PM, Administrative Staff A was provided the Immediate Jeopardy template and notified of the facility's failure to prevent abuse and neglect on 03/21/24 to R2. The immediate jeopardy was determined to first exist on 03/21/24 at approximately 07:00 PM when CNA M roughly put R2 in bed. The surveyor verified the removal of the immediate jeopardy occurred on 03/22/24 at 10:00 PM with the facility implementation of the following actions: 1. Administrative Staff A and Administrative Nurse D interviewed R2 on 03/22/24 at 11:20 AM. R2 confirmed the allegations. 2. CNA M interviewed on 03/22/24 at 02:15 PM by Administrative Staff A and Administrative Nurse D and asked if she had done all the things reported and CNA M responded yes!' and began crying. CNA M suspended. 3. CNA M interviewed by Administrative Staff A on 03/22/24 at 04:00 PM regarding the allegations against CNA N to R2. 4. The LN completed an assessment on 03/22/24. 5. Verbal discipline and education given to LN G for not reporting immediately on 03/22/24. 6. All staff training initiated immediately on reporting allegations of abuse and completed at the start of each shift on 03/22/24 at 10:00 PM. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	7. Written discipline given to LN G on 03/25/24. 8. QAPI meeting held on 03/26/24 with the medical director. 9. On 03/27/24 at 05:11 PM CNA M terminated. Due to the corrective measures implemented prior to the onsite survey, the deficient practice was deemed past non-compliance and existed at a J scope and severity.

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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** 41121 The facility reported a census of 36 residents with four residents sampled. Based on observation, record review, and interview, the facility failed to report abuse and neglect of R2 immediately on 03/21/22 at 10:10 PM. On 03/21/24, R2 reported Certified Nurse Aide (CNA) M was rough with her when assisting her to bed around 06:30 PM to 07:00 PM. R2 stated CNA M threw her into her bed by having a hold of her legs and swung her on the bed, while in the lift sling, during the transfer from the wheelchair to her bed. Afterwards, R2 experienced dizziness, nausea, and difficulty breathing due to lying flat as the head of the bed was flat. R2 activated her call light and when nobody responded to the call light, R2 started yelling out. When CNA M responded to R2, she did so by yelling at R2 from the hallway saying R2 was not the only resident left to take care of. R2's bed remained flat and R2 lacked application of her supplemental oxygen for 3 to 3.5 hours, until CNA N arrived for the 10:00 PM shift. While rounding, R2 hollered out CNA N's name and before she could respond, CNA M yelled from approximately 34 feet away That's enough [R2]! CNA N responded to R2 and found the resident crying and upset. CNA N reported the concerns to Licensed Nurse (LN) G at 10:10 PM. CNA N and LN G failed to report the abuse and neglect to Administrative Staff A immediately. The administrator was not aware of the events until 03/22/24, several hours after her arrival, when reading Report of Concern forms from LN G and CNA N that were placed under her door. CNA M remained on duty until 06:00 AM on 03/22/24, working the last eight hours of her scheduled 12-hour shift on the other side of the facility. This deficient practice placed R2 in immediate jeopardy and allowed potential for further abuse and neglect by CNA M to other residents in the facility for eight more hours. Findings included: - The Medical Diagnosis tab located in the electronic medical record (EMR) for R2 included diagnoses of muscle weakness, anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). The Annual Minimum Data Set (MDS) dated [DATE], assessed R2 with a Brief Interview of Mental Status (BIMS) score of 15, indicating intact cognition. R2 required oxygen. R2 had a range of motion impairment to her upper extremity on one side, was dependent on staff to roll left and right and return to back when in bed, when moving from lying to sitting on the side of the bed, and transfers in and out of the bed. The Functional Abilities Care Area assessment dated [DATE], revealed R2 had limited use of her right arm, used the call light when she needed assistance, and required total assistance from two staff for transfers with the full body lift. The Quarterly MDS dated [DATE], assessed R2 with a BIMS score of 14, indicating intact cognition. R2 required oxygen and continued to have impairment to one side of her upper extremity range of motion. R2 required substantial/maximum assistance from staff for rolling left-to-right and to back when in bed, moving from lying to sitting on the side of the bed, and transfers to/from the bed. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Care Plan dated 01/16/24 revealed R2 required extensive assistance of two staff with bed mobility and transfers with the full body lift. R2 wore oxygen at night to assist with her breathing to keep her oxygen saturations above 90 percent. The User Learning education log dated 05/02/24 revealed CNA M completed education on abuse/neglect/exploitation on 12/05/23 and 02/17/24. The Physician Order tab located in the EMR revealed R2 had an order dated 04/22/22 for oxygen at two liters at bedtime to keep oxygen saturations above 90 percent. The facility Assignment Sheet dated 03/21/24 revealed CNA M was scheduled for 06:00 PM to 10:00 PM on R2's side of the facility and the other side of the facility for the night shift. From 04:00 PM to 08:00 PM, CNA O scheduled on R2' s side of the facility and LN G scheduled the second half of the evening shift on R2's side of the facility, then on night shift was the charge nurse for both sides of the facility. CMA S scheduled for medications on the evening shift and CNA N scheduled on the night shift on R2's side of the facility. The facility Report of Concern dated 03/21/24 by CNA N, revealed when CNA N first walked in to get report R2 was in her room crying and said when she was put to bed, the unidentified staff left her head down flat, and it made her feel dizzy and sick. R2 had put her call light on to ask for help but nobody ever answered her light so then she yelled for help and when CNA M came in, she told R2 she needed to wait and left without helping her. CNA N was getting report from CNA M when R2 yelled CNA N's name from her room and CNA M yelled back at her That's enough [R2] then continued talking. CNA N went to room and R2 was telling her about what had happened and spend the next 30 to 40 minutes crying on and off in her room. CNA N stated R2 was very upset about the situation. The facility Report of Concern dated 03/21/24 by LN G, revealed at 10:10 PM CNA M told her she had been in R2's room and R2 was crying and upset that CNA M and CNA O had put her to bed, CNA M was rude to her, etc. LN G had talked to R2 at 06:00 PM when sitting in her wheelchair next to the television room and she was smiling and happy and stated she had a good day. LN G stated when trying to talk to her later about what happened, R2 got upset and had a difficult time explaining. R2 did stated they just plopped her into bed and left, she put on her call light and after 20 minutes, they had not answered her light, so she called out with her voice. CNA M came in and was rude to her. LN G did not push the issue further with R2 as it caused her to get upset again. LN G explained R2 had not done anything wrong, and LN G would try to investigate the manner. (continued on next page)

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	175226	A. Building B. Wing	05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Iola	600 E Garfield Street Iola, KS 66749

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility investigation revealed an interview with R2 stating she called out for help to put her to bed, she had rung the call light, and nobody came for 30 minutes or longer. When CNA M responded she stated she could not do it alone and she was the only one here, but R2 said CNA O was also on this side. R2 stated CNA M basically threw her in bed and she was sideways with her head towards the window and her feet towards the door with her head all the way down and lacked her oxygen. R2 started getting really dizzy and sick and used the call light and no one came, so she started yelling out and CNA M yelled from the hall that R2 was not the only resident they had to take care of and left. R2 stated her legs were all twisted in her blankets so she could not move herself and she kept getting dizzier, so she started yelling for help. R2 asked for help to untangle her legs so she could maybe get herself straightened up in bed, but nobody came. R2 stated CNA M was really rough with her and basically threw her in bed and she never sleeps with her bed flat because she cannot breathe. R2 was yelling for them to come back and finish and nobody ever came until the night shift got there, and CNA N came in. CNA N applied R2's oxygen first thing then helped R2 to get straight and elevate the head of her bed, then R2's dizziness stopped. R2 stated one time in her room CNA M yelled at her from the hallway and told her she needed to be quiet, or she was going to wake everyone up. R2 said all she wanted was for the CNA to help her, put her oxygen on, and raise the head of the bed up. The investigation included when Administrative Staff A and Administrative Nurse D interviewed CNA M and asked if she did all the things reported, CNA M answered yes. When asked if she felt like anything she had done was considered abuse, CNA M answered yes. The facility Witness Statement dated 03/22/24 by CNA Q, revealed on 03/21/24 she witnessed CNA M, after CNA O left, having multiple call lights on while CNA M remained sitting at the nurse's desk eating her food. The facility Witness Statement dated 03/22/24 by CNA N, revealed on 03/21/24 when first arriving for her shift, CNA M asked for help to pull R2 up in the bed. When walking in R2's room she was crying and would not respond to CNA N when trying to talk to her. CNA N then stated they left her room so CNA M could give CNA N report, and while talking, R2 started yelling CNA N's name and CNA M instead of checking on her yelled back at her down the hallway That's enough [R2] and went back to talking. CNA N went in to check on R2 and to ask what was wrong. While crying R2 said when she was put to bed, the staff had left her head down flat making her feel dizzy and sick. R2 told CNA N she pressed her call light to ask for help and waited but no one answered her light, so she then tried yelling for help. CNA M then came in and told her she needed to wait and left without helping R2. CNA N stated R2 continued crying on and off for the next 30 minutes or so and seemed to be very upset. CNA N told LN G and then filled out a Report of Concern form. The facility Witness Statement dated 03/22/24 by CNA M, revealed on 03/21/24 she arrived at the facility at 06:00 PM. Towards the end of the night close to 10:00 PM while charting R2's light came on and she called asking to be lifted up and CNA M told R2 she was going to need to wait a second for CNA N to get there to help. R2 stated she can't, and CNA N told her she was sorry and did not know what else she could do right then, and R2 seemed okay with the answer. CNA N came in and CNA M started giving report when R2 started to call out/holler and CNA M stated [R2] that's enough and asked CNA N to help lift R2 up. The statement lacked what occurred when assisting R2 to bed and any interactions after that until the request to be pulled up close to 10:00 PM. (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 Witness Statement dated 03/21/24 by LN G, revealed at approximately 10:10 PM CNA M, who came in at 10:00 PM, told LN G she had been in R2's room and R2 was crying and very upset. R2 had told CNA N that CNA M and CNA O put R2 to bed and they were rude to her and etc. LN G had seen her at 06:00 PM sitting in her wheelchair next to the television room smiling and happy and stated she had a very good day. When LN G tried to talk to her later to get an explanation of what happened to get her so upset, but R2 became upset again and had a hard time explaining with words. R2 did say they plopped her down into bed and left. R2 told LN G she put her call light back on and after 20 minutes no one answered her light, so she called out with her voice then CNA M came back into R2's room, was very rude to her, and then left the room. LN G did not push the issue with R2 any further as it was causing her great upset to recall the issue. LN G explained to R2 that R2 did not do anything wrong, and LN G would try to investigate the matter. The Licensed Medication Administration Record dated March 2024, revealed on 03/21/24 at hour of sleep, LN G documented R2's oxygen saturation level as 85 percent. All other days of the month R2's oxygen level was 93 percent or better except on 03/28/24 and 03/29/24 documented not applicable. The Vital Signs tab in the EMR revealed on 03/21/24 at 10:18 PM, LN G assessed R2's oxygen saturation level at 85 percent, eight minutes after CNA N reported R2's concerns to LN G. The Progress Note dated 03/22/24 at 02:00 PM revealed R2 alleged that an unidentified CNA on night shift last night was rough and spoke to her inappropriately. The facility Employee Warning Notice dated 03/25/24 revealed LN G did not follow the ANE (Abuse, Neglect, Exploitation) Policy - did not report ANE immediately. Observation on 05/06/24 at 08:57 AM, revealed R2 sat up in a wheelchair in the activity area with a lift sling under her. Her room was located approximately 34 feet from the east side of the nurse's desk. An unidentified staff member assisted her to her room for the interview. In R2's room, an oxygen concentrator was next to the head of the bed and a full body lift stored in her room. During an interview on 05/06/24 at 08:59 AM, R2 stated she thought on 03/21/24 at approximately 06:30 to 07:00 PM, CNA M and CNA O assisted her to bed using the lift and CNA M had a hold of her and just threw me into bed. R2 stated CNA M did not have a hold of the lift sling, she had a hold of her feet and slung me in there. R2 could not recall if she was crossways in the bed or not and stated both staff walked out after putting her to bed. R2 stated she has to have the head of the bed up; the staff lay it flat when she gets in to bed and then they put it up and she gets really dizzy if she lays flat. R2 stated she turned on her light to get help as she cannot run the bed controls due to her right side messed up and the staff run the controls. R2 stated her feet were all tangled up and everything. R2 stated she hollered out to get help and CNA M stated [R2] that is enough and stated CNA M was always nasty. R2 stated she was dizzy waiting for someone to help her and was nauseated too. R2 stated she was crying, and CNA N came to help her and put her head up. R2 stated she wears oxygen at night. R2 stated CNA O was nice to her that night and always is. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/06/24 at 09:25 AM, LN G reported she thought it was around 08:00 PM when R2 received assistance to go to bed and did not hear anything until 10:00 PM or a little later when CNA N came in. LN G stated CNA N reported to her she had just been in the room with R2, and she was crying and when they put her to bed, they just plopped her down and walked out. LN G stated that was basically all CNA N said, but thought it was important to know R2 was upset. LN G stated she went back into R2's room to talk to her, she was crying again and had a hard time getting anything out, R2 said they (did not specify who) came in there and plopped her on the bed and left and her call light had been on, and they did not come back. LN G stated R2 did not tell her about her head being flat, but she was breaking up when talking and she could not recall if R2 had told her anything that CNA M said to R2. LN G stated she did not report anything at that time to Administrative Staff A and she filled out a report of concern form and placed it under Administrative Staff A's office door. LN G stated when R2 talked to her it really did not sound like anything, she could not spit it out, and she was upset. On 05/06/24 at 10:09 AM, CNA N stated on 03/21/24 when she first walked in, CNA M immediately came up to her and asked if staff could help pull R2 up in the bed. CNA N stated she was in the breakroom dropping off her things before she came to the desk. CNA N stated when entering R2's room she was crying, avoiding eye contact, sniffling, and rubbing her face. CNA N stated it was unusual for R2 to cry. CNA N stated she could not recall if R2 had oxygen on at that time, CNA N stated they then left the room, CNA M started giving her report, they were standing in front of the desk and had just finished rounds and R2 started yelling CNA N's name. CNA M stated before she had a chance to say anything, CNA M stated That's enough [R2] and kept talking like nothing happened and walked off to the other side of the facility. CNA N went to go talk to R2, who was hysterically crying when she walked in and had said a lot about not being able to breathe, would not answer the call light and come help, and CNA M should know better. CNA N left the room and LN G was at the cart, so she went straight to her and told her about it. CNA N stated she filled out a report of concern form and left it under Administrative Staff A's door. CNA N stated she did not contact Administrative Staff A nor Administrative Nurse D as she knew LN G was writing her report and assumed she was going to notify them. On 05/06/24 at 10:48 AM, CNA M stated she worked 06:00 PM to 10:00 PM on R2's side of the building. CNA M stated it was around 06:30 to 07:00 PM when assisting R2 to bed. CNA M denied having a hold of R2's feet or legs during the lift transfer to bed and stated she guided the lift as CNA O was not to run the lift and helped her put R2 to bed. CNA M denied swinging R2 into bed and stated they placed R2 over the bed and lowered her and moved her up in the bed. CNA M could not recall if she or CNA O put R2's oxygen in place and stated R2 had them put her head up a little bit but not too much. CNA M stated R2 had her call light on a few times after that, one for her teeth and one for her drink, and then shortly after that to be pulled up. CNA M stated she had forgotten to take care of her teeth when they laid R2 down, so she went and ahead and took care of that. CNA M stated around 09:30 PM or closer to 10:00 PM, R2 wanted to be pulled up. CNA M stated R2 was hollering, she had put her call light on a few minutes before CNA N arrived and had told R2 that the nurse was busy, and CNA N was not here yet so it would be a few minutes before pulling her up. CNA M stated R2 did not like that answer and started crying and she told R2 she would have to wait, it would be a few minutes and as soon as R2 heard CNA N, she started hollering out into hallway screaming, while we were in the middle of giving report. CNA M said she raised her voice at R2 and said [R2] that is enough while standing at the desk. CNA M admitted she had gotten loud with R2 and after getting her situated she went over to the other side of the facility and worked until 06:00 AM on 03/22/24. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/06/24 at 11:20 AM Administrative Staff A stated on 03/22/24 there was a report of concern from LN G and CNA N under her door that she got to a few hours after arriving to the facility, which was usually 08:00 AM. Administrative Staff A stated she was not aware of R2's concerns prior to that and had she known, she would have suspended CNA M and if the staff truly felt CNA M yelled at R2 they should have called her. Administrative Staff A stated the staff were to call her immediately for allegations of abuse or neglect. On 05/06/24 at 01:14 PM Administrative Staff A stated she had interviewed CNA O and she did not hear or see anything that would be classified as abuse and did not collect a statement from her. The facility's policy for Abuse, Neglect, and Exploitation dated October 2022, revealed the resident has the right to be free from verbal, sexual, physical, and mental abuse and involuntary seclusion. The facility policy was to treat each resident with respect, kindness, dignity, and care, to keep them free form abuse and neglect, and to take swift and immediate action to investigate and adjudicate alleged resident abuse and neglect. All alleged violations involving abuse, neglect, exploitation, or mistreatment are to be reported immediately to the Administrator and/or their designated representative. Any time a report of possible abuse, neglect, or exploitation was made against an employee, that employee should be immediately sent home and suspended without by the person in charge until a thorough investigation could be conducted by the Director of Nursing/Administrator. The facility failed to report abuse and neglect to R2 on 03/21/24 by CNA M immediately to the administrator which allowed her to continue her shift for eight more hours placing other residents in the facility at risk for potential abuse and neglect. On 05/06/24 at 04:33 PM, Administrative Staff A was provided the Immediate Jeopardy template and notified of the facility's failure to prevent abuse and neglect on 03/21/24 to R2. The immediate jeopardy was determined to first exist on 03/21/24 at approximately 07:00 PM when CNA M roughly put R2 in bed. The surveyor verified the removal of the immediate jeopardy occurred on 03/22/24 at 10:00 PM with the facility implementation of the following actions: 1. Administrative Staff A and Administrative Nurse D interviewed R2 on 03/22/24 at 11:20 AM. R2 confirmed the allegations. 2. CNA M interviewed on 03/22/24 at 02:15 PM by Administrative Staff A and Administrative Nurse D and admitted to the allegations. The facility suspended CNA M. 3. CNA M interviewed by Administrative Staff A on 03/22/24 at 04:00 PM regarding the allegations against CNA N to R2. 4. The LN completed an assessment on 03/22/24. 5. Verbal discipline and education given to LN G for not reporting immediately on 03/22/24. 6. All staff training initiated immediately on reporting allegations of abuse, and completed at the start of each shift on 03/22/24 at 10:00 PM. 7. Written discipline given to LN G on 03/25/24. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41121 The facility reported a census of 36 residents with four residents sampled. Based on observation, record review, and interview, the facility failed to protect Resident (R) 2 from further abuse and neglect. On 03/21/22 at 10:10 PM when staff failed to notify the administrator immediately of an allegation of abuse and neglect. R2 reported Certified Nurse Aide (CNA) M was rough with her when assisting her to bed around 06:30 PM to 07:00 PM. R2 stated CNA M threw her into her bed by having a hold of her legs and swung her on the bed, while in the lift sling, during the transfer from the wheelchair to her bed. Afterwards, R2 experienced dizziness, nausea, and difficulty breathing due to lying flat as the head of the bed was flat. R2 activated her call light and when nobody responded to the call light, R2 started yelling out. When CNA M responded to R2, she did so by yelling at R2 from the hallway saying R2 was not the only resident left to take care of. R2's bed remained flat and R2 lacked application of her supplemental oxygen for 3 to 3.5 hours, until CNA N arrived for the 10:00 PM shift. While rounding, R2 hollered out CNA N's name and before she could respond, CNA M yelled from approximately 34 feet away That's enough [R2]! CNA N responded to R2 and found the resident crying and upset. CNA N reported the concerns to Licensed Nurse (LN) G at 10:10 PM. CNA N and LN G failed to report the abuse and neglect to Administrative Staff A immediately and did not remove CNA M from working with residents. The administrator was not aware of the events until 03/22/24, several hours after her arrival, when reading the Report of Concern forms from LN G and CNA N that were placed under her door. CNA M remained on duty until 06:00 AM on 03/22/24, working the last eight hours of her scheduled 12-hour shift on the other side of the facility. This deficient practice placed R2 in immediate jeopardy and did not protect R2 from potential for further abuse and neglect by CNA M and placed any resident CNA M worked with for the next eight hours at risk for abuse and neglect. Findings included: - The Medical Diagnosis tab located in the electronic medical record (EMR) for R2 included diagnoses of muscle weakness, anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). The Annual Minimum Data Set (MDS) dated [DATE], assessed R2 with a Brief Interview of Mental Status (BIMS) score of 15, indicating intact cognition. R2 required oxygen. R2 had a range of motion impairment to her upper extremity on one side, was dependent on staff to roll left and right and return to back when in bed, when moving from lying to sitting on the side of the bed, and transfers in and out of the bed. The Functional Abilities Care Area assessment dated [DATE], revealed R2 had limited use of her right arm, used the call light when she needed assistance, and required total assistance from two staff for transfers with the full body lift. The Quarterly MDS dated [DATE], assessed R2 with a BIMS score of 14, indicating intact cognition. R2 required oxygen and continued to have impairment to one side of her upper extremity range of motion. R2 required substantial/maximum assistance from staff for rolling left-to-right and to back when in bed, moving from lying to sitting on the side of the bed, and transfers to/from the bed. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Care Plan dated 01/16/24 revealed R2 required extensive assistance of two staff with bed mobility and transfers with the full body lift. R2 wore oxygen at night to assist with her breathing to keep her oxygen saturations above 90 percent. The User Learning education log dated 05/02/24 revealed CNA M completed education on abuse/neglect/exploitation on 12/05/23 and 02/17/24. The Physician Order tab located in the EMR revealed R2 had an order dated 04/22/22 for oxygen at two liters at bedtime to keep oxygen saturations above 90 percent. The facility Assignment Sheet dated 03/21/24 revealed CNA M was scheduled for 06:00 PM to 10:00 PM on R2's side of the facility and the other side of the facility for the night shift. From 04:00 PM to 08:00 PM, CNA O scheduled on R2' s side of the facility and LN G scheduled the second half of the evening shift on R2's side of the facility, then on night shift was the charge nurse for both sides of the facility. CMA S scheduled for medications on the evening shift and CNA N scheduled on the night shift on R2's side of the facility. The facility Report of Concern dated 03/21/24 by CNA N, revealed when CNA N first walked in to get report R2 was in her room crying and said when she was put to bed, the unidentified staff left her head down flat, and it made her feel dizzy and sick. R2 had put her call light on to ask for help but nobody ever answered her light so then she yelled for help and when CNA M came in, she told R2 she needed to wait and left without helping her. CNA N was getting report from CNA M when R2 yelled CNA N's name from her room and CNA M yelled back at her That's enough [R2] then continued talking. CNA N went to room and R2 was telling her about what had happened and spend the next 30 to 40 minutes crying on and off in her room. CNA N stated R2 was very upset about the situation. The facility Report of Concern dated 03/21/24 by LN G, revealed at 10:10 PM CNA M told her she had been in R2's room and R2 was crying and upset that CNA M and CNA O had put her to bed, CNA M was rude to her, etc. LN G had talked to R2 at 06:00 PM when sitting in her wheelchair next to the television room and she was smiling and happy and stated she had a good day. LN G stated when trying to talk to her later about what happened, R2 got upset and had a difficult time explaining. R2 did stated they just plopped her into bed and left, she put on her call light and after 20 minutes, they had not answered her light, so she called out with her voice. CNA M came in and was rude to her. LN G did not push the issue further with R2 as it caused her to get upset again. LN G explained R2 had not done anything wrong, and LN G would try to investigate the manner. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility investigation revealed an interview with R2 stating she called out for help to put her to bed, she had rung the call light, and nobody came for 30 minutes or longer. When CNA M responded she stated she could not do it alone and she was the only one here, but R2 said CNA O was also on this side. R2 stated CNA M basically threw her in bed and she was sideways with her head towards the window and her feet towards the door with her head all the way down and lacked her oxygen. R2 started getting really dizzy and sick and used the call light and no one came, so she started yelling out and CNA M yelled from the hall that R2 was not the only resident they had to take care of and left. R2 stated her legs were all twisted in her blankets so she could not move herself and she kept getting dizzier, so she started yelling for help. R2 asked for help to untangle her legs so she could maybe get herself straightened up in bed, but nobody came. R2 stated CNA M was really rough with her and basically threw her in bed and she never sleeps with her bed flat because she cannot breathe. R2 was yelling for them to come back and finish and nobody ever came until the night shift got there, and CNA N came in. CNA N applied R2's oxygen first thing then helped R2 to get straight and elevate the head of her bed, then R2's dizziness stopped. R2 stated one time in her room CNA M yelled at her from the hallway and told her she needed to be quiet, or she was going to wake everyone up. R2 said all she wanted was for the CNA to help her, put her oxygen on, and raise the head of the bed up. The investigation included when Administrative Staff A and Administrative Nurse D interviewed CNA M and asked if she did all the things reported, CNA M answered yes. When asked if she felt like anything she had done was considered abuse, CNA M answered yes. The facility Witness Statement dated 03/22/24 by CNA Q, revealed on 03/21/24 she witnessed CNA M, after CNA O left, having multiple call lights on while CNA M remained sitting at the nurse's desk eating her food. The facility Witness Statement dated 03/22/24 by CNA N, revealed on 03/21/24 when first arriving for her shift, CNA M asked for help to pull R2 up in the bed. When walking in R2's room she was crying and would not respond to CNA N when trying to talk to her. CNA N then stated they left her room so CNA M could give CNA N report, and while talking, R2 started yelling CNA N's name and CNA M instead of checking on her yelled back at her down the hallway That's enough [R2] and went back to talking. CNA N went in to check on R2 and to ask what was wrong. While crying R2 said when she was put to bed, the staff had left her head down flat making her feel dizzy and sick. R2 told CNA N she pressed her call light to ask for help and waited but no one answered her light, so she then tried yelling for help. CNA M then came in and told her she needed to wait and left without helping R2. CNA N stated R2 continued crying on and off for the next 30 minutes or so and seemed to be very upset. CNA N told LN G and then filled out a Report of Concern form. The facility Witness Statement dated 03/22/24 by CNA M, revealed on 03/21/24 she arrived at the facility at 06:00 PM. Towards the end of the night close to 10:00 PM while charting R2's light came on and she called asking to be lifted up and CNA M told R2 she was going to need to wait a second for CNA N to get there to help. R2 stated she can't, and CNA N told her she was sorry and did not know what else she could do right then, and R2 seemed okay with the answer. CNA N came in and CNA M started giving report when R2 started to call out/holler and CNA M stated [R2] that's enough and asked CNA N to help lift R2 up. The statement lacked what occurred when assisting R2 to bed and any interactions after that until the request to be pulled up close to 10:00 PM. (continued on next page)

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	175226	A. Building B. Wing	05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Iola	600 E Garfield Street Iola, KS 66749

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility Witness Statement dated 03/21/24 by LN G, revealed at approximately 10:10 PM CNA M, who came in at 10:00 PM, told LN G she had been in R2's room and R2 was crying and very upset. R2 had told CNA N that CNA M and CNA O put R2 to bed and they were rude to her and etc. LN G had seen her at 06:00 PM sitting in her wheelchair next to the television room smiling and happy and stated she had a very good day. When LN G tried to talk to her later to get an explanation of what happened to get her so upset, but R2 became upset again and had a hard time explaining with words. R2 did say they plopped her down into bed and left. R2 told LN G she put her call light back on and after 20 minutes no one answered her light, so she called out with her voice then CNA M came back into R2's room, was very rude to her, and then left the room. LN G did not push the issue with R2 any further as it was causing her great upset to recall the issue. LN G explained to R2 that R2 did not do anything wrong, and LN G would try to investigate the matter. The Licensed Medication Administration Record dated March 2024, revealed on 03/21/24 at hour of sleep, LN G documented R2's oxygen saturation level as 85 percent. All other days of the month R2's oxygen level was 93 percent or better except on 03/28/24 and 03/29/24 documented not applicable. The Vital Signs tab in the EMR revealed on 03/21/24 at 10:18 PM, LN G assessed R2's oxygen saturation level at 85 percent, eight minutes after CNA N reported R2's concerns to LN G. The Progress Note dated 03/22/24 at 02:00 PM revealed R2 alleged that an unidentified CNA on night shift last night was rough and spoke to her inappropriately. The facility Employee Warning Notice dated 03/25/24 revealed LN G did not follow the ANE (Abuse, Neglect, Exploitation) Policy - did not report ANE immediately. Observation on 05/06/24 at 08:57 AM, revealed R2 sat up in a wheelchair in the activity area with a lift sling under her. Her room was located approximately 34 feet from the east side of the nurse's desk. An unidentified staff member assisted her to her room for the interview. In R2's room, an oxygen concentrator was next to the head of the bed and a full body lift stored in her room. During an interview on 05/06/24 at 08:59 AM, R2 stated she thought on 03/21/24 at approximately 06:30 to 07:00 PM, CNA M and CNA O assisted her to bed using the lift and CNA M had a hold of her and just threw me into bed. R2 stated CNA M did not have a hold of the lift sling, she had a hold of her feet and slung me in there. R2 could not recall if she was crossways in the bed or not and stated both staff walked out after putting her to bed. R2 stated she has to have the head of the bed up; the staff lay it flat when she gets in to bed and then they put it up and she gets really dizzy if she lays flat. R2 stated she turned on her light to get help as she cannot run the bed controls due to her right side messed up and the staff run the controls. R2 stated her feet were all tangled up and everything. R2 stated she hollered out to get help and CNA M stated [R2] that is enough and stated CNA M was always nasty. R2 stated she was dizzy waiting for someone to help her and was nauseated too. R2 stated she was crying, and CNA N came to help her and put her head up. R2 stated she wears oxygen at night. R2 stated CNA O was nice to her that night and always is. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/06/24 at 09:25 AM, LN G reported she thought it was around 08:00 PM when R2 received assistance to go to bed and did not hear anything until 10:00 PM or a little later when CNA N came in. LN G stated CNA N reported to her she had just been in the room with R2, and she was crying and when they put her to bed, they just plopped her down and walked out. LN G stated that was basically all CNA N said, but thought it was important to know R2 was upset. LN G stated she went back into R2's room to talk to her, she was crying again and had a hard time getting anything out, R2 said they (did not specify who) came in there and plopped her on the bed and left and her call light had been on, and they did not come back. LN G stated R2 did not tell her about her head being flat, but she was breaking up when talking and she could not recall if R2 had told her anything that CNA M said to R2. LN G stated she did not report anything at that time to Administrative Staff A and she filled out a report of concern form and placed it under Administrative Staff A's office door. LN G stated when R2 talked to her it really did not sound like anything, she could not spit it out, and she was upset. On 05/06/24 at 10:09 AM, CNA N stated on 03/21/24 when she first walked in, CNA M immediately came up to her and asked if staff could help pull R2 up in the bed. CNA N stated she was in the breakroom dropping off her things before she came to the desk. CNA N stated when entering R2's room she was crying, avoiding eye contact, sniffling, and rubbing her face. CNA N stated it was unusual for R2 to cry. CNA N stated she could not recall if R2 had oxygen on at that time, CNA N stated they then left the room, CNA M started giving her report, they were standing in front of the desk and had just finished rounds and R2 started yelling CNA N's name. CNA M stated before she had a chance to say anything, CNA M stated That's enough [R2] and kept talking like nothing happened and walked off to the other side of the facility. CNA N went to go talk to R2, who was hysterically crying when she walked in and had said a lot about not being able to breathe, would not answer the call light and come help, and CNA M should know better. CNA N left the room and LN G was at the cart, so she went straight to her and told her about it. CNA N stated she filled out a report of concern form and left it under Administrative Staff A's door. CNA N stated she did not contact Administrative Staff A nor Administrative Nurse D as she knew LN G was writing her report and assumed she was going to notify them. On 05/06/24 at 10:48 AM, CNA M stated she worked 06:00 PM to 10:00 PM on R2's side of the building. CNA M stated it was around 06:30 to 07:00 PM when assisting R2 to bed. CNA M denied having a hold of R2's feet or legs during the lift transfer to bed and stated she guided the lift as CNA O was not to run the lift and helped her put R2 to bed. CNA M denied swinging R2 into bed and stated they placed R2 over the bed and lowered her and moved her up in the bed. CNA M could not recall if she or CNA O put R2's oxygen in place and stated R2 had them put her head up a little bit but not too much. CNA M stated R2 had her call light on a few times after that, one for her teeth and one for her drink, and then shortly after that to be pulled up. CNA M stated she had forgotten to take care of her teeth when they laid R2 down, so she went and ahead and took care of that. CNA M stated around 09:30 PM or closer to 10:00 PM, R2 wanted to be pulled up. CNA M stated R2 was hollering, she had put her call light on a few minutes before CNA N arrived and had told R2 that the nurse was busy, and CNA N was not here yet so it would be a few minutes before pulling her up. CNA M stated R2 did not like that answer and started crying and she told R2 she would have to wait, it would be a few minutes and as soon as R2 heard CNA N, she started hollering out into hallway screaming, while we were in the middle of giving report. CNA M said she raised her voice at R2 and said [R2] that is enough while standing at the desk. CNA M admitted she had gotten loud with R2 and after getting her situated she went over to the other side of the facility and worked until 06:00 AM on 03/22/24. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/06/24 at 11:20 AM Administrative Staff A stated on 03/22/24 there was a report of concern from LN G and CNA N under her door that she got to a few hours after arriving to the facility, which was usually 08:00 AM. Administrative Staff A stated she was not aware of R2's concerns prior to that and had she known, she would have suspended CNA M and if the staff truly felt CNA M yelled at R2 they should have called her. Administrative Staff A stated the staff were to call her immediately for allegations of abuse or neglect. On 05/06/24 at 01:14 PM Administrative Staff A stated she had interviewed CNA O and she did not hear or see anything that would be classified as abuse and did not collect a statement from her. The facility's policy for Abuse, Neglect, and Exploitation dated October 2022, revealed the resident has the right to be free from verbal, sexual, physical, and mental abuse and involuntary seclusion. The facility policy was to treat each resident with respect, kindness, dignity, and care, to keep them free form abuse and neglect, and to take swift and immediate action to investigate and adjudicate alleged resident abuse and neglect. All alleged violations involving abuse, neglect, exploitation, or mistreatment are to be reported immediately to the Administrator and/or their designated representative. Any time a report of possible abuse, neglect, or exploitation was made against an employee, that employee should be immediately sent home and suspended without by the person in charge until a thorough investigation could be conducted by the Director of Nursing/Administrator. The facility failed to report abuse and neglect to R2 on 03/21/24 by CNA M immediately to the administrator which allowed her to continue her shift for eight more hours placing other residents in the facility at risk for potential abuse and neglect. On 05/06/24 at 04:33 PM, Administrative Staff A was provided the Immediate Jeopardy template and notified of the facility's failure on 03/21/24 to protect R2 and other residents of the facility from potential further abuse and neglect after receiving an allegation of abuse and neglect regarding CMA M. The immediate jeopardy was determined to first exist on 03/21/24 at 10:10 PM when staff were made aware of the allegation and the surveyor verified the removal of the immediate jeopardy occurred on 03/22/24 at 10:00 PM with the facility implementation of the following actions: The immediate jeopardy was determined to first exist on 03/21/24 at 07:00 PM when CNA M roughly put R2 in bed. The surveyor verified the removal of the immediate jeopardy occurred on 03/22/24 at 10:00 PM with the facility implementation of the following actions: 1. Administrative Staff A and Administrative Nurse D interviewed R2 on 03/22/24 at 11:20 AM. R2 confirmed the allegations. 2. CNA M interviewed on 03/22/24 at 02:15 PM by Administrative Staff A and Administrative Nurse D and asked if she had done all the things reported and CNA M responded yes!' and began crying. CNA M suspended. 3. CNA M interviewed by Administrative Staff A on 03/22/24 at 04:00 PM regarding the allegations against CNA N to R2. 4. The LN completed an assessment on 03/22/24. 5. Verbal discipline and education given to LN G for not reporting immediately on 03/22/24. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	6. All staff training initiated immediately on reporting allegations of abuse and completed at the start of each shift on 03/22/24 at 10:00 PM. 7. Written discipline given to LN G on 03/25/24. 8. QAPI meeting held on 03/26/24 with the medical director. 9. On 03/27/24 at 05:11 PM CNA M terminated. Due to the corrective measures implemented prior to the onsite survey, the deficient practice was deemed past non-compliance and existed at a J scope and severity.

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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** 41121 The facility reported a census of 36 residents, with four residents sampled, including three residents reviewed for risk of elopement (an incident in which a cognitively impaired resident with poor or impaired decision-making ability/safety awareness leaves the facility without the knowledge of staff). Based on observation, record review, and interview, the facility failed to provide adequate supervision and a safe environment, as free of accident hazards as possible, to prevent the elopement of cognitively impaired and independently mobile Resident (R)1. On 04/27/24 during the 05:45 PM to 06:00 AM shift, staff deactivated an exit door alarm on a hallway R1 did not reside on due to a storm causing the alarm to sound. On 04/28/24 at 03:57 PM, R1 attempted to exit a hallway door on the side of the facility the resident resided on, and staff redirected R1. On 04/28/24 at 03:59 PM, R1 sat in a chair in the activity area next to the nurse's station of the area of the facility he resided on. Shortly after, R1 exited the hallway door where the alarm had been deactivated. The facility staff did not know R1 was outside until a visitor in the community, in a house across the street, observed R1 having trouble with his walker going from the facility driveway to the street. The visitor then got in his car and drove over to the facility to report seeing a person outside walking down the street with a walker. At 04:03 PM, staff alerted the charge nurse on the walkie talkie that a resident had gotten outside without staff knowledge. The lack of functioning alarm doors to ensure resident safety and failure to provide appropriate supervision for a resident who displayed active exit seeking behaviors, placed R1 in immediate jeopardy and placed all five residents at risk for elopement. Findings included: - The Medical Diagnosis tab located in the electronic medical record (EMR) for R1 included diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), dementia (progressive mental disorder characterized by failing memory, confusion), muscle weakness, and hallucinations (sensing things while awake that appear to be real, but the mind created). The Admission Minimum Data Set, dated dated dated [DATE], assessed R1 with a Brief Interview of Mental Status (BIMS) score of four, indicating severe cognitive impairment. R1 wandered one to three days of the assessment period, used a walker for mobility, and with setup assistance he could walk 150 feet in the corridor on admission. The Behavioral Symptoms Care Area assessment dated [DATE] revealed R1 wandered at times and, when noted, the staff were to toilet him, feed him, sit him at the activity table and give colors for him to color. R1 also liked to watch Star Trek and old westerns. R1 was an elopement risk and needed to be monitored when he was wandering. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Care Plan initiated on 04/11/24, revealed R1 was an elopement risk/wanderer, had impaired safety awareness, and had cognitive loss that affected his memory. The staff were to provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures, and memory boxes. The staff were to identify patterns of wandering to determine if it was purposeful, aimless, escapist, looking for something, or need for more exercise, and staff were to intervene as appropriate. The staff were to distract R1 from wandering by offering pleasant diversions, structured activities, food, conversation, television, and a book. On 04/29/24, the facility added an intervention for 1:1 observation until further notice. R1 was also a risk for falls/injury. The Clinical Health Review dated 04/11/24, scored R1 at 21 indicating a high elopement risk level. R1 had wandering, exit seeking/door watcher, memory deficit, impaired safety awareness, had physical ability to open doors, able to exit doors independently with or without assistive device and impaired cognition. Elopement risk interventions included the facility had locked/coded doors. The Progress Note dated 04/12/24 at 04:40 PM, revealed R1 admitted to the facility from home, had a diagnosis of Alzheimer's, and tended to wander. Review of the Progress Notes dated 04/12/24 through 04/22/24 revealed R1 had periods of wandering, exit seeking, was witnessed leaving the building once, and had attempts to leave the facility. On 04/27/24 at 06:09 PM, a Code Red Weather Warning was sent out via text message per automated system for the city location of the facility for a severe thunderstorm warning until 07:00 PM. An additional alert was sent out at 10:25 PM until 11:30 PM. The Progress Note dated 04/28/24 at 04:36 PM revealed Licensed Nurse (LN) I heard staff on the walkie talkie at 04:03 PM say I think your resident got out. LN I went to the front of the building and observed two staff members walking R1 back to the facility front door. LN I last saw R1 with a Certified Nurse Aide (CNA) at 03:57 PM. After assessing R1 for injury and finding none, she placed R1 on one-on-one with staff. LN I assessed all doors with a unidentified Certified Mediation Aide (CMA) and found a hallway exit door on the other side of the facility where R1 resided was unlocked, causing the alarm to not sound. The facility Witness Statement dated 04/28/24 by LN H, revealed on 04/27/24 while working the 05:45 PM to 06:15 AM shift, there was a severe thunderstorm warning and tornado warning for the county of the facility location. The wind caused the door on a [deactivated door alarm hallway] to blow open, sounding the alarms. LN H checked the door and secured it making sure the door locked at that time. The facility Witness Statement dated 04/28/24 by CNA O, revealed they observed R1 walking the halls and walked down [deactivated door alarm hall] and R1 tried going out at 03:57 PM. CNA O told R1 it was too cold and would not be good to go out. R1 walked back to the activity room, where CNA O last saw him. The facility Witness Statement dated 04/28/24 by CNA Q, revealed she toileted R1 at 03:00 PM and at 03:59 PM she observed R1 in the activity room with other residents. At 04:16 PM, LN I informed CNA Q that R1 got outside and was back inside. (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 Witness Statement dated 04/28/24 by [Visiting Neighbor] revealed he got up from the couch and noticed a gentleman with a walker, walking in the parking lot. He observed R1 having trouble with the walker coming out of the entrance of the parking lot, so he went over to the facility to let them know, since R1 was not in the parking lot at the time. The statement lacked a time of the observation. The facility Witness Statement dated 04/28/24 by LN J, revealed she was charting at the nurse's desk on the other side of the facility R1 resided on. At approximately 04:30 PM, a gentleman came through the front door and reported an elderly man walking outside with his walker. LN J, CMA R, and CNA P went outside to find the resident and CMA R walked R1 back while CNA P contacted LN I. LN J observed the gentleman reporting get in a car and drive to a house across the street. The facility Witness Statement dated 04/28/24 by CMA R, revealed a gentleman came to the front desk and reported an elderly gentleman was walking down the road with a walker. CMA R, LN J, and another CNA immediately went out the front door to find the resident. CMA R observed R1 walking down the street with his walker going west. CMA R ran to him with the other CNA and R1 said he was enjoying the weather, when asked what he was up to. CMA R walked with resident back to the building through the front door. The statement lacked the time it was reported a resident outside, or the time CMA R observed R1 walking down the street. The facility Witness Statement dated 04/28/24 by CNA P, revealed she was at the desk with another CNA, a CMA, and a nurse when a guy came in the front door to the desk and informed staff there was a guy walking down the road with a walker. CNA P, the other CNA, and the CMA ran out the door to go get the resident. When they asked R1 what he was doing, he responded he was enjoying the weather. CNA P stated they walked with R1 inside while the nurse and alerted the nurse in charge of R1. The statement lacked a time of notification of the missing resident and the time they observed R1 walking down the street. The facility Witness Statement dated 04/28/24 by CMA S, revealed LN I told her R1 had escaped the building and none of the staff heard alarms on any of the doors go off. CMA S checked all the doors and found that the door on the (deactivated door alarm) hallway, was unlocked. Observation on 05/02/24 at 09:32 AM, during tour of the facility, revealed a stop sign secured with Velcro was across the hallway exit doors of four hallways. A key box by each door showed a red light on. Outside the door the facility found was unalarmed/unlocked, was an area of pavement approximately eight feet from the door with a sidewalk on each side of the building that extended from the paved area. Beyond the paved area was a grass area that extended out to a street on the east side of the facility. The double doors at the front of the facility by the nurse's desk required a key code to exit to the front lobby/office area by the front entrance doors of the facility. R1's room was located on another hall on the other side of the facility. Observation on 05/02/24 at 10:33 AM, revealed R1 walking with a front-wheeled walker, gait steady and slow, accompanied by Social Service Staff X, down the hall he resided on and to the activity area where other residents were playing a bag toss game with country music playing. R1 sat in a chair and began mouthing the words to the country song and participated in the game. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation on 05/02/24 at 01:58 PM of the area outside of the hall door that was unlocked when R1 eloped, revealed the sidewalk extended south and adjoined the front parking lot. The end of the driveway to the east had a white sign that read Entrance and on the west side a white sign that read Exit. Observation on 05/02/24 at 03:00 PM, revealed the distance from the hall exit door the facility believed R1 went out to the location where found was approximately 435 feet measured with a GPS (Global Positioning System) device, the curb angles down from the front parking lot to where the Entry facility driveway located. During an interview on 05/02/24 at 11:31 AM, Maintenance Staff U stated for an alarm to not sound on the door, it would have to be shut off with a key, which the two charge nurses, dietary manager, and Maintenance Staff U have. A monitor was at each nurse's desk to identify the exit doors. If the light were on at the monitor, then the alarm was on. If the light was off, then the alarm was off. If the light blinked, then that indicated the alarm had been activated and would sound. Maintenance Staff U stated he checked the doors on 04/26/24 and they were all functioning and locked. During an interview on 05/02/25 at 12:59 PM, CMA R stated she worked on 04/28/24 from 02:00 PM to 10:00 PM on the other side of the facility where R1 resided. CMA R stated in the afternoon, she stood in front of the dining room at the nurse's desk when a gentleman came in the front door. CMA R stated she did not know who the gentleman was, and he stated, Ladies I am sorry to interrupt but there is a gentleman with a walker out front. CMA R stated she saw R1 walking as soon as she got to the front door, and he was 10 to 15 feet west of the white sign going west. CNA P accompanied her to look for R1. When approached, R1 stated he was going out for a stroll. CMA R stated R1 turned back around and walked back in the facility with her. CMA R stated she did not observe R1 on the hall prior to the elopement, nor had she heard a door alarm sound. During an interview on 05/02/24 at 01:06 PM, CNA Q stated she worked on 04/28/24 from 02:00 PM to 06:00 PM and was assigned to the area R1 resided on. CNA Q stated she toileted R1 around 03:00 PM and saw him around 03:57 PM to 03:59 PM sitting in a chair in the activity area by the nurse's desk, and he had his walker with him. CNA Q stated she then went in another resident room to provide cares and when she came out of the room at 04:16 PM, LN I reported to her R1 was discovered outside. CNA Q stated she did not hear a door alarm sound, and if it did, the alarm could be heard when inside a room. CNA Q stated she checks on R1 because he had tried to get out of the doors before. During an interview on 05/02/24 at 01:13 PM, CNA P stated she worked on 04/28/24 from around noon until 10:30 PM on the other side of the facility from where R1 resided. CNA P stated she did not see R1 on her side of the facility prior to the elopement, nor did she hear a door alarm. CNA P stated she was at the nurse's desk when a guy came in and said there was a guy walking down the road with a walker. CNA P went outside with CMA R and R1 returned inside with them. On 05/02/24 at 01:30 PM, an attempt for a phone interview with CMA S was unsuccessful. During an interview on 05/02/24 at 01:33 PM, LN J stated she worked 06:00 AM to 06:00 PM on 04/28/24 on the other side of the facility R1 resided on and had not seen R1 until supper time. LN J stated she had been at the desk charting and did not see R1 go by and had not heard an alarm go off. LN J was not aware of any unlocked exit doors. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175226	A. Building B. Wing	05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Iola	600 E Garfield Street Iola, KS 66749

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 05/02/24 at 01:35 PM, LN I stated she worked on 04/28/24 from 06:00 AM to 06:00 PM and was the charge nurse for R1. LN I stated she last saw R1 around 03:57 PM, wandering around by the nurse's station (for the hall he resided on). LN I stated she was assisting another resident in a room when she was alerted over the walkie talkie around 04:05 PM by an unknown staff member saying I think your guy got out. She could not get a response back on the walkie when asking what and who, so she went to R1's room and he was not there so she ran up to the front doors and on the way out the front doors she saw two staff bringing R1 back and he was barely in the parking lot at that time. LN I stated she did not hear a door alarm sound prior to the elopement and it was found the alarm was off on one of the hall doors (specified the hall), not where R1 resided. LN I stated prior to this she tried to check on R1 every 15 minutes due to his risk for eloping and kept him busy in the activity area. During an interview on 05/02/24 at 01:45 PM, CNA O stated she worked on 04/28/24 from 02:00 PM to 08:00 PM on the side R1 resided on. CNA O stated she saw R1 walking the halls (specified two hallways) and she followed him. R1 was at the exit door on a different hall from where he resided but same side of building, he had reached around the Velcro stop sign and was about to open the door when she told him it was too cold to go out. CNA O stated she was able to get R1 to turn around and he went to the activity area. CNA O went into another resident room after that and after exiting the room she was told R1 had gotten outside. CNA O did not hear a door alarm sound. During an interview on 05/02/24 at 02:08 PM, CMA R stated R1 was 10 to 15 feet west of the Exit sign near the west driveway when she found him. On 05/02/24 at 02:29 PM, Administrative Staff A stated staff should notify her if there is a problem with a door alarm so maintenance could be notified to check it and not shut the alarm off. During an interview on 05/02/24 at 02:44 PM, with the male visitor who alerted staff of R1 being outside, revealed the visitor saw R1 at the east side of the driveway, right on the curb by the street and then the resident went west. He noticed R1 was having trouble with the curb with his walker, at the edge of the west side of the driveway, where it curves and goes west. The facility policy Resident Elopement dated December 2022 included the facility strives to promote a safe and secure environment to help minimize risk of residents leaving the premises or safe area without the necessary supervision or authorization to do so. The facility is to have a process to monitor security of the premises on a routine basis. The facility failed to provide adequate supervision and a safe environment to cognitively impaired and independently mobile R1, identified as an elopement risk, who eloped from the facility with his walker on 04/28/24 without the staff knowledge, until a visitor informed the facility of a man walking outside in the street. On 05/02/24 at 05:32 PM, Administrative Staff A was provided the Immediate Jeopardy template and notified of the facility's failure to provide adequate supervision to R1 and ensure the exit door alarms were on when R1 eloped from the facility on 04/28/24 after 03:59 PM, placed R1 in immediate Jeopardy. (continued on next page)

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	175226	A. Building B. Wing	05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The immediate jeopardy was determined to first exist on 04/27/24 at 06:09 PM and the surveyor verified the facility identified and implemented corrective actions completed on 04/29/24 at 10:00 PM, when the facility completed the following: 1. The facility immediately placed R1 on one-to-one supervision with staff, after the nurse assessed for injuries when he returned back inside the building on 04/28/24 at approximately 04:05 PM. 2. A facility wide door check completed by maintenance to ensure all alarmed doors were in proper working order, completed on 04/28/24 at 04:46 PM. 3. On 04/29/24 at 09:20 AM, R1's elopement assessment updated, and all other residents has elopement assessment completed and care plan reviewed for accuracy and appropriateness on 04/29/24 by 12:00 PM. 4. Stop signs placed on hallway exit doors to remind resident to turn around on 04/29/24 at 03:00 PM. 5. The facility's Elopement book reviewed to ensure accurate content and completed on 04/29/24 at 03:08 PM. 6. The Administrator, Director of Nursing, and Medical Director held a QAPI (Quality Assurance Performance Improvement) meeting via phone on 04/29/24 at 04:48 PM. 7. All staff educated on elopement policy and resident incident starting on 04/28/24 and ending on 04/29/24 at 10:00 PM. Otherwise, employees were suspended pending required in-service. Due to the corrective actions implemented prior to the onsite visit, the deficient practice was deemed past non-compliance and existed at a J scope and severity.