STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175258	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Fort Scott	915 S Horton Fort Scott, KS 66701

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 - Minimal harm or potential for actual harm 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** 40689 The facility reported a census of 26. The sample included three residents reviewed for neglect. Based on observations, record review, and interview, the facility failed to ensure dependent and cognitively impaired Resident (R) 1, who had a diagnosis of dysphagia (swallowing difficulty), oropharyngeal phage (delay in swallowing), and ileus (obstruction of the intestines [gastrointestinal tract that absorbs nutrients and water from food], caused by immobility of the bowel), remain free from neglect when Certified Medication Aide (CMA) S continued to administer R1's morning medications despite R1's request to slow down because she was having a difficult time swallowing. When CMA S left the room, CMA S told R1 there you're done now you can quit your crying. Findings included: - (R)1's "Physician Order Sheet" (POS), dated 08/01/24, documented diagnoses which included: dysphagia (swallowing difficulty), oropharyngeal phage (delay in swallowing), ileus (obstruction of the intestines [gastrointestinal tract that absorbs nutrients and water from food], caused by immobility of the bowel), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and cognitive communication deficit (difficulty with communicating). The Annual Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview of Mental Status (BIMS) score of seven, indicating severely impaired cognition. R1 required setup assistance for eating. R1 had swallowing disorders that included coughing or choking on meals, or when swallowing medications, and complaints of difficulty or pain with swallowing. She required a mechanically altered diet and had no natural teeth or tooth fragments. R1 had no speech therapy during the lookback period but had speech therapy from 11/16/23 to 01/21/24. The "Cognitive Loss/Dementia Care Area Assessment" (CAA), dated 02/19/24, the resident was alert with occasional confusion. The resident's speech was clear, and she was able to voice her wants and needs. The Functional abilities (self-care and mobility) Care Area Assessment (CAA), dated 02/19/24, the resident will get up for meals and assisted by staff. The Nutrition Care Area Assessment (CAA), dated 02/19/24, the resident assisted by staff assist with meals. She was able to make her own menu choices. (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 - Minimal harm or potential for actual harm Residents Affected - Few	R1's Activities of Daily Living Care Plan, dated 03/16/17, instructed nursing staff to administer R1 medications crushed. The Quarterly MDS dated [DATE], documented the resident had a BIMS score of three, which indicated severely impaired cognition. She continued to have swallowing disorders that included coughing and chocking during meals and swallowing medications. She had complaints with difficulty or pain with swallowing. She required a mechanically altered diet and had no natural teeth or tooth fragments. R1's Difficulty Swallowing Care Plan, dated 08/07/24, instructed staff to be patient and take time when administering R1 medications because R1 would become anxious and choke easily. Staff were to crush her medications and mix the medications with applesauce. Review of R1's Electronic Medication Administration Record for 08/02/24, revealed CMA S administered the following medications: MiraLAX Powder (laxative), 17 grams, one scoop by mouth, daily, for constipation, start date 01/30/2023. Bactrim-DS Oral Tablet (antibiotic folate antagonist), 400-80 milligram's (mg), one tablet by mouth, daily, for prophylaxis, start date 02/01/23. Colace Tablet (laxative), 100 mg, one tablet by mouth, twice daily, for constipation, start date 01/30/23. A Registered Dietitian (RD) Assessment, dated 02/23/24, documented the resident required pureed diet with nectar thick liquids. The residents had risk factors such as difficulty chewing, swallowing and dysphagia. She had an altered texture diet, and thickened liquids. On 08/15/24 at 10:00 AM, Outside Resource Staff EE, reported she witnessed CMA S administering the resident medications and the resident was telling CMA S to stop, I need to swallow. Housekeeping/CNA U was also in the resident's room telling the resident to take a drink. Outside Resource Staff EE observed CMA S continued to give the resident her medications even though the resident told her she needed to swallow. Outside Resource Staff EE reported that CMA S made the statement when she walked out of the resident's room it's over with now, you can quit your crying. Outside Resource Staff EE reported she should have reported this to Administrative Staff A and to her supervisor on 08/02/24 but failed to do so. On 08/15/24 at 11:36 AM, CMA S reported that she administered R1's medications on the morning of 08/02/24. The resident was talking and screaming between bites of applesauce with her crushed medications. CMA S reported that she did not remember her crying. Housekeeping/CNA U gave her drinks of thickened liquid between medication bites in the applesauce mixture. CMA S reported she wanted to make sure the resident had all her medication. CMA S reported she had too much on her mind and should not have administered the medications in that manner. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/15/24 at 12:40 PM, Review of Housekeeping/CNA U witness statement revealed she delivered laundry to resident's room the morning of 08/02/04. CMA S was administering R1's medications when she entered the residents room. R1 asked CMA S to stop giving her the medication. R1 was coughing and choking on the medication. CMA S kept administering her medication. She asked CMA S to wait before giving more medication and give the resident a chance to swallow and get some water. CMA S continued to administer the medication. After CMA S finished administering medications, she told the resident she was A crybaby. On 8/15/24 at 10:19 AM, Administrative Nurse D reported she was not aware of CMA S actions until 08/07/24, (five days later), when Housekeeping/CNA U reported the incident to her and Administrative Staff A. Administrative Nurse D reported Housekeeping/CNA U said she got busy and forgot and should have reported the incident on 08/02/24 at the time of the incident. On 08/15/24 at 10:35 AM, Administrative Staff A reported Housekeeping U reported this incident to her and Administrative Nurse D on 08/07/24, instead of when it occurred, because Housekeeping/CNA U forgot to report the occurrence. Administrative Staff A reported Outside Resource staff EE failed to report what she witnessed with CMA S and R1. The facility's Abuse and Neglect Policy, revised dated 10/2022, documented the facility should ensure the resident is free from neglect and to take precautions to ensure the residents safety and well-being. The facility failed to ensure dependent and cognitively impaired Resident (R) 1, remained free from neglect when CMA S continued to administer medications in applesauce, despite R1's request to slow down because she was had a difficult time swallowing, witnessed by Housekeeping Aide/CNA U and Outside Resource Staff EE. When CMA S left the room, CMA S told R1 there you're done now you can quit your crying.

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F 0609 Level of Harm - Minimal harm or potential for actual harm 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** 40689 The facility reported a census of 26. The sample included three residents reviewed for neglect. Based on observations, record review, and interview, the facility failed to ensure dependent and cognitively impaired Resident (R) 1, who had a diagnosis of dysphagia (swallowing difficulty), oropharyngeal phage (delay in swallowing), ileus (obstruction of the intestines [gastrointestinal tract that absorbs nutrients and water from food], caused by immobility of the bowel), remain from neglect when Housekeeping U and Outside Resource Staff EE failed to report to Administrative Staff A that Certified Medication Aide S continued to administer R1's morning medications despite R1's request to slow down because she was had a difficult time swallowing. When CMA S left the room, CMA S told R1 there you're done now you can quit your crying. Findings included: - (R)1's "Physician Order Sheet" (POS), dated 08/01/24, documented diagnoses which included: dysphagia (swallowing difficulty), oropharyngeal phage (delay in swallowing), ileus (obstruction of the intestines [gastrointestinal tract that absorbs nutrients and water from food], caused by immobility of the bowel), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and cognitive communication deficit (difficulty with communicating). The Annual Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview of Mental Status (BIMS) score of seven, indicating severely impaired cognition. R1 required setup assistance for eating. R1 had swallowing disorders that included coughing or choking on meals, or when swallowing medications, and complaints of difficulty or pain with swallowing. She required a mechanically altered diet and had no natural teeth or tooth fragments. R1 had no speech therapy during the lookback period but had speech therapy from 11/16/23 to 01/21/24. The "Cognitive Loss/Dementia Care Area Assessment" (CAA), dated 02/19/24, the resident is alert with occasional confusion. The resident's speech was clear, and she is able to voice her wants and needs. The Functional abilities (self-care and mobility) Care Area Assessment (CAA), dated 02/19/24, the resident's will get up for meals and is assisted by staff. The Nutrition Care Area Assessment (CAA), dated 02/19/24, the resident assist by staff assist by meals. She was able to make her own menu choices. R1's Activities of Daily Living Care Plan, dated 03/16/17, instructed nursing staff to administer R1 medications crushed. The Quarterly MDS dated [DATE], documented the resident had a BIMS score of three, which indicated severely impaired cognition. She continued to have swallowing disorders that included coughing and chocking during meals and swallowing medications. She had complaints with difficulty or pain with swallowing. She required a mechanically altered diet and had no natural teeth or tooth fragments. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Difficulty Swallowing Care Plan, dated 08/07/24, instructed staff to be patient and take time when administering R1 medications because R1 would become anxious and choke easily. Staff were to crush her medications and mix the medications with applesauce. Review of R1's Electronic Medication Administration Record for 08/02/24, revealed CMA S administered the following medications: MiraLax Powder (laxative), 17 grams, one scoop by mouth, daily, for constipation, start date 01/30/2023. Bactrim-DS Oral Tablet (antibiotic folate antagonist), 400-80 milligrams (mg), one tablet by mouth, daily, for prophylaxis, start date 02/01/23. Colace Tablet (laxative), 100 mg, one tablet by mouth, twice daily, for constipation, start date 01/30/23. A Registered Dietitian Assessment, dated 02/23/24, documented the resident required pureed diet with nectar thick liquids. The residents had risk factors such as difficulty chewing, swallowing and dysphagia. She had an altered texture diet, and thickened liquids. On 08/15/24 at 10:00 AM, Outside Resource Staff EE, reported she witnessed CMA S administering the resident's medications and the resident was telling CMA S to stop, I need to swallow. Housekeeping/CNA U was also in the resident's room telling the resident to take a drink. Outside Resource Staff EE observed CMA S continued to give the resident her medications even though the resident told her she needed to swallow. Outside Resource Staff EE reported that CMA S made the statement when she walked out of the resident's room it's over with now, you can quit your crying. Outside Resource Staff EE reported she should have reported this to Administrative Staff A and her supervisor on 08/02/24 but failed to do so. On 08/15/24 at 11:36 AM, CMA S reported that she administered R1's medications on the morning of 08/02/24. The resident was talking and screaming between bites of applesauce with her crushed medications. CMA S reported that she did not remember her crying. Housekeeping/CNA U gave her drinks of thickened liquid between medication bites in the applesauce mixture. CMA S reported she wanted to make sure the resident had all her medication. CMA S reported she had too much on her mind and should not have administered the medications in that manner. On 08/15/24 at 12:40 PM, Review of Housekeeping/CNA U witness statement revealed she delivered laundry to resident's room the morning of 08/02/04. CMA S was administering R1's medications when she entered the residents room. R1 asked CMA S to stop giving her the medication. R1 was coughing and choking on the medication. CMA S kept administering her medication. She asked CMA S to wait before giving more medication and give the resident a chance to swallow and get some water. CMS continued to administer the medication. After CMA S finished administering medications, she told the resident she was A crybaby. On 8/15/24 at 10:19 AM, Administrative Nurse D reported she was not aware of CMA S actions until 08/07/24, (five days later), when Housekeeping/CNA U reported the incident to her and Administrative Staff A. Administrative Nurse D reported Housekeeping/CNA U said she got busy and forgot, and should have reported the incident on 08/02/24 at the time of the incident. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/15/24 at 10:35 AM Administrative Staff A reported Housekeeping U reported this incident to her and Administrative Nurse A on 08/07/24, instead of when it occurred, because Housekeeping/CNA U forgot to report the occurrence. Administrative Staff A reported Outside Resource staff EE failed to report what she witnessed with CMA S and R1. The facility's Abuse and Neglect Policy, revised dated 10/2022, documented the facility should ensure the resident is free from neglect, to take precautions to ensure the residents safety and well-being due to responsibility of every employee of the facility report any abuse and/or neglect The facility failed to ensure dependent and cognitively impaired Resident (R) 1 the facility failed to ensure dependent and cognitively impaired Resident (R) 1, who had a diagnosis of dysphagia, ileus and oropharyngeal phase, remain from neglect when Housekeeping U and Outside Resource Staff EE failed to report to Administrative Staff A that Certified Medication Aide S continued to administer R1's morning medications despite R1's request to slow down because she was had a difficult time swallowing. When CMA S left the room, CMA S told R1 there you're done now you can quit your crying.