STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175275	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Kinsley	620 Winchester Avenue Kinsley, KS 67547

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. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(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	The facility reported a census of 24 residents, with four residents reviewed for abuse. Based on observation, interview, and record review, the facility failed to ensure Resident (R) 1 remained free from verbal abuse and mistreatment. This deficient practice placed the resident at risk for fear and decreased quality of life.Findings included:- R1's Electronic Health Record (EHR) documented diagnoses that included unspecified dementia (a progressive mental disorder characterized by failing memory and confusion).R1's 12/13/24 Significant Change Minimum Data Set (MDS) documented a Brief Interview of Mental Status (BIMS) score of seven, which indicated severely impaired cognition. The assessment documented R1 utilized a wheelchair for locomotion and was dependent on staff for shower/bathing and toileting hygiene. R1 required substantial/maximal assistance for all other cares except eating, which was performed independently. The assessment documented R1 was frequently incontinent of bowel and bladder.The 12/13/24 Delirium CAA documented R1 was unable to focus attention and had disorganized thoughts.The 12/13/24 ADL Functional / Rehabilitation Potential CAA documented R1 needed assistance from staff.R1's 03/14/25 Quarterly MDS documented a BIMS score of 99 which indicated the assessment could not be completed. Staff assessed R1 to have memory problems with moderately impaired cognition. The assessment documented R1 was dependent on staff for shower/bathing and toileting hygiene. R1 required substantial/maximal assistance for all other cares except eating, which required setup/cleanup assistance. R1 was frequently incontinent of bowel and bladder.The EHR Progress Notes tab reviewed from 06/04/25 to 07/02/25 lacked documentation of the incident on 06/08/25.The facility's investigation documented on 06/08/25 at approximately 01:30 AM, Certified Nurse Aide (CNA) M and CNA O provided incontinence care to R1. R1 had feces on one hand, and when CNA O attempted to clean R1's hand, R1 reached for CNA M. CNA O reported that CNA M threatened R1 with physical violence if he touched her. CNA O informed CNA M that the speech was inappropriate and asked CNA M to leave the room.CNA O's undated and unnotarized Witness Statement documented on (the night of) 06/07/25, R1 had a loose bowel movement in bed, and CNA M and CNA O went into R1's room to clean him up. CNA O documented that CNA M was assisting R1 with standing so CNA O could clean the bed and the resident. CNA O documented CNA M said, If you touch me with that hand, I will head butt you to R1. CNA O documented that she informed CNA M that she could not say that to a resident.The facility did not obtain a witness statement from CNA M.During an observation on 07/02/25 at 11:40 AM, R1 self-propelled in his wheelchair in the front lobby of the building without an apparent destination.During an interview on 07/02/25 at 11:40 AM, R1 was unable to answer questions, responding with rambling speech. He indicated he wanted to go fishing after attending religious services.On 07/02/25 at 11:00 AM, CNA O was unavailable for interview, and no contact information was provided by the facility.During an interview on 07/02/25 at 11:30, CNA N revealed if she observed another staff member saying or doing anything inappropriate to a resident, she would intervene and ensure resident was safe then immediately report to the charge nurse, Administrative Staff A or Administrative Nurse D. CNA N confirmed education was provided by leadership staff since the incident that occurred on 06/08/25.During an interview on 07/02/25 at 11:42 AM, Certified Medication Aide (CMA) R revealed if they observed another staff saying or doing anything inappropriate to a resident, they would intervene and ensure the resident remained safe and then immediately report to the charge nurse, Administrative Nurse D or Administrative Staff A. CMA R confirmed education was provided by leadership since the incident that occurred 06/08/25.During an interview on 07/02/25 at 11:45 AM, Maintenance U revealed if another staff member was observed saying or doing anything inappropriate to a resident, he would intervene and ensure the resident was safe, then immediately report to Administrative Staff A. Maintenance U confirmed education had been provided by leadership since the incident that occurred on 06/08/25.During an interview on 07/02/25 at 11:50 AM, Dietary BB revealed if another staff was observed saying or doing anything inappropriate to a resident, their immediate reaction depended on what happened and would report the concern immediately to her supervisor and/or Administrative Staff A. Dietary BB revealed that no education had been provided by leadership since the incident on 06/08/25.During an interview on 07/02/25 at 11:55 AM, Dietary CC revealed if she witnessed anything she suspected was inappropriate, she would immediately report the situation to her supervisor and/or Administrative Staff A. Dietary CC revealed no education had been provided by leadership since the incident on 06/08/25.During an interview on 07/02/25 at 11:56 AM, Laundry W revealed if she saw or heard anything that she thought was inappropriate towards a resident, she would immediately report the situation to

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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. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility reported a census of 24 residents, with four residents reviewed for abuse. Based on observation, interview and record review, the facility failed to report an allegation of abuse for one resident, Resident (R) 1 when on 06/08/24 at approximately 01:30 AM, Certified Nurse Aide (CNA) M verbally threatened R1 with physical violence was witnessed by CNA O, however the incident was not reported to Administrative Nurse D until 06/11/25 at approximately 02:00 PM. This deficient practice allowed CNA M to work an additional three shifts, which had the potential to have a negative psychosocial impact for the residents in the facility.Findings included:- R1's Electronic Health Record (EHR) documented diagnoses that included unspecified dementia (a progressive mental disorder characterized by failing memory and confusion).R1's 12/13/24 Significant Change Minimum Data Set (MDS) documented a Brief Interview of Mental Status (BIMS) score of seven, which indicated severely impaired cognition. The assessment documented R1 utilized a wheelchair for locomotion and was dependent on staff for shower/bathing and toileting hygiene. R1 required substantial/maximal assistance for all other cares except eating, which was performed independently. The assessment documented R1 was frequently incontinent of bowel and bladder. The 12/13/24 Delirium CAA documented R1 was unable to focus attention and had disorganized thoughts.The 12/13/24 ADL Functional / Rehabilitation Potential CAA documented R1 needed assistance from staff.R1's 03/14/25 Quarterly MDS documented a BIMS score of 99, which indicated the assessment could not be completed. Staff assessed R1 to have memory problems with moderately impaired cognition. The assessment documented R1 was dependent on staff for shower/bathing and toileting hygiene. R1 required substantial/maximal assistance for all other cares except eating, which required setup/cleanup assistance. R1 was frequently incontinent of bowel and bladder. The EHR Progress Notes tab reviewed from 06/04/25 to 07/02/25 lacked documentation of the incident on 06/08/25.The facility's investigation documented on 06/08/25 at approximately 01:30 AM, Certified Nurse Aide (CNA) M and CNA O provided incontinence care to R1. R1 had feces on one hand, and when CNA O attempted to clean R1's hand, R1 reached for CNA M. CNA O reported that CNA M threatened R1 with physical violence if he touched her. CNA O informed CNA M the speech was inappropriate and asked CNA M to leave the room. CNA O's undated and unnotarized Witness Statement documented on (the night of) 06/07/25, R1 had a loose bowel movement in bed, and CNA M and CNA O went into R1's room to clean him up. CNA O documented that CNA M was assisting R1 with standing so CNA O could clean the bed and the resident. CNA O documented CNA M said, If you touch me with that hand, I will head butt you to R1. CNA O documented she informed CNA M that she could not say that to a resident. The facility did not obtain a witness statement from CNA M.Review of the facility's staffing schedule revealed CNA M worked 06/07/25, 06/08/25, 06/09/25, and 06/10/25. During an observation on 07/02/25 at 11:40 AM, R1 self-propelled in his wheelchair in the front lobby of the building without an apparent destination.During an interview on 07/02/25 at 11:40 AM, R1 was unable to answer questions, responding with rambling speech. He indicated he wanted to go fishing after attending religious services. On 07/02/25 at 11:00 AM, CNA O was unavailable for interview, and no contact information was provided by the facility.During an interview on 07/02/25 at 11:30 AM, CNA N revealed if she observed another staff member saying or doing anything inappropriate to a resident, she would intervene and ensure resident was safe then immediately report to the charge nurse, Administrative Staff A or Administrative Nurse D. 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