

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175290	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/09/2024
NAME OF PROVIDER OR SUPPLIER Medicalodges Coffeyville on Midland		STREET ADDRESS, CITY, STATE, ZIP CODE 2921 W 1st Street Coffeyville, KS 67337	
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)		
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41121</p> <p>The facility reported a census of 72 residents with four residents sampled and one resident reviewed for neglect. Based on observation, interview, and record review, the facility failed to prevent the neglect of cognitively impaired Resident (R)2, who displayed a recent increase in behaviors. On 08/26/24 at 10:12 PM, Licensed Nurse (LN) G completed a skin assessment on R2 and documented her skin as clean, dry, intact, and without new skin conditions. On 08/27/24 at 10:45 AM, staff observed blood on a tissue after wiping R2 and failed to notify the LN in charge of R2's care. On 08/27/24 at 11:15 AM, Social Service Staff X and Administrative Staff B took R2 out of town to a senior behavioral unit. Upon arrival to the emergency room, R2 expressed the need to use the bathroom and when assisted by facility staff, R2's brief had two dime size spots of blood in it, and she had blood at the front of her peri-area. On 08/27/24 at 02:45 PM, hospital staff began a skin assessment on R2 after she arrived at the behavioral intake area from the emergency room. The assessment revealed R2 had multiple areas of bruising, bleeding, and genital trauma (possible indicators of sexual assault). On 08/27/24 at 08:30 PM, Consultant Staff GG performed a sexual assault examination, which revealed R2 had possible sexual and genital trauma, was having a bloody discharge, had evidence of abrasions to her major and minor labia, evidence of possible penetration, and vaginal edema. Prior to 08/27/24, R2 had increased behaviors, however, the multiple areas of bruising, bleeding, and genital trauma (possible indicators of sexual assault) for R2 were not discovered until they were observed by the hospital staff on 08/27/24, one day after the LN documented no skin issues. This deficient practice placed R2 in immediate jeopardy for neglect and a negative psychosocial impact to R2's sense of safety, protection, health, and well-being.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - The Medical Diagnosis tab for R2 included diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), cognitive communication deficit, muscle weakness, major depressive disorder (major mood disorder which causes persistent feelings of sadness), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). <p>(continued on next page)</p>		

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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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The Admission Minimum Data Set, dated dated dated [DATE], assessed R2 with a Brief Interview for Mental Status score of five, indicating severe cognitive impairment. She did not reject cares and had behaviors symptoms directed towards others that did not interfere with care or put her at risk for significant illness or injury for one to three days of the assessment period. R2 used a walker for mobility and required partial/moderate staff assistance for walking up to 50 feet, transfers, lower body dressing/undressing, and setup assistance for upper body dressing/undressing. R2 was frequently incontinent of urine, occasionally incontinent of bowel, and she did not have any skin issues.</p> <p>The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 07/03/24, revealed R2 had recall deficits with a contributing factor of dementia and risk factors, which included self-care deficits, falls, injuries, incontinence, decreased socialization, and skin breakdown.</p> <p>The Functional Abilities CAA dated 07/03/24, revealed R2 required assistance with her activities of daily living (ADLs) with contributing factors of generalized weakness and decreased safety awareness with risk factors of further ADL decline, falls, incontinence, and skin breakdown.</p> <p>The Urinary Incontinence and Indwelling Catheter CAA dated 07/03/24, revealed R2 had incontinent episodes and required assistance with toileting.</p> <p>The Behavioral Symptoms CAA dated 07/03/24, revealed R2 had dementia and wandered with risk factors of injuring self/others, decreased socialization, and anxiety.</p> <p>The Pressure Ulcer/Injury CAA dated 07/03/24, revealed a LN was to assess R2's skin each week and put in proper interventions to prevent skin breakdown., Caregivers were to assess R2's skin with each bath and when dressing her. The staff were to notify the physician of any abnormal findings.</p> <p>The Care Plan dated 07/03/24, revealed R2 required staff assistance with ADLs related to physical limitations. R2 required psychotropic (alters mood or thought) medications, which included an antianxiety (class of medications that calm and relax people) for restlessness, and an antidepressant (class of medications used to treat mood disorders) for self-isolation. On 08/09/24, the facility added R2 often made statements about the building burning down or some other emergency occurring. On 08/23/24, the facility added R2 required an antipsychotic (class of medications used to treat major mental conditions which cause a break from reality) for behaviors of continuous screaming or yelling, negative delusions, and extreme fear.</p> <p>The Licensed Medication Administration Record (MAR) for August 2024, revealed R2's physician order for as needed (PRN) Ativan (antianxiety medication) changed from every 24 hours to every four hours as needed for anxiety on 08/11/24. R2 continued to have an order for scheduled Ativan twice daily.</p> <p>The Progress Notes dated 08/12/24 at 01:40 AM, by LN I revealed R2 attempted to rise from a sitting position in a recliner with the footrest extended, leaned forward, and fell to the floor. The fall note lacked documentation noting any injuries that occurred from the fall.</p> <p>The Skin Condition Note dated 08/19/24 at 02:42 PM, by LN L revealed R2's skin was clean, dry, intact, and the resident had no new skin issues.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The facility CNA Schedule dated 08/08/24 through 09/04/24 revealed no male staff on duty on 08/26/24 from 10:00 PM to 06:00 AM.</p> <p>The facility Witness Statement dated 09/03/24, by CNA M, revealed on 08/27/24, CNA N and CNA M assisted R2 to the bathroom around 10:45 AM. When CNA M wiped R2, she observed blood so she reported to the nurse (lacked name) who came in and observed R2, stating it may be her hemorrhoids on her rectum.</p> <p>The facility Witness Statement undated, by LN H revealed on 08/27/24 the staff (lacked name) called her into the bathroom and reported when they wiped R2 they witnessed some blood. LN H assessed R2's rectum and observed what appeared to be a hemorrhoid and LN H did not see any blood at that time.</p> <p>The facility Witness Statement undated, by Administrative Staff B, revealed on 08/27/24, she assisted R2 with Social Service Staff X in the restroom, noticed a small amount of blood in her brief, assisted with wiping once R2 had finished, and discovered red blood. Administrative Staff B asked Social Service Staff X to trade places so she could do a skin assessment to see if R2 had any sores or open areas and Social Service Staff X noted blood, but no sores or wounds. After cleaning R2 up, Administrative Staff B and Social Service Staff X informed behavioral unit Consultant Staff MM of the discovery.</p> <p>The facility Witness Statement undated, by Social Service Staff X, revealed on 08/27/24 upon arrival to the emergency room (lacked time) for R2's admission to the behavioral unit, R2 was assisted to the bathroom per her request by Social Service Staff X and Administrative Staff A. When changing R2's brief, there were two small blood spots in her brief. Social Service Staff X looked for any sore spots on R2 and found none. R2 had a small amount of blood dripping from her vaginal area, and they passed that information on to behavioral unit Consultant Staff MM.</p> <p>Observation, on 09/03/24 at 11:32 AM, revealed R2's room to be located approximately 25 feet from the nurse's station, her bed was made, and a wheelchair was parked next to the bed. R2 had a roommate according to signage by the room door. No residents were in the room at this time. R2 had not returned to the facility.</p> <p>On 09/03/24 at 02:54 PM, Consultant Staff JJ stated R2 came from the emergency room to the intake area at 02:45 PM, and when she started to do a skin assessment, she noticed some bruising. Consultant Staff JJ stated she found redness and bruising to R2's right breast, redness in between her inner thigh creases, purple/black/blue bruising on her labia, redness near her anus, bruising to her right and left great toes, swelling and a knot to her right cheek, and bruising to both knees. Consultant Staff JJ stated when emergency room staff pulled down R2's pants to perform a straight catheter, there was bright red blood in R2's brief and a smell I cannot describe so Consultant Staff JJ started looking for wounds. R2 had what appeared to be an open wound on the right labia and she did not touch the area until Consultant Staff GG could examine. Consultant Staff JJ stated when she received report from the facility nurse taking care of R2 (could not recall who), it was reported R2 had no skin issues.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The facility policy Abuse, Neglect and Exploitation dated October 2022 revealed it was the policy of the facility to keep residents free from abuse and neglect. The resident had the right to be free from verbal, sexual, physical and mental abuse. Sexual abuse included, but was not limited to, sexual harassment, sexual coercion, or sexual assault. The policy documented neglect was the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Neglect occurs on an individual basis when a resident receives lack of care in one or more areas.</p> <p>The facility failed to prevent the neglect of cognitively impaired R2 who had multiple areas of bruising and redness, bleeding, and genital trauma observed and discovered by hospital staff on 08/27/24, less than 17 hours after the facility LN documented no skin issues for R2. The presence of R2's bruising, bleeding, and genital trauma prompted completion of a sexual assault kit by the hospital staff. This deficient practice placed R2 in immediate jeopardy.</p> <p>On 09/05/24 at 04:28 PM, Administrative Staff A was provided a copy of the Immediate Jeopardy template and notified of the facility's failure to prevent neglect of R2 when hospital staff observed and identified multiple areas of bruising and redness, bleeding and genital trauma on 08/27/24 at 02:45 PM, less than 17 hours after the facility assessed R2's skin to be clean, dry, intact, and with no new skin issues.</p> <p>The facility provided an acceptable plan for removal of the immediacy on 09/05/24 at 06:43 PM which included the following:</p> <ol style="list-style-type: none"> 1. R2 admitted to the hospital on 08/27/24. 2. R2's responsible party contacted on 09/03/24 at 11:52 AM and had already been made aware by the police department. 3. The facility contacted R2's physician on 09/03/24 at 10:05 AM. 4. The facility began interviewing staff and residents on 09/03/24 for any indications of abuse and neglect. 5. Staff in-service began on 09/03/24 on abuse, neglect and exploitation and education completed on 09/05/24 by 05:00 PM. 6. On 09/03/24 the facility held a quality assurance performance improvement (QAPI) meeting. 7. Starting on 09/05/24 at 05:30 PM, the facility educated staff to provide care in pairs for all residents until further notice and initiated immediately. 8. A skin sweep of all residents in the building initiated on 09/05/24 with care plans revised and physician and responsible party notified with any findings from assessments. 9. R2's responsible party informed the facility on 09/05/24 that R2 would not be returning. 10. On 09/05/24 the facility held a resident council meeting to review abuse, neglect, and exploitation. <p>(continued on next page)</p>		

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