STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175290	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Coffeyville on Midland	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)
F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to complete an annual performance review at least once every 12 months for two Certified Nurse Aides (CNAs) reviewed, to ensure adequate appropriate cares and services provided to the residents of the facility. Findings included:- Review of employee files on 04/08/26 at 03:52 PM revealed a lack of performance evaluations or skills check-off for two Certified Nurse Aides (CNAs), CNA OO and CNA PP. CNA OO had a date of hire of 11/10/23, and CNA PP had a date of hire of 07/29/24. On 04/08/26 PM, Administrative Staff A and Administrative Nurse D confirmed the employee evaluation documents provided to the survey team did not contain performance evaluations for CNA OO and CNA PP. Administrative Staff A stated she expected performance evaluations to be performed annually. The facility did not provide a policy related to annual performance evaluations as requested on 04/09/26.

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to store and prepare food in the kitchen under sanitary conditions which placed the residents of the facility at risk for food borne illnesses. Findings included:- The initial tour of South Kitchen on 04/06/2026 at 08:44 AM, with Dietary Staff DD identified the following concerns:A handwashing sink and backsplash area had grime build-up.One double-door freezer lacked an internal thermometer. The Resource Refrigerator/Freezer Temperature Log signage on the freezer door included the temperature recorded for 04/06/26 as 20 degrees Fahrenheit (F) by Dietary Staff DD. Grime build-up in the alcove of the kitchen along the baseboard.Dry storage with bread unsealed and unlabeled.Refrigerator with two unsealed and unlabeled ham spread sandwiches.Two unlabeled salad dressing bottles.Unlabeled container of pancake batter with congealed white batter on the outside of the container.Unlabeled and unsealed bread/buns bag with two buns missing.Sanitizing strips are unavailable in the south kitchen upon request.Two unlabeled bags of potato chips were on a rack in the dry storage room. An open and undated bag of Cheetos.Plate covers stored on a storage room rack were not inverted, which allows debris to fall in.Two Fryer drop baskets were dirty; the fryer had oil in it with old fried food bits/pieces floating in it, covering the entire surface of the cooking oil in the fryer. Food pieces were also on the sides and outside of the fryer. The dipping spatula was greasy and dirty. The floor had dirt, grease, and food debris. The spike metal can opener had rust and debris on the spike that goes directly into the can and the adjacent mounting bracket.The ice machine had hard water and calcium build-up on the outside of the machine, and there were holes on the outer front-left surface of the ice chest. A cart labeled as clean only was sitting next to the ice machine, with an ice chest on the top shelf for passing ice to residents. The two bottom shelves of the cart were dirty and had food debris, dirty napkins, and unsheathed straws for drinking on the two bottom shelves. Dietary staff DD stated that food should be sealed and labeled with dates to ensure freshness and to prevent foodborne illnesses for residents. Additionally, he stated each refrigerator/freezer unit should have internal thermometers to monitor the temperature of the food to ensure the food remained fresh and did not spoil. Temperatures of those appliances should be checked daily and logged in on the individual appliance temperature log. He confirmed he had recorded the freezer temp on the Freezer temperature lag from another freezer, and not the temperature of that appliance, which was wrong. Additionally, she stated open food should be labelled, dated, and in sealed containers before storing the food item for further use to ensure the food remains fresh and safe for resident consumption. During the tour of the North Kitchen on 04/07/2026 at 10:32 AM, Dietary Staff CC identified the following concerns:Dietary Staff CC noted with a beard and no hair restraint, entering the kitchen food prep area.Deep Fat Fryer outside panel with grease build-up on the outside, measuring approximately two feet by four inches Food steamer with multiple crumbs at the bottom of the steamer door.The area to the left of the sink, next to the puree, has food debris all around the sink and on the counter next to the sink.A wooden board (approximately 18 inches) behind the faucet of the sink was dirty, stained, and wet, with a rusty tool for the garbage disposal lying on the sink. The counter was very dirty with food debris underneath, in front, to the sides, and behind the large, rectangular electric food steamer. On 04/07/2026 at 12:01 PM, Dietary Staff CC entered the North kitchen without a beard guard. He stood over the steam table and checked the temperature of the food, then Dietary Staff BB checked the temperature of the food in the steam table. Dietary Staff BB directed Dietary Staff CC to apply an appropriate beard guard/restraint. On 04/08/2026 at 02:20 PM, Dietary Staff BB stated all dietary staff should wear a beard guard if they have facial hair while in the kitchen. Stored food should be dated, labeled, and sealed, and expired food should be disposed of once it is past the use-by/expiration date. Dietary Staff BB also revealed that the maintenance and cleaning of the fryer is done by kitchen staff. Additionally, she stated staff should ensure a thermometer is maintained in (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	each cooling unit and record the individual temperature in the unit on their separate log. Furthermore, the hospitality aids are responsible for cleaning the dirty cart by the ice maker near the South Kitchen, and the nursing aides are responsible for passing water to the residents. The Facility policy titled Food Storage (Dry, Refrigerated, and Frozen dated 2016 and Hair Restraints, dated 2011. The document included:Food shall be stored on shelves in a clean, dry area, free from contaminants. Food shall be stored at appropriate temperatures and using appropriate methods to ensure the highest level of food safety. All food items will be labelled to include the name of the food and the date by which it should be consumed or discarded. Follow and adhere to the guidance regarding proper storage temperatures and maximum length of storage. Place internal hanging thermometers in the warmest part of the refrigerator.Additionally, Staff should wear hair restraints in all food preparation and serving areas to prevent hair from contacting exposed foods.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide appropriate activity of daily living (ADL) cares to Resident (R)39 regarding an unshaven face, dried food on face and jagged, dirty fingernails; R6 regarding an unshaven face; R44 regarding an unshaven face and dirty clothing and R51 regarding jagged, dirty fingernails. Findings included:- R6's Electronic Medical Record (EMR) documented a diagnosis of dementia (a progressive mental disorder characterized by failing memory and confusion). R6's Annual Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of nine, indicating moderately impaired cognition. He required substantial to maximal staff assistance for showering and personal hygiene. R6's Activity of Daily Living (ADL) Care Area Assessment (CAA), dated 10/24/25, documented the resident required substantial assistance of staff for bathing and personal hygiene. R6's Quarterly MDS, dated [DATE], documented the resident had a BIMS score of five, indicating severe cognitive impairment. He required substantial to maximal staff assistance with bathing and personal hygiene. R6's Care Plan, revised 01/16/26, instructed staff he had a diagnosis of dementia and required substantial assistance in the completion of ADLs. R6's EMR from 03/06/26 through 04/06/26 documented he required substantial/maximal assistance with personal hygiene. On 04/06/26 at 10:11 AM, the resident had long facial whiskers. On 04/07/26 at 08:30 AM, the resident remained with long facial whiskers. On 04/07/26 at 08:46 AM, Certified Nurse Aide (CNA) NN stated residents are to be shaven on their shower days, but the task does not always get done. CNA NN confirmed the resident needed to be shaved. On 04/08/26 at 09:43 AM, CNA O stated the residents did not always get shaven on their shower days. On 04/07/26 at 08:50 AM, Licensed Nurse (LN) G stated residents were to be shaven on shower days, but it did not always happen. On 04/06/26 at 01:30 PM, Administrative Nurse D stated residents were to be shaven on their shower days and as needed (PRN). The facility policy Your Rights and Protections as a Nursing Home Resident, undated, included: Residents have the right to be treated with dignity and respect. - R51's Electronic Medical Record (EMR) documented a diagnosis of dementia (a progressive mental disorder characterized by failing memory and confusion). R51's Annual Minimum Data Set (MDS), dated [DATE], documented the staff cognitive assessment revealed severe cognitive impairment. She was dependent on staff for personal hygiene. R51's Activity of Daily Living Care Area Assessment (CAA), dated 09/25/25, did not trigger. R51's Quarterly MDS, dated [DATE], documented the staff cognitive assessment revealed severe cognitive impairment. She was dependent on staff for personal hygiene. R51's Care Plan, revised 03/20/26, instructed staff to trim the resident's fingernails weekly. On 04/06/26 at 09:47 AM, the resident sat in her recliner in the commons area. Her fingernails were jagged and dirty. On 04/07/26 at 08:35 AM, the resident sat in her recliner in the commons area. Her fingernails were jagged and dirty. On 04/07/26 at 08:46 AM, Certified Nurse Aide (CNA) NN stated residents were to have their fingernails always trimmed, kept smooth, and clean. On 04/08/26 at 09:43 AM, CNA O stated staff were to clean, trim, and file the resident's fingernails at least weekly. On 04/07/26 at 08:50 AM, Licensed Nurse (LN) G stated residents were to have clean, smooth fingernails. On 04/06/26 at 01:30 PM, Administrative Nurse D stated staff were to ensure residents' fingernails were always kept clean and smooth. The facility policy Your Rights and Protections as a Nursing Home Resident, undated, included: Residents have the right to be treated with dignity and respect. - R44's Electronic Medical Record (EMR) documented a diagnosis of dementia (a progressive mental disorder characterized by failing memory and confusion). R44's Significant Change Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of nine, indicating moderately impaired cognition. He was dependent on staff for his Activities of Daily Living (ADL). R44's ADL Care Area Assessment (CAA), dated 08/21/25, documented the resident required substantial assistance of staff for bathing and personal hygiene. R44's Quarterly MDS, dated [DATE], documented the resident had a (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Medicalodges Coffeyville on Midland		STREET ADDRESS, CITY, STATE, ZIP CODE 2921 W 1st Street Coffeyville, KS 67337	

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Brief Interview for Mental Status (BIMS) score of five, indicating severely impaired cognition. He was dependent on staff for his Activities of Daily Living (ADL). On 04/06/26 at 10:23 AM, the resident sat in his recliner in the commons area. His face was unshaven, and he had dried-on food debris on the front of his t-shirt. On 04/06/26 at 02:07 PM, the resident's face remained unshaven, and he continued to have dried-on food debris on the front of his t-shirt. On 04/07/26 at 08:46 AM, Certified Nurse Aide (CNA) NN stated residents were to be shaven on their shower days, but the task does not always get done. CNA NN confirmed the resident needed to be shaven and was wearing a t-shirt with dried-on food substance on the front. On 04/08/26 at 09:43 AM, CNA O stated the residents did not always get shaven on their shower days, and their clothes would be changed anytime they were dirty. On 04/07/26 at 08:50 AM, Licensed Nurse (LN) G stated residents were to be shaven on shower days, but it did not always happen. The staff should make sure the residents have clean clothes. On 04/06/26 at 01:30 PM, Administrative Nurse D stated residents were to be shaven on their shower days and as needed (PRN), as well as have their clothes changed when dirty. The facility policy Your Rights and Protections as a Nursing Home Resident, undated, included: Residents have the right to be treated with dignity and respect. - R39's Electronic Medical Record (EMR) documented a diagnosis of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure). R39's Annual Minimum Data Set (MDS), dated [DATE], documented the staff assessment revealed severe cognitive impairment. He was dependent on staff for personal hygiene. R39's Activity of Daily Living (ADL) Care Area Assessment (CAA), dated 12/31/25, documented the resident required staff assistance with completing ADLs. R39's Quarterly MDS, dated [DATE], documented the staff assessment revealed severe cognitive impairment. He was dependent on staff for personal hygiene. R39's Care Plan, revised 03/20/26, instructed staff the resident was dependent for completion of personal hygiene tasks. Staff were to offer to shave the resident when showering. R39's EMR from 03/06/26 through 04/06/26 documented he required substantial/maximal assistance with personal hygiene. On 04/06/26 at 10:07 AM, the resident was unshaven, and he had jagged, dirty fingernails. On 04/07/26 at 02:07 PM, the resident remained unshaven with jagged, dirty fingernails, and he had dried-on food on his face around his mouth. On 04/07/26 at 08:46 AM, Certified Nurse Aide (CNA) NN stated residents are to be shaven on their shower days, but the task does not always get done. CNA NN confirmed the resident needed to be shaven and had jagged, dirty fingernails. On 04/08/26 at 09:43 AM, CNA O stated the residents did not always get shaven on their shower days. Staff were to trim and file residents' fingernails weekly and make sure their faces were clean following meals. On 04/07/26 at 08:50 AM, Licensed Nurse (LN) G stated residents were to be shaven on shower days, but it did not always happen. Staff were to trim and file the resident's fingernails and ensure they had clean faces. On 04/06/26 at 01:30 PM, Administrative Nurse D stated residents were to be shaven on their shower days and as needed (PRN). Staff were also to ensure residents' fingernails were kept clean and smooth, and were to clean residents' faces following meals PRN. The facility policy Your Rights and Protections as a Nursing Home Resident, undated, included: Residents have the right to be treated with dignity and respect.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide a resident specific activity program for Resident (R)4, R6, R39, R44, and R51. Findings included:- R4's Electronic Medical Record (EMR) documented a diagnosis of dementia (a progressive mental disorder characterized by failing memory and confusion). R4's Annual Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 99, indicating severe cognitive impairment. It was very important for her to listen to music she liked, participate in her favorite activities, participate in religious services, and go outside to get fresh air when the weather was good. R4's Activity Care Area Assessment (CAA), dated 12/18/25, did not trigger. R4's Quarterly MDS, dated [DATE], documented the resident had a BIMS score of 99, indicating severe cognitive impairment. R4's Care Plan, revised 03/26/26, lacked staff instruction on the residents' preferred activities. R4's Activity Assessment, completed 03/18/26, documented the resident enjoyed attending church services, parties, watching westerns on TV, and listening to country music. Review of the resident's EMR from 03/06/26 through 04/06/26 documented the resident participated in one activity of a music program on 03/31/26. No other activities were documented. Review of the Activity Calendar on the wall of the memory unit documented the following scheduled activity: 04/06/26 at 02:00 PM, Afternoon Hand and Nail Spa On 04/06/26 at 02:07 PM, the resident rested in her bed with the door to her room shut. The scheduled activity was not provided. On 04/06/26 at 04:23 PM, Certified Nurse Aide (CNA) M stated the fingernail activity did not take place that afternoon. Instead, the staff handed out snacks to the residents. CNA M stated she was unsure why the scheduled activity did not take place, as scheduled. On 04/07/26 at 12:30 PM, Activity Staff Z stated the activities on the memory unit are done by the staff who work on the unit. On 04/07/26 at 12:35 PM, CNA N stated Activity Staff Z was responsible for creating the activity schedule for the memory unit and for ensuring the scheduled activity takes place. CNA confirmed there were not many activities on the memory unit, but staff would always make sure the TV was on for their entertainment. On 04/07/26 at 12:37 PM, Licensed Nurse (LN) G stated the memory unit did not have activities. Staff will pass out snacks each morning and each afternoon, and that was somewhat of an activity. On 04/06/26 at 01:30 PM, Administrative Nurse D stated Activity Staff Z was responsible for planning the activities for the memory unit, and the nurses working on the memory unit were responsible for executing the scheduled activities and documenting them in each resident's EMR. The facility policy for Activities and Resident Rights, dated 10/2019, included: The Activity Department staff are to provide an activity program that provides a positive self-esteem, a sense of well-being, and satisfaction with the facility's active lifestyle. - R51's Electronic Medical Record (EMR) documented a diagnosis of dementia (a progressive mental disorder characterized by failing memory and confusion). R51's Annual Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 99, indicating severe cognitive impairment. It was very important for the resident to listen to music she liked, to do her favorite activities, to participate in religious activities, and to go outside to get fresh air when the weather was good. R51's Activity Care Area Assessment (CAA), dated 12/18/25, did not trigger. R51's Quarterly MDS, dated [DATE], documented the staff assessment for cognition, which revealed severely impaired cognition. R51's Care Plan, revised 03/20/26, lacked staff instruction on the residents' preferred activities. R51's Activity Assessment, completed03/20/26, documented she enjoyed attending church services, attending parties, having visitors, entertainment, and listening to all types of music. Review of the resident's EMR from 03/06/26 through 04/06/26 documented the resident participated in one activity of a music program on 03/31/26. No other activities were documented. Review of the Activity Calendar on the wall of the memory unit documented the following scheduled activity: 04/06/26 at 02:00 PM, Afternoon Hand and Nail Spa On 04/06/26 at 02:07 PM, the resident rested in her recliner in the (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	commons area with her eyes closed. The scheduled activity was not provided. On 04/06/26 at 04:23 PM, Certified Nurse Aide (CNA) M stated the fingernail activity did not take place that afternoon. Instead, the staff handed out snacks to the residents. CNA M stated she was unsure why the scheduled activity did not take place, as scheduled. On 04/07/26 at 12:30 PM, Activity Staff Z stated the activities on the memory unit are done by the staff who work on the unit. On 04/07/26 at 12:35 PM, CNA N stated Activity Staff Z was responsible for creating the activity schedule for the memory unit and for ensuring the scheduled activity takes place. CNA confirmed there were not many activities on the memory unit, but staff would always make sure the TV was on for their entertainment. On 04/07/26 at 12:37 PM, Licensed Nurse (LN) G stated the memory unit did not have activities. Staff will pass out snacks each morning and each afternoon, and that was somewhat of an activity. On 04/06/26 at 01:30 PM, Administrative Nurse D stated Activity Staff Z was responsible for planning the activities for the memory unit, and the nurses working on the memory unit were responsible for executing the scheduled activities and documenting them in each resident's EMR. The facility policy for Activities and Resident Rights, dated 10/2019, included: The Activity Department staff are to provide an activity program that provides a positive self-esteem, a sense of well-being, and satisfaction with the facility's active lifestyle. - R44's Electronic Medical Record (EMR) documented a diagnosis of dementia (a progressive mental disorder characterized by failing memory and confusion). R44's Significant Change Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 99, indicating severe cognitive impairment. His activity preferences were not assessed. R44's Activity Care Area Assessment (CAA), dated 08/21/25, did not trigger. R44's Quarterly MDS, dated [DATE], documented the resident had a BIMS score of 99, indicating severe cognitive impairment. R44's Care Plan, revised 02/05/26, lacked staff instruction on the residents' preferred activities. R44's Activity Assessment, completed 02/05/26, documented he enjoyed watching baseball and Westerns on TV, going for walks, and listening to country music. Review of the resident's EMR from 03/06/26 through 04/06/26 documented the resident participated in one activity of a music program on 03/31/26. No other activities were documented. Review of the Activity Calendar on the wall of the memory unit documented the following scheduled activity: 04/06/26 at 02:00 PM, Afternoon Hand and Nail Spa On 04/06/26 at 02:07 PM, the resident sat in his recliner in the commons area with his eyes closed. No scheduled activity was provided. On 04/06/26 at 04:23 PM, Certified Nurse Aide (CNA) M stated the fingernail activity did not take place that afternoon. Instead, the staff handed out snacks to the residents. CNA M stated she was unsure why the scheduled activity did not take place, as scheduled. On 04/07/26 at 12:30 PM, Activity Staff Z stated the activities on the memory unit are done by the staff who work on the unit. On 04/07/26 at 12:35 PM, CNA N stated Activity Staff Z was responsible for creating the activity schedule for the memory unit and for ensuring the scheduled activity takes place. CNA confirmed there were not many activities on the memory unit, but staff would always make sure the TV was on for their entertainment. On 04/07/26 at 12:37 PM, Licensed Nurse (LN) G stated the memory unit did not have activities. Staff will pass out snacks each morning and each afternoon, and that was somewhat of an activity. On 04/06/26 at 01:30 PM, Administrative Nurse D stated Activity Staff Z was responsible for planning the activities for the memory unit, and the nurses working on the memory unit were responsible for executing the scheduled activities and documenting them in each resident's EMR. The facility policy for Activities and Resident Rights, dated 10/2019, included: The Activity Department staff are to provide an activity program that provides a positive self-esteem, a sense of well-being, and satisfaction with the facility's active lifestyle. - R6's Electronic Medical Record (EMR) documented a diagnosis of dementia (a progressive mental disorder characterized by failing memory and confusion). R6's Annual Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of nine, indicating moderately impaired cognition. It was very important for him to take care of his personal belongings, listen to music he likes, and be around animals. R6's Activity Care Area Assessment (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(CAA), dated 12/18/25, did not trigger. R6's Quarterly MDS, dated [DATE], documented the resident had a BIMS score of five, indicating severe cognitive impairment. R6's Care Plan, revised 01/16/26, lacked staff instruction on the residents' preferred activities. R6's Activity Assessment, dated 01/16/25, documented he enjoyed church services, participating in parties, visiting with others, watching westerns on TV, listening to country music, and going outside when the weather was good. Review of the resident's EMR from 03/06/26 through 04/06/26 documented the resident participated in one activity of a music program on 03/31/26. No other activities were documented. Review of the Activity Calendar on the wall of the memory unit documented the following scheduled activity: 04/06/26 at 02:00 PM, Afternoon Hand and Nail Spa 04/06/26 at 02:00 PM, the resident sat at the dining room table. The scheduled activity was not provided. On 04/06/26 at 04:23 PM, Certified Nurse Aide (CNA) M stated the fingernail activity did not take place that afternoon. Instead, the staff handed out snacks to the residents. CNA M stated she was unsure why the scheduled activity did not take place, as scheduled. On 04/07/26 at 12:30 PM, Activity Staff Z stated the activities on the memory unit are done by the staff who work on the unit. On 04/07/26 at 12:35 PM, CNA N stated Activity Staff Z was responsible for creating the activity schedule for the memory unit and for ensuring the scheduled activity takes place. CNA confirmed there were not many activities on the memory unit, but staff would always make sure the TV was on for their entertainment. On 04/07/26 at 12:37 PM, Licensed Nurse (LN) G stated the memory unit did not have activities. Staff will pass out snacks each morning and each afternoon, and that was somewhat of an activity. On 04/06/26 at 01:30 PM, Administrative Nurse D stated Activity Staff Z was responsible for planning the activities for the memory unit, and the nurses working on the memory unit were responsible for executing the scheduled activities and documenting them in each resident's EMR. The facility policy for Activities and Resident Rights, dated 10/2019, included: The Activity Department staff are to provide an activity program that provides a positive self-esteem, a sense of well-being, and satisfaction with the facility's active lifestyle. - R39's Electronic Medical Record (EMR) revealed a diagnosis of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure). R39's Annual Minimum Data Set (MDS), 12/31/25, documented the staff assessment for cognition revealed severe cognitive impairment. It was very important for him to take part in his favorite activities. 39's Activity Care Area Assessment (CAA), dated 12/31/25, did not trigger. R39's Quarterly MDS, dated [DATE], documented the staff assessment for cognition revealed severe cognitive impairment. R39's Care Plan, revised 03/29/26, lacked staff instructions regarding the residents' preferred activities. Review of the resident's EMR from 03/06/26 through 04/06/26 documented the resident participated in one activity of a music program on 03/31/26. No other activities were documented. Review of the Activity Calendar on the wall of the memory unit documented the following scheduled activity: 04/06/26 at 02:00 PM, Afternoon Hand and Nail Spa On 04/06/26 at 02:07 PM, the resident wandered about the unit. The scheduled activity was not provided. On 04/06/26 at 04:23 PM, Certified Nurse Aide (CNA) M stated the fingernail activity did not take place that afternoon. Instead, the staff handed out snacks to the residents. CNA M stated she was unsure why the scheduled activity did not take place, as scheduled. On 04/07/26 at 12:30 PM, Activity Staff Z stated the activities on the memory unit are done by the staff who work on the unit. On 04/07/26 at 12:35 PM, CNA N stated Activity Staff Z was responsible for creating the activity schedule for the memory unit and for ensuring the scheduled activity takes place. CNA confirmed there were not many activities on the memory unit, but staff would always make sure the TV was on for their entertainment. On 04/07/26 at 12:37 PM, Licensed Nurse (LN) G stated the memory unit did not have activities. Staff will pass out snacks each morning and each afternoon, and that was somewhat of an activity. On 04/06/26 at 01:30 PM, Administrative Nurse D stated Activity Staff Z was responsible for planning the activities for the memory unit, and the nurses working on the memory unit were responsible for executing the scheduled activities and documenting them in each resident's EMR. The facility policy for Activities and Resident Rights, dated 10/2019, included: The (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175290	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Coffeyville on Midland	2921 W 1st Street Coffeyville, KS 67337

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Activity Department staff are to provide an activity program that provides a positive self-esteem, a sense of well-being, and satisfaction with the facility's active lifestyle.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide privacy for Resident (R)4, while she was in her room in bed. Findings included:- R4's Electronic Medical Record (EMR) documented a diagnosis of dementia (a progressive mental disorder characterized by failing memory and confusion). R4's Annual Minimum Data Set (MDS), dated [DATE], documented the staff assessment for cognition revealed severe cognitive impairment. She was dependent on staff for all Activities of Daily Living (ADL). R4's ADL Care Area Assessment (CAA), dated 12/18/25, did not trigger. R4's Quarterly MDS, dated [DATE], documented the staff assessment for cognition revealed severe cognitive impairment. She was dependent on staff for all ADLs. R4's Care Plan, revised 03/26/26, instructed staff she was dependent on staff for all ADLs. On 04/06/26 at 10:03 AM, the resident rested in her bed, covered with blankets, and the door to her room was open to the hallway. R39 wandered into R4's room and began to move around the blankets covering her on the bed. License Nurse (LN) H assisted R39 out of R4's room when she received a report of R39 being in R4's room. On 04/06/26 at 04:23 PM, Certified Nurse Aide (CNA) M stated the residents were allowed to ambulate wherever they liked on the memory unit. On 04/06/26 at 10:03 AM, LN H stated on the memory care unit residents were permitted to go wherever they wanted. There were no boundaries for wandering on the unit. On 04/06/26 at 01:30 PM, Administrative Nurse D stated the idea of the memory care unit was to allow residents to wander wherever they wanted even if it meant going into and out of other resident rooms. The facility policy for Activities and Resident Rights, dated 10/2019, included: Resident dignity and privacy are to be respected.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide Resident (R) 3, and R7 a written notification of transfer to the resident and/or his representative as soon as practicable and failed to send a copy of that notification to the ombudsman. Findings included: - R3's Electronic Health Record (EHR) documented diagnoses that included dementia (a progressive mental disorder characterized by failing memory and confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) R3's Discharge – Return Anticipated Minimum Data Set (MDS) dated [DATE] documented R1 had an unplanned discharge from the facility to a hospital on [DATE]. The EHR Progress Notes documented: On 01/11/26 at 05:42 PM, a Nurse's Note documented R3 was admitted to the hospital with a right hip fracture (broken bone) On 01/12/26 at 01:17 PM, a Social Service Progress Note documented the care plan meeting scheduled for the next day was cancelled due to the resident being in the hospital. R3's EHR Misc tab lacked evidence that the facility provided a written bed-hold documentation to R3 or R3's representative. On 04/07/26 at 04:20 PM, Licensed Nurse (LN) J stated that when a resident is transferred out from the facility, nursing staff has no part in giving the resident or the resident's representative a bed hold and that process is handled by someone in social services, but she wasn't sure who. On 04/07/26 at 04:30 PM, Social Services Y, Administrative Nurse D, and Administrative Staff A stated Administrative Staff C issued the bed-hold notices to residents or residents' representatives upon transfers or discharges. On 04/07/26 at 04:40 PM, Administrative Staff C stated she was notified via the dashboard in the EHR when a resident was transferred or discharged from the facility. Administrative Staff C stated she would fill out a bed-hold and then would give it to the resident or the resident's representative when they returned to the facility and obtained a signature then. If the resident didn't return to the facility after a couple of days, Administrative Staff C said she would mail the bed-hold to the resident's representatives with a self-addressed-stamped-envelope (SASE) for the representative to return the signed form to the facility. The facility's Notice of Bed Hold Policy and Returns policy, dated 12/14/17, documented the facility would provide a written notice to residents, residents' family members, or residents' representatives at the time of admission and again at the time of transfer to a hospital or therapeutic leave. The policy documented the charge nurse would send a blank Notice of Bed Holdy Policy and Returns with the resident at the time of discharge, and within 24 hours, administration staff would attempt to contact the resident or a responsible party to complete the form. The policy also documented the facility staff were expected to document multiple attempts to reach the resident or their representative and (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	document the attempts on the form. R7's Electronic Medical Record (EMR) revealed a diagnosis of dementia (a progressive mental disorder characterized by failing memory and confusion), Stage 2 (partial-thickness skin loss into but no deeper than the dermis, including intact or ruptured blisters), and congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid). R7's Nurse's Note dated 12/06/25 at 12:03 PM documented R7 had a temperature and was short of breath when he moved. R7 had chest pain when breathing. The on-call doctor gave the order to send him to the hospital. R7's Nurse's Note dated 12/06/25 at 06:08 PM documented R7 was admitted to the hospital with pneumonia (an infection in the lungs). R7's Nurse's Note dated 02/12/26 at 11:44 AM documented R7 became pale and weak and was diaphoretic (sweating heavily). R7 was not responsive for about 10 seconds. He was drooling. Vital signs were taken, and he had low blood pressure. The doctor gave the order to transfer R7 to the hospital. R7's Nurse's Note dated 02/12/26 at 05:00 PM documented R7 was admitted to the hospital for Pneumonia. R7's EMR lacked documentation of a written notification to the residents and/or the representative, which explained the reason for the transfer to the hospital. On 04/07/26 at 03:02 PM, Social Services X stated that the business office manager is the person who got the Bed Hold signed. Social Services X said she was unaware of the regulation to notify the residents in writing of the reason for the transfer. They did notify the ombudsman of transfers. On 04/08/26 at 02:15 PM, Administrative Nurse D and Administrative Staff A stated the bed hold should be completed and signed when a person was transferred out of the facility. Administrative Staff A said the facility does not notify the residents' representative in writing of a discharge or transfer. On 04/08/25 at 10:55 AM, Administrative Nurse D stated the facility did not have a discharge policy.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record reviews, the facility failed to ensure adequate catheter care within the standards of practice was provided for Resident (R) 59 when staff failed to secure the catheter tubing to R59's thigh to prevent pulling and/or dislodgement and also failed to empty the catheter bag before getting too full, to prevent catheter-related urinary tract infections (UTI). Findings included:- R59's Electronic Medical Record (EMR) from the Diagnosis tab documented Alzheimer's Disease (progressive mental deterioration characterized by confusion and memory failure), chronic kidney disease-stage three (CKD), benign prostatic hyperplasia (BPH-non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency, and urinary tract infections), atrial fibrillation (rapid, irregular heartbeat), obstructive uropathy, neurogenic bladder and weakness. The Quarterly Minimum Data Set (MDS), dated [DATE], documented a Brief Interview of Mental Status (BIMS) score of 13, which indicated minimally impaired cognition. The MDS documented R59 had an indwelling catheter during the observation period. The Functional Abilities Care Area Assessment (CAA) dated 03/18/26 documented staff assistance was required with activities of daily living (ADLs) due to R59's physical limitations and decreased safety awareness. The Urinary Incontinence CAA, dated 03/18/26, documented the need for a urinary catheter due to obstructive uropathy and to help prevent skin breakdown and risk of UTI. R59's Care Plan, dated 10/24/24, directed staff to encourage R59 to increase his fluid intake to reduce constipation. On 02/28/25, the plan documented the use of a urinary catheter, size 16Fr, to be used for acute urinary retention with obstruction of normal flow (of urine), with use of a Stat-lock (securement device for prevention of catheter removal) to hold the catheter in place and reduce tugging. The plan of care documented the staff would monitor the catheter output of urine every shift. During an observation on 04/06/26 at 10:00 AM, R59 began self-propelling his wheelchair slowly up the hallway. A few minutes later, a steady stream of what appeared to be urine was noted on the floor, where R59 was sitting, all the way up the hallway. Less than two minutes later, a male housekeeper arrived with a wet mop and began cleaning up the stream of urine, stating, I know who this belongs to. An observation conducted on 04/08/2026 at 10:37 AM with Certified Nursing Assistant (CNA) II and CNA Q revealed catheter care, which included emptying R59's catheter bag and noting the amount and color of the urine before discarding it. A CNA cleaned around the insertion site of the catheter and determined there were no catheter defects or skin issues that needed to be reported to the nurse. R59 did not have Stat-lock on his thigh to anchor his catheter tubing. Upon interviewing CNA II after the completion of this task, she stated they are supposed to empty the catheter at the end of our shift. When asked if a Stat-lock was supposed to be used, CNA II stated no, because he just takes them off. R59 was observed sitting patiently in the dining room on 04/07/26 at 03:42 PM in his wheelchair, with his feet resting on his foot pedals. A full, round catheter bag was noted, hanging under R59's wheelchair. A nursing staff member behind the desk was notified. During an interview on 04/08/26 at 11:00 AM with Licensed Nurse (LN) I stated CNA's typically empty the catheter bags at the end of their shift. She also stated all catheterized residents should have a stat lock on their leg, and there were four cases of them in stock. An interview on 04/08/26 with Administrative Nurse D at 11:22 AM, she revealed her expectations to be as the care plan dictates, which are to have the stat lock on the resident unless he cannot tolerate it, which should be documented in the Care Plan. The facility did not provide a policy related to catheter care. On 04/09/26 at 12:21 PM, Administrative Nurse D stated the facility did not have a policy for catheter care and followed the standards of practice.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to offer non-pharmaceutical interventions for pain for one Resident (R)3, who had acute pain. Findings included:- R3's Electronic Medical Record (EMR) documented a diagnosis of a wedge compression fracture (a type of spinal fracture where the front of a vertebra collapses while the back remains intact) of the second lumbar vertebra. R3's Significant Change Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of nine, indicating moderately impaired cognition. She received as-needed (PRN) pain medications and non-medication pain interventions during the assessment period. Pain was not assessed. She received opioid (narcotic pain medication) medication during the seven-day look-back period. The Pain Care Area Assessment (CAA), dated 01/19/26, did not trigger. The re-admission MDS, dated [DATE], documented the resident had a BIMS score of seven, indicating severe cognitive impairment. The resident did not receive scheduled or PRN pain medications and did not utilize non-medication pain interventions during the look-back period. The resident reported occasional pain, with the worst pain in the past five days, being eight on the one to ten pain scale (a tool for patients to rate pain intensity, where 0 is no pain and 10 is the worst imaginable pain). She received opioid (narcotic pain medication) medication during the seven-day look-back period. R3's Care Plan, revised 03/31/26, instructed staff to utilize alternative methods of pain management such as massage, aroma therapy, warm packs, and distraction. R3's EMR included the following physician's orders: Ibuprofen (an over-the-counter, anti-inflammatory analgesic), 400 milligrams (mg), by mouth (po), every (Q) six hours, PRN, for a diagnosis of pain, ordered 03/17/26 Hydrocodone-Acetaminophen (an opioid medication), 7.5-325 mg, po, Q six hours, PRN, for a diagnosis of pain, ordered 03/17/26 R3's Medication Administration Record (MAR), for 04/01/26 through 04/07/26, documented the resident's pain to range from one to seven on the one to ten pain scale. Staff administered the physician's ordered pain medication with effective results documented. On 04/07/26 at 08:33 AM, the resident sat at the dining room table. The resident was tearful with clenched fists and facial grimacing. On 04/07/26 at 10:31 AM, Certified Nurse Aide (CNA) P and CNA NN transferred the resident from her wheelchair to the recliner using extensive assistance. The resident had facial grimacing and audible indicators of pain during the transfer. On 04/07/26 at 10:31 AM, CNA P stated the resident often complained of pain following a fall she had. CNA P stated he was not aware of any non-pharmacologic pain interventions being utilized for the resident. On 04/07/26 at 08:46 AM, CNA NN stated the resident had a lot of pain in her hips. CNA NN stated the nurse would give the resident pain medication, but CNA was unaware of any non-pharmacologic pain interventions for the resident. On 04/08/26 at 10:59 AM, Administrative Nurse D stated that, along with the scheduled and PRN pain medications, it was the expectation for staff to attempt non-pharmacologic pain interventions. Administrative Nurse D stated the facility did not have an actual policy for pain management, but used the standard of care.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to maintain an effective infection control program related to the Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high contact care) when providing care. The facility also failed to store respiratory treatment devices in a sanitary manner. Findings included:- Observation on 04/06/26 10:36 AM, R20 oxygen tubing was wound around the portable oxygen tank. R20's nebulizer mouthpiece was attached to the medication bowl with a small amount of fluid in the medication bowl and attached to the nebulizer machine. On 04/08/26 at 10:35 AM, R1's nebulizer machine was attached to the face mask with the medication bowl attached with fluid in it. It laid on her chair beside her bed with the tubing wound up with a blacket, and her back brace laid on top of the nebulizer. An observation of catheter care was conducted on 04/08/2026 at 10:37 AM with Certified Nursing Assistant (CNA) II and CNA Q assisting R59 with toileting and catheter care. Both staff members entered R59's room, donned gloves, and wheeled R59 into the bathroom. This resident had a bowel movement, and CNA II assisted with cleaning the resident and changing his clothes into a clean pair of jeans and a shirt. The catheter bag was emptied into a plastic urinal and placed on the back of the toilet, with 600 milliliters of amber colored urine. After the catheter was emptied and the resident finished and dressed, he was assisted back into his wheelchair. The urine was emptied into the toilet, both CNAs removed their gloves, one CNA washed her hands, and the other CNA exited the room and escorted R59 down to the dining room. The CNAs were interviewed at 10:55 AM, and both stated they forgot to put on the Enhanced Barrier Precautions (EBP) gowns that were on the resident's door. CNA Q stated that washing was supposed to be done before and after handling a patient or a catheter. On 04/08/26 at 12:50 PM, Licensed Nurse (LN) K stated when she gave a resident a breathing treatment, she checked the order and got the breathing treatment out of the cart. She put the medication into the medication cup that was attached to the mouthpiece. LN K stated she rinsed out the cup if it was dirty (had drops of moisture in it). LN K stated she rinsed out the mask and dried it with a paper towel, then put it back together and placed it on the nebulizer when she finished breathing treatment. On 04/08/26 at 01:00 PM, LN K stated when a breathing treatment is complete, she turned it off and rinsed the mouthpiece and medication cup out. LN K stated they allowed it to air dry, then placed it in a plastic bag to prevent bacteria that could cause infection. On 04/08/26 at 01:27 PM, Administrative Nurse E stated the nurse was to clean out the mouthpiece and medication cup, allow it to dry, and place it in a bag for infection control. She expected staff to use proper EBP when caring for a resident with a wound or with a catheter. The facility's policy Infection Control Surveillance documented all staff are to be educated on infection control prevention practices as it relates to their job.

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F 0814 Level of Harm - Potential for minimal harm Residents Affected - Many	Dispose of garbage and refuse properly. The facility reported a census of 65 residents. Based on observation, interview, and record review, the facility failed to maintain and/or dispose of kitchen garbage and refuse properly. Findings included:During the initial kitchen tour on 04/06/26 at 08:44 AM, with Dietary Staff BB, the following concerns were identified at the facility dumpster:Two used gloves lay on the ground beside the base of the dumpster.One broken metal and upholstered armchairFour cloth recliners with large black stain/substance on the fabric surface, which included one red recliner with the back pulled/broken off. A broken chest of drawers with broken shelving and top. On 04/06/26 at 08:54 AM, Dietary Staff BB confirmed the above findings and reported she was not aware of the trash and garbage accumulation around the dumpster and did not know what arrangements were made to pick up the trash and garbage. The maintenance department handled the disposal of trash, garbage, and refuse. On 04/08/26 at 02:20 PM, Maintenance staff U stated maintenance the staff were responsible for the maintenance and cleaning of the dumpster area. He put the chairs out by the dumpster to be disposed of in January 2026. Maintenance Staff U reported that the person who picked up and disposed of the garbage and trash around the dumpster just stopped doing it, and he had not found a replacement for that duty. He agreed that the dumpster area with debris and trash posed potential for rodent infestation, as well as the gloves posed a risk for cross-contamination and the spread of infection to the residents and staff of the facility. The undated facility policy Housekeeping, Laundry and Maintenance- Basic Services Provided documentation included storage areas must be kept neat and free of extraneous material such as refuse and discarded furniture.