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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175313 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/10/2025 |
| NAME OF PROVIDER OR SUPPLIER Medicalodges Arkansas City | | STREET ADDRESS, CITY, STATE, ZIP CODE 203 E Osage Avenue Arkansas City, KS 67005 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| (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** 46960</p> <p>The facility reported a census of 41 residents with 13 residents reviewed for abuse. Based on observation, interview, and record review, the facility failed to ensure residents remained free from resident-to-resident abuse when on 01/25/25 Resident (R)1 grabbed R3's breast, and the facility failed to place any interventions to protect R3 and other residents from R1's unwanted sexual advances and touching. The facility placed R1 on a one-to-one with staff and sent the resident to a geriatric psychiatric (geri-psych) facility but did not implement interventions to prevent further resident-to-resident abuse when R1 returned on 02/22/25 other than medication for sexual aggression. On 03/01/25 staff observed R1 rubbing the leg of an unidentified female resident. The facility did not implement interventions in response to this incident. On 03/05/25 R1 grabbed R2's breast and staff directed R1 to his room but did not implement interventions to prevent further sexual contact. On 03/10/25 the facility placed R1 on visual one-to-one when R1 was outside his room though on 03/19/25, R1 again attempted to touch a female resident's leg but was redirected by staff back to his room with no further interventions noted. On 03/20/25 the facility documented R1 was on one-to-one when out of his room and there had been no inappropriate incidents. On 03/27/25 staff observed R1 stroking his penis next to an unidentified male resident but did not implement any interventions related to this incident. On 03/30/25 staff observed R1 stroking R3's leg. The facility noted that R1 gravitated to R3 as R3 resembled R1's spouse and the facility-initiated arms-length one-to-one. The facility's failure to ensure cognitively impaired residents remained free from sexual and/or physical resident-to-resident abuse placed R2, R3, and all cognitively impaired female residents unable to consent in immediate jeopardy.</p> <p>Findings included:</p> <p>- R1's Electronic Health Record (EHR) included the diagnoses of altered mental status, psychotic disorder (a mental disorder characterized by gross impairment in reality perception) with delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), high-risk sexual behavior, and Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure).</p> <p>The Admission Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of three, which indicated severely impaired cognition. R1 displayed no behaviors to indicate psychosis. The assessment documented R1 utilized a walker and/or wheelchair for locomotion.</p> <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.

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| 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 Cognitive Loss/Dementia Care Area Assessment (CAA) dated 01/21/25 documented R1 had dementia (a progressive mental disorder characterized by failing memory, and confusion) with short-term and long-term memory loss.</p> <p>The Psychosocial Well-Being CAA dated 01/21/25 documented R1 lacked interest in interacting with or participating in activities.</p> <p>R1's Care Plan, reviewed 04/08/25, documented on 01/19/25, the resident had a cognitive loss that affected memory. Interventions dated 01/19/25 directed staff to help R1 establish a regular daily schedule with tasks divided into several steps. The plan directed staff to be patient with R1, remind R1 who they were, and explain care prior to initiation; staff would provide one instruction at a time in a calm tone. An update dated 01/27/25 noted R1 was placed on one-to-one monitoring for redirecting of behaviors, initiated on 01/25/25, created on 01/27/25, and revised on 03/10/25. The plan noted that R1 would be evaluated by geriatric psychiatry for behaviors of touching another person without their approval, which was initiated on 01/25/25, created on 01/27/25, and revised on 04/02/25.</p> <p>R1's Care Plan reviewed 04/08/25 documented on 01/27/25, R1 was at risk for sexually inappropriate behaviors related to maladaptive (unhealthy or ineffective ways of coping with something difficult or stressful) mood and behavior. The care plan included an intervention dated 01/27/25 that directed staff to administer medications as ordered to manage R1's behavior, created on 01/28/25. Interventions created on 01/28/25 effective for 01/27/25 included staff observing R1's mood and behaviors, staff obtaining a psychiatric evaluation as ordered, staff redirecting inappropriate behavior with alternative activities, and staff reporting changes in behavior to the nurse and physician being informed as indicated. The plan documented that staff would ensure R1 was on one-on-one observation at an arm's length when not in his room, created on 01/28/25 and revised on 04/02/25</p> <p>The Progress Notes section of R1's EHR documented the following notes:</p> <p>On 01/25/25 at 11:14 AM, staff observed R1 walked up to R3, a cognitively impaired resident, and touched her breast. Staff redirected R1 to his room.</p> <p>On 02/03/25 at 01:59 PM, staff documented a root cause analysis of the incident on 01/25/25 and documented that, according to R1's responsible person, R1 had a history of sexual aggression and grabbed R3's left breast. R1 was immediately removed from the area back to his room and placed on one-on-one monitoring when not in his room; R1 was started on medication for sexual aggression.</p> <p>On 03/01/25, Licensed Nurse (LN) I documented staff observed R1 rubbing the leg of an unidentified female resident.</p> <p>On 03/05/25, LN I documented R1 grabbed R2's (a cognitively impaired resident) breast, and staff directed R1 to his room. LN I documented the notification of Administrative Staff A and Administrative Nurse B of the incident.</p> <p>On 03/06/25 at 11:56 AM, Administrative Nurse B documented that LN I reported R1 had grabbed R2's breast in the dining area.</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>On 03/10/25 at 01:03 PM, staff documented a root cause analysis of the incident on 03/05/25 and documented that according to R1's responsible person, R1 had a history of sexual aggression and R1 grabbed R2's left breast. R1 was immediately removed from the area back to his room and placed on one-on-one monitoring when not in his room.</p> <p>On 03/19/25 at 05:51 AM, staff documented R1 was up and down during the night and wandered from his room to the common area and back; redirection attempts were unsuccessful. Additionally, staff documented an unknown Certified Nurse Aide (CNA) stopped R1 from reaching for an unidentified female resident's leg. The CNA told R1 to stop and R1 walked back to his room before physical contact was made. Staff documented that Administrative Staff A and Administrative Nurse B were notified.</p> <p>On 03/20/25 at 03:16 PM, Social Services Designee (SSD) M documented R1 was observed throughout the week related to a previous incident (undated) and R1 remained on one-on-one observation when outside of his room. SSD M documented R1 had no inappropriate incidents.</p> <p>On 03/27/25 at 02:15 AM, staff documented R1 was observed stroking his penis while seated next to another male resident at 02:05 AM. Staff documented there was no physical contact observed between the two residents, and Administrative Staff A and Administrative Nurse B were notified.</p> <p>On 03/30/25 at 06:20 AM, LN F documented R1 stroked R3's left lower leg. Staff moved R3 and R1 returned to his room.</p> <p>On 03/30/25 at 07:51 AM, staff documented R1 looked up the dresses on wooden the Easter decorations in the dining room and stated, Let me get that [expletive].</p> <p>On 03/30/25 at 06:02 PM, staff documented R1 continued to try and look up the dresses on the Easter decorations.</p> <p>On 04/03/25 at 02:17 PM, SSD M documented the facility sent a referral for R1 to be transferred to a different facility.</p> <p>On 04/02/25 at 10:44 AM, LN F documented that on 03/30/25 R1 was observed slowly rubbing R3's lower left leg. The note documented LN F placed herself between R1 and R3 and remained there until R1 returned to his room. LN F assessed R3 and determined her to be free of injury. The note recorded R1 continued to be on one-on-one observation. LN F documented she notified Administrative Staff A and Administrative Nurse B.</p> <p>On 04/08/25 at 02:14 PM, staff documented a root cause analysis, and the facility noted that R1 gravitated to R3 as R3 resembled R1's spouse; the facility-initiated arms-length one-on-one monitoring for R1 and continued to try to get the resident transferred to an all-male facility.</p> <p>A review of the facility's investigation and witness statements for the 01/25/25 incident revealed no additional information. The investigation report lacked documentation that the facility notified Law Enforcement (LE).</p> <p>The facility lacked an investigation report for the incident on 03/01/25.</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>A review of the facility's investigation and witness statements for the 03/05/25 incident revealed no additional information. The investigation report lacked documentation that the facility notified.</p> <p>The facility lacked an investigation report for the incident on 03/27/25.</p> <p>A review of the facility's investigation for the 03/30/25 incident revealed no additional information. The investigation report lacked witness statements and lacked documentation that the facility notified LE.</p> <p>On 04/08/25 at 01:40 PM, R1 was unable to be interviewed due to the resident's cognitive impairment.</p> <p>During an interview on 04/08/25 at 04:40 PM, LN F stated on 03/30/25 R1 was observed rubbing the lower left leg of R3. LN F stated she placed herself between R1 and R3 until R1 went back to his room.</p> <p>During an interview on 04/09/25 at 03:20 PM, Administrative Staff A stated the facility did not notify LE of any of the documented incidents from 01/25/25 to 04/09/25.</p> <p>During an interview on 04/09/25 at 03:42 PM, CNA H stated she was unaware of the details of the events and stated R3 looks like R1's wife. CNA H stated R1 was confused and continued to attempt to touch R3 and rub her leg. CNA H stated if staff observed R1 with this type of behavior, staff had to stand between R1 and the female residents and report the incidents to the nurse on duty.</p> <p>During an interview on 04/09/25 at 03:46 PM, CNA J stated if R1 reached for a female resident staff would protect the female resident and attempt to redirect R1 with a different activity and report the incident to the nurse or a member of management.</p> <p>During an interview on 04/09/25 at 04:15 PM, LN K stated she was aware of the incidents with R1 and inappropriate contact and stated if staff observed R1 attempt inappropriate contact, R1 should be removed as quickly as possible to ensure the safety of the other residents. LN K stated she would report the incident to management immediately and then follow management's discretion as to whether to call law enforcement.</p> <p>During an interview on 04/09/25 at 04:25 PM, Administrative Nurse C stated the facility's expectation in the event of unwanted or inappropriate sexual contact staff should separate the residents to ensure resident safety and perform any required assessments and document everything in the EHR. Staff would then notify management who would immediately develop and implement an intervention to prevent the incident from happening again. This included notifying and educating all the staff and obtaining signatures. Administrative Nurse C stated after the incident on 01/25/25, R1 was placed under visual one-on-one monitoring until R1 was sent to a behavioral health unit (BHU). Administrative Nurse C stated she was unaware if the management team was aware of the incident on 03/01/25, and after the incident on 03/05/25 R1 was placed on one-on-one monitoring when he was out of his room. Administrative Nurse C stated when the incident occurred on 03/30/25 R1 was placed on one-on-one monitoring where staff must stay within an arms-reach of R1 when out of his room with a staff member placed outside the door to his room. Administrative Nurse C stated the management team was actively trying to find alternate placement for R1 at a more appropriate facility. Administrative Nurse C stated LE should be contacted for any unwanted physical or sexual contact and confirmed that LE was not contacted for any incidents that involved R1 between 01/25/25 and 04/09/25.</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>During an interview on 04/09/25 at 04:54 PM Administrative Staff A revealed that after the incident on 01/25/25, R1 was placed under one-on-one visual monitoring until he was transferred to the behavioral health unit. Administrative Staff A said when R1 returned to the facility, he was self-isolating and would only come out of his room for meals and after the incident on 03/05/25, R1 was placed on one-on-one visual monitoring when he was outside of his room. Administrative Staff A stated after the incident on 03/30/25, R1 was placed on one-on-one monitoring within arm-length reach of staff except when he was in his room, then staff would be outside his room. Administrative Staff A stated the facility continued to try to find alternative placement at an all-male dementia unit. Administrative Staff A in the event of unwanted physical or sexual contact between residents, she expected staff to immediately separate the residents, assess the residents involved, and then notify management. Administrative Staff A stated staff followed the appropriate procedure for all the events reviewed involving R1. Administrative Staff A stated the event on 03/01/25 was not fully investigated or called to LE because the contact was not believed to be sexual in nature. Administrative Staff A confirmed the Progress Note dated 03/19/25 and stated she was unaware of the information and stated it would be considered a near-miss. Administrative Staff A stated the event documented on 03/27/25 was not investigated or reported because the other male resident in the area was unaware of R1's actions, R1's genitals were not exposed and R1 was not aggressive. Administrative Staff A stated LE should only be notified if another resident is harmed or if the resident's family wants LE involved. Administrative Staff A confirmed if someone touched anyone's breast without consent, LE should be notified and further confirmed R2 and R3 were incapable of providing consent and the touching from R1 was sexual in nature so it should have been reported to LE.</p> <p>The facility's Abuse, Neglect and Exploitation policy dated 10/2022 documented that residents have the right to be free from verbal, sexual, physical, and mental abuse. The facility would keep residents free from abuse and take swift and immediate action to investigate allegations of abuse. The policy documented every employee had the responsibility to report allegations of abuse and the Administrator or Director of Nursing (DON) would investigate allegations and report the results to the proper authorities. All reports or suspicions of abuse would result in an investigation and all reasonable suspicions of a crime would be reported as required.</p> <p>On 04/10/25 at 11:35 AM, Administrative Staff L and Administrative Nurse C were provided the Immediate Jeopardy (IJ) template and informed that the facility's failure to ensure cognitively impaired residents remained free from sexual and/or physical resident-to-resident abuse placed R2, R3, and all cognitively impaired female residents unable to consent in immediate jeopardy.</p> <p>The facility submitted an acceptable plan for removal of the immediate jeopardy on 04/10/25 at 02:56 PM which included the following:</p> <p>The facility placed R1 on one-on-one monitoring until an appropriate alternate placement was secured.</p> <p>The facility notified Law Enforcement on 04/10/25.</p> <p>LN I received disciplinary action for failure to report the incident on 03/10/25.</p> <p>LN F received disciplinary action for failure to report the incident on 03/30/25 until 04/02/25.</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 updated R2 and R3's Care Plans to include social services follow-up with each resident weekly and as needed for their psychosocial well-being.</p> <p>The facility updated R1's Care Plan to include one-on-one monitoring until appropriate alternate placement was secured. Staff would assist R1 to a private location when fondling his genitals.</p> <p>The facility immediately educated all staff on 04/10/25 regarding abuse prevention, reporting, and expectations related to immediate interventions and investigations. The facility re-educated all staff on the definition of one-on-one monitoring with associated documentation.</p> <p>The facility held an Ad-hoc Quality Assurance Process Improvement (QAPI) meeting by telephone on 04/10/25.</p> <p>Implementation of the corrective measures to remove the immediacy was verified on-site on 04/10/25 at 03:35 PM. The deficient practice remained at a scope and severity level of a G (isolated actual harm) to represent the psychosocial impact of the abuse for R2 and R3 using the reasonable person concept, due to the residents' inability to self-identify and/or verbally express their feelings.</p> |

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| <p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> | <p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46960</p> <p>The facility reported a census of 41 residents, including 11 female residents with moderate to severe cognitive impairment. The sample included 13 residents reviewed for abuse. Based on observation, interview, and record review, the facility failed to report allegations of resident-to-resident abuse to the Licensed Nursing Home Administrator (LNHA), State Agency (SA) and/or Law Enforcement (LE) as appropriate when Resident (R) 1 repeatedly touched cognitively impaired female residents, R2 and R3, and displayed sexual behaviors such as masturbating in the presence of other residents. On 01/25/25 R1 grabbed R3's breast. The facility placed R1 on one-to-one with staff and sent the resident to an acute behavioral facility, but did not implement interventions to prevent further resident-to-resident abuse when R1 returned on 02/22/25 other than a medication for sexual aggression. The facility failed to notify LE. On 03/01/25 staff observed R1 rubbing the leg of an unidentified female resident. On 03/05/25 R1 grabbed R2's breast and staff directed R1 to his room but did not notify LE. On 03/10/25 the facility placed R1 on visual one-to-one when R1 was outside his room. On 03/19/25 R1 attempted to touch a female resident's leg but was redirected by staff back to his room with no further interventions noted. On 03/20/25 the facility documented R1 was on one-to-one when out of his room and there had been no inappropriate incidents. On 03/27/25 staff observed R1 stroking his penis next to an unidentified male resident but did not implement any interventions related to this incident or report the incident as alleged abuse to the SA. On 03/30/25 staff observed R1 stroking R3's leg. The facility noted that R1 gravitated to R3 as R3 resembled R1's spouse and the facility-initiated arms-length one-to-one. The facility's failure to report allegations of resident-to-resident abuse to the LNHA, SA, and LE as appropriate placed R2, R3 and all cognitively impaired female residents in immediate jeopardy.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - R1's Electronic Health Record (EHR) included the diagnoses of altered mental status, psychotic disorder (a mental disorder characterized by gross impairment in reality perception) with delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), high-risk sexual behavior, and Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure). <p>The Admission Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of three, which indicated severely impaired cognition. R1 displayed no behaviors to indicate psychosis. The assessment documented R1 utilized a walker and/or wheelchair for locomotion.</p> <p>The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 01/21/25 documented R1 had dementia (a progressive mental disorder characterized by failing memory, and confusion) with short-term and long-term memory loss.</p> <p>The Psychosocial Well-Being CAA dated 01/21/25 documented R1 lacked interest in interacting with or participating in activities.</p> <p>(continued on next page)</p> | | |

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| <p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> | <p>R1's Care Plan, reviewed 04/08/25, documented on 01/19/25, the resident had a cognitive loss that affected memory. Interventions dated 01/19/25 directed staff to help R1 establish a regular daily schedule with tasks divided into several steps. The plan directed staff to be patient with R1, remind R1 who they were, and explain care prior to initiation; staff would provide one instruction at a time in a calm tone. An update dated 01/27/25 noted R1 was placed on one-to-one monitoring for redirecting of behaviors, initiated on 01/25/25, created on 01/27/25, and revised on 03/10/25. The plan noted that R1 would be evaluated by geriatric psychiatry for behaviors of touching another person without their approval, which was initiated on 01/25/25, created on 01/27/25, and revised on 04/02/25.</p> <p>R1's Care Plan reviewed 04/08/25 documented on 01/27/25, R1 was at risk for sexually inappropriate behaviors related to maladaptive (unhealthy or ineffective ways of coping with something difficult or stressful) mood and behavior. The care plan included an intervention dated 01/27/25 that directed staff to administer medications as ordered to manage R1's behavior, created on 01/28/25. Interventions created on 01/28/25 effective for 01/27/25 included staff observing R1's mood and behaviors, staff obtaining a psychiatric evaluation as ordered, staff redirecting inappropriate behavior with alternative activities, and staff reporting changes in behavior to the nurse and physician being informed as indicated. The plan documented staff would ensure R1 was on one-on-one observation at an arm's length when not in his room, created on 01/28/25 and revised on 04/02/25</p> <p>The Progress Notes section of R1's EHR documented the following notes:</p> <p>On 01/25/25 at 11:14 AM, staff observed R1 walked up to R3, a cognitively impaired resident, and touched her breast. Staff redirected R1 to his room.</p> <p>On 02/03/25 at 01:59 PM, staff documented a root cause analysis of the incident on 01/25/25 and documented, according to R1's responsible person, R1 had a history of sexual aggression and grabbed R3's left breast. R1 was immediately removed from the area back to his room and placed on one-on-one monitoring when not in his room; R1 was started on medication for sexual aggression.</p> <p>On 03/01/25, Licensed Nurse (LN) I documented staff observed R1 rubbing the leg of an unidentified female resident.</p> <p>On 03/05/25, LN I documented R1 grabbed R2's (a cognitively impaired resident) breast, and staff directed R1 to his room. LN I documented the notification of Administrative Staff A and Administrative Nurse B of the incident.</p> <p>On 03/06/25 at 11:56 AM, Administrative Nurse B documented LN I reported R1 had grabbed R2's breast in the dining area.</p> <p>On 03/10/25 at 01:03 PM, staff documented a root cause analysis of the incident on 03/05/25 and documented according to R1's responsible person, R1 had a history of sexual aggression and R1 grabbed R2's left breast. R1 was immediately removed from the area back to his room and placed on one-on-one monitoring when not in his room.</p> <p>(continued on next page)</p> | | |

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| <p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> | <p>On 03/19/25 at 05:51 AM, staff documented R1 was up and down during the night and wandered from his room to the common area and back; redirection attempts were unsuccessful. Additionally, staff documented an unknown Certified Nurse Aide (CNA) stopped R1 from reaching for an unidentified female resident's leg. The CNA told R1 to stop and R1 walked back to his room before physical contact was made. Staff documented the notification of Administrative Staff A and Administrative Nurse B.</p> <p>On 03/20/25 at 03:16 PM, Social Services Designee (SSD) M documented R1 was observed throughout the week related to a previous incident (undated) and R1 remained on one-on-one observation when outside of his room. SSD M documented R1 had no inappropriate incidents.</p> <p>On 03/27/25 at 02:15 AM, staff documented R1 was observed stroking his penis while seated next to another male resident at 02:05 AM. Staff documented there was no physical contact observed between the two residents, and Administrative Staff A and Administrative Nurse B were notified.</p> <p>On 03/30/25 at 06:20 AM, LN F documented R1 stroked R3's left lower leg. Staff moved R3 and R1 returned to his room.</p> <p>On 03/30/25 at 07:51 AM, staff documented R1 looked up the dresses on wooden Easter decorations in the dining room and stated, Let me get that [expletive].</p> <p>On 03/30/25 at 06:02 PM, staff documented R1 continued to try and look up the dresses on the Easter decorations.</p> <p>On 04/03/25 at 02:17 PM, SSD M documented a referral for R1 to be transferred to a different facility was sent.</p> <p>On 04/02/25 at 10:44 AM, LN F documented on 03/30/25 R1 was observed slowly rubbing R3's lower left leg. The note documented LN F placed herself between R1 and R3 and remained there until R1 returned to his room. LN F assessed R3 and determined her to be free of injury. The note recorded R1 continued to be on one-on-one observation. LN F documented she notified Administrative Staff A and Administrative Nurse B.</p> <p>On 04/08/25 at 02:14 PM, staff documented a root cause analysis, and the facility noted that R1 gravitated to R3 as R3 resembled R1's spouse; the facility-initiated arms-length one-on-one monitoring for R1 and continued to try to get the resident transferred to an all-male facility.</p> <p>A review of the facility's investigation and witness statements for the 01/25/25 incident revealed no additional information. The investigation report lacked documentation that Law Enforcement (LE) was notified.</p> <p>The facility lacked an investigation report for the incident on 03/01/25.</p> <p>A review of the facility's investigation and witness statements for the 03/05/25 incident revealed no additional information. The investigation report lacked documentation that LE was notified.</p> <p>The facility lacked an investigation report for the incident on 03/27/25.</p> <p>(continued on next page)</p> | | |

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| <p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> | <p>A review of the facility's investigation for the 03/30/25 incident revealed no additional information. The investigation report lacked witness statements and lacked documentation that LE was notified.</p> <p>On 04/08/25 at 01:40 PM, R1 was unable to be interviewed due to the resident's cognitive impairment.</p> <p>During an interview on 04/08/25 at 04:40 PM, LN F stated on 03/30/25 R1 was observed rubbing the lower left leg of R3. LN F stated she placed herself between R1 and R3 until R1 went back to his room.</p> <p>During an interview on 04/09/25 at 03:20 PM, Administrative Staff A stated the facility did not notify LE of any of the documented incidents from 01/25/25 to 04/09/25.</p> <p>During an interview on 04/09/25 at 03:42 PM, CNA H stated she was unaware of the details of the events and stated R3 looks like R1's wife. CNA H stated R1 was confused and continued to attempt to touch R3 and rub her leg. CNA H stated if staff observed R1 with this type of behavior, staff had to stand between R1 and the female residents and report the incidents to the nurse on duty.</p> <p>During an interview on 04/09/25 at 03:46 PM, CNA J stated if R1 reached for a female resident staff would protect the female resident and attempt to redirect R1 with a different activity and report the incident to the nurse or a member of management.</p> <p>During an interview on 04/09/25 at 04:15 PM, LN K stated she was aware of the incidents with R1 and inappropriate contact and stated if staff observed R1 attempt inappropriate contact, R1 should be removed as quickly as possible to ensure the safety of the other residents. LN K stated she would report the incident to management immediately and then follow management's discretion as to whether to call law enforcement.</p> <p>During an interview on 04/09/25 at 04:25 PM, Administrative Nurse C stated the facility's expectation in the event of unwanted or inappropriate sexual contact staff should separate the residents to ensure resident safety and perform any required assessments and document everything in the EHR. Staff would then notify management who would immediately develop and implement an intervention to prevent the incident from happening again. This included notifying and educating all the staff and obtaining signatures. Administrative Nurse C stated after the incident on 01/25/25, R1 was placed under visual one-on-one monitoring until R1 was sent to a behavioral health unit (BHU). Administrative Nurse C stated she was unaware if the management team was aware of the incident on 03/01/25, and after the incident on 03/05/25 R1 was placed on one-on-one monitoring when he was out of his room. Administrative Nurse C stated when the incident occurred on 03/30/25 R1 was placed on one-on-one monitoring where staff must stay within an arms-reach of R1 when out of his room with a staff member placed outside the door to his room. Administrative Nurse C stated the management team was actively trying to find alternate placement for R1 at a more appropriate facility. Administrative Nurse C stated LE should be contacted for any unwanted physical or sexual contact and confirmed that LE was not contacted for any incidents that involved R1 between 01/25/25 and 04/09/25.</p> <p>(continued on next page)</p> | | |

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| <p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> | <p>During an interview on 04/09/25 at 04:54 PM Administrative Staff A revealed that after the incident on 01/25/25, R1 was placed under one-on-one visual monitoring until he was transferred to the behavioral health unit. Administrative Staff A said when R1 returned to the facility, he was self-isolating and would only come out of his room for meals and after the incident on 03/05/25, R1 was placed on one-on-one visual monitoring when he was outside of his room. Administrative Staff A stated after the incident on 03/30/25, R1 was placed on one-on-one monitoring within arm-length reach of staff except when he was in his room, then staff would be outside his room. Administrative Staff A stated the facility continued to try to find alternative placement at an all-male dementia unit. Administrative Staff A in the event of unwanted physical or sexual contact between residents, she expected staff to immediately separate the residents, assess the residents involved, and then notify management. Administrative Staff A stated staff followed the appropriate procedure for all the events reviewed involving R1. Administrative Staff A stated the event on 03/01/25 was not fully investigated or called to LE because the contact was not believed to be sexual in nature. Administrative Staff A confirmed the Progress Note dated 03/19/25 and stated she was unaware of the information and stated it would be considered a near-miss. Administrative Staff A stated the event documented on 03/27/25 was not investigated or reported because the other male resident in the area was unaware of R1's actions, R1's genitals were not exposed and R1 was not aggressive. Administrative Staff A stated LE should only be notified if another resident is harmed or if the resident's family wants LE involved. Administrative Staff A confirmed if someone touched anyone's breast without consent, LE should be notified and further confirmed R2 and R3 were incapable of providing consent and the touching from R1 was sexual in nature so it should have been reported to LE.</p> <p>The facility's Abuse, Neglect and Exploitation policy dated 10/2022 documented residents have the right to be free from verbal, sexual, physical, and mental abuse. The facility would keep residents free from abuse and take swift and immediate action to investigate allegations of abuse. The policy documented every employee had the responsibility to report allegations of abuse and the Administrator or Director of Nursing (DON) would investigate allegations and report the results to the proper authorities. All reports or suspicions of abuse would result in an investigation and all reasonable suspicions of a crime would be reported as required.</p> <p>On 04/10/25 at 11:35 AM, Administrative Staff L and Administrative Nurse C were provided the Immediate Jeopardy (IJ) template and informed that the facility's failure to report allegations of resident-to-resident abuse to the LNHA, SA, and/or LE as appropriate placed R2, R3 and all cognitively impaired female residents in immediate jeopardy</p> <p>The facility submitted an acceptable plan for removal of the immediate jeopardy on 04/10/25 at 02:56 PM which included the following:</p> <p>The facility placed R1 on one-on-one monitoring until an appropriate alternate placement was secured.</p> <p>The facility notified Law Enforcement on 04/10/25.</p> <p>LN I received disciplinary action for failure to report the incident on 03/10/25.</p> <p>LN F received disciplinary action for failure to report the incident on 03/30/25 until 04/02/25.</p> <p>(continued on next page)</p> | | |

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| <p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> | <p>The facility updated R2 and R3's Care Plans to include social services follow-up with each resident weekly and as needed for their psychosocial well-being.</p> <p>The facility updated R1's Care Plan to include one-on-one monitoring until appropriate alternate placement was secured. Staff would assist R1 to a private location when fondling his genitals.</p> <p>The facility immediately educated all staff on 04/10/25 regarding abuse prevention, reporting, and expectations related to immediate interventions and investigations. The facility re-educated all staff on the definition of one-on-one monitoring with associated documentation.</p> <p>The facility held an Ad-hoc Quality Assurance Process Improvement (QAPI) meeting by telephone on 04/10/25.</p> <p>Implementation of the corrective measures to remove the immediacy was verified on-site on 04/10/25 at 03:35 PM. The deficient practice remained at a scope and severity level of E (patterned, potential harm).</p> | | |

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| <p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> | <p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46960</p> <p>The facility reported a census of 41 residents and 11 female residents with moderate to severe cognitive impairment. The sample included 13 residents reviewed for abuse. Based on observation, interview, and record review, the facility failed to immediately implement protective measures to prevent further potential abuse, after an allegation of resident-to-resident abuse and further failed to conduct thorough investigations when Resident (R) 1 repeatedly touched cognitively impaired female residents, R2 and R3, and displayed sexual behaviors such as masturbating in the presence of other residents. On 01/25/25 R1 grabbed R3's breast. The facility placed R1 on one to one with staff and sent the resident to the acute behavioral facility but did not implement interventions to prevent further resident to resident abuse when R1 returned on 02/22/25 other than a medication for sexual aggression. On 03/01/25 staff observed R1 rubbing the leg of an unidentified female resident. The facility did not implement interventions in response to this incident or investigate the incident. On 03/05/25 R1 grabbed R2's breast and staff directed R1 to his room but did not implement interventions to prevent further sexual contact. On 03/10/25 the facility placed R1 on visual one to one when R1 was outside his room. On 03/19/25 R1 attempted to touch a female resident's leg but was redirected by staff back to his room with no further interventions noted. On 03/20/25 the facility documented R1 was on one to one when out of his room and there had been no inappropriate incidents. On 03/27/25 staff observed R1 stroking his penis next to an unidentified male resident but did not implement any interventions related to this incident or investigate the incident. On 03/30/25 staff observed R1 stroking R3's leg. The facility noted that R1 gravitated to R3 as R3 resembled R1's spouse and the facility-initiated arms -length one to one. The facility's failure to immediately implement protective measures to prevent further potential abuse, after an allegation of resident-to-resident abuse, and to conduct thorough investigations placed R2, R3 and all cognitively impaired female residents in immediate jeopardy.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - R1's Electronic Health Record (EHR) included the diagnoses of altered mental status, psychotic disorder (a mental disorder characterized by gross impairment perception) with delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), high-risk sexual behavior and Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure). <p>The Admission Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) of three, which indicated severely impaired cognition. R1 displayed no behaviors to indicate psychosis. The assessment documented R1 utilized a walker and/or wheelchair for locomotion.</p> <p>The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 01/21/25 documented R1 had dementia (a progressive mental disorder characterized by failing memory, and confusion) with short-term and long-term memory loss.</p> <p>The Psychosocial Well-Being CAA dated 01/21/25 documented R1 lacked interest in interacting with or participating in activities.</p> <p>(continued on next page)</p> | | |

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| <p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> | <p>R1's Care Plan, reviewed 04/08/25, documented on 01/19/25, the resident had a cognitive loss that affected memory. Interventions dated 01/19/25 directed staff to help R1 establish a regular daily schedule with tasks divided into several steps. The plan directed staff to be patient with R1, remind R1 who they were, and explain care prior to initiation; staff would provide one instruction at a time in a calm tone. An update dated 01/27/25 noted R1 was placed on one-to-one monitoring for redirecting of behaviors, initiated on 01/25/25, created on 01/27/25, and revised on 03/10/25. The plan noted that R1 would be evaluated by geriatric psychiatry for behaviors of touching another person without their approval, which was initiated on 01/25/25, created on 01/27/25, and revised on 04/02/25.</p> <p>R1's Care Plan reviewed 04/08/25 documented on 01/27/25, R1 was at risk for sexually inappropriate behaviors related to maladaptive (unhealthy or ineffective ways of coping with something difficult or stressful) mood and behavior. The care plan included an intervention dated 01/27/25 that directed staff to administer medications as ordered to manage R1's behavior, created on 01/28/25. Interventions created on 01/28/25 effective for 01/27/25 included staff observing R1's mood and behaviors, staff obtaining a psychiatric evaluation as ordered, staff redirecting inappropriate behavior with alternative activities, and staff reporting changes in behavior to the nurse and physician being informed as indicated. The plan documented staff would ensure R1 was on one-on-one observation at an arm's length when not in his room, created on 01/28/25 and revised on 04/02/25</p> <p>The Progress Notes section of R1's EHR documented the following notes:</p> <p>On 01/25/25 at 11:14 AM, staff observed R1 walked up to R3, a cognitively impaired resident, and touched her breast. Staff redirected R1 to his room.</p> <p>On 02/03/25 at 01:59 PM, staff documented a root cause analysis of the incident on 01/25/25 and documented, according to R1's responsible person, R1 had a history of sexual aggression and grabbed R3's left breast. R1 was immediately removed from the area back to his room and placed on one-on-one monitoring when not in his room; R1 was started on medication for sexual aggression.</p> <p>On 03/01/25, Licensed Nurse (LN) I documented staff observed R1 rubbing the leg of an unidentified female resident.</p> <p>On 03/05/25, LN I documented R1 grabbed R2's (a cognitively impaired resident) breast, and staff directed R1 to his room. Additionally, Administrative Staff A and Administrative Nurse B were notified of the incident.</p> <p>On 03/06/25 at 11:56 AM, Administrative Nurse B documented LN I reported R1 had grabbed R2's breast in the dining area.</p> <p>On 03/10/25 at 01:03 PM, staff documented a root cause analysis of the incident on 03/05/25 and documented according to R1's responsible person, R1 had a history of sexual aggression and R1 grabbed R2's left breast. R1 was immediately removed from the area back to his room and placed on one-on-one monitoring when not in his room.</p> <p>(continued on next page)</p> | | |

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| <p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> | <p>During an interview on 04/09/25 at 04:54 PM Administrative Staff A revealed that after the incident on 01/25/25, R1 was placed under one-on-one visual monitoring until he was transferred to the behavioral health unit. Administrative Staff A said when R1 returned to the facility, he was self-isolating and would only come out of his room for meals and after the incident on 03/05/25, R1 was placed on one-on-one visual monitoring when he was outside of his room. Administrative Staff A stated after the incident on 03/30/25, R1 was placed on one-on-one monitoring within arm-length reach of staff except when he was in his room, then staff would be outside his room. Administrative Staff A stated the facility continued to try to find alternative placement at an all-male dementia unit. Administrative Staff A in the event of unwanted physical or sexual contact between residents, she expected staff to immediately separate the residents, assess the residents involved, and then notify management. Administrative Staff A stated staff followed the appropriate procedure for all the events reviewed involving R1. Administrative Staff A stated the event on 03/01/25 was not fully investigated or called to LE because the contact was not believed to be sexual in nature. Administrative Staff A confirmed the Progress Note dated 03/19/25 and stated she was unaware of the information and stated it would be considered a near-miss. Administrative Staff A stated the event documented on 03/27/25 was not investigated or reported because the other male resident in the area was unaware of R1's actions, R1's genitals were not exposed and R1 was not aggressive. Administrative Staff A stated LE should only be notified if another resident is harmed or if the resident's family wants LE involved. Administrative Staff A confirmed if someone touched anyone's breast without consent, LE should be notified and further confirmed R2 and R3 were incapable of providing consent and the touching from R1 was sexual in nature so it should have been reported to LE.</p> <p>The facility's Abuse, Neglect and Exploitation policy dated 10/2022 documented residents have the right to be free from verbal, sexual, physical, and mental abuse. The facility would keep residents free from abuse and take swift and immediate action to investigate allegations of abuse. The policy documented every employee had the responsibility to report allegations of abuse and the Administrator or Director of Nursing (DON) would investigate allegations and report the results to the proper authorities. All reports or suspicions of abuse would result in an investigation and all reasonable suspicions of a crime would be reported as required.</p> <p>On 04/10/25 at 11:35 AM, Administrative Staff L and Administrative Nurse C were provided the Immediate Jeopardy (IJ) template and informed of the facility's failure to immediately implement protective measures to prevent further potential abuse, after multiple allegations and/or incidents of resident-to-resident abuse, and to conduct thorough investigations, placed R2, R3, and all cognitively impaired female residents in immediate jeopardy.</p> <p>The facility submitted an acceptable plan for removal of the immediate jeopardy on 04/10/25 at 02:56 PM which included the following:</p> <p>The facility placed R1 on one-on-one monitoring until an appropriate alternate placement was secured.</p> <p>The facility notified Law Enforcement on 04/10/25.</p> <p>LN I received disciplinary action for failure to report the incident on 03/10/25.</p> <p>LN F received disciplinary action for failure to report the incident on 03/30/25 until 04/02/25.</p> <p>(continued on next page)</p> | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175313 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/10/2025 |
| NAME OF PROVIDER OR SUPPLIER Medicalodges Arkansas City | | STREET ADDRESS, CITY, STATE, ZIP CODE 203 E Osage Avenue Arkansas City, KS 67005 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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|---|---|
| <p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> | <p>The facility updated R2 and R3's Care Plans to include social services follow-up with each resident weekly and as needed for their psychosocial well-being.</p> <p>The facility updated R1's Care Plan to include one-on-one monitoring until appropriate alternate placement was secured. Staff would assist R1 to a private location when fondling his genitals.</p> <p>The facility immediately educated all staff on 04/10/25 regarding abuse prevention, reporting, and expectations related to immediate interventions and investigations. The facility re-educated all staff on the definition of one-on-one monitoring with associated documentation.</p> <p>The facility held an Ad-hoc Quality Assurance Process Improvement (QAPI) meeting by telephone on 04/10/25.</p> <p>Implementation of the corrective measures to remove the immediacy was verified on-site on 04/10/25 at 03:35 PM. The deficient practice remained at a scope and severity level of E (patterned, potential harm).</p> |