STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175313	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Arkansas City	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility reported a census of 40 residents. Based on observation, interview, and record review, the facility failed to maintain a clean, comfortable, and homelike environment in two of the three resident halls including the shower room on Hall A and Hall B as well as one supply storage room on Hall A which placed the residents at risk of unsanitary living conditions. Findings included: - During an environmental tour on 06/30/25 at 08:49 with Hskp/Maintenance U, the following concerns were noted: Hall A The shower room window had a build-up of dust, debris, and dead bugs. A four-tiered metal cart used to hold clean towels, wash clothes and toiletries had multiple areas of rust. The toilet seat was discolored and had several gouged areas on the seating surface. A storage room had two boxes resting directly on the floor. One unopened box contained urinary catheter (a flexible tube inserted into the bladder to drain urine) supplies. One opened box contained various wound supplies including assorted dressings, tape, and measuring devices. Hall B The shower room window had a build-up of dust, debris, and dead bugs. A four-tiered metal cart used to hold clean towels, wash clothes and toiletries had multiple areas of rust. The shower corner had missing caulk around approximately 50 percent (%) of the area. The hand-washing sink had rust around the faucet and drain. The paper towel dispenser contained multiple areas of rust. On 06/30/25 at 08:49 Hskp/Maintenance U confirmed the areas of concern listed above needed to be addressed. The facility policy for Housekeeping, Laundry and Maintenance, undated, included: Staff shall ensure sinks and paper towel dispensers are kept clean. Boxes shall be kept off the floor at all times.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The facility identified a census of 40 residents. The sample included 14 residents. Based on observation, record review, and interview, the facility failed to ensure residents remained free from resident-to-resident sexual abuse when Resident (R) 1, who had a history of inappropriate sexual behaviors, exposed his genitals to R9, a cognitively impaired resident. This deficient practice resulted in the residents being at risk for impaired psychosocial well-being including fear and embarrassment, and risk for ongoing sexual abuse. Findings included: - R1's Electronic Medical Record (EMR) revealed the following diagnoses: schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R1's 12/06/24 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) of 15, indicating intact cognition. The MDS recorded R1 had no symptoms of depression or behaviors. The MDS noted R1 received antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) and antidepressant (a class of medications used to treat mood disorders) medications. R1's 12/06/24 Psychotropic Drug Use Care Area Assessment (CAA) documented R1 took antipsychotic medications to manage his schizophrenia and delusional disorder and an antidepressant to manage his depression. R1's Care Plan intervention dated 12/28/16 directed staff to speak calmly to him during a behavior. He had childlike behaviors and lacked impulse control. The plan directed staff to attempt to redirect though it may be difficult. The plan directed staff that if R1 becomes disruptive, allow personal space; and use positive reinforcement. R1's Care Plan dated 12/07/24 documented R1 took antipsychotic medications for delusional disorder and schizophrenia. He took Zyprexa (an antipsychotic medication), Clozaril (an antipsychotic medication), valproic acid (a mood stabilizing medication), and Paxil (a medication to treat depression that lowers libido). R1 occasionally displayed the following behaviors: obsessive with needs, rude and demanding of staff, hoarding, and food obsession; he made statements of feeling sad. R1's Care Plan dated 12/07/24 documented R1 had obsessive behaviors with his needs; he was rude and demanding of staff. The plan noted he made statements of feeling sad, had sexually inappropriate behaviors, and had hallucinations (sensing things while awake that appear to be real, but the mind created) and paranoia (a thought process believed to be heavily influenced by anxiety or fear to the point of irrational thinking) that are monitored by staff. R1's Care Plan dated 06/24/25 documented R1's Paxil was increased related to increased sexual behavior. R1's Physician's Orders documented a 09/12/19 order for one tablet of Estrace (a hormone), one milligram (mg), by mouth one time a day for delusional disorder. R1's Physician's Orders documented a 09/26/23 order for one tablet of Zyprexa, five mg, by mouth at bedtime related to delusional disorder. R1's Physician's Orders documented a 02/12/24 order for two capsules of valproic acid 250 mg, by mouth one time a day, for mood disorder. R1's Physician's Orders documented a 04/23/24 order for one Clozaril 100 mg tablet by mouth one time a day and two tablets at bedtime for schizophrenia and anxiety. R1's Physician's Orders documented on 06/25/25 the psychiatric provider ordered one Paxil 20 mg by mouth one time a day for increased sexual behaviors related to anxiety. R1's EMR behavior monitoring tasks documented R1 was sexually inappropriate one time in the last 30 days and refused care one time in the last 30 days. No other behaviors were documented. R1's Progress Notes dated 06/21/25 at 04:31 PM documented R9 (a female resident with severe cognitive impairment) reported to Administrative Staff B that R1 inappropriately touched her leg and exposed himself to her. The facility called the police who came to the facility and interviewed both residents. The officer stated he would write a report. The note documented R1 would be one-on-one with staff. Staff notified Administrative Staff A and R1's Durable Power of Attorney (DPOA). R1's Behavior Note dated 06/22/25 at 04:13 AM documented R1 was one-on-one for inappropriate behaviors. He had behaviors of taking items from his room and giving them to the nurse. R1 reported he did not want the items, or he thought they were not his. R1's Behavior Note dated 06/22/25 at 03:13 PM documented he was one-on-one for inappropriate behaviors. The note documented R1 had no behaviors. R1's EMR lacked evidence indicating one-on-one documentation for the night shift on 06/22/25. R1's Nurse's Note dated 06/23/25 at 10:01 AM documented staff called R1's physician to notify her of R1's change in behavior. The staff received an order for a urine analysis (UA). The order directed if the UA was negative, to refer to R1's mental health provider for possible medication adjustments. R1's Nurse's Note dated 06/23/25 at 10:25 AM documented staff obtained the UA and sent it to the lab. R1's Behavior Note dated 06/23/25 at

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility reported a census of 40 residents. The sample included three residents reviewed for abuse. Based on observation, record review, and interview, the facility failed to ensure staff reported an incident of verbal abuse immediately to the Administrator as required when Certified Nurse Aide (CNA) M began taunting Resident (R)1 and making fun of R1's eyebrows and wrinkles. This deficient practice placed R1 at risk for impaired psychosocial wellbeing and ongoing abuse.Findings Include:- R1's Electronic Medical Record (EMR) revealed the following diagnoses: encephalopathy (broad term for any brain disease that alters brain function or structure), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), diabetes mellitus (the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), hypertension (HTN-elevated blood pressure), hypothyroidism (condition characterized by decreased activity of the thyroid gland), chronic kidney disease (a condition where the kidneys are damaged and cannot filter blood effectively leading to a buildup of waste and extra fluid).R1's 04/04/25 admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of zero indicating severely cognitive impairment. The MDS recorded R1 had physical behaviors towards others occurring one to three days during the look back period; verbal behaviors towards others occurred one to three days during the look back period; and other behaviors such as hitting occurred one to three days during the look back period.R1's 03/04/25 Cognitive Loss Care Area Assessment (CAA) triggered secondary to orientation, memory and recall deficits noted during the BIMS interview. Contributing factors included long and short-term memory loss., self-care deficits, falls and injuries, incontinence, decreased socialization, skin breakdown, weight loss and fluid imbalance.R1's Care Plan dated 04/04/25 directed staff to monitor behaviors such as resistance to cares, grabbing, and pushing staff away. The plan directed staff If R1 appeared restless, anxious or wandered, assess R1 for pain, thirst or hunger.R1's Care Plan dated 04/04/25 indicated R1 experiences mood, behavior and psychosocial problems. The plan directed staff to monitor for aggressive and attention seeking behavioral expressions. The plan instructed staff to intervene as necessary to protect the rights and safety of others. Staff were directed to speak in a calm manner, divert attention from the situation, and take to an alternative location as needed.R1's Risk Progress Notes dated 08/05/25 at 11:56 AM documented a root cause that indicated a staff member did not follow policy and procedure regarding appropriate interactions with a resident. The note listed interventions which included a state report, law enforcement and family notification, suspension of the staff member, nursing assessment, an all-staff in-service on the abuse neglect and exploitation policy; R1's Care Plan was updated.R1's Administrator Note dated 08/06/25 at 12:30 PM documented Administrative Staff A was able to contact R1's durable power of attorney (DPOA) that day after several attempts over the past couple of days to notify her of an abuse allegation involving R1.The facility's investigation documented that during the evening shift on 07/31/25, R1 got up after being put to bed at 06:20 PM and wheeled herself to the dining room. R1 began calling the staff explicit names and CNA M and her coworker started to laugh because it was so random. R1 then started throwing hands and elbows to the two staff that tried to help her so CNA M went to try and help lay R1 down. CNA M started to antagonize R1 with statements that her eyebrows were bushy, and her skin was wrinkled. A report was made with the local law enforcement with a case number of A25-10288.CNA O's Witness Statement dated 08/04/25 documented between 08:30 PM to 9:00 PM on 07/31/25 there was three CNA staff in the is dining room when CNA M tried to take R1 to her room. CNA O noted R1 turned around and elbowed CNA M because she was not ready to go back to her room. CNA M continued to keep her hand on the handle of the wheelchair and mocked R1 making comments about her eyebrows and her wrinkled skin. CNA P's Witness Statement dated 08/04/25 documented R1 got up out of bed and came into the dining room R1 was interested in what the staff members were doing with their eyelashes; R1 then made an inappropriate statement to the staff. The staff started laughing and tried to take R1 back to bed. R1 did not want to go back to bed, and she started to stand up at the nurses' station. CNA P was able to get her to sit down so she would not fall but R1 did swing at that staff member. CNA M was making fun of R1's eyebrows then proceeded to clock out and go home.On 08/12/25 at 09:50 AM R1 sat in the commons area in her wheelchair having a conversation with another staff member.During an interview on 08/12/25 at 08:25 AM, R1 revealed that she has not had any staff members were mean to her. R1 said it was great there, everyone was nice to her.During an interview on 08/12/25 at 12:05 PM CNA N said she observed CNA M on the evening shift on 07/31/25 being rude to R1 and making fun of her. CNA N also said she did not know what to

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 40 residents; the sample included 14. Based on observation, interview, and record review, the facility failed to complete an accurate Minimum Data Set (MDS) for Resident (R)1, regarding antidepressants (medications used to treat symptoms of depression, a mood disorder that can cause persistent sadness, loss of interest in activities, and difficulties with daily functioning) medication. This placed the resident at risk for impaired care due to unidentified care needs. Findings included: - R1's Electronic Medical Record (EMR) included the following diagnoses: schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) and delusional disorders (untrue persistent belief or perception held by a person although evidence shows it was untrue). R1's Annual Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. He received an antipsychotic and antidepressant (medications used to treat symptoms of mood disorders that can cause persistent sadness, loss of interest in activities, and difficulties with daily functioning) medications during the assessment period. The Psychotropic Drugs Care Area Assessment (CAA), dated 12/06/24, documented the resident took psychotropic medications to manage his diagnoses of Schizophrenia and delusional disorder. R1's Quarterly MDS, dated 06/06/25, documented the resident had a BIMS score of 13, indicating intact cognition. He received antipsychotic medications during the assessment period. The MDS inaccurately documented the resident did not receive antidepressant medications during the observation period. R1's Care Plan revised 03/25/25 instructed staff the resident occasionally displayed behaviors and staff were to be firm but gentle when redirecting with the resident. R1's EMR revealed the following physician's order: Paxil (an antidepressant medication), 10 milligrams (mg), by mouth (PO), every day (QD), for a diagnosis of anxiety, ordered 04/30/25. On 06/30/25 at 02:11 PM, the resident ambulated in the hall and the commons area. On 06/30/25 at 07:55 AM, Administrative Nurse D confirmed the Quarterly MDS, dated 06/06/25, was inaccurate as the resident received anti-depressant medication during the assessment period. The facility reported they utilized the Resident Assessment Instrument (RAI) for accurate completion of the MDS and did not provide a policy.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 40 residents; the sample included 14 residents. Based on observation, record review, and interview, the facility failed to complete a comprehensive care plan for Resident (R)23, regarding Black Box Warnings (BBW), placing the resident at risk for inadequate care due to uncommunicated care needs. Findings included: - R23's Electronic Medical Record (EMR) included psychotic disorder with delusions (significant impairment in an individual's perception of reality, leading to the presence of false beliefs that are not based in reality) and high-risk behaviors (actions that significantly increase the likelihood of experiencing negative consequences). R23's admission Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of three, indicating severe cognitive impairment. The resident did not receive any high-risk medication during the assessment period. The Psychotropic Drug Use Care Area Assessment (CAA), dated 01/21/25, did not trigger. R23's Quarterly MDS, dated 04/18/25, documented the resident had a BIMS score of three, indicating severe cognitive impairment. He received antipsychotic (medications used to manage psychosis, including symptoms like delusions, hallucinations, and disordered thoughts) and antidepressant (medications used to treat symptoms of depression, a mood disorder that can cause persistent sadness, loss of interest in activities, and difficulties with daily functioning) medications during the assessment period. R23's Care Plan revised 04/21/25, lacked staff instruction regarding Black Box Warnings (BBW) for medications the resident received. R23's EMR revealed the following physician's orders: Sertraline (an antidepressant medication), 100 milligrams (mg), by mouth (PO), every day (QD), for a diagnosis of psychotic disorder with delusions, ordered 05/22/25. Zyprexa (an antipsychotic medication), 5 mg, PO, QD, for a diagnosis of high-risk behaviors, ordered, 05/22/25. A review of R23's Medication Administration Mar (MAR) for May 2025, revealed the resident received the medications, as ordered. On 06/30/25 at 07:55 AM, Administrative Nurse D stated he expected expectation all BBW medications to be included in the care plan. The facility policy for Electronic Care Plans revised 12/2020, included: Medications will be addressed in each resident's care plan.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. The facility identified a census of 40 residents. The sample included 14 residents. Based on observation, interview, and record review, the facility failed to revise Resident (R) 3's Care Plan with the interventions to prevent further weight loss. This deficient practice placed the resident at risk for continued weight loss due to uncommunicated care needs. Findings: - R3's Electronic Medical Record (EMR) revealed the following diagnoses: unspecified psychosis (any major mental disorder characterized by a gross impairment in reality perception), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) R3's 07/26/24 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) of five, indicating severely impaired cognition. The MDS recorded R3's weight was 193 pounds, and she had no known weight loss. R3 consumed a regular textured diet with no eating or swallowing concerns. The 07/26/24 Nutritional Status Care Area Assessment (CAA) documented R3's weight as 193 pounds, and her height as five foot two inches. R3's risk factors included weight instability, impaired fluid balance, abnormal lab values, and impaired skin integrity. R3's 04/25/25 Quarterly MDS documented a BIMS score of four, indicating severely impaired cognition. The MDS recorded R3's weight was 173 pounds, and she had no known weight loss. R3 consumed a regular textured diet with no eating or swallowing concerns. R3's Care Plan dated 05/29/24 documented she likes cranberry juice and black coffee at breakfast and any juice at lunch and supper. The plan directed staff to provide a regular diet and encourage low sugar and low sodium. Updated on 09/05/24, the plan documented R3 needed set up and or physical help for meals. On 06/25/25 R3's Care Plan was updated to include a mug with a handle, lid, and straw. The plan noted R3 gets tired and may not be able to hold her cup for long. The plan directed staff to provide R3 with built-up utensils at every meal as they are easier for her to grab and hold. R3's Care Plan lacked documentation that R3 was on a fortified diet and had an order for health shakes. R3's Physician's Orders noted a sugar-free supplement one time a day for a nutritional supplement, ordered on 02/21/25. R3's Physician's Orders documented an order for a fortified foods diet, regular texture, and regular consistency fluids dated 06/10/25. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's Progress Note from the Registered Dietician (RD) dated 05/05/25 at 12:56 PM documented R3 currently weighed 164 pounds and continued to lose weight due to inadequate oral intake related to pneumonia (an infection in the lungs). R3 took a few bites at lunch and fell asleep. The Certified Medication Aide (CMA) reported R3 had been declining the sugar-free supplements. The RD noted the resident needed about 1700 calories per day to maintain current weight and 1950 calories per day for a half-pound weight gain per week. The RD recommends the addition of a fortified diet to the current diet order due to weight loss. The RD recommended staff notify the physician of the significant weight loss. On 06/26/25 at 11:28 AM Certified Nurse Aide (CNA) S sat beside R3. R3 had a clothing protector on and had a cup with a lid a handle, and a straw. Staff did not offer her a drink and she did not take a drink. At 11:45 AM, R3 remained at the table, staff had not offered her a drink. At 11:48 AM, R3's food arrived. It was a wrap with french fries. CNA S gently touched R3 and asked her if she wanted to take a bite. CNA S placed some French fries on the fork and offered her a bite. R3 did not want the bite. CNA S waited for a minute then pushed the food to the middle of the table and left to go assist another resident. They did not provide built-up utensils as directed in the care plan. On 06/30/25 at 08:50 AM, Administrative Nurse D stated that he or the MDS Nurse completed the care plans and was responsible for updating them. Administrative Nurse D said fortified foods should have been updated on the care plan. Administrative Nurse D stated he was unsure about the built-up utensils but had not seen the resident use them. The facility policy Electronic Care Plan, dated 12/2020, documented the resident's person-centered plan of care as an active working document that reflects the care needs and resident's voice.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** - R30's Electronic Medical Record (EMR) revealed a diagnosis of cardiovascular accident (CVA-also known as a stroke, a medical emergency where blood flow to a part of the brain is interrupted, leading to brain cell damage). R30's Annual Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. He required set-up assistance for mobility in his manual wheelchair. He had impairment on one side of his upper and lower extremities. The Functional Abilities Care Area Assessment (CAA), dated 01/24/25, documented the resident had left upper and lower extremity weakness and decreased safety awareness. Staff were to expect further activity of living (ADL) decline. R30's Quarterly MDS, dated 04/25/25, documented the resident had a BIMS score of 12, indicating moderately impaired cognition. He had upper and lower extremity weakness on one side and was independent with mobility in his manual wheelchair. R30's Care Plan, revised 4/21/25, instructed staff the resident would propel himself in his wheelchair by placing one foot on top of the other, but he would frequently request staff assistance in propelling him in his wheelchair. A review of the resident's EMR from 05/28/25 through 06/25/25 revealed the resident was occasionally dependent on staff assistance with mobility in his wheelchair. On 06/26/25 at 09:20 AM, Certified Medication Aide (CMA) T propelled R30 in his wheelchair from the front commons area to the beauty shop to administer medication. R30's left foot was not on the foot pedal of his wheelchair and became caught underneath the seat of the wheelchair when CMA T began to propel the wheelchair. R30 had facial grimacing and audible moans and exclamations of pain. Upon assessment, the resident had no injury. On 06/26/25 at 09:20 PM, R30 stated his left foot had not been on the foot pedal when CMA T began to propel his wheelchair. He said his foot became caught underneath the wheelchair which caused him pain in his foot and ankle. The resident stated the pain went away once staff placed his foot back onto the foot pedal. On 06/26/25 at 09:20 AM, CMA T stated the resident's left foot did not always stay on the foot pedal of his wheelchair. CMA T said the resident would often propel himself in the wheelchair and staff would propel him at times, as well. On 06/30/25 at 09:43 AM, Administrative Nurse D stated it was the expectation for staff to utilize foot pedals while propelling residents in their wheelchairs. The facility did not provide a policy for utilizing foot pedals while propelling residents in their wheelchairs. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- R24's Electronic Medical Record (EMR) revealed a diagnosis of dementia (a progressive mental disorder characterized by failing memory and confusion). R24's admission Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of one, indicating severe cognitive impairment. He had impairment on one side of his lower extremity and was dependent on staff for mobility in his wheelchair. The Functional Abilities Care Area Assessment (CAA), dated 11/01/24, documented the resident required staff assistance with all activities of daily living (ADLs). R24's Quarterly MDS, dated 05/02/25, documented the resident had a BIMS score of three, indicating severe cognitive impairment. He had impairment on one side of his lower extremity and was independent with wheelchair mobility. R24's Care Plan, revised 04/29/25, instructed staff the resident was able to propel himself in his wheelchair but required staff assistance at times. On 06/24/25 at 03:50 PM, Certified Nurse Aide (CNA) N propelled the resident in his wheelchair to the dining room. R24's shoed feet skimmed the floor underneath the wheelchair during transport. The wheelchair lacked foot pedals. On 06/24/25 at 03:50 PM, CNA N stated the resident's wheelchair did not have foot pedals because he would propel himself at times. On 06/26/25 at 03:20 PM, CNA R stated staff should utilize foot pedals when propelling residents in their wheelchairs. On 06/30/25 at 09:43 AM, Administrative Nurse D stated it was the expectation for staff to utilize foot pedals while propelling residents in their wheelchairs. The facility did not provide a policy for utilizing foot pedals while propelling residents in their wheelchairs. The facility reported a census of 40 residents; the sample included 14 residents including seven residents reviewed for accidents. Based on observation, interview, and record review, the facility failed to implement appropriate interventions following falls for Residents (R)9 and the facility failed to utilize foot pedals for R30 and R24, placing the residents at risk for injuries and further accidents. Findings included: - R9's Electronic Medical Records (EMR) documented R9 had diagnoses that included intellectual disability (a significantly below-average score on a test of mental ability or intelligence and limitations in the ability to function in areas of daily life), generalized muscle weakness, and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R9's 02/14/25 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of seven, indicating R9 had severe cognitive impairment. The MDS documented R9 had no falls. (continued on next page)

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	175313	A. Building B. Wing	06/26/2025

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Medicalodges Arkansas City	203 E Osage Avenue Arkansas City, KS 67005

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 02/14/25 Falls Care Area Assessment (CAA) documented R9 had impaired gait and mobility. She was dependent for all cares except eating; she did not walk with or without assistance. She had no falls. The 02/14/25 Cognitive Loss/Dementia CAA documented R9 had orientation, memory, and recall deficits, as well as short-term and long-term memory loss. R9's Quarterly MDS documented R9 had a BIMS score of four, indicating severe cognitive impairment. The MDS documented R9 had a noninjury fall. R9's Care Plan documented on 08/30/23 that R9 was at risk for falls related to weakness, frequent falls at home, and knee pain. The plan recorded interventions that instructed R9 was supposed to wear non-slip footwear; initiated on 02/13/23. R9's bed should be in the lowest position and the floor mat was to be in place to decrease the chance of injury as she occasionally tried to get out of bed on her own; initiated 06/20/24. R9's Care Plan documented on 03/13/25, R9 had a non-injury fall. Her bed was in the lowest position and the floor mat was in place. The plan noted staff reminded R9 to use her call light before trying to get up alone. R9's Fall Note dated 03/14/25 at 11:11 AM, documented R9 sat on the floor with her legs stretched out in front of her. She had regular socks on both feet. R9 was able to tell staff that she was getting up and going to call help. R9's Progress Note dated 04/07/25 at 04:20 PM documented a root cause analysis for R9's fall was completed. The note documented R9 tried to move herself to a sitting position in her bed and fell to her mat on the floor. R9's bed was in the low position and a grab rail was in place. R9 had been working with restorative and made very good progress. R9 felt she would be able to transfer herself to a sitting position, but was unable to and did not use call light for assistance. R9 was educated to use the call light so that staff could assist her if needed. Observation on 06/24/25 at 04:51 PM, R9 sat in a high-back wheelchair and rocked forward and back in her wheelchair. On 06/26/25 at 03:20 PM, Certified Nurse Aide (CNA) R said when a resident fell, the nurse assessed the resident, assessed the situation to find out what caused the fall, and then put an appropriate intervention in place. CNA R stated Administrative Nurse D updated the care plans. CNA R said R9 attempted to get up on her own. CNA R stated staff lowered R9's bed, but she still tried to get up every once in a while. On 06/30/25 at 08:28 AM, Licensed Nurse (LN) G was unsure whose responsibility it was to come up with the interventions to prevent falls. LN G said Administrative Nurse D updated the care plan with the new interventions. LN G stated it was not an appropriate intervention just to remind R9 to use her call light and not attempt to get up alone because R9 would not remember. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/30/25 at 08:50 AM, Administrative Nurse D stated sometimes the nurse comes up with an intervention after a fall and then staff discuss it in the morning meeting making sure the root cause analysis was completed, and the intervention was appropriate. Administrative Nurse D verified that reminders or education were not an appropriate intervention for residents with a low BIMS. The facility's policy Falls Management dated 12-2022, documented the facility strives to minimize the risk tor resident falls and to reduce injuries associated with resident falls. The plan of care is to be reviewed and revised with each fall occurrence and new interventions implemented.

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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** The facility identified a census of 40 residents. The sample included 14 residents with one resident reviewed for urinary tract infections (UTI). Based on observation, record review, and interviews, the facility failed to provide adequate care and services to prevent UTI to the extent possible for Resident (R) 1 when failed to provide incontinence care monitor identify, and report signs and symptoms of ongoing UTI. This placed the resident at risk for ongoing UTI and related complications. Findings included: - R2's Electronic Health Record (EHR) revealed diagnoses of chronic kidney disease (a condition where the kidneys are damaged and can't filter blood properly, leading to a buildup of waste and fluid in the body), unspecified urinary incontinence (involuntary leakage of urine), and irritable bowel syndrome with diarrhea (IBS- abnormally increased motility of the small and large intestines). R2 ' s Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. The assessment documented R2 was always incontinent of urine, and she utilized a wheelchair and walker for locomotion. The Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 09/13/24 documented R2 required substantial to maximum assistance for toileting hygiene. The Urinary Incontinence and Indwelling Catheter CAA dated 09/13/24 documented R2 required assistance for toileting and was always incontinent. R2's Quarterly MDS, dated 06/13/25 documented a BIMS score of 12, which indicated moderate cognitive impairment. Per the staff interview, R2 had memory problems with severely impaired cognition. The assessment documented R2 utilized a wheelchair for locomotion, was dependent on staff for toileting needs, and required substantial assistance for bathing activities of daily living (ADL). R2's Discharge with Return Anticipated Minimum Data Set (MDS), dated [DATE] did not document a Brief Interview for Mental Status (BIMS) score. The assessment documented R2 utilized a wheelchair for locomotion was dependent on staff for toileting needs and required substantial assistance for bathing activities of daily living (ADL). R2's Care Plan noted on 06/09/18, that R2 was at risk for recurrent urinary tract infections (UTIs) due to her history of UTIs. The plan recorded interventions for staff to monitor for signs and symptoms of dehydration such as lethargy, increased weakness, and decreased urine output. The plan also recorded interventions that directed staff to report continued signs and symptoms of infection to the charge nurse and that staff would encourage fluids as tolerated with each meal and each time care is provided. The plan recorded that intervention that staff would provide proper peri care with each incontinence episode to help prevent infection. An Infection Note documented on 06/12/25 at 01:14 PM that R2 had completed antibiotic therapy for her UTI on 06/11/25 and that R2 reported that she still felt as though the UTI was still present, but she was unable to specify the symptoms. It was documented that the physician was aware. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Nursing Note documented on 06/12/25 at 01:16 PM that R2 was seen by a provider that day and concerns were voiced about the UTI still being present. No orders were given, and staff were advised to continue to monitor R2. An Infection Note documented on 6/12/2025 at 10:06 PM that R2 remained on antibiotic follow-up for UTI and had no adverse reactions. The note documented that R2 denied pain but did express concerns of burning and stinging at times upon urination. An Infection Note was documented on 06/13/25 at 03:46 PM that R2 continued antibiotic follow-up for a recent UTI and she showed no s/s of adverse reactions. A Nursing: Progress Note documented on 06/20/25 at 07:09 AM that the nurse went into the resident's room at 06:45 AM and R2 was sitting in her wheelchair unable to respond to questions but she would track with her eyes. R2 then started to have yellowish/green emesis. The nurse notified the provider and received an order to send R2 out to the hospital via Emergency Medical Services (EMS) for further evaluation. A Nursing: Progress Note documented on 06/24/25 at 07:44 AM, as a late entry for 06/19/25 at 09:34 AM, noted that staff certified nurse aides (CNA) reported to the nurse that R2 had increased confusion and refused to go to bed, which was unusual for R2. The progress note recorded that R2 notified the staff that she had burning upon urination. This nurse assessed R2 and noted that she would answer appropriately at times but then would talk about something else. The progress note also recorded that R2 was monitored frequently due to confusion and would also take off her nasal cannula. A Nursing: Progress Note documented on 06/24/25 at 07:50 AM, as a late entry for 06/20/25 at 05:00 AM, recorded R2 was assisted to bed during the night but ended up getting back up into her wheelchair without assistance. R2 showed no signs of distress, no complaints of nausea or vomiting were noted, and no unresponsive episodes were noted. The staff spoke with the day nurse and made her aware of R2 ' s behavior and both agreed that she possibly had another UTI and the provider would be notified. R2's EHR documented an order for methenamine hippurate (urinary tract antiseptic) two times a day as a UTI prophylactic (preventative in nature). The medication was started on 01/06/25. Observation on 06/26/25 at 09:21 AM R2 was in bed with her eyes closed. Observation on 06/26/25 at 11:05 AM, R2 continued to remain in bed with eyes closed. On 06/24/25 at 03:31 PM, R2 and her representative reported that R2 had been sent to the hospital for a UTI the morning of 06/20/25 and returned to the facility on [DATE]. R2 and her representative also reported that R2 was left in her wheelchair all night on 06/19/25. On 06/25/25 at 03:15 PM, Licensed Nurse (LN) G stated that to help prevent a UTI she would try to toilet the resident every two hours and encourage fluids. LN G also stated that she would ensure the resident was properly cleaned and dried with each toileting. LN G further stated that she would have then monitored for urinary frequency and urgency for UTI early signs, and difficulty urinating, and would have asked if there was a burning sensation, and monitored for confusion or increased confusion. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/25/25 at 03:22 PM, Certified Nurse Aide (CNA) N stated that for UTI prevention she checked residents and toileted them every two hours, and when they requested. CNA N also stated that she would report to the nurse if the resident developed any mood swings, behavior changes, or urine color changes, and if the resident reported if it hurt to urinate. On 06/25/25 at 03:32 PM, CNA O stated that for UTI prevention she would do frequent, every two-hour, toileting and checks or changes and proper peri-care for the residents. CNA O would monitor for any unusual behaviors outside of their norm, monitor urine odor, and ask the resident if they had any pain or changes in urinating. On 06/25/25 at 03:36 PM, Administrative Nurse D stated that UTI prevention and monitoring expectations were to push and encourage fluids, staff were to provide proper peri-care (the cleaning of the genital and anal areas), staff were to monitor for change in mentation, behavior changes, pain and/or difficulty in urination and report immediately to the nurse. Administrative Nurse D further stated that staff were supposed to do two-hour rounds on the residents and that included toileting checks, and staff were to chart in EHR the bowel/bladder elimination if the residents were incontinent or toileted. On 6/26/25 at 9:21 AM, CNA P reported that R2 requested to go back to bed to rest after breakfast that morning. On 06/26/25 at10:37 AM, Consultant GG stated that it's expected for staff to toilet residents as soon as possible for prevention of UTI, toileting in general varies from resident to resident, those that continuously leak urine or are less aware need more frequent toileting. Consultant GG further stated that staff should monitor for changes in behavior, mentation, and urinary signs such as pain or burning and he expected to be notified by the next morning. Consultant GG also stated that R2 was not typically prone to urosepsis and had been treated for a UTI within the last month. On 06/26/25 at 11:05, Certified Medication Aide (CMA) T stated that R2 reported that she felt weak that day. On 06/26/25 at 11:06 AM, LN G stated she had not been notified of any changes in R2, she had assisted her back into bed at about 09:00 AM and noticed that she was but had not notified anyone yet. The facility policy Nursing Services: Incontinence Management Protocol-Procedure, not dated, indicated that a urinary incontinence assessment will be completed for residents who are identified by the MDS as a2.3.4 for bladder incontinence. The policy further indicated that the nursing staff would monitor and evaluate the resident's responses to preventative efforts and treatment interventions and revise the approaches as appropriate with the interdisciplinary team. The facility policy Incontinence Management Policy, dated 12/2017 indicated that the facility's purpose was to restore or maintain the resident's current bowel and bladder function unless clinically indicated. The policy further indicated that the residents were to be assessed to identify their history and pattern of bowel and bladder function. The policy also indicated that the plan of care would address individualized focus, goals, and interventions directed toward managing the resident's bowel and bladder incontinence.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. The facility identified a census of 40 residents. The sample included 14 residents with three residents sampled for nutrition Based on observation, interview, and record review, the facility failed to provide care and services to maintain acceptable parameters of nutritional status for Resident (R) 3 when the facility failed to implement interventions and recommendations including providing fortified foods to prevent further loss. This deficient practice placed the resident at risk for continued weight loss. Findings: - R3's Electronic Medical Record (EMR) revealed the following diagnoses: unspecified psychosis (any major mental disorder characterized by a gross impairment in reality perception), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) R3's 07/26/24 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) of five, indicating severely impaired cognition. The MDS recorded R3's weight was 193 pounds, and she had no known weight loss. R3 consumed a regular textured diet with no eating or swallowing concerns. The 07/26/24 Nutritional Status Care Area Assessment (CAA) documented R3's weight as 193 pounds, and her height as five foot two inches. R3's risk factors included weight instability, impaired fluid balance, abnormal lab values, and impaired skin integrity. R3's 04/25/25 Quarterly MDS documented a BIMS score of four, indicating severely impaired cognition. The MDS recorded R3's weight was 173 pounds, and she had no known weight loss. R3 consumed a regular textured diet with no eating or swallowing concerns. R3's Care Plan dated 05/29/24 documented she likes cranberry juice and black coffee at breakfast and any juice at lunch and supper. The plan directed staff to provide a regular diet and encourage low sugar and low sodium. Updated on 09/05/24, the plan documented R3 needed set up and or physical help for meals. On 06/25/25 R3's Care Plan was updated to include a mug with a handle, lid, and straw. The plan noted R3 gets tired and may not be able to hold her cup for long. The plan directed staff to provide R3 with built-up utensils at every meal as they are easier for her to grab and hold. R3's Care Plan lacked documentation that R3 was on a fortified diet and had an order for health shakes. R3's Physician's Orders noted a sugar-free supplement one time a day for a nutritional supplement, ordered on 02/21/25. R3's Physician's Orders documented an order for a fortified foods diet, regular texture, and regular consistency fluids dated 06/10/25. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's Progress Note from the Registered Dietician (RD) dated 05/05/25 at 12:56 PM documented R3 currently weighed 164 pounds and continued to lose weight due to inadequate oral intake related to pneumonia (an infection in the lungs). R3 took a few bites at lunch and fell asleep. The Certified Medication Aide (CMA) reported R3 had been declining the sugar-free supplements. The RD noted the resident needed about 1700 calories per day to maintain current weight and 1950 calories per day for a half-pound weight gain per week. The RD recommends the addition of a fortified diet to the current diet order due to weight loss. The RD recommended staff notify the physician of the significant weight loss. R3's Weight Progress Note dated 05/23/25 at 04:27 PM documented R3 had a significant weight loss of 10 percent (%). R3 was on a regular diet with health shakes. R3's Progress Note from the RD dated 06/09/25 at 01:26 PM documented R3 weighed 163 pounds, which was a 10% weight loss since 01/08/25. The RD noted the weight loss was due to a decrease in oral intake and refusing meals. The RD recommended continuing with the sugar-free supplement and adding a fortified diet. R3's Weight Progress Note dated 06/10/25 at 12:59 PM documented R3 received a fortified diet and a sugar-free house supplement that she refused half of the time. The Weight Progress Note dated 06/10/25 documented staff notified the physician regarding R3's weight loss. On 06/26/25 at 11:28 AM Certified Nurse Aide (CNA) S sat beside R3. R3 had a clothing protector on and had a cup with a lid, a handle, and a straw. Staff did not offer her a drink and she did not take a drink. At 11:45 AM, R3 remained at the table, staff had not offered her a drink. At 11:48 AM, R3's food arrived. It was a wrap with french fries. CNA S gently touched R3 and asked her if she wanted to take a bite. CNA S placed some French fries on the fork and offered her a bite. R3 did not want the bite. CNA S waited for a minute then pushed the food to the middle of the table and left to go assist another resident. On 06/26/25 at 11:55 AM, CNA P reported that sometimes R3 just won't eat. CNA P said she would try something else when she was done assisting another resident. Later she reported that she tried dessert, and R3 spit it out. CNA P also reported that she did not use built-up silverware as was in R3's plan of care. CNA P said R3 was dependent on staff assistance. CNA P said she was unsure if R3's meal had a fortified food item On 06/26/25 at 12:01 PM, CNA S reported she had been working at the facility for almost a year and R3 required staff assistance for meals since CNA S started. CNA S said R3 had not used built-up silverware and verified that R3 did not have any fortified foods for lunch. On 06/26/25 at 12:22 PM, Dietary Staff CC reported R3 was on a regular diet. Dietary Staff CC said in order to make fortified foods, they add items like extra butter or cheese to add extra calories and fat to foods. Dietary Staff CC confirmed R3 did not get any fortified items and stated R3 was not on a fortified diet. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/26/25 at 12:29 PM, CMA T stated that R3 does not drink her shake at all. CMA T reviewed the charting for June 2025 and verified 14 out of the 25 days were marked as shake refused. On 06/26/25 at 03:20 PM, CNA R reported that when R3 does not want to eat, she will scream if staff persists, R3 will slap items away. On 06/30/25 at 08:50 AM, Administrative Nurse D stated that R3 spits out food if she does not want to eat. Administrative Nurse D said the facility fortifies foods by adding cheese to eggs and items to increase calories and fat in food. Administrative Nurse D said if a resident's diet order changes, the nurse should communicate it to dietary staff with a dietary communication slip and the dietary manager also has access to the EMR. Administrative Nurse D said R3's diet order for fortified foods should have been communicated. The facility policy Weight Assessment and Intervention, dated 2011, included: that a 10% weight loss is undesirable and severe. The care plan would be reviewed by the interdisciplinary team and updated. Interventions will be individualized and based on careful consideration of choice, nutrition needs, function, and environmental factors.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. The facility reported a census of 40 residents. Based on interviews and record review, the facility failed to complete an annual performance review at least once every 12 months for one of the five Certified Nurse Aides (CNA) reviewed, CNA M, placing the affected residents at risk for decreased quality of care. Findings included: A review of five employee personnel files, employed by the facility for greater than one year, revealed the following: CNA M's personnel file revealed she was hired on 12/13/23. Her file lacked an annual performance review. On 06/26/25 at 09:45 AM, Administrative Staff A stated the facility had not completed an annual evaluation for CNA M. The facility policy for Performance Reviews, undated, included: Full and part-time employees shall receive a formal, written evaluation on an annual basis.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. The facility reported a census of 40. There were 14 residents included in the sample. Based on interview, observation, and record review the facility failed to implement effective behavioral interventions for Resident (R) 37 ' s behaviors. This deficient practice placed the resident at risk for mental anguish, social isolation, and impaired quality of life. Findings include: - A review of R37 ' s Electronic Health Record (EHR) revealed diagnoses of anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), severe intellectual disabilities (a significantly below-average score on a test of mental ability or intelligence and limitations in the ability to function in areas of daily life), unspecified mood [affective] disorder (category of mental health problems, feelings of sadness, helplessness, guilt, and wanting to die were more intense and persistent than what may normally be felt from time to time), insomnia (inability to sleep), and impulsiveness (sudden, forceful, irresistible urges to do something). R37 ' s admission Minimal Data Set (MDS), dated 09/01/24 documented R37 ' s behaviors impacted others related to him significantly intruding on the privacy or activity of others and significantly interfering with the other resident's participation in activities or social interactions. The assessment also indicated that R37 would wander frequently and that his wandering would intrude upon other ' s privacy. The Communication Care Area Assessment (CAA), dated 09/01/24 documented that R37 had an impaired ability to make himself understood through verbal and non-verbal expression and had an impaired ability to understand others through verbal content. The Behavioral Symptoms CAA, dated 09/01/024 documented that R37 wandered. R37's Quarterly MDS, dated 05/30/25 documented a Brief Interview for Mental Status score of three, indicating severe cognitive impairment. The assessment documented that R37 wandered for one to three days during the observation period. R37's Care Plan noted on 05/12/25, R37 required staff assistance with activities of daily living (ADL) due to intellectual disability and the interventions included that staff would provide 1:1 monitoring with visual contact at the doorway when in R37 ' s room and within appropriate distance during meals and any activity outside of his room as to provide intervention/redirection immediately when behaviors indicated (ie touching others). R37's Care Plan noted on 05/12/25, that R37 had mood/behavior and psychosocial problems, and could be manipulative, passive/aggressive, and attention-seeking at times. The interventions included 1:1 monitoring, and staff were to redirect R37 to more appropriate behavior. Staff were to report any aggressive behaviors to his family and physician. Staff were to also assist R37 in developing more appropriate methods of coping and interacting with staff and encourage R37 to express feelings appropriately. (continued on next page)

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	175313	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Arkansas City	203 E Osage Avenue Arkansas City, KS 67005

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Nursing: Progress Note documented on 04/10/25 at 07:49 AM documented that the nurse was notified by the Certified Nurse Aide (CNA) that a female resident was touched by R37 on the chest and he tried to kiss her. The note documented that the CNA had seen R37 walking toward the female resident and told R37 to stop several times, but he did not stop or respond to requests to stop. The note recorded the CNA then observed the male resident trying to touch the female resident ' s breast. The progress note further documented that the residents were separated by staff and R37 went to his room. A Behavior Note, documented on 05/30/25 at 12:11 PM that R37 continued to be on 1:1 with staff and he frequently moved between his bedroom and the dining area and was not easily redirected and ignored staff when they tried to assist him. A Behavior Note, documented on 06/20/25 at 04:22 PM R37 had outbursts of foul language and extremely loud noises and was difficult to redirect at times but calmed after taking his evening medications. A Behavior Note, documented on 06/21/25 at 03:10 PM R37 remained 1:1 with loud outbursts of foul language and attempted touching multiple staff that shift. A Behavior Note, documented on 06/26/25 at 02:28 PM R37 remained 1:1 with some behaviors that shift that included very loud noises, did not listen to staff and R37 attempted to and did touch staff but was eventually redirected. Observed on 06/24/25 at 10:00 AM R37 walked up and grabbed and hugged the female state surveyor upon entry into the facility; staff were present but did not intervene or redirect R37. Observed on 06/26/25 at 12:15 PM R37 continuously grabbed and pushed down on the female CNA Q's left arm and kept holding onto her left arm. CNA Q did not stop R37 ' s behavior or redirect him. On 06/24/25 at 03:06 PM, Consultant HH stated that R37 was 1:1 due to sexual inappropriateness towards females and that he would grab and hug female staff. On 06/25/25 at 11:53 AM, Administrative Staff A stated that 1:1 was a decision that was made with the interdisciplinary team based on the resident's behaviors and needs. Administrative Staff A reported that R37 was 1:1 based on his behaviors of inappropriate touching and that he was very touchy and grabbing/hugging; he was not allowed to touch any person without permission from that person. On 06/25/25 at 12:07 PM, Administrative Nurse D stated that 1:1 was determined by the behavior of the resident and if other interventions had failed. Administrative Nurse D reported that R37 was 1:1 because he would inappropriately pinch people. On 06/26/25 at 12:15 PM, CNA Q stated that R37 wasn't really bothering her so she did not ask him to stop his behavior that occurred in the dining room. She said it was better than causing a scene or escalating his behaviors. The facility did not provide a policy for behavioral management.

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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. The facility reported a census of 40 residents, one main kitchen and one kitchenette. Based on observation, record review, and interview, the facility failed to prepare and serve food under sanitary conditions to prevent the potential for food-borne bacteria. This placed the residents at risk for foodborne illness. Findings included: - During an initial tour of the kitchen on 06/24/25 at 03:39 PM, the following areas of concern were noted: 1. The stationary can opener had a sticky, thick substance covering the entire can opener. 2. Two machines utilized to puree food had dried food and liquids. 3. The inside and outside of the microwave oven had dried on foods and liquids. 4. Four cutting boards had deep grooves making them unsanitizable. 5. The front of the white cabinet doors and upper cabinet doors throughout the kitchen had dried on food and liquids. The handles to the cabinets contained a build-up of a sticky substance. 6. The inside of the cabinets which contained plastic pitchers, equipment parts, and other kitchen supplies rested directly on the bottom of the cabinets which contained a sticky, unknown substance. 7. A three-tiered metal cart holding eating utensils, syrup, measuring cups, and clean dishes had food debris on all three layers. 8. Eight plastic containers that contained cooking utensils, scoops, spatulas, and other utensils had a sticky substance on the lids. 9. Two black, plastic three-tiered carts used to transport cups of fluid to the residents in the dining room had food debris on all three layers. 10. Four plastic containers containing dry cereal had lids covered in dust. 11. A five-gallon container of sherbet ice cream was uncovered and undated in the reach-in freezer. 12. An empty gallon container of vanilla ice cream in the reach-in freezer was undated. 13. One of the two-door reach-in freezers had dried food and liquid on the front of the doors. 14. One of the two-door reach-in freezers had three boxes of food with a heavy build-up of ice. The kitchenette in the south dining room had the following concerns: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. The hand-washing sink was visibly dirty with a brown substance and small pieces of trash. 2. The microwave had dried food and liquid on the inside and outside. 3. The trash can had dried food and liquid covering the front. 4. The freezer contained three open containers of ice cream which were unlabeled and undated. 5. The bottom shelf of the freezer had food debris and hair. 6. The two-door cabinet had dried on food and liquids. On 06/26/25 at 01:58 PM, Dietary staff BB confirmed the areas of concern and stated they would be added to the cleaning schedule. The facility policy for Date Marking, dated 2011, included: All foods stored for more than 24 hours will be properly labeled. The Cleaning Rotation for the kitchen, dated 2011, documented that can openers, blenders, and food processors shall be cleaned following each use. The hand-washing sink, microwave oven, and food carts shall be cleaned each day. Trash barrels, drawers, and cupboards shall be cleaned weekly. Refrigerators, freezers, and storage bins shall be cleaned monthly.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. The facility reported a census of 40 residents. The sample included 14 residents. Based on interviews, record reviews, and observation, the facility staff failed to implement adequate and acceptable infection control practices related to laundry services. This deficient practice placed the residents at risk for infections. Findings included: - During an observation on 06/24/25 at 02:56 PM, residents' clean clothes were carried by a hanger down the hall, uncovered, and placed in a resident's room by laundry staff. During an observation on 06/25/25 at 10:13 AM, staff carried resident clothes on a hanger down the hallway, uncovered. During an observation on 06/30/25 at 12:05 PM, observed in the soiled laundry storage there was a barrel with soiled laundry in and no cover, and there was soiled laundry sitting in the open on a covered transport bin. During an observation on 06/30/25 at 12:10 PM, the washing room, next to a washer, had a parked housekeeping cart, also observed were dirty mop buckets sitting on the drainage grate behind the washers. During an observation on 06/30/25 at 01:10 PM, the clean laundry folding counter at one end had a dryer sheet box, a dumbbell weight, a stuffed dog, and two large totes. Observed on the other end of the clean laundry folding counter was a binder, a laptop and speakers, and a refrigerator. On 06/30/25 at 12:10 PM, Maintenance V stated that the housekeeping staff stored their cleaning carts in the washing room. On 06/30/25 at 01:10 PM, Maintenance V stated that the refrigerator on the clean laundry folding counter was for the staff ' s personal use and personal food items. On 06/30/25 at 12:12 PM, Housekeeping W stated that the resident's clothes were transported by the transport carts and that they should be closed completely when transporting them down the hall and when the resident's clothes were taken into the resident ' s room. On 06/30/25 at 12:40 PM, Administrative Staff A stated that it was not acceptable to have items other than clean laundry on the clean laundry folding counters. Administrative Staff A further stated that dirty mop buckets should not have been left or stored between or behind the washers. On 06/30/25 at 12:57 PM, Housekeeping U stated that the only items that should have been on the clean laundry counter were clean laundry; it was not appropriate for other items to be stored there. Housekeeping U further stated that dirty mop buckets should not have been stored or left between the washers. On 06/30/25 01:48 PM, Housekeeping U reported that the facility did not have a policy related to clean laundry storage and delivery. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility policy titled Infection Management Process, dated 12/2019 indicated that laundry services were performed off the resident living units and laundry services included cleaning of clothing using proper product and water temperature mix. It further indicated that soiled resident linen and clothing would be transported in an enclosed container to the laundry to avoid contamination to the resident living areas and to the employees.

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F 0921 Level of Harm - Potential for minimal harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. The facility reported a census of 40 residents. The sample included 14 residents. Based on interviews, record reviews, and observation, the facility failed to ensure a safe environment in all areas of the facility including the laundry area. Findings included: - During an observation on 06/30/25 at 12:05 PM the dryer-maintenance access room had large pieces of paint coming off around and above the dryers. During an observation on 06/30/25 at 01:10 PM there were multiple fluorescent light fixture covers that were broken and hanging. One light cover was above the clean laundry hanging counter and the other plastic cover was above the clean laundry delivery carts. Multiple light fixtures have broken plastic covers. Another observation made at this time revealed paint flaking off the ceiling above the clean laundry delivery carts. On 06/30/25 at 12:05 PM, Maintenance V stated the paint flaking in the dryer-maintenance access room was not much of an issue because the dryer elements and the electrical components were enclosed. On 06/30/25 at 12:40 PM, Administrative Staff A reported that it was not acceptable to have peeling paint anywhere, especially above the clean linen or where it can fall on the dryers. Administrative Staff A also stated that new light covers had been ordered for the broken fixtures in the clean linen room and the old ones had to be left in place to cover the bulbs until the new ones would arrive. On 06/30/25 at 12:57 PM, Housekeeping U stated that there should not have been flaking paint anywhere, especially over the laundry or over the dryers. Housekeeping U further stated that the light fixture covers should have been removed and/or replaced somehow, it was unacceptable to leave broken and hanging fixtures above the clean laundry areas. The facility policy titled Housekeeping, Laundry and Maintenance indicated that housekeeping, laundry, and maintenance must provide their services to the facility on a 24-hour basis, either as scheduled or on an on-call basis. The policy stated that the departments must maintain the interior and exterior of the facility and furnishings in a clean, orderly, and attractive manner. The policy further indicated that the facility will be kept free of offensive odors, safety hazards, and accumulations of dust, dirt, and unacceptable levels of bacterial and viral organisms using standard procedures and work methods.