STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175413	A. Building B. Wing	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Paola	501 Assembly Lane Paola, KS 66071

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40689 The facility reported a census of 65 residents. The sample included three residents reviewed for accidents. Based on observation, interview, and record review, the facility failed to prevent the neglect of Resident (R)1, when staff did not utilize appropriate transfer equipment to safely meet the needs of R1, who displayed signs of weakness during cares. On 08/28/24 at 02:40 PM, Licensed Nurse (LN) G, Certified Nurse Aide (CNA) M, CNA N, and Certified Medication Aide (CMA) R assisted R1 to stand, with use of a gait belt that was not the appropriate size for R1. As two of the staff members attempted to pull R1's incontinence brief up, R1's legs became weak, and staff lowered R1 to the floor. During the lowering, the resident's left leg buckled underneath the resident and rotated outward, which caused a popping noise. The facility called Emergency Medical Services (EMS) to transfer R1 to the Emergency Department (ED). R1 admitted to the hospital with an obliquely oriented fracture (the bone fractured at an angle) through the middle to distal (lower portion) femoral (thigh bone) diaphysis (shaft). This deficient practice placed the facility in immediate jeopardy. Findings include: - R1's Physician Order Sheet (POS) dated 07/09/24, revealed diagnoses of chronic obstructive pulmonary disease (progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), congestive heart failure (a condition with low heart output and the body becomes congested with fluid), osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), tricompartmental osteoarthritis (cartilage that cushions and protects the bones in certain regions gradually degenerates), morbid (severe) obesity (excessive body fat) with alveolar hypoventilation (a condition causing low oxygen intake causing high levels of carbon dioxide in the blood), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and mood disorder (category of mental health problems, feelings of sadness, helplessness, guilt, wanting to die were more intense and persistent than what may normally be felt from time to time). The 08/05/24 Entry Minimum Data Set, (MDS), documented the resident admitted to the facility on [DATE]. The 08/12/24 Admission MDS documented the resident had a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The resident used a manual wheelchair for mobility. The resident required supervision with transfers and toileting due to functional limitations of mobility in bilateral (both) lower extremities. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175413	A. Building B. Wing	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Paola	501 Assembly Lane Paola, KS 66071

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The ADL [Activities of Daily Living] Functional/Rehabilitation Potential Care Area Assessment (CAA), dated 08/20/24, documented the resident required assistance with ADLs due to impaired balance and transition during transfers and functional impairment in activity. The Fall CAA, dated 08/20/24, documented the resident required assistance with transfers due to impaired gait (manner or style of walk) and mobility. R1's Activities of Daily Living Care Plan, dated 08/14/24, included R1 required assistance with ADLs related to physical limitations. R1 required assistance of one staff for dressing and personal care. R1 could self-propel in her manual wheelchair throughout the facility. R1 required more assistance if she complained of pain. An update on 08/20/24 instructed the staff to assist R1 with transfers from the wheelchair to the toilet, as well as dressing after toileting. R1's Fall Care Plan, dated 08/21/24, instructed staff that R1 was at risk for falls. The care plan further instructed staff to remind the resident to utilize her call light when she needed assistance, ensure the pathway in her room remained clean and unobstructed, and all the resident's commonly used items remained in her reach. A 08/30/24 revision instructed staff to transfer R1 with a mechanical lift only. The Fall Risk assessment dated [DATE] and 08/27/24 indicated R1 was a moderate risk for falls. Review of R1's left hip, left femur, and left knee x-ray report, dated 08/28/24, documented obliquely oriented fracture (the bone fractured at an angle) through the middle to distal (lower portion) femoral (thighbone) diaphysis (shaft). The report noted tricompartmental (three compartments of the knee) osteoarthritic (arthritis [painful inflammation and stiffness of the joints] that affects all three compartments of the knee) change for R1. A Nursing Note on 08/28/24 at 05:23 PM, revealed LN G, CNA M, CNA N, and CMA R attempted to change and transfer R1. There were two staff members on each side of R1 and two staff members behind the resident. The resident's legs became weak and staff lowered her to the floor. The resident's bilateral lower extremities were tucked underneath her, and LN G heard an audible pop. LN G observed the resident's left lower extremity rotated outward. Administrative Nurse D assessed R1 and the resident was transported by Emergency Medical Services (EMS) to the Emergency Department (ED). Review of a RISK Progress Note dated 08/30/24 at 12:57 PM, revealed staff lowered R1 to the floor on 08/28/24 at 02:40 PM to prevent a fall. The facility documented suspected abuse or neglect was not determined due to the resident's diagnosis of tricompartmental osteoarthritis (cartilage that cushions and protects the bones in certain regions gradually degenerates in this illness), that could cause femoral stress fractures and the cause of injury was medically related. Review of Administrative Nurse A's Witness Statement on 08/28/24, revealed staff requested her assistance to R1's room. R1 was observed supine (lying face upward) on the floor with her left lower extremity turned outward. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175413	A. Building B. Wing	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Paola	501 Assembly Lane Paola, KS 66071

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 09/03/24 at 11:48 AM, LN G reported R1 readmitted to the facility from the hospital within the last 24 hours related to acute respiratory distress and appeared to be very weak. CMA R entered the resident's room to administer medications and noticed the resident required more assistance due to weakness. LN G reported that she and CMA R attempted to place a gait belt around the resident, but the facility did not have a gait belt that was the appropriate size for R1. LN G reported while providing cares for R1, the resident required more than two staff members due to difficulty standing. LN G reported she asked for CNA M and CNA N to assist with cares. R1 stood as she held onto her wheelchair, assisted by LN G and CMA R on each side of her, while CNA M and CNA N were pulling up her brief. The resident began to express that her legs were becoming too weak to stand and she had shortness of breath, while wearing oxygen at 3 liters. The staff members lowered the resident to the floor. LN G reported while lowering the resident to the floor, there was an audible pop. LN G observed the resident's bilateral lower extremities buckled underneath the resident and her left lower extremity was in an outward rotation. LN G requested for Administrative Nurse A to assess the resident and for a staff member to call for Emergency Medical Services (EMS). When EMS arrived, staff assisted the paramedics to transfer the resident from the floor onto the gurney, and EMS transported R1 to the Emergency Department (ED). LN G reported she did not know the resident's transfer status and she had not received report on R1 after she was readmitted to the facility, prior to lowering the resident to the floor. LN G reported when she initially entered the resident's room to assist CMA R, she should have asked CMA R to wait so that she could receive guidance from Administrative Nurse D, because the resident appeared weak and short of air at that time. LN G reported that a mechanical lift should have been used during the transfer. On 09/03/24 at 12:09 PM CNA M reported LN G requested her assistance with R1 to change the resident's bedding, clothing, brief, and assist with a transfer. CNA M said the gait belt was too small to wrap around the resident and the facility did not have a gait belt that was the appropriate size for R1. CNA M said the resident was able to stand up with LN G and CMA R on each side to stabilize her. CNA N and CNA M assisted R1 with a change of clothes and a clean brief. R1 became weak and her leg began to buckle so the four staff members assisted the resident to the floor and heard loud audible pops. CMA R exited the resident's room to ask Administrative Nurse D for assistance. EMS arrived, place the resident in a sitting position, and with staff assistance, transferred the resident from the floor to the gurney with a transfer sling. R1 transported to the ED. CNA M said when the resident returned from her hospital stay, the Kardex (communication and documentation system for nursing staff) and her care plan should have immediately been revised for a mechanical lift. When a resident was newly admitted , staff should receive the type of cares and transfer status during report. CNA M reported she should have asked Administrative Nurse D for guidance on the mechanical lift. During an interview on 09/03/24 at 12:30 PM, CNA N reported on 08/28/24 she was asked to assist with R1's cares and transfer. CNA N reported R1 required two-person assistance for her cares when she was readmitted to the facility on [DATE]. When CNA N entered the resident's room, the resident was standing up, holding onto her wheelchair, assisted by LN G and CNA M. CNA N reported the resident began to have shortness of air and requested to sit down. The resident sat on the side of the bed and began to slide, and staff then assisted R1 to the floor. CNA N said the resident's bilateral lower extremities were underneath her with her left lower extremity extended outward. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175413	A. Building B. Wing	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Paola	501 Assembly Lane Paola, KS 66071

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 09/03/24 at 12:39 PM, CMA R reported she asked LN G to assist with R1's incontinent care. CMA R said the staff tried two different two gait belts, but both gait belts were too small. The resident legs became increasingly weak, and staff lowered R1 to the floor. LN G noticed R1's left leg was underneath her and observed an outward rotation. CMA R said the resident required more than one or two staff members. The resident was not care planned for a mechanical lift at the time but should have been care planned for a full body mechanical lift. During an interview on 09/03/24 at 03:37 PM, Administrator Nurse D said based on the investigation the resident should have been care planned and transferred with a mechanical lift. Administrator Nurse D said LN G should have stopped cares and transferred R1 with a mechanical lift. The facility's Abuse, Neglect and Exploitation policy, dated 10/2022, documented that the resident had the right to be free from neglect. The facility failed to prevent the neglect of Resident (R) 1, when staff did not utilize appropriate transfer equipment to safely meet the needs of R1, who displayed signs of weakness during cares and staff had to lower the resident to the floor and sustained an obliquely oriented fracture (the bone fractured at an angle) through the middle to distal (lower portion) femoral (thighbone) diaphysis (shaft). On 09/04/24 at 01:06 PM an IJ template was provided to Administrative Staff A and notified the facility failed to prevent the neglect of R1, when staff did not utilize appropriate transfer equipment to safely meet the needs of R1, who displayed signs of weakness during cares. On 08/29/24 at 02:40 PM, LN G, CNA M, CNA N, and CMA R attempted to stand R1 with use of a gait belt. The gait belt was not utilized due to the gait belt was too small for the resident. The four staff members assisted R1 to a standing position from her bed, as two staff members attempted to pull up her brief. The resident's legs became weak, and staff lowered R1 to the floor. During the lowering, the resident's left leg was buckled underneath the resident, and rotated outward, that caused a popping noise. The facility called Emergency Medical Services (EMS) to transfer R1 to the Emergency Department (ED). R1 admitted to the hospital with an obliquely oriented fracture (the bone fractured at an angle) through the middle to distal (lower portion) femoral (thighbone) diaphysis (shaft). The facility provided an acceptable plan for removal of the immediacy on 09/04/24 at 04:36 PM. On 09/04/24 at 11:00 AM, Administrative Nurse D reported education/training started on 09/04/24 and would be completed on 09/04/24. Administrative Nurse D reported that she reported to the nursing staff R1 was a mechanical lift for transfer when she reported on 08/27/24 from the hospital. All nursing staff would complete the abuse and neglect training prior to working their next shift. The Immediate Jeopardy was determined to first exist on 08/27/24 at 02:40 PM, when Licensed Nurse (LN) G, Certified Nurse Aide (CNA) M, CNA N, and CMA R transferred R1 without the appropriate equipment. The facility identified and implemented the following corrective actions, completed on 09/04/24: 1. On 08/28/24 at 02:40 PM, staff assessed R1. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175413	A. Building B. Wing	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Paola	501 Assembly Lane Paola, KS 66071

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. The facility updated R1's care plan related to transfer. All will have transfer ability assessed with revision care plan as 3. Nursing staff educated on R1 to be Hoyer (full body mechanical lift) transfer upon return from the hospital on 09/04/24. Staff would be educated upon hire and prior to working their next scheduled shift. 4. Nursing staff educated that if a resident transfer required more than two staff, staff were to use a full body mechanical lift and report to the Director of Nursing immediately. Educated on 08/28/24. 5. Licensed staff educated on updating care plans upon readmission, education began on 09/05/24. 6. Staff would be educated upon hire and prior to working their next scheduled shift. 7. Abuse, Neglect and Exploitation (ANE) training completed with staff by 09/04/24. 8. Staff would be educated to utilize the appropriate size of gait belt for R1. The surveyor verified the implementation of the above corrective actions onsite on 09/04/24 at 04:36 PM, and the deficient practice remained at a G scope and severity.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175413	A. Building B. Wing	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Paola	501 Assembly Lane Paola, KS 66071

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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 40689 The facility reported a census of 65 residents. The sample included three residents reviewed for accidents. Based on observation, interview, and record review, the facility failed to report the elopement (an incident in which a cognitively impaired resident with poor or impaired decision-making ability/safety awareness leaves the facility without the knowledge of staff) of Resident (R)2 to the State Agency, as required. On 08/27/24 at 08:48 PM R2 left the facility without staff knowledge or supervision and at approximately 10:41 PM, Law Enforcement called the facility to advise them they had received calls noting that R2 was walking on the highway, entered a gas station approximately 0.9 miles from the facility. Law Enforcement advised License Nurse (LN) H that someone needed to come to their location because Law Enforcement had the R2 surrounded with their patrol cars due to his threats to Law Enforcement and the store clerk, yelling, cursing and agitation. The LN H reported she immediately drove to the gas station in her personal vehicle, without contacting Administrative Staff A or Administrative Nurse D and returned to the facility with the R2. While LN H drove back to the facility, she reported the R2 made several attempts to grab the steering wheel of the car while she was driving. The failure of the facility to report an elopement to the State Agency as required, placed R2 in immediate jeopardy. Findings include: - R2's Physician Order Sheet (POS) dated 07/09/24, revealed his diagnoses included schizoaffective disorder (mental health disorder with mood disorder), bipolar type (major mental illness that caused people to have episodes of severe high and low moods), communication deficit (impairments in language comprehensive, speech, verbal, and nonverbal communication), extrapyramidal and movement disorder (movement disorders as a result of taking certain medications), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and drug induced subacute dyskinesia (involuntary movement disorder). The 07/05/24 Admission Minimum Data Set (MDS) documented the resident had a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The resident had disorganized thinking and verbal behaviors. The resident was independent with his Activities of Daily Living (ADLs) and had a history of falls. R2's Fall Care Plan, dated 01/11/24, instructed staff the resident would get eight hours of sleep per night. The 01/11/24 Care Plan for R2 did not include Sign Out privileges for R2. R2's Elopement Risk Assessment, dated 05/03/24, revealed a score of 5, indicating a low risk for elopement. R2's Fall Risk Assessment, dated 05/17/24, revealed a score of 15, indicating a moderate risk for falls. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175413	A. Building B. Wing	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Paola	501 Assembly Lane Paola, KS 66071

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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Behavior Note, dated 08/27/24 at 10:41 AM by LN H, revealed Law Enforcement called the facility and reported they received a call stating R2 was walking on the highway, walked into a gas station, and attempted to buy cigarettes with postage stamps. LN H drove her personal car to the location Law Enforcement gave her and returned the resident to the facility. The resident refused an assessment and staff placed the resident on one-on-one monitoring the following morning (08/28/24) at 09:30 AM. Review of a Social Service Progress Note dated 08/28/24 at 09:00 AM, revealed the facility contacted R2's Durable Power of Attorney (DPOA) and they gave R2 Sign Out Privileges (SOP) at that time. The revised Care Plan, dated 08/28/24 (after R2's elopement), instructed staff to know the resident's guardian approved the resident to walk in the community. The resident was educated on the Sign Out Privileges (SOP) policy, where/how to sign out, and to inform the nursing staff if R2 was going to utilize the SOP. On 09/04/24 at 11:33 AM, review the facility video surveillance revealed on 08/27/24 at 08:48 PM, R2 exited the smoking door from the dining room and did not return at that time. The resident wore shoes, jeans, shirt, and a jacket. Review of the State Agency database for the facility revealed lack of reporting the 08/27/24 elopement of R2. On 09/03/24 at 12:09 PM, CNA M reported she was not an approved driver for the facility. CNA M reported the facility policy included an approved driver would transport the resident in the facility van if the facility had an elopement. The front door alarm was to be turned on at 07:00 PM and the smoking door alarm was to be turned on at 11:00 PM. With the behaviors that were reported (agitation, threatening, yelling, and cussing), a staff member should not have picked R2 up in their personal car. Law Enforcement should have transported the resident to the facility. The facility had a communication board at the nurse's desk which indicated which door was opened with clear surveillance video to identify who exited the door. On 09/03/24 at 12:30 PM, CNA N reported when she returned to work on 08/28/24, she was asked by Administrative Nurse D to sit with R2 one-on-one because the resident left the facility grounds. CNA N said R2 had not shown exit seeking behaviors to leave the facility grounds and the resident would sit outside in the smoking area with peers. On 09/03/24 at 11:48 AM, LN G reported she received education related to elopement and stated prior to the elopement on 08/27/24, she was not aware that R2 had left the facility grounds unsupervised. LN G reported that R2 did leave the facility with family but did not have Sign Out Privileges to leave the facility grounds unsupervised. On 08/28/24, R2's family authorized Sign Out Privileges for R2. LN G reported R2 does sit outside in the smoking area and in front of the building on facility benches. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175413	A. Building B. Wing	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Paola	501 Assembly Lane Paola, KS 66071

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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 09/03/24 at 01:10 PM, LN H reported Law Enforcement called the facility on 08/27/24 at 10:40 PM and informed the facility that R2 was at a gas station, and he threatened a gas station clerk. The resident wanted to buy cigarettes with postage stamps. Law Enforcement reported to LN H that police had R2 surrounded with the patrol units due to his threatening behaviors of agitation, yelling, and cursing. She drove to the gas station, (approximately 0.9 miles from the facility) and picked up R2 and brought him back to the facility. As LN H transported the resident to the facility in her personal car, the resident made attempts to grab the steering wheel. LN H reported she was not an approved driver and she knew she was not to transport residents in her personal car. On 09/03/24 at 03:24 PM, Administrative Staff A reported he visited with R2, and R2 reported he exited the facility to buy a pack of cigarettes. Administrative Staff A reported staff would provide R2 with five cigarettes in the morning and five cigarettes in the afternoon. Administrative Staff A reported since R2 planned on returning to the facility after obtaining cigarettes, he felt this was not reportable to the State agency. The facility's Elopement Policy & Procedure policy dated, 12/2022, documented that the facility will minimize the risk of residents leaving the premises without the necessary supervision or authorization to do so. The facility's Elopement Policy & Procedure policy lack information regarding reporting to the State Agency after an elopement. The facility failed to report the 08/27/24 elopement of R2 to the State Agency, as required. On 09/04/24 at 01:06 PM, the IJ template was provided to the Administrative Staff A and notified the facility failure to notify the State Agency of R2's 08/27/24 elopement, when he exited the facility from the smoking door from the dining room exit door on 08/27/24 at 08:48 PM, placed the resident in immediate jeopardy to his health and safety. Law Enforcement notified the facility on 08/27/24 at 10:41 PM of calls that R2 was walking on the highway and entered a gas station approximately 0.9 miles from the facility, threatening a store clerk, wanting to buy cigarettes with postage stamps. On 09/04/24 at 01:30 PM, Administrative Nurse D reported training started on 09/04/24 and would be completed on 09/05/24. Administrative Nurse D reported staff would complete the Elopement Policy & Procedure in-service, prior to working their next shift. The immediate jeopardy was determined to first exist on 08/27/24 at 08:48 PM when R2 exited the facility unsupervised and without the facility's knowledge through the smoking door on 08/27/24 at 08:48 PM, and the facility did not notify the State Agency. The facility provided an acceptable plan for removal of the immediacy on which 09/04/24 04:36 PM, which included the following: 1. The staff would be educated on elopement policy and accountability of resident location by 09/04/24. Staff would be educated upon hire and prior to working their next scheduled shift. 2. On 09/04/24 at 03:50 PM, Administrative Staff A, Administrative Nurse D & Administrative Nurse E received education on Federal Required Reporting. The surveyor verified the implementation of the above corrective actions 09/04/24 at 04:36 PM, and the deficient practice remained at a D scope and severity.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175413	A. Building B. Wing	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Paola	501 Assembly Lane Paola, KS 66071

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 40689 The facility reported a census of 65 residents. The sample included three residents reviewed for accidents. Based on observation, interview, and record review, the facility failed to protect Resident (R) 2 from possible harm when he exited the facility unsupervised and without staff knowledge (elopement) on 08/27/24 at 08:48 PM. At approximately 10:41 PM, Law Enforcement called the facility to inform them they received calls noting R2 was walking on the highway, then entered a gas station (approximately 0.9 miles from the facility), threatened a store clerk, and wanted to buy cigarettes with postage stamps. Law Enforcement informed License Nurse (LN) H someone needed to come to their location because Law Enforcement had R2 surrounded with their patrol cars due to his threats of yelling, cursing and agitation to Law Enforcement Officers and the store clerk. LN H reported she immediately drove her personal vehicle to the gas station, without contacting Administrative Staff A or Administrative Nurse D, and returned to the facility with R2. LN H said as she drove R2 back to the facility, R2 made several attempts to grab the steering wheel of the car while she was driving. This deficient practice placed the resident in immediate jeopardy. Findings include: - R2's Physician Order Sheet (POS) dated 07/09/24, revealed his diagnoses included schizoaffective disorder (mental health disorder with mood disorder), bipolar type (major mental illness that caused people to have episodes of severe high and low moods), communication deficit (impairments in language comprehensive, speech, verbal, and nonverbal communication), extrapyramidal and movement disorder (movement disorders as a result of taking certain medications), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and drug induced subacute dyskinesia (involuntary movement disorder). The 07/05/24 Admission Minimum Data Set (MDS) documented the resident had a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The resident had disorganized thinking and verbal behaviors. The resident was independent with his Activities of Daily Living (ADLs) and had a history of falls. R2's Fall Care Plan, dated 01/11/24, instructed staff the resident would get eight hours of sleep per night. The 01/11/24 Care Plan for R2 did not include Sign Out privileges for R2. R2's Elopement Risk Assessment, dated 05/03/24, revealed a score of 5, indicating a low risk for elopement. R2's Fall Risk Assessment, dated 05/17/24, revealed a score of 15, indicating a moderate risk for falls. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175413	A. Building B. Wing	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Paola	501 Assembly Lane Paola, KS 66071

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Behavior Note, dated 08/27/24 at 10:41 AM by LN H, revealed Law Enforcement called the facility and reported they received a call stating R2 was walking on the highway, walked into a gas station, and attempted to buy cigarettes with postage stamps. LN H drove her personal car to the location Law Enforcement gave her and returned the resident to the facility. The resident refused an assessment and staff placed the resident on one-on-one monitoring the following morning (08/28/24) at 09:30 AM. Review of a Social Service Progress Note dated 08/28/24 at 09:00 AM, revealed the facility contacted R2's Durable Power of Attorney (DPOA) and they gave R2 Sign Out Privileges (SOP) at that time. The revised Care Plan, dated 08/28/24 (after R2's elopement), instructed staff to know the resident's guardian approved the resident to walk in the community. The resident was educated on the Sign Out Privileges (SOP) policy, where/how to sign out, and to inform the nursing staff if R2 was going to utilize the SOP. On 09/04/24 at 11:33 AM, review of the facility video surveillance revealed on 08/27/24 at 08:48 PM, R2 exited the smoking door from the dining room and did not return at that time. The resident wore shoes, jeans, shirt, and a jacket. During an interview on 09/03/24 at 12:09 PM, CNA M reported she was not an approved driver for the facility. CNA M reported the facility policy included an approved driver would transport the resident in the facility van if the facility had an elopement. The front door alarm was to be turned on at 07:00 PM and the smoking door alarm was to be turned on at 11:00 PM. With the behaviors that were reported (agitation, threatening, yelling, and cussing), a staff member should not have picked R2 up in their personal car. Law Enforcement should have transported the resident to the facility. The facility had a communication board at the nurse's desk which indicated which door was opened with clear surveillance video to identify who exited the door. During an interview on 09/03/24 at 12:30 PM, CNA N reported when she returned to work on 08/28/24, she was asked by Administrative Nurse D to sit with R2 one-on-one because the resident left the facility grounds. CNA N said R2 had not shown exit seeking behaviors to leave the facility grounds and the resident would sit outside in the smoking area with peers. During an interview on 09/03/24 at 11:48 AM, LN G reported she received education related to elopement and stated prior to the elopement on 08/27/24, she was not aware that R2 had left the facility grounds unsupervised. LN G reported that R2 did leave the facility with family but did not have Sign Out Privileges to leave the facility grounds unsupervised. On 08/28/24, R2's family authorized Sign Out Privileges for R2. LN G reported R2 does sit outside in the smoking area and in front of the building on facility benches. During an interview on 09/03/24 at 01:10 PM, LN H reported Law Enforcement called the facility on 08/27/24 at 10:40 PM and informed the facility that R2 was at a gas station, and he threatened a gas station clerk. The resident wanted to buy cigarettes with postage stamps. Law Enforcement reported to LN H that police had R2 surrounded with the patrol units due to his threatening behaviors of agitation, yelling, and cursing. She drove to the gas station, (approximately 0.9 miles from the facility) and picked up R2 and brought him back to the facility. As LN H transported the resident to the facility in her personal car, the resident made attempts to grab the steering wheel. LN H reported she was not an approved driver and she knew she was not to transport residents in her personal car. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175413	A. Building B. Wing	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Paola	501 Assembly Lane Paola, KS 66071

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 09/03/24 at 03:24 PM, Administrative Staff A reported he received a call from LN I after staff brought R2 back to the facility. Administrative Staff A reported R2 was immediately placed on one-on-one observation on 08/27/24 at 10:45 PM until 08/28/24 at 09:30 AM. Administrative Staff A reported he was unsure what time R2 exited the facility. The nursing staff reported they last saw R2 on 08/27/24 at 09:15 PM. On 08/28/24, staff notified R2's Durable Power of Attorney (DPOA) and they gave R2 Sign Out Privileges. After visiting with R2 on 08/28/24, Administrative Staff A reported R2 said he planned to return after he purchased cigarettes. Administrative Staff A also reported the facility had authorized drivers that lived locally to transport residents at any hour. The facility staff were not authorized to transport residents in their personal vehicles. According to Administrative Staff A, prior to R2 exiting the facility grounds unsupervised, staff provided ten cigarettes that morning for the day for R2, but on 08/27/24, R2 had smoked the ten cigarettes earlier in the day. Administrative Staff A reported he visited with R2, and R2 reported he exited the facility to buy a pack of cigarettes. Administrative Staff A reported staff would provide R2 with five cigarettes in the morning and five cigarettes in the afternoon. The facility's Elopement Policy & Procedure policy dated, 12/2022, documented that the facility will minimize the risk of residents leaving the premises without the necessary supervision or authorization to do so. The facility failed to protect R2 from possible harm when R2 exited the facility unsupervised and without facility staff knowledge from the smoking door from the dining room exit door on 08/27/24 at 08:48 PM. On 08/27/24 at approximately 10:41 PM, Law Enforcement called the facility to advise the facility the resident had entered a gas station approximately 0.9 miles from the facility and threatened a store clerk, wanting to buy cigarettes with postage stamps. On 09/04/24 at 01:06 PM, the IJ template was provided to Administrative Staff A and notified the facility failed to protect R2 from possible harm when he exited the facility from the smoking door off of the dining room exit door on 08/27/24 at 08:48 PM. On 08/27/24 at approximately 10:41 PM, Law Enforcement called the facility to advise the facility that the Law Enforcement received calls that R2 had been walking on the highway, then entered a gas station approximately 0.9 miles from the facility and threatened a store clerk, wanting to buy cigarettes with postage stamps. The immediate jeopardy was determined to first exist on 08/27/24 at 08:48 PM when R2 exited the facility unsupervised and without the facility's knowledge through the smoking door on 08/27/24 at 08:48 PM. The facility provided an acceptable plan for removal of the immediacy on 09/04/24 at 04:36 PM, which included the following: 1. On 08/27/24 at 10:40 PM, the resident was assisted back to the facility by a nurse and the resident refused an assessment. 2. The residents guardian approved walking privileges for R2 with the care plan revised on 08/28/24. 3. R2 educated on the sign out process with care plan revised on 08/28/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175413	A. Building B. Wing	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Paola	501 Assembly Lane Paola, KS 66071

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. R2 would be assessed to determined sign out privileges and safe walking with the care plan revised by 09/04/24. 5. The staff would be educated on elopement policy and accountability of resident location by 09/04/24. Staff would be educated upon hire and prior to working their next scheduled shift. The surveyor verified the implementation of the above corrective actions 09/04/24 at 04:36 PM, and the deficient practice remained at a D scope and severity.