STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation # KS00185772, KS00184588, and KS00182494. This 2567 was electronically sent to the facility on 03/04/24.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F 550		

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
	175294	A. BUILDING _____ B. WING _____	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

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F 550	Continued From page 1	F 550		

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 38 residents with 13 residents sampled, that included five residents selected for review related to dignity. Based on interview, observation, and record review, the facility failed to protect the privacy and dignity of Residents (R)40 and R95. This deficient practice led to R40's and R95's respective urinary catheter (a tube inserted into the bladder to drain urine and into a collection bag) bags to be visible to visitors and other residents. This practice had the potential to lead to negative psychosocial effects related to dignity.

Findings included:

- R40's Electronic Health Record (EHR) revealed a diagnosis of benign prostatic hyperplasia (BPH, a non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency and urinary tract infections).

The "Admission Minimum Data Set" (MDS) dated 11/12/23, documented a "Brief Interview for Mental Status" (BIMS) of 13, which indicated intact cognition. R40 had an indwelling urinary catheter (a tube inserted into the bladder to drain

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 2	F 550		

urine and into a collection bag) and required substantial or maximal assistance with all cares except eating, which he was independent.

The "Quarterly MDS" dated 01/19/24, documented a BIMS of 13, which indicated intact cognition and that R40 had an indwelling urinary catheter.

The "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA) dated 11/12/23 documented that R40 required assistance with toileting needs and actual incontinent episodes.

The "Care Plan", dated 11/20/23, revealed R40 had an indwelling catheter related to urinary retention (lack of ability to urinate and empty the bladder) and included the following interventions:

On 11/20/23, staff were to change the catheter every 30 days.

On 11/20/23, staff were to change the catheter as needed.

On 11/20/23, staff were to monitor catheter output every shift.

On 01/20/24, staff were to change the catheter every 30 days at bedtime on the 16th of every month.

The care plan lacked interventions related to maintaining or protecting the resident's privacy or dignity related to the urinary catheter.

The EHR "Physician Orders" documented the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

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F 550	Continued From page 3	F 550		

1. On 02/16/24, urinary catheter in place and to change every 30 days and as needed on the 13th of each month related to BPH with urinary obstruction.

2. On 02/14/24, flush catheter nightly with 60 milliliters (mL) of sterile water at bedtime related to BPH with urinary obstruction.

On 02/20/24 at 01:23 PM, R40 observed from the hallway resting in bed with a urinary catheter drainage bag hanging from the bed frame. The drainage collection bag was approximately 1/3 full of a transparent light-straw colored liquid.

On 02/22/24 at 11:25 AM, Certified Nurse Aide (CNA) G revealed that urinary catheter bags should always be covered with a dignity bag or otherwise obscured from view of visitors and other residents to protect the resident's dignity.

On 02/21/24 at 01:10 PM, Licensed Nurse (LN) F revealed urinary catheter bags should be inside dignity bags when ever they are visible to other residents or visitors and explained if a resident was in their bed, the drainage bag should be placed on the other side of the bed, other than in view of the hallway door. When a resident sat in their recliner or wheelchair, the drainage bag should be in a dignity bag or other device to obscure it from public view.

On 02/26/24 at 12:57 PM, Administrative Nurse B revealed that all urinary catheter drainage bags should be in a dignity bag or otherwise always obscured from the view of other residents or visitors.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	02/26/2024

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MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

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F 550	Continued From page 4	F 550		

The facility's undated "Resident Rights" policy documented that each resident has the right to a dignified existence and should be treated with consideration, respect and full recognition of their dignity and individuality which included privacy in treatment and care of their personal needs.

The facility failed to protect the privacy and dignity of R40. This deficient practice led to R40's urinary catheter bag to be visible to visitors and other residents. This practice had the potential to lead to negative psychosocial effects related to dignity.

- Resident (R) 95's signed physician orders dated 02/09/24, revealed the diagnosis that included bladder neck obstruction (lack of ability to urinate and empty the bladder).

The "Admission Minimum Data Set" (MDS) dated 02/14/24 revealed a "Brief Interview for Mental Status" (BIMS) score of 11, indicating moderate cognitive impairment. The resident required moderate assist with toileting and supervision with mobility. The resident had an indwelling urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag).

The "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA) dated 02/14/24, revealed R95 required assistance with toileting needs and actual incontinent episodes. Contributing factors included weakness, impaired mobility, and cognitive loss. The risk factors included skin breakdown, falls, and recurrent UTIs (urinary tract infections). A care plan will be initiated/reviewed to improve/maintain current toileting skills and ability to transfer to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 5	F 550		

commode, continence status, decrease fall and pressure ulcer risk, and decrease risk for UTI. The CAA lacked documentation of the resident having an indwelling urinary catheter on admission to the facility due to bladder neck obstruction.

R95's "Care Plan" dated 02/06/24, revealed the resident had an indwelling urinary catheter. Staff were to change the catheter every eight to ten days related to bladder obstruction and to monitor the output every shift.

Review of the physician's admission orders, dated 02/08/24, revealed orders for a Foley catheter (urinary catheter), 18 French, with a 10 cubic centimeter (cc) bulb. Change every eight to ten days due to bladder neck obstruction.

Observation on 02/20/24 at 09:00 AM, revealed staff assisted R95 to ambulate in the hallway with a walker as a mobility device. The resident's catheter bag hung on a bar on the side of the walker with no dignity bag in place and yellow urine was visible in the tubing and the urine collection bag.

Observation on 02/20/24 at 01:35 PM, revealed the resident on his bed. The resident's catheter bag hung from the footboard of the bed. The urine collection bag lacked a covering, and yellow urine was visible from the hallway outside of the resident's room.

Observation on 02/20/24 at 03:43 PM, revealed the catheter bag hung from the footboard on the bed above the level of the bladder. The collection bag lacked a covering and the resident's uncovered collection bag was visible from the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

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F 550	Continued From page 6 hallway. Observation on 02/21/24 at 09:39 AM, revealed the resident on his bed. The collection bag contained urine and lacked a dignity bag. R95's door was open, and the uncovered collection bag was visible from the hallway. On 02/21/24 at 09:48 AM, Certified Nursing Assistant (CNA) D reported staff should cover the urinary collection bag. On 02/21/24 at 09:45 AM, Licensed Nurse (LN) E reported staff should keep a dignity bag on urinary collection bags. On 02/22/23 at 11:00 AM, Administrative Nurse B reported CNA's have skills checklists and should know how to care for a resident with a urinary catheter. All catheter bags should be kept in a dignity bag. The undated facility's policy for "Resident Rights" revealed the resident shall be treated with consideration, respect, and full recognition of their dignity and individuality, including privacy in treatment and in the care of personal needs. The facility failed to protect the privacy and dignity of R95 by not providing a dignity bag to cover his catheter drainage bag.	F 550		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and	F 584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 7	F 584		

supports for daily living safely.

The facility must provide-
§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 38 residents. Based on observation, record review, and interview, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

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F 584	Continued From page 8	F 584		

facility failed to maintain a clean, comfortable and homelike environment to the residents that resided in the facility.

Findings included:

- On 02/22/24 at 04:00 PM, initial walk through of the facility with Administrative Staff A, identified a broken fiberglass reinforced panel (FRP - a waterproof plasticized product that is often used on high-contact surfaces such as walls or doors to prevent damage to the structural integrity of the material underneath), with a jagged edge approximately 10-12 inches off the floor on the door to the shower room on 100 hall that was only utilized by the residents on the 100 hall.

On 02/22/24 at 04:05 PM, Administrative Staff A stated that the shower room would be removed from service until the door had been repaired and notified the appropriate personnel to remove and replace the panel.

On 02/26/24 at 07:30 AM, surveyor verified with Administrative Staff A that the door panel had been replaced and with visual inspection of the shower room door on the 100 hall.

On 02/26/24 at 01:30 PM, environmental tour with Maintenance Supervisor J revealed and confirmed the following areas of concern:

1. Seventeen (17) areas of concern where the carpet had frayed at the seams in the dining area, main hallway, nurses station area, 100 hall carpet and 200 hall carpeting.

2. A broken transition and frayed carpeting between the hallway and the shower room on 200

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 9	F 584		

hall that was only utilized by residents of the 200 hall.

3. Numerous broken tiles in shower room on 200 hall that was only utilized by residents of the 200 hall.

4. The ceiling in the nursing station area immediately inside the main entry that led to the 200 hall had a seam where the drywall panels separated, and the seam had fallen away from the ceiling but was still attached to the ceiling.

5. Multiple areas on numerous visible walls in the residents' rooms, and hallways with wallpaper peeling away from the wall.

6. An area on the ceiling and the wall of 200 hall that transitioned from the nursing station where the wallpaper was held in place with scotch tape.

On 02/26/24 at 01:45 PM, Maintenance Supervisor J was unable to provide an explanation why the identified items had not been replaced and/or repaired by the facility.

The facility's undated "Housekeeping, Laundry and Maintenance" policy documented that the maintenance person is responsible for the routine repair and maintenance of the facility and equipment and preventative maintenance must be performed as listed in the "Preventative Maintenance" manual.

The facility failed to provide a "Preventative Maintenance" manual.

The facility's "Housekeeping, Laundry and Maintenance" policy, dated 06/03/14,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 10 documented that housekeeping, laundry and maintenance were responsible to keep the interior of the building clean, safe and orderly. Further documented that maintenance would maintain the facility in good repair and free from hazards such as loose or cracked floor coverings and other similar conditions. The facility failed to maintain a clean, comfortable and homelike environment to the residents that resided in the facility.	F 584		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: The facility reported a census of 38 residents with 13 residents selected for review. Based on observation, interview, and record review, the facility failed to accurately complete the Minimum Data Set (MDS) for one sampled resident, Resident (R)195, related to the use of indwelling urinary catheter (a tube inserted into the bladder to drain urine into a collection bag). This placed the resident at risk for uncommunicated care needs. Findings include: - R195's Electronic Health Record (EHR) revealed diagnoses that included the following: urinary tract infection (UTI-an infection in any part of the urinary system), lack of coordination, overactive bladder, encounter following surgical amputation (surgical removal of a body part),	F 641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 11	F 641		

osteomyelitis (local or generalized infection of the bone and bone marrow), need for assistance with personal care and generalized weakness.

R195's "Admission Minimum Data Set" (MDS) dated 09/21/23 documented a "Brief Interview for Mental Status" (BIMS) score of 15, which indicated intact cognition. R195 required total care of two persons for all cares except eating which required supervision. R195 had an indwelling urinary catheter (a tube inserted into the bladder to drain urine into a collection bag).

R195's "Quarterly MDS", dated 01/24/24 documented a BIMS score of 13, which indicated intact cognition. R195 was occasionally incontinent of urine and had no indwelling or external urinary catheters.

R195's "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA) documented R195 was incontinent of urine and at risk for recurrent UTIs with contributing factors of weakness, impaired mobility and cognitive loss.

The "Care Plan", dated 01/07/24, revealed that R195 had an indwelling urinary catheter and included the following interventions:

On 09/16/24, staff were to provide assistance with pericare (care of the skin of the area of the body between the anus and genitals) and catheter care.

On 01/07/24, staff were to change the catheter as needed.

On 01/07/24, staff were to monitor catheter output every shift.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 12	F 641		

On 01/19/24, staff were to flush the catheter every night at bedtime.

On 01/20/24, staff were to change the catheter every 30 days.

The EHR "Physician Orders" documented the following:

1. On 01/11/24, to insert indwelling urinary catheter and lacked indication for use.

2. On 02/15/24, to flush urinary catheter every night at bedtime for wound care management.

3. On 02/15/24, to change the indwelling urinary catheter every 30 days for wound care management.

The "Progress Notes" documented the following:

On 01/06/24 at 12:12 PM, that staff had spoken with resident and family about changing from a condom catheter (a tube attached to a sheath for the penis used to carry urine to a collection bag) to indwelling catheter

On 01/10/24 at 03:45 PM, that staff had spoken to wound clinic who had sent the resident from the wound clinic to the Emergency Department (ED) and staff explained that they had put in an indwelling catheter (at undocumented date/time) due to condom catheter being insufficient to control urinary incontinence.

Review of EHR "Tasks" documented 39 entries that indicated the completion of catheter care between 01/06/24 and 02/22/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 13 On 02/22/24 at 02:30 PM, Administrative Nurse B revealed that the resident had a condom catheter changed to indwelling catheter some time on 01/06/24. On 02/26/24 at 12:57 PM, Administrative Nurse B confirmed that R195's "Quarterly MDS", dated 01/24/24 incorrectly documented no indwelling or external urinary catheters. Further stated that her expectation was for all assessments including MDS assessments to be accurate. The facility failed to provide a policy related to accuracy of assessments as requested on 02/26/24 at 01:00 PM. The facility failed to accurately complete the MDS for R195 related to the use of indwelling urinary catheter. This placed the resident at risk for uncommunicated care needs.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 14	F 656		

required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 38 residents, with 13 residents selected for review. Based on observation, record review and interview, the facility failed to develop a comprehensive person-centered care plan for Resident (R)39, regarding the need for isolation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

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F 656	Continued From page 15	F 656		

Findings included:

- Resident (R)39's signed physician orders, dated 02/16/24 revealed the diagnosis included respiratory syncytial virus (RSV is a contagious virus that causes infections of the respiratory tract).

The "Admission Minimum Data Set" (MDS) dated 08/08/23, revealed a "Brief Interview for Mental Status" (BIMS) score of 14, indicating intact cognition. The resident required extensive assistance of two for daily care and was non-ambulatory. The resident received pain medication on an as needed basis for pain of 6/10 scale.

The "Quarterly MDS" dated 12/22/23, revealed no significant changes in cognition or cares.

R39's "Care Plan" dated 08/03/23 revealed the following:

R39 required staff assistance with daily cares related to physical limitations.

R39 required assistance of two staff for toileting ad transfers.

R39 could occasionally self-propel the wheelchair around the facility, and other times, required staff assistance for propelling the wheelchair.

The care plan lacked interventions for isolation for RSV care of the resident.

Review of the physician orders dated 02/18/24 revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 16	F 656		

On 02/18/24, Quarantine (isolation) for 10 days due to RSV.

Observation on 02/20/24 at 08:30 AM, revealed the resident dressed and well-groomed sitting in his wheelchair in his room, and finished eating breakfast. The resident was talkative and sounded congested as he spoke with an occasional cough. Personal protective equipment (PPE) barrels were in the room by the door for staff to doff PPE.

On 02/20/24 at 8:30 AM, the resident reported he felt better but still had no energy. He needed to rest during the day. The resident did not like having to remain in his room. Staff came in but only when he needed something, then staff had to wear all that "garb".

On 02/21/24 at 10:20 AM, certified nursing assistant (CNA) D reported the resident was on quarantine for RSV. Staff must gown and glove and wear a mask when entering the room.

On 02/22/24 at 01:30 PM, CNA L reported the resident still had the cough, but felt better. He is on isolation, and he understands he must stay in his room. The resident Has RSV.

On 02/22/24 at 02:00 PM, Licensed Nurse (LN) reported the facility had a lot of residents in isolation due to RSV. They had to be in isolation for 10 days. Staff are educated e on wearing PPE and have it right outside the residents' rooms. He does have a cough. He continues to cough up small amounts of thick yellow sputum (a mixture of saliva and mucus produced by the lungs as a result of viral or bacterial infections).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 17 On 02/26/24 at 12:57 PM, Administrative Nurse B reported staff try to update the care plan as soon as possible when changes develop. She confirmed incomplete data on R24's care plan. Review of the facility's policy for "Electronic Care Plan" dated 12/18 revealed Care Plan Revision- The interdisciplinary Team are to review, revise, and sign the person-centered plan of care with revisions. The facility failed to develop and implement R39's care plan to include his isolation status and treatment for RSV. This placed the resident at risk to not receive appropriate cares and treatment.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 18	F 657		

resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 38 residents. The sample included 13 residents. Based on observation, interview and record review, the facility failed to review and revise one resident's care plans, related to adequate monitoring and care of Resident (R)26's multiple skin areas/wounds.

Findings included:

- Review of Resident (R)26's undated "Physician Orders," (POS) documentation included diagnoses of multiple sclerosis (MS- progressive disease of the nerve fibers of the brain and spinal cord) , anxiety disorder (mental or emotional reaction disorder characterized by apprehension, uncertainty and irrational fear) , chronic inflammation (a normal body's response to injury or infection) polyneuritis (inflammation of several peripheral nerves at the same time), and diabetes (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin).

The "Annual Minimum Data Set," (MDS) dated 04/21/23, documentation included a "Brief Interview for Mental Status," score (BIMS) of 14, indicating cognitively intact. The resident required extensive assistance of staff with his bed mobility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 19	F 657		

He had a formal skin assessment completed which identified him as not at risk for pressure ulcer/injury and without skin care issues.

The "Pressure Ulcer/Injury Care Area Assessment," (CAA), dated 05/10/23, documentation included the resident required staff assistance with bed mobility, transfers, walking, locomotion, dressing, toileting, personal hygiene, and bathing during his look back period. The resident was incontinent of bladder and frequently incontinent of bowel during his look back period. The CAA contributing factors which included Activities of daily living (ADL)/functional/mobility impairment and incontinence. Risk factors included pain, the development of Pressure ulcer/skin condition, and fluid deficit risk. A licensed nurse to assess the resident's skin each week and put proper interventions in place to prevent skin breakdown. Skin is also assessed by caregivers with each bath and each time the resident is dressed. Notify the physician of any abnormal findings and treatment orders obtained. His caregivers assist with repositioning at least every two hours and as needed for comfort.

The "Care Plan" dated 01/28/24, directed staff the resident was at risk for skin breakdown. Staff were to provide skin assessments per protocol and as indicated. Additionally, to monitor and report any changes, skin tears, or bruising while providing daily cares, and assisting the resident with his bathing. The care plan lacked address of the resident scratching his legs that resulted in multiple scabbed areas on his legs. The care plan lacked interventions for monitoring the areas or treatment for the multiple scabbed areas on his bilateral (both) legs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 20	F 657		

Review of the resident's "Skin Condition Note," dated 09/08/2023 at 08:57 AM, documented the resident's skin as warm and dry. The resident with a history of picking and scratching with both open and scabbed over areas to bilateral (both) lower extremities (BLE) and bilateral upper extremities (BUE). No areas over 1.0 centimeter (cm) with no indication of infection noted. No current treatment order initiated as needed for open areas with excessive bleeding. He was non-compliant with education provided regarding scratching and picking. The "Skin Condition Note," lacked details regarding the number of skin area, location, characteristics, or measurements, to provide a baseline of information for monitoring for worsening skin condition.

Each subsequent weekly "Skin Condition Note," dated 09/15/23 through 01/21/24 documented the resident's condition in general terms such as "sporadic scabbed over areas related to picking and scratching," and lacked assessment details regarding the number of skin area, characteristics, nor measurements, to provide a baseline of information for monitoring of skin condition and need for intervention to prevent complications for this dependent diabetic resident.

On 02/21/24 at 09:37 AM, the resident sat in the wheelchair with an undated bandage on his left lower front leg. He had multiple open areas with red wound bed with scant blood present as well as scabbed areas with surrounding redness and bluish discoloration on the front portion of his right lower leg. The right lower leg did not have a bandage present. On inquiry, the resident stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 21	F 657		

he reason the bandage was on his left leg was because he picked his leg. When asked what happened to his other leg (right leg), he stated he picked and scratched it as well. The resident reported his legs itched and he did not know why the staff just put the bandage on his left leg.

On 02/21/24 at 01:51 PM, Licensed Nurse (LN) F stated the resident picks at his legs and sometimes they bleed. The resident likes to watch them bleed. She verified the resident lacked orders for dressings or treatment for his legs, but the staff sometimes put bandages on the areas to stop them from bleeding because the resident took blood thinners. She verified the lack of address in the resident's care plan of his scratching or picking at his skin, nor interventions to monitor and prevent further injury to his skin. Additionally, she reported the resident received a weekly skin check. She verified the "Skin Condition Notes," lacked number, location, characteristics, and measurements of the wounds on the resident's bilateral legs.

On 02/22/24 at 02:45 PM, Administrative Nurse C assessed the resident's bilateral legs and confirmed his left leg with edema and seven scabbed areas from just above the knee on the left outer side extending to the ankle . Additionally, Administrative Nurse C assessed the right leg and noted 13 scabbed areas which included two wounds with surrounding redness. She explained to the resident that he needed to stop scratching his legs to prevent cellulitis (skin infection caused by bacteria) in his legs. She continued to explain cellulitis was an infection of the skin and he was at a greater risk to potentially lose his legs because he was a diabetic.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 22	F 657		

On 02/26/24 at 02:13 PM, Administrative Nurse B confirmed the above findings. She stated the "Skin Condition Notes," should include the measurements, characteristics, and location of wounds to facilitate monitoring for condition change and to determine the need for further intervention. She stated the Care plan should include updated status of wounds based on the assessment to direct the staff in providing care to prevent further complications for this dependent resident with diabetes.

The facility policy "Electronic Care Plan," dated 12/2018, documentation included the purpose of the care plan is to provide a guide to the Interdisciplinary Team (IDT), resident, and responsible party, to promote quality care and quality of life by facilitating communication about the resident's barriers and needs. Care plan review and revisions are to be completed will the wellness program.

The facility failed to review and revise the care plan, related to the monitoring and care of this resident with multiple skin areas/wounds (20).

- Resident (R) 24's signed physician orders revealed the following diagnoses: diabetes mellitus type 2 (when the body cannot use glucose, not enough insulin is made or the body cannot respond to the insulin), hypertension (elevated blood pressure), pain, and congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid).

The "Annual Minimum Data Set" (MDS) dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 23	F 657		

08/18/23, revealed a "Brief Interview for Mental Status" (BIMS) score of 12, indicating moderate cognitive impairment. The resident received pain medication on schedule. The resident received antidepressants (class of medications used to treat mood disorders).

The Quarterly MDS dated 02/02/24, revealed no changes in cognition Medications included an antidepressant.

The "Psychotropic Drug Use Care Area Assessment" (CAA), dated 08/18/23 revealed R24's CAA triggered secondary to use of psychotropic medication to manage a psychiatric illness or condition.

Review of the Care Plan dated 02/21/24 revealed R24 used therapeutic psychotropic medications. The resident received the antidepressant duloxetine for behaviors of rejection of care and abusive language. R24 required psychiatric services. R24's Buspar dosage increased per order due to increased anxiety with delusional thinking. The use of psychotropic drugs puts R24 at risk for falls, lethargy, and depression.

Review of the Physician orders revealed Buspar, 10 milligrams (mg), twice a day, revealed the medication was discontinued on 11/07/22.

Review of the Consulting Pharmacist Monthly Medication Regimen Review revealed the following:

On 02/23/23- Please remove Buspar from the care plan. Resident is no longer on medication since 11/07/22.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 24	F 657		

On 03/15/23- Please remove Buspar from the care plan. Resident is no longer on medication since 11/07/22.

Observation on 02/21/24 at 08:00 AM revealed the resident's family propelled R24 to the dining room. R24 visited with family and no signs of distress.

Observation on 02/22/24 at 01:00 PM, revealed R24 without signs of distress.

On 02/20/24 at 09:00 AM, Certified Nursing Assistant (CNA) D reported the resident and her family spent a lot of time in their room with their own activities. The resident required assist of one with all her cares but was alert and could make needs known.

On 02/22/24 at 03:00 PM CNA L reported the resident had no real behaviors. She required assist of one with her care.

On 02/22/24 at 02:00 PM, Licensed Nurse (LN) M reported the resident was pleasant and cooperative with staff with all her cares.

On 02/26/24 at 12:57 PM, Administrative Nurse B reported staff should update the care plan care as soon as possible when changes would develop. She confirmed inaccurate data on R24's care plan.

Review of the facility's policy "Electronic Care Plan" dated 12/18, revealed for the care plan revision, the Interdisciplinary Team are to review, revise, and sign the person-centered plan of care with revisions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 25 The facility failed to update the resident care plan when the antianxiety medication was discontinued on 11/07/22.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: The facility reported a census of 38 residents. The sample included 13 residents with one resident sampled for skin condition, not related to pressure ulcer/injury. Based on observation, interview and record review, the facility failed to ensure adequate monitoring of one Resident (R)26's skin condition, to ensure resolution of multiple skin areas/wounds (20). Findings included: - Review of Resident (R)26's undated "Physician Orders," (POS) documentation included diagnoses of multiple sclerosis (MS- progressive disease of the nerve fibers of the brain and spinal cord) , anxiety disorder (mental or emotional reaction disorder characterized by apprehension, uncertainty and irrational fear) , chronic inflammation (a normal body's response to injury or infection) polyneuritis (inflammation of several peripheral nerves at the same time), and diabetes	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 26	F 684		

(DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin).

The "Annual Minimum Data Set," (MDS) dated 04/21/23, documentation included a "Brief Interview for Mental Status," score (BIMS) of 14, indicating cognitively intact. The resident required extensive assistance of staff with his bed mobility. He had a formal skin assessment completed which identified him as not at risk for pressure ulcer/injury and without skin care issues.

The "Pressure Ulcer/Injury Care Area Assessment," (CAA), dated 05/10/23, documentation included the resident required staff assistance with bed mobility, transfers, walking, locomotion, dressing, toileting, personal hygiene, and bathing during his look back period. The resident was completely incontinent of bladder and frequently incontinent of bowel during his look back period. The CAA contributing factors which included Activities of daily living (ADL)/functional/mobility impairment and incontinence. Risk factors included pain, the development of Pressure ulcer/skin condition, and fluid deficit risk. A licensed nurse to assess the resident's skin each week and put proper interventions in place to prevent skin breakdown. Skin is also assessed by caregivers with each bath and each time the resident is dressed. Notify the physician of any abnormal findings and treatment orders obtained. His caregivers assist with repositioning at least every two hours and as needed for comfort.

The "Care Plan" dated 01/28/24, directed staff the resident was at risk for skin breakdown.
Staff were to provide skin assessments per

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 27	F 684		

protocol and as indicated. Additionally, to monitor and report any changes, skin tears, or bruising while providing daily cares, and assisting the resident with his bathing. The care plan lacked address of the resident scratching his legs that resulted in multiple scabbed areas on his legs. The care plan lacked interventions for monitoring the areas or treatment for the multiple scabbed areas on his bilateral (both) legs.

Review of the resident's "Skin Condition Note," dated 09/08/2023 at 08:57 AM, documented the resident's skin as warm and dry. The resident with a history of picking and scratching with both open and scabbed over areas to bilateral lower extremities (BLE) and bilateral upper extremities (BUE). No areas over 1.0 centimeter (cm) with no indication of infection noted. No current treatment order initiated as needed for open areas with excessive bleeding. He was non-compliant with education provided regarding scratching and picking. The "Skin Condition Note," lacked details regarding the number of skin area, location, characteristics, or measurements, to provide a baseline of information for monitoring for worsening skin condition.

Each subsequent weekly "Skin Condition Note," dated 09/15/23 through 01/21/24 documented the resident's condition in general terms such as "sporadic scabbed over areas related to picking and scratching," and lacked assessment details regarding the number of skin area, characteristics, nor measurements, to provide a baseline of information for monitoring of skin condition and need for intervention to prevent complications for this dependent diabetic resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 28	F 684		

On 02/21/24 at 09:37 AM, the resident sat in the wheelchair with an undated bandage on his left lower front leg. He had multiple open areas with red wound bed with scant blood present as well as scabbed areas with surrounding redness and bluish discoloration on the front portion of his right lower leg. The right lower leg did not have a bandage present. On inquiry, the resident stated the reason the bandage was on his left leg was because he picked his leg. When asked what happened to his other leg (right leg), he stated he picked and scratched it as well. The resident reported his legs itched and he did not know why the staff just put the bandage on his left leg.

On 02/21/24 at 01:51 PM, Licensed Nurse (LN) F stated the resident picks at his legs and sometimes they bleed. The resident likes to watch them bleed. She verified the resident lacked orders for dressings or treatment for his legs, but the staff sometimes put bandages on the areas to stop them from bleeding because the resident took blood thinners. She verified the lack of address in the resident's care plan of his scratching or picking at his skin, nor interventions to monitor and prevent further injury to his skin. Additionally, she reported the resident received a weekly skin check. She verified the "Skin Condition Notes," lacked number, location, characteristics, and measurements of the wounds on the resident's bilateral legs.

On 02/22/24 at 02:45 PM, Administrative Nurse C assessed the resident's bilateral legs and confirmed his left leg with edema and seven scabbed areas from just above the knee on the left outer side extending to the ankle. Additionally, Administrative Nurse C assessed the right leg and noted 13 scabbed areas which included two

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

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F 684	Continued From page 29 wounds with surrounding redness. She explained to the resident that he needed to stop scratching his legs to prevent cellulitis (skin infection caused by bacteria) in his legs. She continued to explain cellulitis was an infection of the skin and he was at a greater risk to potentially lose his legs because he was a diabetic. On 02/26/24 at 02:13 PM, Administrative Nurse B confirmed the above findings. She stated the "Skin Condition Notes," should include the measurements, characteristics, and location of wounds to facilitate monitoring for condition change and to determine the need for further intervention. She stated the Care plan should include updated status of wounds based on the assessment to direct the staff in providing care to prevent further complications for this dependent resident with diabetes. The facility lacked a policy related to monitoring skin conditions to prevent complications. The facility failed to ensure adequate monitoring of this resident's skin condition to ensure resolution of multiple skin areas/wounds the dependent diabetic Resident.	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.	F 690		

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	175294	A. BUILDING _____ B. WING _____	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

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F 690	Continued From page 30 §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: The facility reported a census of 38 residents with 13 residents sampled, that included two reviewed for urinary catheter (a tube inserted into the bladder to drain urine into a collection bag) care. Based on interview, observation, and record review, the facility failed to provide appropriate treatment and services of Resident (R)95 when resident was transported with the urinary collection bag above the level of his bladder. This deficient practice had the potential to negatively affect R95.	F 690		

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	175294	A. BUILDING _____ B. WING _____	02/26/2024

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MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

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F 690	Continued From page 31	F 690		

Findings include:

- Resident (R) 95's signed physician orders dated 02/09/24, revealed the diagnosis that included bladder neck obstruction (lack of ability to urinate and empty the bladder).

The "Admission Minimum Data Set" (MDS) dated 02/14/24 revealed a "Brief Interview for Mental Status" (BIMS) score of 11, indicating moderate cognitive impairment. The resident required moderate assist with toileting and supervision with mobility. The resident had an indwelling urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag).

The "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA) dated 02/14/24, revealed R95 required assistance with toileting needs and actual incontinent episodes. Contributing factors included weakness, impaired mobility, and cognitive loss. The risk factors included skin breakdown, falls, and recurrent UTIs (urinary tract infections). A care plan will be initiated/reviewed to improve/maintain current toileting skills and ability to transfer to the commode, continence status, decrease fall and pressure ulcer risk, and decrease risk for UTI. The CAA lacked documentation of the resident having an indwelling urinary catheter on admission to the facility due to bladder neck obstruction.

R95's "Care Plan" dated 02/06/24, revealed the resident had an indwelling urinary catheter. Staff were to change the catheter every eight to ten days related to bladder obstruction and to monitor the output every shift.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

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F 690	Continued From page 32	F 690		

Review of the physician's admission orders, dated 02/08/24, revealed orders for a Foley catheter (urinary catheter), 18 French, with a 10 cubic centimeter (cc) bulb. Change every eight to ten days due to bladder neck obstruction.

Observation on 02/20/24 at 01:35 PM, revealed the resident on his bed. The resident's catheter bag hung from the footboard of the bed. The level was above the resident's bladder level.

Observation on 02/20/24 at 03:43 PM, revealed the catheter bag hung from the footboard on the bed above level of bladder.

Observation on 02/21/24 at 09:39 AM, revealed the resident on his bed. The resident's catheter bag hung from the footboard above the level of his bladder.

On 02/21/24 at 09:48 AM, Certified Nursing Assistant (CNA) D reported staff should hang the resident's urinary collections bags below the level of the resident's bladder.

On 02/21/24 at 09:45 AM, Licensed Nurse (LN) E reported staff should keep the resident's urinary collection bag below the resident's bladder.

On 02/22/23 at 11:00 AM, Administrative Nurse B reported CNA's have skills checklists and should know how to care for a resident with a urinary catheter. Staff should make sure the resident's collection bag was below the resident's bladder to prevent back flow of the urine into the resident's bladder.

A policy for catheter care was requested on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

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F 690	Continued From page 33 02/26/24 with no policy provided. The facility failed to ensure appropriate treatment and services to prevent possible urinary tract infections to this resident who required a urinary catheter,	F 690		
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: The facility reported a census of 38 residents. Based on interview and record review, the facility failed to conduct annual performance reviews for one of the two Certified Nurse Aides that the facility had employed over a year. Findings included: - During review of employment records for the two Certified Nurse Aides (CNA), employed by the facility for over a year, the facility failed to complete one of the two CNA's annual performance review for Certified Nurse Aide (CNA) K, hired 09/29/2015. The most recent unsigned performance evaluation for CNA K, dated 08/31/2022 (six months past due). On 02/22/24 at 10:30 AM, Administrative Nurse B verified CNA K lacked an annual performance evaluation, which should have been completed	F 730		

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	175294	A. BUILDING _____ B. WING _____	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 730	Continued From page 34 within 12 months. She reported the facility lacked a policy regarding completion of annual performance evaluations for employees, but she was aware it was a regulatory requirement. The facility lacked a policy to address the completion of annual performance evaluations. The facility failed to conduct annual performance reviews for one of the two Certified Nurse Aides that the facility had employed over a year which provided care for the residents of the facility.	F 730		
F 761 SS=F	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	02/26/2024

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MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

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F 761	Continued From page 35	F 761		

quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 38 residents. Based on observation, interview, and record review, the facility failed to store "Controlled Medications" (medications which fall under US Drug Enforcement Agency (DEA) Schedules II-V), have a potential for abuse, ranging from low to high, and may also lead to physical or psychological dependence), permitting only authorized personnel to have access related to diversion of "controlled medication" for three residents. Resident (R)145 for unknown quantity of Lorazepam, 0.5 milligram(mg) tablets (anti-anxiety medication), R 146 for unknown quantity of Oxycodone 10/325 mg. tablets (a narcotic/pain medication), and R 147 for unknown quantity of Lorazepam. Additionally, the facility failed to provide a safe environment for all residents by the failure to ensure one of two medication carts, used to store resident's medications remained locked when not in direct line of vision of the licensed nurse passing medications from their carts.

Findings included:

- On 02/22/24 at 10:29 AM, Administrative Nurse B confirmed the diversion of controlled medications reported on 12/08/23 of two residents, (R)145 and R 146 resulting in the discovery of an additional missing controlled medication card for resident R 147. She reported the events as follows:

On 12/08/23 at 12:23 PM, Licensed Nurse (LN) N called Administrative Nurse B and reported during

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

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F 761	Continued From page 36	F 761		

the shift change medication reconciliation between LN N and LN P they identified a discrepancy. Two medication cards of controlled medications were missing. The card count (vacuum sealed cards which contained up to 31 tablets) for Lorazepam 0.5 mg Ativan for Resident (R)146 and Oxycodone 10/325 for (R) 145. There were two missing cards with unknown quantities of controlled medication. The total tablet count was not established due to the alleged perpetrator (AP Administrative Nurse O,) removed the count sheet used for reconciliation which contained the number of tablets in each medication card. LN N reported he asked LN P (no longer employed) the day shift nurse why the cards were missing, and LN P informed him Administrative Nurse O (no longer employed) had taken them out of the locked narcotic medication drawer earlier in the day to destroy them. Administrative Nurse B stated the facility protocol required both Administrative Nurse B and Administrative Nurse O to be present when removing controlled medication from the medication cart to be destroyed. Controlled medications should be destroyed when the medication order changed, or the resident is discharged from the facility. She stated the two administrative nurses have different keys to the lock box for controlled medications and the destroy cabinet. Both keys were required to enter the controlled medication cabinet where and /or the medication cart, the director of nursing (DON) and Assistive director of nursing (ADON) are to be present when medications are taken out of the Cart to the Nursing office with the corresponding narcotic sheet, to verify the medication count and then put in the destroy closet to be destroyed when the pharmacist comes to the building. The destroy medication closet is to be locked and

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	175294	A. BUILDING _____ B. WING _____	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 37	F 761		

requires the two administrative nurse's keys to be opened. Upon reconciling medications, Administrative Nurse B reported she noted the destroyed medication closet was missing an additional card of unknown quantity of Lorazepam for R 147 in addition to the two missing cards that Administrative Nurse O reportedly removed from the medication cart to place in the destroy closet. She stated when she opened the closet while conducting the investigation of the first two missing medication cards, she noted the destroyed narcotic count book with logged entries with the last line whitened out, the count revealed the third missing card of medications for R 147. Upon inquiry, Administrative Nurse B stated that at the time of the missing medication cards she had kept her keys to the destroyed closet in a purse under her desk, the AP was the assistant director of nursing at the time and had the second key required to enter the destroy closet. LN P was a new nurse and may not have been aware of the policy to only allow the removal of controlled medications from the cart with two administrative nurses present at the time of removal. Additionally, Administrative Nurse B reported she could not get into the destroy closet to investigate because Administrative Nurse O had the second key, so she had to call the policy to break into the closet to conduct the investigation. The police came and broke in the door to gain access to the closet and the reconciled closet content revealed R 147, was missing Ativan 0.5 mg card and the paper sheet. His medications were taken out of the medication cart and put in the closet on 11/29/23, because he was deceased. The police came out filed a report. She reported she then notified the state agency on 12/12/23.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

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F 761	Continued From page 38	F 761		

On 02/22/24 at 12:05 PM, LN M, performed the count for the North Hall Medication Cart and the medication storage room. Reconciliation of the count sheets and the medications was completed accurately.

On 02/22/24 at 12:25 PM, LN M stated when a physician discontinued a resident's-controlled medication, the narcotics were pulled by two administrative nurses at the same time. They count and reconcile the medications at that time and put them in the destroyed medication closet. The nurses count the medication each time when we switch cart. Medication aides do not have access to narcotics nurses only pass the controlled medications. Nurses are to count every shift change.

On 02/26/24 at 12:58 PM, Administrative Nurse B confirmed the above findings. She stated the diversion did occur. Administrative Nurse O accessed both keys entered the cart independently, removed two controlled medication cards for two residents. She reported she should have maintained her key on her person at all times, to prevent any one person having access to both keys. Additionally, she stated the new nurse's orientation should have included not to give access to the controlled medication drawer to remove medications to be destroyed without the direct presence of two administrative nurses. She agreed the facility failed to implement the system designed to ensure secure storage of controlled medications.

The facility policy, "Storage of Medication", dated 2007, documentation included controlled medications should be stored separately from non-controlled medications. The access system

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

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F 761	Continued From page 39 (key, security codes) used to lock schedule II medications and other medications subject to abuse, cannot be the same access system used to obtain the non-scheduled medications. The facility failed to store "Controlled Medications" permitting only authorized personnel to have access related to diversion of "controlled medication" for the residents of the facility. - On 02/22/24 at 08:25 AM, a Nurse treatment cart that contained wound care supplies and medicated ointments had been unlocked and unattended. At 08:30 AM, Administrative Nurse C stated that the cart was the nurse's responsibility and confirmed that the cart was unlocked and unattended. Administrative Nurse C stated that the treatment cart should be locked when unattended. The facility's "Storage of Medication" policy, dated 01/2023 documented that the medication supply shall be accessible to licensed nursing personnel, pharmacy personnel or staff members that are lawfully authorized to administer medications. Further documented that to limit the access to prescription medications, storage areas should remain locked when not in use or attended by persons with authorized access. The facility failed to provide a safe environment for all residents by the failure to ensure a medication cart used by the facility remained locked when not in direct line of vision of the licensed nurse passing medications from their carts.	F 761		
F 842 SS=D	Resident Records - Identifiable Information	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

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F 842	Continued From page 40 CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 41	F 842		

a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 38 residents with 13 residents sampled, that included two reviewed for urinary catheter (a tube inserted into the bladder to drain urine into a collection bag) care. Based on interview, observation, and record review, the facility failed to provide appropriate treatment and services of Resident (R)195 from lack of documented catheter care. This deficient practice had the potential to negatively affect R195.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 42	F 842		

Findings included:

- R195's Electronic Health Record (EHR) revealed diagnoses that included the following: urinary tract infection (UTI-an infection in any part of the urinary system), lack of coordination, overactive bladder, encounter following surgical amputation (surgical removal of a body part), osteomyelitis (local or generalized infection of the bone and bone marrow), need for assistance with personal care and generalized weakness.

R195's "Admission Minimum Data Set" (MDS) dated 09/21/23 documented a "Brief Interview for Mental Status" (BIMS) score of 15, which indicated intact cognition. R195 required total care of two persons for all cares except eating which required supervision. R195 had an indwelling urinary catheter (a tube inserted into the bladder to drain urine into a collection bag).

R195's "Quarterly MDS", dated 01/24/24 documented a BIMS score of 13, which indicated intact cognition. R195 was occasionally incontinent of urine and had no indwelling or external urinary catheters.

R195's "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA) documented R195 was incontinent of urine and at risk for recurrent UTIs with contributing factors of weakness, impaired mobility and cognitive loss.

The "Care Plan", dated 01/07/24, revealed that R195 had an indwelling urinary catheter and included the following interventions:

On 09/16/24, staff were to provide assistance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 43	F 842		

with pericare (care of the skin of the area of the body between the anus and genitals) and catheter care.

On 01/07/24, staff were to change the catheter as needed.

On 01/07/24, staff were to monitor catheter output every shift.

On 01/19/24, staff were to flush the catheter every night at bedtime.

On 01/20/24, staff were to change the catheter every 30 days.

The EHR "Physician Orders" documented the following:

1. On 01/11/24, insert an indwelling urinary catheter. The order lacked an indication for use.

2. On 02/15/24, flush the urinary catheter every night at bedtime, for wound care management.

3. On 02/15/24, to change the indwelling urinary catheter every 30 days for wound care management.

The "Progress Notes" documented the following:

On 01/06/24 at 12:12 PM, staff spoke with the resident and the family about changing from a condom catheter (a tube attached to a sheath for the penis used to carry urine to a collection bag) to an indwelling catheter.

On 01/10/24 at 03:45 PM, staff spoke to the wound clinic who had sent the resident from the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 44 wound clinic to the Emergency Department (ED), and staff explained that they had put in an indwelling catheter (at undocumented date/time) due to the condom catheter being insufficient to control his urinary incontinence. Review of EHR "Tasks" documented 55 opportunities for catheter care between 01/06/24 and 02/22/24 with 16 opportunities left blank and undocumented. On 02/22/24 at 02:30 PM, Administrative Nurse B revealed that the resident had a condom catheter changed to indwelling catheter some time on 01/06/24 and confirmed the 16 missing entries in the task record. Further Administrative B revealed that if a task was not documented, it was not done. The facility lacked a policy related to indwelling catheter care and maintenance as requested on 02/26/24. The facility failed to provide appropriate treatment and services of personal hygiene needs with incontinence for R195 when staff failed to document catheter care 16 out of 55 times between 01/06/24 and 02/22/24. This deficient practice had the potential to develop into negative outcomes which include UTIs.	F 842		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care	F 851		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 851	Continued From page 45	F 851		

staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS.

§483.70(q)(1) Direct Care Staff.
Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping).

§483.70(q)(2) Submission requirements.
The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following:
(i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS);
(ii) Resident census data; and
(iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual).

§483.70(q)(3) Distinguishing employee from agency and contract staff.
When reporting information about direct care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 851	Continued From page 46	F 851		

staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency.

§483.70(q)(4) Data format.
The facility must submit direct care staffing information in the uniform format specified by CMS.

§483.70(q)(5) Submission schedule.
The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 38 residents. Based on interview and record review, the facility failed to electronically submit to "Centers for Medicare and Medicaid Services", (CMS) complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS (i.e., "Payroll Base Journal" [PBJ]), related to weekend staffing data is excessively low.

Findings included:

- Review of the "Payroll Based Journal" (PBJ) Staffing Data Report submitted revealed weekend staffing data excessively low as follows:

1. The first quarter of fiscal year (FY) 2023, (10/01/22 through 12/31/22).

2. The second quarter of FY 2023, (January 01,2023 through March 31/2023).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 851	Continued From page 47	F 851		

3. The third quarter of FY 2023, (04/01/2023 through 06/30/2023).

4. The fourth quarter of FY 2023 (July 01/2023 through September 30, 2023).

Review of the nursing staff schedule, agency staff, and staff postings for direct care on the weekends identified above were inaccurate and did not capture the direct care time delivered by licensed nurses, certified department heads, and agency staff. Additionally, review of the agency staff time sheets, and the certified department heads attendance revealed the available staff present which provided direct care during the identified weekends noted in the above quarters.

On 02/22/24 at 10:45 AM, Administrative Nurse B reported here were some weekends the facility was short of preferred nurse staffing, but the positions were covered by the administrator, department heads, and agency staff that were licensed or certified, to ensure direct care was provided for the residents. Upon review of the documentation noted above, she confirmed the PBJ failed to accurately reflect the direct care staff available to provide care on the weekends for the above noted quarters.

On 02/22/24 at 12:40 PM, Administrative Staff A confirmed the PBJ did not capture the agency staff and the department heads that worked on the weekends as CNAs time accurately for the above noted.

The facility lacked a policy to address the submission of accurate PBJ staffing report to CMS.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 851	Continued From page 48 The facility failed to electronically submit to "Centers for Medicare and Medicaid Services", (CMS) complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS (i.e., "Payroll Base Journal" [PBJ]), related to weekend staffing data is excessively low.	F 851		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 49	F 880		

but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 50	F 880		

This REQUIREMENT is not met as evidenced by:
The facility reported a census of 38 residents with 13 residents sampled. Based on observation, interview, and record review, the facility failed to maintain an effective infection control program with the failure of staff to follow infection control standards when delivering laundry to resident rooms and failure to follow the standard of practice when performing a partial bed bath to Resident (R) 195's perineum (the area of skin between the anus and the genitals). This deficient practice has the potential to lead to cross contamination between residents, and to place the residents receiving bed baths at increased risk of developing infections.

Findings include:

- On 02/20/24 at 12:46 PM, Laundry Staff I observed with an uncovered linen cart with clean linen being transported down the hallway, and Laundry Staff I delivered linens to several resident rooms while wearing the same gloves, no hand hygiene or glove change performed between contacts with resident rooms.

On 02/20/24 at 12:50 PM, Laundry Staff I reported the linen cart could be covered or uncovered, depending on the preference of whomever delivered the laundry. Further stated that she was unsure what the policy documented related to the delivery of clean linens. The act of wearing gloves were for her protection and that she had not received training to change gloves or perform hand hygiene between resident room contacts.

On 02/20/24 at 04:19 PM, Maintenance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 51	F 880		

Supervisor J revealed that he did not know if linen carts were to be covered or if staff should change gloves or perform hand hygiene between resident room contacts.

On 02/26/24 at 01:24 PM AM, Administrative Nurse B stated that her expectation for laundry personnel to change gloves (if applicable) and perform hand hygiene between resident room contacts. Administrative Nurse B stated that at the time of the observation on 02/20/24 when Laundry Staff I transported clean linens down the hallway, she was unaware of any requirement to transport clean linens by methods that ensure cleanliness and protect from dust and soil. Additionally stated that it was an infection control concern for cross-contamination between residents if the linen cart remained uncovered.

The facility's 11/2023 "Infection Management Process" policy failed to document instructions for staff related to delivery of clean linens.

The facility's 05/2017 "Hand Hygiene" policy documented that hand hygiene should be completed by staff before and after resident contact and between glove changes.

The facility failed to maintain an effective infection control program with the failure of staff to follow infection control standards for handling and transporting linens to prevent the spread of infection. This deficient practice has the potential to lead to cross contamination between residents and negatively affect every resident in the facility.

- R195's Electronic Health Record (EHR) revealed diagnoses that included the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 52	F 880		

urinary tract infection (UTI-an infection in any part of the urinary system), lack of coordination, overactive bladder, encounter following surgical amputation (surgical removal of a body part), osteomyelitis (local or generalized infection of the bone and bone marrow), need for assistance with personal care and generalized weakness.

R195's "Admission Minimum Data Set" (MDS) dated 09/21/23 documented a "Brief Interview for Mental Status" (BIMS) score of 15, which indicated intact cognition. R195 required total care of two persons for all cares except eating which required supervision. R195 had an indwelling urinary catheter (a tube inserted into the bladder to drain urine into a collection bag).

R195's "Quarterly MDS", dated 01/24/24 documented a BIMS score of 13, which indicated intact cognition. R195 was occasionally incontinent of urine and had no indwelling or external urinary catheters.

R195's "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA) documented R195 was incontinent of urine and at risk for recurrent UTIs with contributing factors of weakness, impaired mobility and cognitive loss.

On 02/21/24 at 01:25 PM, Certified Nurse Aide (CNA) G performed peri-care (cleaning of the area between resident's anus and genitals) and a partial bed bath which included cleaning of several wounds on the resident's buttocks, perineum and coccyx (small triangular area at the base of the spine). CNA G performed hand hygiene and collected a basin full of warm soapy water that had previously been placed on an over the bed table. Staff positioned the resident on his

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 53	F 880		

back and spread his legs and exposed his genitals and perineum. CNA G washed area above genitals, then returned the soiled washcloth back to basin of soapy water and reused the same washcloth. CNA G then washed the resident's left inguinal crease (the area of the body where the leg joins the torso), then returned the washcloth back to the basin of soapy water and reused the washcloth. CNA G then washed the right inguinal crease, then returned the washcloth back to the basin of soapy water and reused the washcloth. CNA G then washed the resident's genitals, then returned the washcloth back to the basin of soapy water and reused the washcloth. CNA G then assisted the resident to roll to his left side and cleaned perineum and anus, then returned the washcloth back to the basin of soapy water and reused the washcloth. CNA G then washed the resident's right buttock, then returned the washcloth back to the basin of soapy water and reused the washcloth. Resident was assisted to roll to his right side. CNA G then picked up the basin of soapy water and walked around to the other side of the bed and placed the basin of soapy water onto the fall mat positioned on the floor. CNA G then assisted the resident to stay on his right side with her left hand and bent down to the floor and retrieved the same washcloth from the basin of soapy water on the floor and washed the resident's left buttock. CNA G then assisted resident to roll left to right and removed the bath blanket that was under the resident. CNA G utilized a single washcloth to perform peri care and returned the washcloth back to the basin full of soapy water throughout the entire procedure.

On 02/21/24 at 01:40 PM, CNA G stated that this method of cleaning was how she was trained to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 54	F 880		

perform this task. Stated that she has seen other CNAs perform this task by utilizing multiple washcloths to perform the same task. Further, CNA stated that she did not know what the policy or procedure was to perform this task. CNA G then stated that if the washcloth was visibly soiled, she would have utilized a new washcloth for additional cleaning. Additionally confirmed that the washcloth could have been soiled with contaminates that were not visible to normal human vision.

On 02/21/24 at 01:45 PM, Licensed Nurse (LN) E stated the standard of care for peri-care and bed baths was that the tasks should be performed with a one-wipe-per-swipe method without regard to whether a washcloth or disposable wipe was used and that the wash basin should be set on a surface at waist height and not on the floor.

On 02/21/24 at 02:00 PM, LN F stated that the standard of care for peri-care and bed baths was that the tasks should be performed with either washcloths or disposable wipes utilizing a one-wipe-per-swipe method and that wash basins should be set on a surface at waist height and not on the floor.

On 02/21/24 at 02:20 PM, Administrative Nurse B stated that peri care should be done using one wipe per swipe and preferably with disposable wipes. Further stated that the wash basin or pack of disposable wipes should be set on the bedside table or some other surface, but never on the floor. Stated that all staff perform a skills check-off to perform cares and that indicated to use at least four disposable wipes for the procedure. Stated that she was unsure if there's a specific policy/procedure guide for the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 55 performance of this skill and confirmed improper cleansing technique was an infection control concern. On 02/22/24 at 08:15 AM, Administrative Nurse B stated that peri care should be performed to the professional standard of care and that the facility lacked a policy or procedure guide specific to this task. The facility failed to maintain an effective infection control program with the failure of staff to follow infection control standards when delivering laundry to resident rooms and failure to follow the standard of practice when performing a partial bed bath to Resident (R) 195's perineum (the area of skin between the anus and the genitals). This deficient practice has the potential to lead to cross contamination between residents, and to place the residents receiving bed baths at increased risk of developing infections.	F 880		
F 921 SS=F	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: The facility reported a census of 38 residents. Based on observation, interview, and record review the facility failed to ensure a safe sanitary environment for the residents and staff in the facility laundry. Findings included:	F 921		

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F 921	Continued From page 56	F 921		

- On 02/22/24 at 08:04 AM, the tour of the laundry with Maintenance Staff J and Laundry Staff I revealed the following concerns:

1. The linoleum floor with multiple raised, unsealed, and unsanitizable areas throughout the laundry area.

2. The ceiling with an approximate six-foot brown stain.

3. An approximate four-to-five-foot section of the sheetrock wall had missing and bubbling paint. The wall with the bubbling paint measured approximately a 4 by 5-foot section.

4. A unpainted, unsealed, irregular textured epoxy patch along the wall which was unsanitizable.

5. Approximately one to two feet of torn sheetrock behind the soiled linen barrels storage.

6. Multiple broken and missing floor tiles.

On 02/22/24 at 08:24 AM, the tour of the laundry with Maintenance Staff J and Laundry Staff I confirmed and agreed with the above identified concerns .

On 02/22/24 at 08:45, Administrative Staff A confirmed the above concerns related to the laundry environment and sanitation. He reported the maintenance supervisor should address the noted concerns.

The facility policy "Housekeeping, Laundry, and Maintenance," dated 06/03/2014, documentation included the goals of the Housekeeping, Laundry,

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	175294	A. BUILDING _____ B. WING _____	02/26/2024

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F 921	Continued From page 57 and Maintenance are to maintain a sanitary, comfortable environment and help prevent the development and transmission of infection. The facility failed to ensure a safe sanitary environment for the residents and staff in the facility laundry.	F 921		
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: The facility reported a census of 38 residents. Based on interview and record review, the facility failed to ensure no less than 12 hours per year required in-service training to ensure the continuing competence of nurse aides for one of the two nurse aides employed for a year or more.	F 947		

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F 947	Continued From page 58	F 947		

Findings included:

- During review of employment records for the two Certified Nurse Aides (CNA), employed by the facility for over a year, the facility failed to ensure no less than 12 hours per year required in-service training to ensure the continuing competence for Certified Nurse Aide (CNA) K, hired 09/29/2015. Review of her education profile revealed the CNA with 10.5 hours of continuing in-service training in the previous year.

On 02/22/24 at 10:30 AM, Administrative Nurse B verified CNA K lacked the required 12 hours of continuing education to ensure competency. She reported the facility lacked a policy regarding the required 12 hours of in-service training annually for CNAs, but she was aware it was a regulatory requirement.

The facility lacked a policy to address the required 12 hours of in-service training annually for CNAs.

The facility failed to ensure no less than 12 hours per year required in-service training to ensure the continuing competence of nurse aides which provided care for the residents of the facility.