STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175141	A. Building B. Wing	05/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Atchison	1637 Riley Street Atchison, KS 66002

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. 47834 The facility identified a census of 39 residents. The sample included three residents reviewed for misappropriation of property. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 1 and R2 remained free from misappropriation of medications when during a random controlled substance audit it was discovered three of the nine entries from 03/01/25 to 03/26/25 for R1 and three out of six entries from 03/24/25 to 03/26/25 for R2 were signed out on the count sheet by Licensed Nurse (LN) G but were not documented on the Electronic Medication Administration Record (EMAR). Further investigation by the facility revealed LN G signed out medications as being destroyed using another nurse's initials and initials that were identified as not belonging to any member of the licensed facility staff. This deficient practice placed R1 and R2 at risk for missed medications and further misappropriation of medications. Findings included: - The facility's investigation, dated 04/03/25, documented on 03/26/25 Consultant GG conducted a monthly on-site visit that consisted of a medication documentation review and a controlled substance audit. The results of the audit were reviewed and indicated missing entries on two of the four residents that were selected through the random controlled substances audit. Upon further review, it was determined that three of the nine entries from 03/01/25 to 03/26/25 for R1 and three out of the six entries for R2 from 03/24/25 to 03/26/25 were signed out on the count sheet but were not documented on the EMAR. Administrative Nurse D analyzed these results and initiated an audit of R1's and R2's controlled medications. This audit consisted of a comparison of the controlled medication count sheet to each medication administration record for each resident with the scheduled and as-needed controlled medication orders. The results of this audit revealed the following for R1 and R2: On 03/10/25 hydrocodone-acetaminophen (a combination medication used to treat moderate to severe pain) 5 milligrams (mg)-325 mg was not signed out on the EMAR but was signed out on the controlled drug record. It was recorded as being given at 08:21 PM and then appeared that the number 19 was written over the 20 on the controlled drug record by LN G. On 03/11/25 it was indicated on the EMAR that the hydrocodone-acetaminophen 5 mg-325 mg was signed out by LN G at 01:38 AM and marked effective. When compared to the controlled medication record, this medication was signed out at 03:30 AM. On 03/15/25 LN H documented R1 was out of the facility. (continued on next page)

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

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

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/15/25 LN G pulled hydrocodone-acetaminophen 5 mg-325 mg and signed it out in the morning. This medication was an as-needed medication for pain. R1 was documented as not in the facility at that time, as R1 was admitted to the hospital on 03/14/25. Per investigation, on the controlled drug record, it was indicated that the medication pulled on 03/15/25 was destroyed by LN G. A second set of initials was indicated next to LN G's; however, those initials were unknown. The nurse on shift at the time was LN H who was unaware of this medication being destroyed and verified that the initials on the controlled drug record were not hers. On 03/15/25 LN G signed out the morning dose of tramadol (medication used to treat moderate to moderately severe pain) and the word destroyed was documented to the left of LN G's signature. A second set of initials was indicated on this same entry that was not legible and did not match any initials of licensed staff. LN H was on shift the same date LN G signed out the tramadol. When asked if the initials in question belonged to LN H, LN H stated that they were not her initials. On 03/24/25 R2 returned to the facility. A medication card for R2 that contained 15 oxycodone (medication used to relieve moderate to severe pain) 5 mg tablets was received at the facility and signed in by LN H. The oxycodone was ordered to be given every six hours as needed. On 03/24/25 LN G signed one oxycodone 5 mg out from the controlled drug record at 11:00 PM but did not chart on R2's EMAR. The investigation documented upon review of the controlled drug record, the number three, in the initial time indicated 11:00 PM, appeared to have been written over with the number one. On 03/25/25 LN G documented on the controlled drug record at 03:00 AM that one oxycodone 5 mg was pulled. LN G documented the administration time on the EMAR as 03:30 AM. Upon further review it was recorded that the entry had been created at 04:00 AM, time-stamped at 03:30 AM. On 03/25/25 at 07:52 PM LN G documented on the controlled drug record that an oxycodone HCL 5 mg was pulled. Next to LN G's initials, the word wasted was recorded with what appeared to be the initials for LN H. Upon review with LN H, she stated that the initials on this entry did not belong to her and that she did not waste this medication with LN G. An oxycodone was documented on the EMAR and progress note by LN G at 06:30 PM. This documentation was created on 03/25/25 at 10:22 PM. At 09:00 PM, LN G documented the medication was pulled, LN G did not document it on R2's EMAR and the medication was pulled three hours and 30 minutes after the previous dose was administered. The order was as needed every six hours. On 03/26/25 LN G documented that an oxycodone 5 mg was pulled, with no time documented on the controlled drug record, and the medication was not documented on R2's EMAR. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility investigation further documented that once the audits were completed, Administrative Nurse D reached out to LN G to discuss the findings and was unable to make immediate contact. Administrative Nurse D then reached out to LN H as she was indicated as the second nurse involved in the disposal of medications with LN G. LN H stated that she had not destroyed any controlled medications with LN G and that she could not recall any other times she wasted narcotics with LN G. LN G reviewed the initials that were documented as the second nurse witnessing the disposal of narcotics and LN H stated that the initials documented were not hers because the handwriting was not hers. Administrative Nurse D then interviewed all other licensed nursing staff individually regarding the disposal of the controlled medications signed out by LN G. Upon completing interviews, there were no staff nurses that recalled ever wasting narcotics with LN G. During the interviews, Administrative Nurse D asked the nurses if LN H ever held the narcotic keys and counted with them at shift change and all nurses stated LN G was the night nurse on her rotation that would count and have possession of the narcotic keys. The investigation further documented Administrative Nurse D reached out to LN G via phone and asked LN G to come into the facility, but LN G was unable to come to the facility due to car trouble. Administrative Nurse D then discussed the findings of the audits with LN G. LN G explained to Administrative Nurse D that she could not recall wasting any medications. LN G stated she did not waste R1's narcotics and that she must have mistakenly documented they were wasted, but she did in fact administer the medications. Administrative Nurse D verified back to LN G what she stated and then Administrative Nurse D discussed with LN G that there was no way the medications were administered because R1 was out of the facility and admitted to the hospital on 03/14/25. The documentation for the medication being destroyed was on 03/15/25. LN G then stated they did not know what happened. The investigation documented Administrative Nurse D discussed the disposal of R2's oxycodone. There were doses pulled that were not administered and there were doses pulled that were administered within three hours of each other when the order stated the medication was to be administered every six hours as needed. LN G stated that she had to have wasted the medication if it was documented. Administrative Nurse D asked LN G if LN H was with her when wasting medications because LN H had stated she did not recall wasting medication with LN G. Administrative Nurse D questioned how LN H's initials were documented in LN G's handwriting and not LN H's. Per investigation, LN G stated LN H knew that LN G wasted medications that LN H had given LN G permission to sign LN H's name and credentials, and that LN G would just make LN H aware when she did it. The investigation documented Administrative Nurse D explained the policy required two nurses to be present when narcotic medications were wasted, and that it was against the law to document another nurse's initials and credentials. Administrative nurse D informed LN G that LN H denied giving permission for LN G to ever sign her name or initials on the controlled medication count sheet and did not have any knowledge of these medications being destroyed. Administrative Nurse D informed LN G that the same medication was pulled less than three hours later but it was never documented that the medication was given and that it would have been too early for that medication to have been given. The facility investigation further documented Administrative Nurse D and Administrative Staff A informed LN G that she was being released from duties and was no longer employed at the facility for falsifying documentation and for not following policy on the destruction of narcotics. The investigation documented local police, the State Agency, the Chief Nursing Officer, the Medical Director, the primary care provider, and the Regional [NAME] President were notified. The investigation documented the state board of nursing was notified and all missing medications were replaced with all expenses paid by the facility. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A notarized Witness Statement dated 04/04/25 for LN H documented Administrative Nurse D questioned if LN H had witnessed the wasting of R2's oxycodone 5 mg on 03.25.25. The statement documented LN H did not provide witness and the initials on the narcotic count sheet were not LN H's and were not signed by her. The statement further documented LN H did not witness wasting hydrocodone 5 mg-325 mg on 03/15/25 for R1. R1 and R2 were not in the facility at the time of the investigation and no observations could be made. On 05/19/25 attempts to reach LN G via phone were unsuccessful. On 05/19/25 at 02:28 PM, LN H stated the issue with her signature was brought to her attention after there were noted inconsistencies with the handwriting style her initials were documented in the narcotic book. LN H stated LN G used random initials that did not belong to anyone at the facility and LN G attempted to use LN H's initials to sign. LN H stated when she signs in the narcotic book, she signs her last name and not just her initials. LN H stated she did not sign as a witness for any of the medications LN G documented as wasted and that she didn't know LN G had used her initials to sign with. LN H stated she never would have given permission for another nurse to sign using her name or initials and she stated she had to observe the medication being destroyed before she would have signed off. LN H further stated she did not know her name was being used until it was brought to her attention by other facility staff. On 05/19/25 at 02:54 PM, Administrative Nurse D stated Consultant GG comes to the facility monthly and if there are issues, they would do an audit. Administrative Nurse D stated the facility also has a consultant who comes quarterly to audit the pharmacist. Administrative Nurse D stated she has been reviewing the narcotic book to see if nurses are signing out PRN medications more often than others to see if there are any potential issues. Administrative Nurse D stated she reviews the narcotic book one to two times per week to track how often PRN medications are given out. Administrative Nurse D stated the facility was not able to say definitively that LN G took the medications; however, she stated while interviewing LN G there were too many red flags. Administrative Nurse D stated LN G stated there must have been some mistake when asked why she signed out medications while R1 was out of the facility and LN G stated she believed se must have thought the medications were for another resident. Administrative Nurse D stated they could not get LN G to come in to give an official statement as to what happened. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/19/25 at 02:59 PM Administrative Staff A stated the pharmacist conducted an audit and noted three out of nine entries were signed out on the count sheets but not documented in the residents' EMAR. Administrative Staff A stated this concerns reported in the audit prompted the facility to dig deeper and they noted LN G was the nurse to be tied to all three instances. Administrative Staff A stated the facility did further auditing to verify if anything else was signed out but not documented as administered. Administrative Staff A stated they were not notified that medications were missing, only that they were not being documented in both places and they noticed a trend with LN G and noted R1 was out of the facility when medication was signed out. Administrative Staff A stated she reported the issue to the State Agency as soon as she suspected there may be missing medications and reported it to local law enforcement shortly after. Administrative Staff A stated another concern was LN G signed out an AM dose of Tramadol for R1, who was out of the facility, and LN G was a night shift nurse. Administrative Staff A stated LN G made excuses as to why she could not come into the facility and give a statement and would only speak over the phone. Administrative Staff A stated LN G would say she was on her way to the facility but never showed up. Administrative Staff A stated they were trying to find out why she signed out medications for a resident who was out of the facility at the time. Administrative Staff A stated the facility replaced all suspected missing medications and the cost was charged to the facility. Administrative Staff A stated the facility leadership is doing audits and monitoring in the facility's daily clinical excellence meetings that are held each morning. Administrative Staff A stated they are monitoring for signatures and that everything is signed out accordingly. Routine audits will be done one to two times per month, the pharmacy consultant would continue with monitoring, and data would be tracked through QAPI to identify any trends, so the facility could get a head of any potential issues going forward. Administrative Staff A further stated in-depth education was provided to staff related to knowing who was in the building and who was not, proper documentation, and not signing for other staff. Administrative Staff A stated the facility also provided Elder Justice Act and ANE education for staff. The facility's Disposal of Medications, Syringes, and Needles: Disposal of Medications policy, copyrighted 2007, documented that controlled substances would be disposed of by the nursing care center in the presence of appropriately titled professionals. The policy further documented a single dose of a controlled substance would be destroyed by two licensed nurses employed by the nursing care center. The policy directed that if a controlled medication is unused, refused by the resident or not given for any reason, it could not be returned to the container and was to be disposed of and documented on the accountability record on the line representing that dose with the required signatures. The facility's Controlled Medication Reconciliation policy revised on 11/2024 documented that the controlled medication inventory sheet would be maintained for each medication cart or storage area with controlled medications. The facility's The 8 Rights of Medication Administration protocol, undated, directed that staff were to document the administration after giving the ordered medication. The protocol directed staff to chart the time, route, and any other specific information as necessary. The facility's Medication Administration: Controlled Substances policy, copyrighted 2007, documented that Controlled Medications were substances that had an accepted medical use (medications that fall under U.S. Drug Enforcement Agency (DEA) Schedule II-V), have the potential for abuse, ranging from low to high, and may also lead to physical and psychological dependence. The policy documented that these medications were subject to special handling, storage, disposal, and record-keeping at the nursing care center, in accordance with federal and state laws and regulations. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility completed corrective actions, which were completed on 03/28/25 and included a controlled substance audit conducted, medications replaced, Licensed Nurse interviews conducted, Alleged Perpetrator Interviewed, suspended & terminated. Law enforcement was notified. Impromptu QAPI meeting conducted, ANE education conducted. Licensed nurse training was conducted regarding the following policies and procedures: controlled medication reconciliation, controlled medication inventory, controlled medication shift count sheet, the 8 rights of medication administration, controlled medication individual reconciliation, disposal of medications, controlled medication storage, documentation requirements, and controlled substances. Due to the corrective action completed before the onsite survey, the citation was deemed past noncompliance at an D scope and severity.