

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  175141	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/27/2024
NAME OF PROVIDER OR SUPPLIER  Medicalodges Atchison		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>49634</p> <p>The facility identified a census of 37 residents. The sample included 12 residents. Based on observation and interviews, the facility failed to provide a clean, home-like environment for Resident (R)11. This placed R11 at risk for impaired comfort and decreased psychosocial well-being.</p> <p>Findings included:</p> <p>- On 06/25/24 at 07:55 AM in R11's room, there were three flies on the top of the bed, on R11's sheet above his head. Further observation revealed there were three flies on R11's bedside table, two flies on his transfer pole, and a fly on R11's right upper arm.</p> <p>On 06/26/24 at 07:22 AM there were two flies on a cream-colored blanket in R11's room and two flies on the foot of the bed on a white sheet covering R11's right leg.</p> <p>On 06/27/24 at 07:14 AM five flies were observed on R11's bed on a white-colored sheet that covered the resident's abdomen. There were two flies on the bedside table and one fly on a cream-colored blanket in a chair in the resident's room. There were two flies flying in R11's room.</p> <p>On 06/27/24 at 07:30 PM Licensed Nurse (LN) G stated if there were issues with flies in a resident's room, she would get the resident a fly swatter, or she would just go into the resident's room and swat the flies. LN G stated the process to report rodents, pests, or broken equipment, was to let maintenance staff know with a work order.</p> <p>On 06/27/24 at 07:41 AM LN G stated she went into R11's room, killed the flies, and left R11 a fly swatter. LN G stated R11 said he was going to ask maintenance to make a hook for the fly swatter.</p> <p>On 06/27/24 at 08:01 AM Maintenance Staff U stated he was just informed about the flies in R11's room. Maintenance Staff U stated he would check on the room a couple of times daily and he would check windows and the air conditioner to find out how the flies were coming into the R11's room. Maintenance Staff U stated he would ensure R11 had a fly swatter.</p> <p>On 06/29/23 at 04:02 PM Administrative Nurse D stated staff would report to maintenance and fill out a work order for any rodents or pests that needed to be controlled. She stated the facility had a pest control program which comes monthly.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 175141
		If continuation sheet Page 1 of 16

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

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility did not provide a home-like environment policy.</p> <p>The facility failed to provide a clean and homelike environment for R11. This placed R11 at risk for impaired comfort and decreased psychosocial well-being.</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45668</p> <p>The facility identified a census of 37 residents. The sample included 12 residents with two reviewed for care plan revisions. Based on observation, record review, and interviews, the facility failed to revise Resident (R) 25's Care Plan to reflect her bed rail evaluation and current use. The facility additionally failed to revise R11's plan to reflect his weight monitoring. This deficient practice placed both residents at risk for uncommunicated care needs.</p> <p>Findings Included:</p> <ul style="list-style-type: none"> <li>- The Medical Diagnosis section within R25's Electronic Medical Records (EMR) diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), insomnia (difficulty sleeping), hypertension (high blood pressure), and a history of repeated falls.</li> </ul> <p>R25's Admission Minimum Data Set (MDS) completed 05/07/24 noted a Brief Interview for Mental Status (BIMS) score of three indicating severe cognitive impairment. The MDS indicated she had no upper or lower extremity impairments. The MDS indicated she required partial to moderate assistance with bed mobility, toileting, bathing, dressing, and personal hygiene. The MDS indicated she had no falls since her admission. The MDS indicated she had no bed rails.</p> <p>R25's Functional Abilities Care Area Assessment (CAA) completed 05/10/2024 indicated she required staff assistance, prompting, and cueing for all her activities of daily living (ADLs). The CAA indicated she had weakness with poor endurance and participated in therapy strengthening services.</p> <p>R25's Care Plan initiated 03/23/23 indicated she required assistance from one staff for dressing, personal hygiene, toileting, bed mobility, and transfers. The plan indicated she utilized her wheelchair for mobility with minimal staff assistance. The plan indicated she had bilateral bed canes to assist with bed mobility and transfers.</p> <p>R25's EMR indicated a Clinical Health Review (dated 05/01/24) was completed upon her admission. The review indicated she attempted to get into and out of his bed unassisted, was able to turn herself from side to side, and currently used the bed rails for positioning. The review indicated she had a diagnosis that required increased safety measures. The review indicated side rails, grab bars, or transfer bars would not be used.</p> <p>On 06/27/24 at 09:04 AM an inspection of R25's room revealed she had non-skid strips in her restroom and a pressure-reducing mattress on her bed. R25's bed lacked bilateral bed canes.</p> <p>On 06/27/24 at 09:05 AM Certified Nurse's Aide (CNA) P stated R25 had bilateral bed canes on her bed to assist with transferring and rolling from side to side. Upon inspection of R25's bed, CNA P acknowledged R25 had no bed canes installed on her bed. She stated she was not sure why they were removed but remembered R25 having them. She stated all staff had access to the care plans. She stated she was not sure who was responsible for assessing the railings but stated the nurses evaluated the need for the railing.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 06/27/24 at 10:24 AM Licensed Nurse (LN) G stated maintenance installed the bed canes, but she was not sure if the railing was inspected or checked after they were installed. She stated the care plans should reflect the most recent safety assessments for the residents.</p> <p>On 06/27/24 at 11:59 AM Administrative Nurse D stated the facility sometimes used the bed canes on R25's bed for mobility. She stated they were removed recently. She stated the bed canes were used company-wide and she didn't think they needed to be assessed as bed railing. She stated maintenance installed the bed canes, but the facility was unable to provide documentation showing how often the canes were assessed, the potential risks related to the assistive canes, and consent for the bed canes. She stated the interdisciplinary team met weekly to review the care plan. She stated the plans would be updated by the MDS team.</p> <p>The facility's Electronic Care Plan policy dated December 2018 documented that the MDS coordinator was to initiate a review of the plan of care. Care plan review and revisions were to be completed with the wellness program. The interdisciplinary team (IDT) was to review, revise, and sign the person-centered plan of care related to their discipline. The MDS Coordinator was to complete the review of the care plan in the EMR.</p> <p>The facility failed to revise R25's care plan to reflect her bed rail evaluation. This deficient practice placed R25 at risk for uncommunicated care needs.</p> <p>49634</p> <p>- R11's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of lymphedema (swelling caused by accumulation of lymph, cellulitis (skin infection caused by bacteria) of right limb, obesity (excessive body fat), need for assistance for personal care, muscle weakness, and urinary retention.</p> <p>The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented that R11 was dependent on two staff members' assistance for activities of daily living (ADLs). The MDS documented R11 had an indwelling catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) during the observation period.</p> <p>The ADL Functional Rehabilitation Potential Care Assessment Area (CAA) dated 08/09/23 documented R11 was admitted from the hospital after having worsening skin impairment from a yeast infection. The CAA documented R11 had morbid obesity and was unable to perform self-care due to impaired mobility. The CAA documented R11 was alert and oriented and could verbalize his needs. The CAA documented R11 requires extensive to dependent assistance of staff for completion of ADL. The CAA documented R11 had participated in occupation and physical therapies to improve his strength and endurance, basic self-care, and safe transfers. The CAA documented that the nursing staff was to perform wound care per the physician's orders until the area was healed. The facility would care plan continued assistance of R11's ADLs to ensure his needs were met.</p> <p>R11's Care Plan dated 08/04/23 documented R11 was at risk of losing or gaining weight due to his disease process of obesity. The plan of care dated 01/11/24 documented that staff would weigh R11 daily and report any changes to the charge nurse.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R11's EMR under the Vitals tab revealed weights for 08/03/23, 09/12/23, 10/03/23,10/10/23, 10/19/23, 10/31/23, 11/10/23, 12/21/23, 01/04/24, 01/13/24, 02/02/24, 03/03/24, 04/09/24, 05/02/24, and 06/06/24.</p> <p>R11's EMR lacked orders or direction to staff when to obtain R11's weights.</p> <p>On 06/25/24 at 07:55 AM R11 lay in his bed on his back, R11 visited appropriately with the visitor.</p> <p>On 06/26/24 at 07:18 AM R11 lay in his bed talking on his cell phone.</p> <p>On 06/27/24 at 07:50 AM, Certified Nurses Aid (CNA) N stated the CNAs knew who needed to be weighed by looking at the Kardex (a nursing tool that gives a brief overview of the care needs of each resident). CNA N stated nursing had a notebook that indicated who needed to be weighed daily.</p> <p>On 06/27/24 at 07:54 AM, Licensed Nurse (LN) G stated the care plan should identify specific resident information. She stated all nursing staff have a part in the care plan. LN G stated all nurses were to ensure the care plan reflected accurate information for a specific resident.</p> <p>On 06/27/24 at 11:59 AM Administrative Nurse D stated the care plans were updated quarterly with anything that needs to be resolved or placed on the care plan. Administrative Nurse D stated all nursing staff can update or resolve a care plan.</p> <p>The facility's Electronic Care Plan policy dated December 2018 documented that the MDS coordinator was to initiate a review of the plan of care. Care plan review and revisions were to be completed with the wellness program. The interdisciplinary team (IDT) was to review, revise, and sign the person-centered plan of care related to their discipline. The MDS Coordinator was to complete the review of the care plan in the EMR.</p> <p>The facility failed to revise R11's Care Plan with his current care regarding weights. This deficient practice placed R11 at risk for impaired care due to uncommunicated care needs.</p>		

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<p>F 0661</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50660</p> <p>The facility identified a census of 37 residents. The sample included 12 residents with one resident reviewed for discharge. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 38 had a recapitulation of their stay including medication reconciliation. This placed R38 at risk for not receiving timely and appropriate care.</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- The Electronic Medical Record (EMR) for R38 documented a diagnosis of rhabdomyolysis (breakdown of damaged skeletal tissue).</li> </ul> <p>The Admission Minimum Data Set (MDS) dated [DATE] documented R38 had a Brief Interview for Mental Status (BIMS) score of three which indicated severe cognitive impairment.</p> <p>The Functional Care Area Assessment (CAA) dated 02/26/24 for R38 documented he was skilled and was seen by therapy with the goal of returning home; improvement was anticipated as he worked with therapy. R38 required assistance with his activities of daily living (ADLs).</p> <p>R38's EMR recorded a Discharge Note dated 03/27/24 at 03:11 PM that documented R38 left the facility against medical advice (AMA) with family. R38's family was previously educated on leaving AMA and educated regarding the implications and risks. The facility's licensed master's social worker (LMSW) and nurse re-educated R38's family regarding leaving the facility AMA. R38's family asked questions and the LMSW answered their questions and the family voiced understanding.</p> <p>A Progress Note dated 03/28/24 at 09:21 AM recorded the LMSW made a report to Adult Protective Services with concerns for R38 due to cognition, safety awareness, and physical limitations.</p> <p>R38's clinical record lacked evidence the facility completed a recapitulation of R38's stay and lacked evidence of medication reconciliation.</p> <p>On 06/27/24 at 12:05 PM Administrative Nurse D stated that upon discharge the charge nurse was to send medications and set up services the resident would need to be successful in the home setting. Administrative Nurse D said when a resident left AMA, the charge nurse was to send enough medications to get the resident through a weekend if the pharmacy was closed. Administrative Nurse D said no services outside the facility could be set up when a resident leaves against medical advice but the charge nurse was expected to document a discharge with a recapitulation of the stay and include what medications were sent with the resident.</p> <p>The facility did not provide a policy and procedure for discharge.</p> <p>The facility failed to ensure R38's discharge summary had a recapitulation of the stay. This placed R38 at risk for not receiving timely and appropriate care.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>45668</p> <p>The facility had a census of 37 residents. The sample included 12 residents with three reviewed for accidents. Based on observation, record review, and interview, the facility failed to ensure a safe environment free from hazardous materials and equipment from nine cognitively impaired independently mobile residents. This deficient practice placed the residents at risk for preventable accidents and injuries.</p> <p>Findings Included:</p> <p>- On 06/25/24 at 07:05 AM a walkthrough of the facility was completed. An inspection of an unsecured soiled utility room on 100 Hall revealed multiple cleaning aerosol deodorizers, a spray bottle of Virex II (used to kill viral germs), and a laundry presoak chemical on a counter in the room. The items contained the warning, Keep out of reach of children, hazardous to humans can cause eye irritation, harmful if swallowed.</p> <p>An inspection of an unsecured 400 Hall utility closet revealed a bottle of Virex II and multiple room deodorizer spray cans. The items contained the warning, Keep out of reach of children, hazardous to humans can cause eye irritation, harmful if swallowed.</p> <p>An inspection of an unlocked shower room the next day room revealed two unsecured aerosol room deodorizer cans on the shelf. The items contained the warning, Keep out of reach of children, hazardous to humans can cause eye irritation, harmful if swallowed.</p> <p>On 06/25/24 at 07:22 AM an inspection of the facility's service hallway revealed no locking mechanism on the door from the resident accessible hallway into the service hallway. An inspection of the service hallway revealed the rear kitchen door was propped open. The service hallway's laundry room door's key was left in the door lock. An inspection of the room revealed multiple cleaning chemicals and a laundry sink with a Hot Water warning sign above it.</p> <p>On 06/25/24 at 09:20 AM Resident (R)31, a severely cognitively impaired and independently mobile resident, sat in her wheelchair outside her room facing a Hoyer lift (total body mechanical lift) placed in an egress next to her room's entry. The lift contained a cloth bag with orange disinfectant (bleach) wipes. R31 stated she needed a wipe as she grabbed the cloth bag. R31 attempted to pull the wipe container out of the bag several times before she gave up and entered back into her room.</p> <p>On 06/27/24 at 10:10 AM the orange wipe container on the Hoyer lift next to R31's room's lid was open and two wipes dangled out from the container.</p> <p>On 06/27/24 at 10:12 AM Certified Nurse Aide (CNA) P stated staff was expected to keep all hazardous chemicals locked up and away from the residents. She stated the wipes should be kept within visual supervision and removed from the lift once the lifts were sanitized. She stated the resident did not go into the service hallway, but the doors should remain closed and locked.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 06/27/24 at 11:59 AM Administrative Nurse D stated the doors within the service hallway were to remain locked, but the residents didn't go back there. She stated staff should not be propping the doors open or leaving the keys in the locks. She stated the residents should not have access to potentially hazardous chemicals or utility areas within the building.</p> <p>The facility was unable to provide a policy related to safe chemical storage or accidents as requested on 06/27/24.</p> <p>The facility failed to ensure a safe environment free from hazardous materials and equipment for nine cognitively impaired independently mobile residents. This deficient practice placed the residents at risk for preventable accidents and injuries.</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49634</p> <p>The facility identified a census of 37 residents. The sample included 12 residents with one resident observed for a catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid). Based on observation, record reviews, and interviews the facility failed to ensure the standard of care was provided for Resident (R)1, who had a history of urinary tract infection (UTI-an infection in any part of the urinary system). This deficient practice placed R1 at risk of catheter-related complications and further UTIs.</p> <p>Finding included:</p> <ul style="list-style-type: none"> <li>- R1's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of, cerebral palsy (a progressive disorder of movement, muscle tone or posture caused by injury or abnormal development in the immature brain, most often before birth), kidney failure ( a condition in which the kidneys stop working and are not able to remove waste and extra water from the blood or keep body chemicals in balance, anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and urine retention.</li> </ul> <p>R1's Significant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 12 which indicated moderately impaired cognition. The MDS documented R1 was dependent on two-member assistance for activities of daily living (ADLs). R1 had an indwelling catheter and was taking an antibiotic during the observation period.</p> <p>The Quarterly MDS dated [DATE] documented a BIMS score of 12 which indicated moderately impaired cognition. The MDS documented R1 had a catheter during the observation period.</p> <p>R1's Care Plan dated 04/19/24 documented R1 had a suprapubic catheter (urinary bladder catheter inserted through the abdomen into the bladder) to dependent drainage related to chronic UTIs and urinary retention. The plan of care documented staff was to provide catheter care every shift and staff would wash R1's peri-area with soap and water and dry well.</p> <p>R1's EMR under the Orders tab revealed the following physician orders:</p> <p>Clindamycin Palmitate HCl Oral Solution Reconstituted (Clindamycin Palmitate Hydrochloride) (antibiotic), Give 400 mg via feeding tube four times a day for suprapubic infection for nine days dated 05/08/24.</p> <p>Suprapubic catheter, staff to apply split four-by-four gauze to the area and secure with tape, change daily and as needed (PRN), dated 05/13/24.</p> <p>Doxycycline Hyclate (antibiotic) oral tablet 100 mg, give 100 mg by mouth two times a day for suprapubic catheter drainage for seven days dated 05/28/24.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Levofloxacin (antibiotic) oral tablet give 750 milligrams (mg), give one tablet by mouth one time a day for suprapubic catheter infection for seven days., dated 06/04/24.</p> <p>Change suprapubic catheter every month on the day shift, use 16 French with 10 milliliters (ml) of normal saline, dated 06/18/24.</p> <p>On 06/25/24 at 07:28 AM R1 lay in his bed. His bed was in a low position and his fall mat was in place on the side of his bed. R1 had a urinary catheter bag secured to his bed frame.</p> <p>On 06/26/24 at 07:17 AM R1 lay on his bed. Certified Nurse's Aide (CNA) M put on an isolation gown, washed her hands, and donned her gloves. CNA M explained to R1 that she was going to do peri-care and get him dressed and up for breakfast. CNA M had CNA O help tuck R1's brief and then rolled R1 to his left side. CNA M washed R1's buttocks with a wipe, and then R1 was helped to roll onto his back. CNA M washed R1's front peri area with the same gloves and a clean wipe. CNA M failed to doff her gloves and perform hand hygiene from the dirty area to the clean area. CNA M and CNA O changed their gloves, did hand hygiene, and put a clean brief on R1 by rolling him from right to left.</p> <p>On 06/26/24 at 07:28 AM CNA M stated she should have doffed her gloves and performed hand hygiene while doing peri care when going from a dirty area to a clean area. CNA M stated all nursing staff had been inserviced on peri care and catheter care.</p> <p>On 06/27/24 at 07:18 AM, Licensed Nurse (LN) G stated the facility's process was to doff gloves and to perform hand hygiene from dirty to clean when doing peri care or catheter care.</p> <p>On 06/27/24 at 11:59 AM, Administrative Nurse D stated staff should have completed hand hygiene when going from a dirty area to a clean area, to avoid cross-contamination.</p> <p>The facility did not provide a policy for peri care and or catheter care.</p> <p>The facility failed to ensure the standard of care was provided during peri care for R1. This deficient practice placed R1 at risk of catheter-related complications and further UTIs.</p>		

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NAME OF PROVIDER OR SUPPLIER  Medicalodges Atchison		STREET ADDRESS, CITY, STATE, ZIP CODE  1637 Riley Street Atchison, KS 66002	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>45668</p> <p>The facility identified a census of 37 residents. The sample included 12 residents with three residents reviewed for accidents. Based on observation, record review, and interviews, the facility failed to ensure that Resident (R)7 had a documented safety assessment for the use of side rails, consent for the use of the side rails, and failed to ensure the resident and/or responsible party were advised of the risks and/or benefits of the use of the side rails. This placed the R7 at risk for uninformed decisions and impaired safety related to the risks associated with the use of side rails.</p> <p>Findings Included:</p> <ul style="list-style-type: none"> <li>- The Medical Diagnosis section within R7's Electronic Medical Records (EMR) noted diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), cerebrovascular accident (CVA-stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), dysphagia (swallowing difficulty), repeated falls, and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).</li> </ul> <p>R7's Admission Minimum Data Set (MDS) completed 05/22/24 noted a Brief Interview for Mental Status (BIMS) score of six indicating severe cognitive impairment. The MDS indicated he had upper and lower extremity impairments. The MDS indicated he required maximal assistance from staff for bed mobility, transfers, bathing, dressing, and grooming. The MDS indicated he had one non-injury fall since his admission. The MDS indicated no bed rails or body restraints were in use.</p> <p>R7's Functional Abilities Care Area Assessment (CAA) completed 05/29/23 indicated he depended on staff for activities of daily living (ADLs). The CAA indicated he exhibited communication difficulties with disorganized thoughts and inattention. The CAA indicated had fractured his left humerus and ribs in a fall prior to his admission to the facility.</p> <p>R7's Care Plan initiated 05/16/24 indicated he required staff assistance with his ADLs related to his physical limitations. The plan indicated he required the assistance of two staff and a gait belt for all transfers. The plan noted he was at risk for falls and had a perimeter mattress placed on his bed. The plan instructed staff to ensure his bed was positioned against the wall to decrease his risk of falls. The plan lacked documentation related to his bed canes (railing attached to assist with transferring).</p> <p>R7's EMR indicated a Clinical Health Review (dated 05/16/24) was completed upon his admission. The review indicated he attempted to get into and out of his bed unassisted, was able to turn himself from side to side, and currently used the grab bars to promote increased independence, bed mobility, and positioning.</p> <p>R7's EMR and physical chart lacked documentation related to potential risks for the assistive device, assessment of the device's placement, and consent for use.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 06/26/24 at 02:02 PM, R7 slept in his bed. R7's bed was positioned next to his wall and a perimeter mattress was in place. R7's bed had bilateral bed canes mounted. R7's wheelchair sat next to his bed and his call light was within reach.</p> <p>On 06/27/24 at 10:10 AM Certified Nurse Aide (CNA) P stated staff would check each resident's bed each shift, but she was unsure who was responsible for assessing the bed canes for safety or checking for gaps in them.</p> <p>On 06/27/24 at 10:24 AM Licensed Nurse (LN) G stated maintenance installed the bed canes, but she was not sure if the railing was inspected or checked after they were installed. She stated she was not where the bed rail assessments were completed.</p> <p>On 06/27/24 at 11:59 AM Administrative Nurse D stated the bed canes were used company-wide wide and she didn't think they needed to be assessed as bed railing. She stated maintenance installed the bed canes, but the facility was unable to provide documentation showing how often the installed canes were assessed, the potential risks related to the assistive canes, and consent for the bed canes.</p> <p>The facility was unable to provide a policy related to the management or assessment of bed rails as requested on 06/27/24.</p> <p>The facility failed to ensure that R7 had a documented risk assessment for the use of side rails, a consent for the use of the side rails, and failed to ensure the resident and/or responsible party were advised of the risks and/or benefits of the use of the side rails. This placed the R7 at risk for uninformed decisions and impaired safety related to the risks associated with the use of side rails.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>50660</p> <p>The facility identified a census of 37 residents. The sample included 12 residents, three medication carts, and two medication rooms. Based on observation, record review, and interviews, the facility failed to properly store medications in one of the three medication carts. This placed the residents at risk for adverse outcomes or ineffective medication regimens.</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- On 06/25/24 at 07:27 AM a medication cart in the common area between halls 300 and 400 was unlocked and unattended. Inspection of the medication cart revealed the cart contained eye drops, nasal spray, stock medications, and numerous cards of medication. Three residents in wheelchairs were sitting near the unlocked and unattended medication cart.</li> </ul> <p>On 06//25/24 at 07:37 AM Certified Medication Aide (CMA) R stated that the medication cart contained overflow medications. CMA R locked the medication cart and stated the cart should be locked at all times when unattended.</p> <p>On 06 /27/24 at 12:15 PM Administrative Nurse D stated that all medication carts were to be locked when unattended.</p> <p>The facility policy Medication Storage dated 2007 states that in order to limit access to prescription medications, only licensed nurses, pharmacy staff, and those lawfully authorized to administer medications (such as medication aides) are allowed access to medication carts. Medication rooms, cabinets, and medication supplies should remain locked when not in use or attended to by persons with authorized access.</p> <p>The facility failed to properly store medications. This placed the affected residents at risk for adverse consequences or ineffective treatment to the affected residents.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>50660</p> <p>The facility identified a census of 37 residents. The facility had one main kitchen. Based on observations, record reviews, and interviews, the facility failed to properly label and store food and failed to follow standards for food and supply storage. This deficient practice placed the residents at risk for foodborne illness.</p> <p>Findings included:</p> <p>- On 06/25/24 at 07:13 AM, an initial tour of the kitchen revealed the following observations:</p> <p>The freezer contained a box of waffles that were open and were not sealed. The box did not have a resident's name or the date it was opened. An open bag of French fries was not dated with the date they were opened.</p> <p>On 06/25/24 at 07:21 AM the top of the dishwasher had a significant amount of calcium buildup.</p> <p>On 06/25/24 at 07:40 AM an inspection of the service hall was completed. The facility's ice machine's catch tray had calcium buildup and dirt around the opening of the door and water drain bin.</p> <p>On 06/26/24 at 07:10 AM bowls, soup cups, and dessert bowls were stored on open shelving in the kitchen and were not covered or stored inverted.</p> <p>On 06/27/24 at 09:49 AM, Dietary BB stated that all dishes were to be covered or stored inverted. She stated that cleaning the ice machine was a maintenance task and not a dietary task. Dietary BB stated that delimiting the dishwasher was not on the cleaning list though upon review of the cleaning list, Dietary BB identified it was noted that delimiting is on the cleaning list.</p> <p>The facility policy Food Storage (Dry, Refrigerated, and Frozen) dated 2016 stated that food shall be stored on shelves in a clean, dry area, free from contaminants. Food shall be stored at appropriate temperatures and using appropriate methods to ensure the highest level of food safety.</p> <p>The facility policy Storing Utensils, Tableware, and Equipment dated 2016 stated that glass and cups should be stored inverted.</p> <p>The facility failed to properly label and store food, and failed to store clean dishes inverted and. This deficient practice had the risk of spreading foodborne illness to all affected residents.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>45668</p> <p>The facility identified a census of 37 residents. The facility identified four residents on enhanced barrier precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms which employs targeted gown and glove use during high contact care). Based on record review, observations, and interviews, the facility failed to follow sanitary infection control standards related to the handling of soiled laundry and hand hygiene during care. These deficient practices placed the residents at risk for infectious diseases.</p> <p>Findings Included:</p> <p>-On 06/25/24 at 07:30 AM an inspection of the shower room next to the nurse's station revealed a pile of used towels placed directly on the floor of the shower room.</p> <p>On 06/26/24 at 07:17 AM Resident (R)1 lay on his bed. Certified Nurse's Aide (CNA) M put on an isolation gown, washed her hands, and donned her gloves. CNA M explained to R1 that she was going to do peri care get him dressed and put him in his chair for breakfast. CNA M had CNA O help tuck R1's brief and then rolled R1 to his left side. CNA M washed his buttocks with a wipe, and then was helped to roll to his back. CNA M washed R1's front peri area with the same gloves and a clean wipe. CNA M failed to doff her gloves and perform hand hygiene from the dirty area to the clean area. CNA M and CNA O changed their gloves, did hand hygiene, and put a clean brief on R1 by rolling him from right to left.</p> <p>On 06/26/24 at 08:49 AM an inspection of R2's room revealed dirty clothing on the floor next to his bed.</p> <p>On 06/26/24 at 07:28 AM CNA M stated she should have doffed her gloves and performed hand hygiene while doing peri care when going from a dirty area to a clean area. CNA M stated all nursing staff were educated on peri care and catheter care. She stated laundry should be taken directly to the soiled utility room and not placed on the floor. She stated that used towels should be placed in a soiled bin for washing.</p> <p>On 06/27/24 at 07:18 AM, Licensed Nurse (LN) G stated the facility's process was to doff gloves and to perform hand hygiene from dirty to clean when doing peri care or catheter care. She stated linen and clothing should never be placed on the floor.</p> <p>On 06/27/24 at 11:59 AM, Administrative Nurse D stated staff should have completed hand hygiene when going from a dirty area to a clean area, to avoid cross-contamination. She stated items should never be thrown on the floor due to the risk of contamination to other residents. She stated soiled items were expected to be taken to the soiled utility rooms.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility's Infection Control and Surveillance policy revised 11/2023 indicated infection control and prevention training would be completed routinely. The policy indicated staff would be educated on the use of proper hand hygiene and practices to reduce the risks of preventable infections and illness. The policy indicates the facility will educate staff on the proper management of the resident's environment and infection control standards to manage equipment, environment, personal care, and treatments.</p> <p>The facility failed to follow sanitary infection control standards related to the handling of soiled laundry and hand hygiene during care. These deficient practices placed the residents at risk for infectious diseases.</p>