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	04/08/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, and served food in a sanitary manner for the residents who reside in the facility and receive meals from the facility kitchen.Findings included:- On 04/06/26 at 09:50 AM, during the initial tour of the kitchen, the following dry goods lacked an open-on date:Two cocoa powder bags, one bag approximately half full and the second bag approximately two thirds full, were held closed with a clip.One buttermilk pancake mix bag approximately a quarter of the way full, held closed with a clip.One brownie mix bag approximately a quarter of the way full, held closed with a clip.One chocolate instant pudding mix bag approximately a third of the way full, held closed with a clip.One bag of [NAME] Krispy cereal approximately halfway full, held closed with a clip.One plastic Tupperware container without a lid had a handful of loose pretzels opened at the bottom of the container and an open sandwich bag of Pretzels dated 03/30.There were three large bins underneath the counter that had the toaster on it. These bins lacked identification that could be read. The lids on all three containers had multiple particles and crumbs on the lids and appeared dirty. One bin had a ladle hanging in it. The drawer below the toaster that held measuring cups and measuring spoons had crumbs visible along the left side of the drawer that ran the length of the drawer. The backsplash to the counter had particles of something on it and was gritty to touch. The windowsill that was above the backsplash, counter area contained spices and the windowsill had what appeared to be spices spilled all over the windowsill.On the rack that holds pans, there were two pans with a total of 27 pieces of cake between the two pans that were uncovered beside the toaster.There was black, gray residue on the floor underneath the clean dish counter. The area was moist and grimy.On 04/06/26 at 10:18 AM, Dietary BB stated that she was not trained to put an open date on anything that was opened. Dietary BB stated, but the opened bags do not sit for very long. She confirmed that the lids to the bins, that she reported were flour, sugar, and chicken batter, were not clean nor labeled. While looking at the bins, Dietary BB pulled the ladle out of the sugar. Dietary BB confirmed that there were crumbs along the left side of the measuring cups and measuring spoons drawer and that it should be cleaned and the crumbs should not be there. Dietary BB confirmed that the backsplash and windowsill were gritty and dirty, and they needed to be cleaned. When asked about the pieces of cake that were uncovered, Dietary BB stated that they should be covered. Dietary BB observed the floor beneath the clean dish counter and stated that it should not be grimy underneath the dish area.The facility's Sanitation of Dining and Food Service Areas policy, 2016 edition, documented the dining services staff would uphold sanitation of the dining areas according to a thorough, written schedule. The policy documented all staff would be trained on the frequency of cleaning, a cleaning schedule would be posted for all cleaning tasks, and staff would be held responsible for all cleaning tasks.The facility's Sanitizing Equipment and Food Contact Surfaces policy, 2016 edition, employees shall sanitize equipment and food contact surfaces utilizing proper sanitizing solution. The policy further documented employees would follow the sanitizing recommendations and procedures for each piece of equipment or food contact surface as discussed in the cleaning guideline.The facility failed to provide a policy for food storage, as requested on 04/08/26.

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, record review, and interview, the facility failed to ensure a sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections when staff failed to change gloves or wash hands between cares for Resident (R)24. Staff also failed to place Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms, which employ targeted gown and glove use during high contact care) signage on R3 and R6, who had Foley catheters (a tube inserted into the bladder to drain urine into a collection bag), and R20, who had a percutaneous endoscopic gastrostomy (PEG tube-a tube surgically placed through an artificial opening into the stomach). Staff also failed to wear appropriate EBP when providing wound care for R8. The facility also failed to document the times and dates the stagnant water areas were flushed to prevent the growth of Legionella disease (a serious type of lung infection caused by inhaling water droplets or mist contaminated with Legionella bacteria).Findings included:- 1. On 04/06/26 at 11:06 AM, observation revealed R20 had a peg tube, and his room door lacked EBP signage.On o4/06/26 at 11:20 AM, observation revealed R3 had a Foley catheter, and outside his room door lacked EBP signage.On 04/06/26 at 11:40 AM, observation revealed R6 had a Foley catheter, and outside his room door lacked EBP signage.On 04/07/2026 at 2:13 PM, Administrative Nurse D verified the above findings and stated she conducted an audit earlier today regarding EBP, and the EBP signs are now on the door. 2. On 04/07/26 at 08:50 AM, observation revealed R8 lying in bed on her back with eyes closed. Licensed Nurse (LN) G and LN H entered the room (without donning gowns) and asked R8 if they could change the wound dressing on her left buttocks. R8 replied yes. Both nurses applied gloves, and LNH assisted the resident in turning on her right side, while LN G removed the old dressing. Further observation revealed that LN H placed the calcium alginate into the wound bed, then topped it with an adhesive dressing.On 04/07/26 at 09:15 AM, when asked if R8 was on EBP, LN H replied she did not know; she would have to check R8's medical record. When asked what the EBP signage on the door frame meant, LN H replied that the resident was on EBP and stated she should have worn a gown when assisting with the wound dressing change.On 04/08/26 at 10:30 AM, Administrative Nurse D stated that if a resident is on EBP, she would expect staff to donn a gown and apply gloves when providing wound care.3. On 04/08/26 at 10:47 AM, Certified Nurse Aide (CNA) M and CNA N provided perineal (private area) to a resident. While transitioning from cleaning the resident up and removing the soiled brief to applying the clean brief, both CNAs doffed their gloves and applied a clean pair without sanitizing their hands. The CNAs completed the care for the resident, collected the trash, made sure that the call light was within reach, and then removed their gloves and washed their hands before leaving the resident's room. When asked about the transition from cleaning and removing the soiled brief to applying the clean brief, CNA M stated that they did not sanitize or wash their hands then because they did not want to leave the resident unattended in the bed. CNA N stated they had never really washed or sanitized their hands in between.On 04/08/26 01:55 PM, Administrative Nurse D stated they should have washed their hands.On 04/08/26 at 09:30 AM, a review of the white binder with the water management plan to prevent the growth of legionella and other water-borne pathogens revealed a lack of documentation regarding the date and times the stagnant areas in the facility were flushed.On 04/08/26 at 09:30 AM, Maintenance Supervisor (MS) U stated he was responsible for documentation regarding the water management plan. MS U verified he had not documented when he flushed the stagnant water areas in the facility and was unaware he should.Upon request, the facility failed to provide an EBP policy.Upon request, the facility failed to provide a Legionella policy.The facility's Infection Control Policy, revised 11/23, documented staff would be educated on hand hygiene and other infection control prevention practices upon hire and thereafter routinely.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to develop a comprehensive care plan for one resident, Resident (R) 7 for his dentures and glasses.Findings included:- The Electronic Medical Record (EMR) documented R7 had repeated falls, dementia (progressive mental disorder characterized by failing memory, confusion), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and need for assistance with personal care.R7's Significant Change Minimum Data Set (MDS) dated [DATE] documented R7 had severely impaired cognition. R7 was dependent on staff with oral cares, toileting, shower/bathing, upper and lower body dressing, putting on and taking off footwear, and personal hygiene.R7's Delirium Care Area Assessment (CAA) dated 11/28/25, documented R7 was alert with very impaired cognition. Staff were to anticipate R7's needs throughout the day.R7's Communication CAA dated 11/28/25, documented he would miss communication or not understand what was being said to him. R7 has minimal hearing loss and chooses not to wear any hearing device.R7's Nutrition Care Plan initiated on 06/03/25, directed staff to please give verbal cues and reminders to assist him with eating.R7's Activities of Daily Living (ADL) Care Plan initiated on 06/03/25 directed staff that R7 needed assistance of one staff for dressing and personal cares. Staff were further directed that R7 needed assistance with grooming needs,R7's care plan lacked identification R7 had dentures or glasses. R7's care plan further lacked R7's preference related to his dentures and glasses and whether he wanted them on or off, or how he responded to using the dentures or glasses.The Social Service Progress Note dated 10/20/25 at 12:26 PM documented that R7's bottom dentures had been broken. Witnesses reported that R7 placed his dentures in his overall pocket, and when getting R7 ready for bed and taking his overalls off his dentures fell out and broke.The Registered Dietitian Note dated 02/18/26 at 01:58 PM documented R7 had poor intake concerns. R7 had dentures and reported difficulty chewing tougher meats.The Social Service Quarterly Note dated 02/27/26 at 12:21 PM, documented R7 did not always exhibit good eye contact during conversation.On 04/08/26 at 10:45 AM, R7 sat in his Broda chair (specialized wheelchair with the ability to tilt and recline) in the sitting area by the television. R7 did not have his glasses on or his dentures. R7 was restless and fidgeting.On 04/08/26 at 01:35 PM, Social Services X stated that R7's dentures and his glasses were in his room. She further stated that it depended on R7's mood as to whether or not he would allow staff to put the dentures in or the glasses on.On 04/08/26 at 02:02 PM, Administrative Nurse E stated R7's care plan should reflect that he had the dentures and glasses. She said that the care plan should documented that there were times that R7 did not want to wear them.On 04/08/26 at 1:55 PM, Administrative Nurse D stated that she expected R7's care plan to reflect that he had dentures and glasses and that there were times he did not want them.The facility utilizes Resident Assessment Instrument (RAI) dated October 2025 for developing care plans. The RAI documented that clinical competence, observational, interviewing and critical thinking skills, and assessment expertise from all disciplines are required to develop individualized care plans. The RAI documented helping the nursing home staff gather definitive information on a resident's strengths and needs, which must be addressed in an individualized care plan. The RAI further documented it also assisted staff with evaluating goal achievement and revising care plans accordingly.