

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175220	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/28/2025
NAME OF PROVIDER OR SUPPLIER Onaga Operator, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 500 Western Street Onaga, KS 66521	

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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</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

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 32 residents, with three residents reviewed for abuse and neglect. Based on record review, observation, and interview, the facility failed to prevent sexual abuse when Resident (R)2 used topical pain medication as lubrication and penetrated cognitively impaired resident R1 anally and vaginally. On 07/11/25 at 03:05 PM, cognitively impaired R1 reported to LN G she felt nauseated, and LN G noted R1 to be anxious. R1 stated R2 utilized topical pain medication (Voltaren) during a sexual encounter, as lubrication, R1 felt sick, and reported hurting and bleeding. LN G asked R1 to clarify if it was used in her vagina or rectum, and R1 stated vagina. R1 reported R2 had put it on himself, and then it went in. R1 was unable to provide a date or time when the incident with R2 occurred, but stated it was a couple of days ago. R1 was tearful, voiced embarrassment, reported feeling ashamed, and said she told R2 to stop, but R2 did not stop. The Social Services Staff X took R1 to the hospital, where R1 reported sexual activity and bleeding. R1 told the emergency room (ER) doctors she was penetrated anally by R2. The examination revealed a small internal hemorrhoid and excoriation of the rectal tissue. R1 stated when R2 touched her, she felt afraid, helpless, and scared. R1 continued to have uncontrolled anxiety and tearfulness, was found shaking uncontrollably in bed, and was very difficult to calm. This deficient practice placed R1 in immediate jeopardy, and other female residents at risk for sexual abuse. Findings included:- R1's Electronic Medical Record (EMR) documented R1 had diagnoses of stroke, hemiplegia (paralysis of one side of the body) affecting the left non-dominant side, hypertension (high blood pressure), peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel), aphasia (condition with disordered or absent language function), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R1 had a Brief Interview for Mental Status score of eight, which indicated moderately impaired cognition. The MDS documented R1 had no behaviors, required set-up/clean-up assistance with eating, required moderate staff assistance with bathing, and was independent with all other activities of daily living (ADL). The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 10/29/24, documented R1 was at risk for a decline in cognitive status. The staff oriented R1 frequently, R1 required extra time to respond to questions, and the staff were to ask simple, direct questions which were easier for R1 to answer. The Communication CAA, dated 10/29/25, documented R1 was at risk for decline in functional communication. The CAA documented R1 was able to answer simple, direct questions if given the time. The Functional Abilities CAA, dated 10/29/25, documented R1 as at risk for a decline in functional ability with ADLs. The CAA documented R1 was mostly independent with her ADLs. R1's Care Plan documented R1 had a BIMS of eight and directed staff to speak about one topic at a time and wait on her response for understanding (10/28/24). The care plan documented R1 had a diagnosis of depression and directed staff to engage R1 in conversation when she felt sad and provide emotional support (02/19/25). The care plan documented R1 had anxiety attacks and directed staff to reassure R1 when she had negative thoughts that brought her stress and anxiety (06/25/25). The Nurses Note, dated 07/10/25, documented R1 reported she had moderate (about a tablespoon) of bright red blood after having a soft stool this evening. R1 stated she strained a little bit, denied a history of bleeding or hemorrhoids, stated she did not know if the bleeding was rectal or vaginal, and denied pain or discomfort. R1 declined an emergency room visit for evaluation but agreed staff could contact her provider in the morning and schedule an office visit. R1 agreed she would notify staff of further episodes and not flush before the nurse visualized. The Social Services Note, dated 07/11/25 at 02:18 PM, documented Certified Nurse Aide (CNA) M came to Social Services Staff X's office at about 02:09 PM and reported R1 was very tearful. Social Services Staff X went to R1's room, and R1 wanted her door shut during the visit. R1 stated a male resident had her cream and told R1 she was not lubricated enough. R1 admitted to having sex with the male resident [R2]. R1 was tearful because she noticed blood coming from her rectum. The note documented R1 expressed embarrassment. Administrative Staff A asked R1 if the sexual activities were consensual or not, and R1 replied, No, I did not want to do it. R1 was calming down and weeping less and agreed to get examined by a doctor, in case her sexual activity had harmed her in any way, especially using arthritis cream [as lubrication]. Social Services Staff X transported R1 to the emergency room, where a Sexual Assault Nurse Examiner (SANE) saw R1. R1 provided the nurse with her story and claimed she was a bad girl. The SANE nurse asked R1 if the sex was consensual and R1 replied</p>		