STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175220	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Onaga Operator, LLC	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on record review, observations, and interviews, the facility failed to ensure Resident (R)2's continuous positive airway pressure (CPAP- ventilation device that blows a gentle stream of air into the nose to keep the airway open during sleep) mask, R3's nebulizer (a device that changes liquid medication into a mist easily inhaled into the lungs) masks and nasal cannula, and R32's nasal cannula were stored in a sanitary manner when not in use. The facility failed to ensure clean laundry was transported in a sanitary manner. The facility further failed to ensure staff performed adequate hand hygiene.Findings included:- On 04/27/26 at 07:40 AM, R2's CPAP mask lay on his bed and was not stored in a sanitary container.R3's nebulizer mask lay on her bedside table. R3's nasal cannula laid on her bed. They were not stored in sanitary containers.R32's oxygen nasal canula was wrapped around her oxygen canister and not stored in a sanitary containerOn 04/27/26 at 08:02 AM, Housekeeping V carried a grey comforter with white bedding down the hall in his arms next to his clothing. Housekeeping V did not transport the linens in a sanitary manner.On 04/28/26 at 09:51 AM, Laundry Supervisor U carried a gray long sleeve shirt down the hall on a hanger; the shirt was not covered.On 04/28/26 at 09:52 AM, R32's nasal cannula oxygen tubing was wrapped around the handle of her oxygen concentrator and was not stored in a sanitary container. On 04/28/26 at 09:55 AM, R2's CPAP mask laid on his bedside table, the CPAP was not stored in a sanitary container.On 04/28/26 11:25 AM, Laundry Supervisor V carried a gray short sleeve shirt down Hall 300 on a hanger. The shirt was not covered.On 04/30/26 at 08:11 AM, R2's CPAP lay on his bedside table and was not stored in a sanitary container.On 04/30/26 at 09:00 AM, R32's nasal cannula was wrapped around her oxygen canister, and a nasal cannula was wrapped around the handle of a portable oxygen tank in her room. R32's nasal cannulas were not stored in sanitary containers.On 04/30/26 at 09:59 AM, R14 transferred herself from a wheelchair to the toilet. R14 took her incontinent brief and slacks off, tossed the incontinent brief in the trash can, and placed her slacks on the floor. Certified Nurse's Aide (CNA) M instructed R14 to pull the call light chord when she was done and left the room. CMA R returned to R14's room and had R14 stand. CMA R locked the wheelchair brakes and asked R14 if she needed a new pair of slacks. R14 replied she did not know yet. R14 picked the slacks off the floor and placed them in her hands feeling all around them and then reported they were wet she would need a new pair of slacks. CNA M took the wet pair of slacks in her ungloved hands and placed them in the basket in the bathroom. CNA M then retrieved a pair of slacks from R14's dresser drawer. CNA M assisted R14 in putting on her slacks and shoes, touching both the slacks and shoes with her ungloved hands. CNA M applied a gait belt around R14's waist, assisted R14 in standing, and transferred to her wheelchair. CNA M touched R14's gait belt and the back of her shirt. CNA M then unlocked R14's wheelchair and R14 self-propelled out of the bathroom. R14 and CNA R did not wash their hands. On 04/30/26 at 10:15 AM, two shirts on hangers laid on top of a pink laundry bin outside the dirty utility room. The shirts were not transported in a sanitary manner. On 04/30/26 at 10:19 AM, CNA M verified she did not wash her hands, nor did she have R14 wash her hands. CNA M stated she should have washed her hands when entering the room after helping with incontinent cares and when leaving R14's room and stated she should have asked R14 if she wanted help with hand hygiene.On 04/30/26 at 11:00 AM, Administrative Nurse D stated staff should wash their hands before and after (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	providing incontinent care and when touching contaminated materials. Administrative Nurse D stated the facility had containers for nebulizers to be stored in after nurses wash the nebulizer pieces. She stated that CPAP masks have a compartment in the CPAP machine that the masks are placed in after each use. She stated the nasal cannulas have bags dated that are connected either to the resident's chair, or to the residents' canisters. She stated laundry should be transported covered when it was taken to the residents' rooms. The facility's Handling of Clean Linen and Linen Distribution policy dated 06/26 documented clean laundry/bedding should be handled in a manner that prevents gross microbial contamination of the air and person handling the linen.The facility's Handwashing/Hand Hygiene dated 10/25 documented staff should be trained and regularly in-service on the importance of hand hygiene and preventing transmission of healthcare-associated infections. Staff should follow handwashing hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors.The facility's Administering Medications through a Small Volume Nebulizer dated 11/25, documented staff should disassemble the parts and rinse them with hot water after each use. When the equipment is completely dry, store in a plastic bag the residents' name and date.The facility did not provide a CPAP or nasal cannula storage policy as requested on 04/30/26.

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F 0801 Level of Harm - Potential for minimal harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on observation, record review, and interview, the facility failed to employ a full-time certified dietary manager for the 28 residents who resided in the facility and received meals from the facility kitchen. Findings included:- On 04/28/26, the noon meal consisted of beef enchiladas, Spanish rice, and cheesecake. On 04/28/26 at 11:00 AM, observation revealed Dietary Staff (DS) BB was in the kitchen overseeing the preparation of the noon meal. On 04/27/26 at 07:35 AM, DS BB verified she was not a Certified Dietary Manager (CDM). DS BB stated she had enrolled and finished classes but had not taken the test. On 04/29/26 at 10:00 AM, Administrative Nurse D verified DS BB had no dietary manager certification but confirmed DS BB had enrolled in the dietary certification course though had not yet taken the test. Upon request, the facility did not provide a policy regarding a certified dietary manager.

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F 0851 Level of Harm - Potential for minimal harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on record review and interview, the facility failed to submit complete and accurate staffing information to the federal regulatory agency through Payroll Based Journaling (PBJ).Findings included:- The PBJ Staffing Data Report CASPER Report 1705D provided by the Centers for Medicaid and Medicare (CMS) for Fiscal Year (FY) 2026 Quarter (Q)1 documented excessively low weekend staffing.Review of the facility's actual working schedule sheets from 11/01/25 to 04/01/26 revealed the facility maintained and had the same number of staff scheduled and worked as during the week: One nurse for day shift, one nurse for evening and night shift; two to three nurse aides day shift, and two nurse aides on evening and night shift; and one medication aide on day and evening shift.The facility's Facility Assessment revised on 12/10/25, documented the specific needs of each resident in the community were identified and staffing was adjusted as needed. The facility assessment included staffing for each shift. The direct care staff was to have one licensed nurse for day shift, and one licensed nurse for evening; one medication aide on day and evenings; two to three nurse aides on day shift and two nurse aides on evening shift, and night shift; and one medication aide for day, and evening shift.On 04/21/26 at 08:06 AM, Administrative Staff A stated she was unsure why the facility showed extremely low weekend staffing on the PBJ. She stated she had worked on weekends as a nurse aide and had worked weekends as the charge nurse. Administrative Staff A stated she was not sure if her hours worked were reported in the PBJ data tracking. She also stated the facility had also had a nurse quit during the time the PBJ was showing extremely low weekend staffing.The facility's Payroll Based Journal dated 10/26 documented our community would submit payroll data in a uniform format to CMS, including staffing information for community, agency and contract staff. Direct Care Staff were defined as 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.