STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E534	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Attica Long Term Care Facility	302 N Botkin Attica, KS 67009

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. The facility reported a census of 44 residents. The sample included five residents who were reviewed for abuse. Based on observation, interview, and record review, the facility failed to ensure residents remained free from resident-to-resident abuse. On 08/29/25 at approximately 01:10 PM, Resident (R)l, a cognitively impaired resident with a known history of aggression towards staff and other residents, approached her roommate, R2, in the common area, placed her hands around R2's neck, and began choking her. Staff heard the altercation, responded and intervened, though R1 continued to pull R2's hair while staff attempted to separate them. Staff separated the residents and assessed them. R1 had a small cut to her face and R2 had redness around her neck but no other visible injuries. The facility's failure to ensure residents remained free from abuse placed R2 in Immediate Jeopardy. Findings included:- R1's Electronic Health Record (EHR) documented diagnoses that included unspecified dementia (a progressive mental disorder characterized by failing memory and confusion) and Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure). R1's 07/28/25 admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of four, which indicated severely impaired cognition. The assessment documented R1 had hallucinations (sensing things while awake that appear to be real, but the mind created) with physical and verbal behavioral symptoms directed towards others and wandering behaviors that occurred during the look-back period. The assessment documented the behaviors significantly intruded on the privacy or activities of others. The 07/28/25 Cognitive Loss/Dementia Care Area Assessment (CAA) documented R1 previously lived at home with her spouse and had a diagnosis of Alzheimer's with difficulty remembering her room and saying things that were untrue. The 07/28/25 Behavioral Symptoms CAA documented R1 had wandering behavior that included going into other residents' rooms. R1 became easily upset and/or irritated with direction or redirection from staff. When R1 saw another resident sitting at a table, R1 displayed aggression and started to get in his face, and staff had to step between the residents to physically separate them. R1 also displayed behaviors of charging staff and ramming staff with her walker, throwing water on staff, and grabbing staff's clothing. The 07/28/25 Psychotropic Drug Use CAA documented R1 previously lived at home with her spouse, and he had administered Seroquel (quetiapine - a medication used to treat psychosis [any major mental disorder characterized by a gross impairment in reality perception]) to R1 three times at home since 06/25/25. The current medication regimen included Rexulti (a medication used to treat agitation associated with dementia due to Alzheimer's disease). R1's Care Plan dated 08/05/25 documented R1 had poor comprehension, which affected her understanding of her current impairments that caused increased restlessness and irritability. Interventions dated 07/30/25 directed staff to monitor R1's location and try to redirect any attempts to leave or enter other residents' rooms as best as possible to prevent a safety risk. The intervention provided suggestions such as sitting up front with peers and watching television, or on the patio as weather permitted. Staff would encourage activities and monitor for signs and symptoms of depression or anxiety and encourage R1 to express her feelings and provide support as needed. Staff were to attempt to provide a calm environment for her needs, redirect inappropriate behaviors, and offer food or fluids as needed for redirection. The (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	intervention documented staff attempted the individualized activity of folding towels. Staff would monitor as needed use of Seroquel (quetiapine) for increased restlessness and irritability and monitor the use of Rexulti for dementia with anger and inappropriate behaviors, and unsettled restlessness. R1's Care Plan did not address interventions related to resident-to-resident abuse/aggression. Review of R1's EHR Census Records documented R1 admitted to the facilty on 07/17/25 at 10:21 AM. Review of the facility's investigation dated 07/17/25 revealed R1 was involved in an incident of resident-to-resident abuse on 07/17/25 at approximately 05:20 PM with R3 who received minor injuries. R1's EHR lacked information related to the resident-to-resident abuse incident that occurred on 07/17/25. Review of R1's EHR Census Records documented on 08/02/25 at 08:28 AM, R1's room assignment changed to the special care unit in a semi-private room with R2. R1's Progress Notes dated 08/29/25 at 02:03 PM, revealed Licensed Nurse (LN) G documented R1 pulled another resident's hair. LN G notified R1's son, who apologized for the incident, and LN G reassured R1's son the behavior was due to the dementia. Certified Nurse Aide (CNA) M's 08/29/25 Witness Statement recorded, on an undocumented date at approximately 12:30 PM, staff heard someone yelling. CNA M went into a resident's room where R1 had a hold of R2's arm and was pushing R2. CNA M was able to get between R1 and R2 and release R1's grip on R2; R1 slapped CNA M across the face. At approximately 01:00 PM, CNA M and the other [unnamed] staff were assisting another resident when they heard someone scream for help. CNA M noted they observed R1 grasping R2 by the throat and hair. Staff intervened and separated R1 and R2, and R1 attempted to bite the staff. Staff returned R1 to her room and called the nurse on duty. CNA M documented R1 was holding a clump of R2's hair in her hand when R1 returned to her room. CNA O's 09/29/25 Witness Statement recorded, on an undocumented date and illegible time, she was assisting another [unnamed] staff when R2 was heard yelling Help from the common area. CNA O went to investigate and observed R1 choking R2 and pulling R2's hair. CNA O alerted the other staff in the area. CNA O was unable to release R1's hand, so CNA O held R1 back while the other [unnamed] staff released R1's hand; R1 attempted to bite CNA O's chest. When R1's grip was released from R2, staff escorted R1 to her room, and she fought staff and attempted to bite them. CNA O stayed with R1 while the other staff member called the nurse to come as soon as possible. LN G's 08/29/25 Witness Statement documented on 08/29/25, staff called her on the unit and informed her that they heard R2 scream and then found R1 choking R2 with one hand and pulling her hair with the other. Staff attempted to pull R1's hands off R2's neck and hair and were successful after a short while. Staff escorted R1 back to her room. LN G assessed R2 and found red marks around her neck and many loose strands of hair on her clothes and on the recliner. LN G assessed R1 and found a small wound to her right upper lid. R1 had R2's hair woven through her fingers and on the front of her shirt. R1 denied doing anything to anyone and stated she would never hurt anyone. LN G documented staff moved R1 to a different room and performed one-on-one observation for others' safety. LN G documented the incident was reported to the on-call nurse and the residents' families. Review of the facility's investigation revealed CNA staff reported they came out of a resident's room to find R1 with her hands around the neck of R2. Both aides assisted in separating the residents, and R1 continued to pull on R2's hair. Once R1 and R2 were separated, staff contacted the charge nurse, who went to the [special care] unit to assess both residents. R2 had no visible injuries and was able to swallow and talk without discomfort; R1 had a small scratch to the upper right lip. The investigation noted that because the actual incident was unwitnessed, the administration reviewed camera footage, which revealed R2 sat in a recliner, running her fingers through her hair, and looking out the patio door. R1 exited her shared room with R2 and walked directly towards R2. R1 approached R2 and immediately grabbed the left side of R2's head and hair with both hands. Next, R1 took her left hand and encircled R2's throat. R2 attempted to pull away from R1 while staff exited a resident's room. Staff were behind R1 and attempted to remove R1 and got between both residents. While attempting to separate the residents, R1 clutched onto R2's hair. Once the two were separated, R1 attempted to bite the staff member's wrist. With staff on each side of R1, (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	they assisted R1 back to her room, and staff stayed inside the room while the other staff went to the phone to call for help. Staff brought R1 out into the main commons area to keep R1 and R2 separated for a few minutes. After a while, R1 returned to the unit without further incident. The investigation revealed the facility performed one-on-one supervision until 09/03/25. Review of R1's EHR Census Records documented on 09/01/25 at 12:32 AM, R1's room assignment changed to a private room on the special care unit. During an observation on 10/14/25 at 12:25 PM, R1 rested in bed with her eyes closed. During an observation on 10/14/25 at 12:25 PM, R2 rested in bed with her eyes closed. During an interview on 10/14/25 at 12:30 PM, CNA N revealed in the event of a resident being aggressive or violent to another resident, staff would de-escalate the situation as best as possible while separating the residents and redirecting the aggressor. The nurse would be notified as soon as possible. Once the nurse arrived, the staff would follow the directions of the nurse. CNA N revealed she was aware of the incident that occurred between R1 and R2 on 08/29/25, but she was not working that shift. When CNA N returned to work after the incident on 08/29/25, R1 was having one-on-one observation, but CNA N could not recall for how long. CNA N denied knowledge of anywhere in the EHR or on paper where one-on-one observation was documented. CNA N denied any knowledge of any aggressive behaviors from R1 towards staff, or any additional aggressive behaviors towards other residents since 08/29/25. CNA N confirmed they received in-service training since the incident on 08/29/25. During an interview on 10/14/25 at 12:35 PM, CNA P revealed in the event of one resident being irritable or aggressive/violent to another resident, staff would separate the residents, de-escalate the situation, and redirect as needed, then alert the nurse. The nurse would then come, and the staff would follow the instructions of the nurse. CNA P stated she was aware of the incident that occurred between R1 and R2 on 08/29/25, although she was not working when it happened. When she came back to work, R1 was under one-on-one observation, and staff were instructed to stay within an arm's reach of R1. CNA P was unable to recall how long one-on-one observation was in place for. CNA P stated if a resident was in the common area, one staff member stayed with them, and if two staff were required to perform any care with any resident during that time, another staff member would come onto the special care unit so that no residents were left unsupervised in the common area. CNA P confirmed she has received in-service training since 08/29/25. During an interview on 10/14/25 at 01:00 PM, CNA Q revealed if one resident was being aggressive or irritable towards another resident, staff would attempt to de-escalate the situation by redirecting one or both residents with a variety of options such as food, drink, a distracting activity, or going for a walk. CNA Q revealed she was not aware of any resident-to-resident abuse incidents but reported she recently received an in-service training related to abuse. During an interview on 10/14/25 at 01:05 PM, LN H revealed if residents were being aggressive or irritable to one another, staff would separate and de-escalate the situation and notify the nurse as soon as possible. The nurse would assess the residents involved for any injury and render aid as needed. Once the situation was over, the nurse would notify the manager on duty and would collaboratively investigate. The nurse would also notify the residents' physician(s) as well as family or responsible parties and would hold a huddle with the staff members on duty to explain what new interventions would be implemented. LN H revealed she was aware of the incident that occurred on 08/29/25 between R1 and R2, but she was not working that shift. LN H stated the next time she worked after the incident, R1 was on one-on-one observation where staff remained within an arm's length of R1, perhaps two arm lengths. LN H said she was unsure of any documentation to show one-on-one observation was performed, other than the schedule that documented an extra person staffed in the special care unit. LN H revealed she was aware of reports of R1 being verbally aggressive towards staff and other residents and physically aggressive towards staff. During an interview on 10/14/25 at 01:30 PM, Administrative Nurse D revealed if a resident was aggressive with another resident, the expectation was that staff would separate and redirect the residents while also ensuring the safety of all the residents involved, then report the incident to the nurse as soon as possible. The nurse would collect written statements from everyone with any (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	knowledge of the incident and then collaborate with the manager on duty to develop an intervention until the interdisciplinary team (IDT) could meet and develop an intervention to be placed on the care plan. After the incident on 08/29/25 between R1 and R2, R1 was placed on one-on-one observation until 09/03/25. Administrative Nurse D revealed the special care unit had dedicated staff, and all the dedicated staff received in-service training related to abuse prevention on 10/03/25. The facility's Preventing Resident-to-Resident Abuse policy, dated 05/2022, documented the facility would attempt to prevent resident-to-resident abuse through assessments and individualized interventions. The IDT would evaluate history obtained from the resident and their family, along with medical history related to the resident's history of physical and/or verbal abuse. The team would then develop a plan to create an environment supportive of the resident to decrease the opportunity for resident-to-resident abuse that focused on non-medication interventions. On 10/14/25 at 04:45 PM, Administrative Staff A, Administrative Nurse D, and Administrative Nurse E received a copy of the Immediate Jeopardy [IJ] Template and were informed of the IJ.The facility identified, implemented, and completed corrective measures on 10/03/25, which included the following: 1. On 08/29/25, R1 was placed on one-on-one supervision at all times.2. On 09/01/25, R1 was moved from a semi-private room on the special care unit with R2 to a private room on the special care unit.3. On 09/23/25, the facility held a quality assurance, process improvement (QAPI) meeting to discuss the incident.4. On 09/25/25, R1 was assessed by Physician Extender V, and the medication regimen was adjusted effective 09/26/25.5. On 10/03/25, staff education was provided to the dedicated staff for the special care unit related to aggressive behavior, resident-to-resident abuse, and dementia care.The onsite surveyor verified the above completed corrective action. Due to all corrections completed prior to the onsite survey, the deficient practice was cited as past noncompliance at a scope and severity of J (isolated, immediate jeopardy).