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	06/11/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** R12's Electronic Medical Record (EMR) included the following diagnoses: post-traumatic stress disorder (PTSD- a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). R12's Annual Minimum Data Set (MDS), dated [DATE], documented the staff assessment for cognition revealed moderately impaired cognition. He received antianxiety (a class of medications that calm and relax people) and an antidepressant (a class of medications used to treat mood disorders) during the assessment period. R12's Psychoactive Medications Care Area Assessment (CAA), dated 12/09/24, documented the resident received medications to treat the signs and symptoms of anxiety and depression. R12's Quarterly MDS, dated 03/10/25, documented the staff assessment for cognition revealed moderately impaired cognition. He received antianxiety and antidepressant medications during the assessment period. R12's Care Plan, revised 03/19/25, instructed staff the resident took medications for signs and symptoms of anxiety and depression. R12's EMR revealed the following physician's orders: Lorazepam (an antianxiety medication), 0.5 milligrams (mg), by mouth (PO), every day (QD), for a diagnosis of PTSD, ordered 06/03/25. Lorazepam, 0.5 mg, PO, at bedtime (HS), for a diagnosis of PTSD, ordered 06/03/25. Mirtazapine (an antidepressant medication), 15 mg, PO, atHS, for a diagnosis of abnormal weight loss, ordered 06/03/25. Sertraline (an antidepressant medication), 25 mg, PO, QD, for a diagnosis of depression, ordered 07/23/23. R12's EMR lacked evidence of informed consent for the use of lorazepam, mirtazapine, and sertraline. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/10/25 at 03:24 PM, Administrative Nurse D stated the facility had not completed informed consent for R12's psychotropic medications. The facility policy for Psychotropic Medication, approved 03/2025, included: The facility shall inform the resident, family and/or representative of the benefits, risks, and alternatives for each medication prior to adding, discontinuing, or changing any psychotropic medication. - R13's Electronic Medical Record (EMR) included the following diagnoses: panic disorder (frequent and unexpected panic attacks), major depressive disorder (major mood disorder that causes persistent feelings of sadness), and bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods). R13's Annual Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. She received antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), antianxiety (a class of medications that calm and relax people), and antidepressant (a class of medications used to treat mood disorders) medications during the assessment period. R13's Psychotropic Medication Care Area Assessment (CAA), dated 04/21/25, documented the resident had a history of mental health issues that affected her daily life. R13's Quarterly MDS, dated 01/27/25, documented the resident had a BIMS score of 12, indicating moderately impaired cognition. She received antipsychotic, antianxiety, and antidepressant medications during the assessment period. R13's Care Plan, revised 02/04/25, instructed staff the resident had a history of depression and anxiety. R13's EMR revealed the following physician's orders: Buspirone (an antidepressant medication), 10 milligrams (mg), by mouth (PO), twice daily (BID), for a diagnosis of panic disorder, ordered 01/28/24. Desvenlafaxine (an antidepressant medication), 100 mg, PO, every day (QD), for a diagnosis of major depressive disorder, ordered 05/17/23. Lorazepam (an antianxiety medication), 0.5 mg, PO, three times daily (TID), for a diagnosis of anxiety, ordered 09/16/24. Olanzapine (an antipsychotic), five mg, PO, at bedtime (HS), for a diagnosis of bipolar disorder, ordered 11/12/24. R13's EMR lacked evidence of informed consent for the use of buspirone, desvenlafaxine, lorazepam, and olanzapine. On 06/10/25 at 03:24 PM, Administrative Nurse D stated the facility had not completed informed consent for R13's psychotropic medications. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy for Psychotropic Medication, approved 03/2025, included: The facility shall inform the resident, family and/or representative of the benefits, risks, and alternatives for each medication prior to adding, discontinuing, or changing any psychotropic medication. The facility reported a census of 36 residents. The sample included 13 residents. Based on interview, observation, and record review, the facility failed to inform Resident (R)32, R35, R12, R13 and/or their representative regarding the risks related to psychotropic (alters mood or thoughts) medications. These deficient practices had the potential to lead to negative and unwarranted physical side effects. Findings included: - R32's Electronic Health Record (EHR) included diagnoses of depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and adjustment disorder with mixed anxiety and depressed mood (a mental health condition that arises when someone struggles to cope with a significant life change or stressful event). R32's admission Minimum Data Set (MDS), dated 03/10/25, documented a Brief Interview of Mental Status (BIMS) score of 15, indicating the resident's cognitive function was intact. The MDS section for mood indicated that R32 would sometimes isolate. The Psychotropic Medication Use Care Area Assessment (CAA), dated 03/10/25, documented the resident was taking an antidepressant (a class of medications used to treat mood disorders). R32 exhibited signs of depression, and disturbances of balance, gait, and positioning ability. R32's Quarterly MDS, dated 06/02/25, documented a BIMS score of 13, which indicated the resident's cognitive function was intact. The MDS section for mood indicated that R32 triggered for mild depression. R32's Care Plan dated 06/04/25 documented R32 had the potential to feel frustrated with life's challenges. An intervention dated 09/12/24 recorded staff monitored the use of bupropion (a medication used to treat depression) for depression with anxiety and restlessness and monitored R32's use of citalopram (a medication used to treat depression) for depression with tearfulness and frequent complaints. R32's EHR documented an order dated 03/03/25 for bupropion hydrochloride (HCL). R32's EHR documented an order dated 05/13/25 for citalopram. R32's EHR lacked evidence R32, or her representative, received education and/or informed consent with regards to the bupropion HCL or citalopram use including reason for use, expected therapeutic benefits and potential risks and side effects. During an interview on 06/10/25 at 03:24 PM, Administrative Nurse D reported that the facility did not have consent for psychotropic medications. Administrative Nurse D stated that she thought the consent was only needed if the facility started new psychotropic medications, not for residents that were currently taking psychotropic medications when they admitted to the facility. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy for Psychotropic Medication, approved 03/2025, included: The facility will administer psychotropic medications, including anti-anxiety/hypnotic, antipsychotic, and antidepressant medication, appropriately to ensure the appropriate use, evaluation, and monitoring. The policy also indicated that the facility should inform the resident, family, and/or representative of the benefits, risks, and alternatives for each medication prior to adding, discontinuing, or changing any psychotropic medication. - R35's Electronic Health Record (EHR) included diagnoses of insomnia (inability to sleep), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and unspecified dementia (a progressive mental disorder characterized by failing memory and confusion). R35's Significant Change in Status Minimum Data Set, dated 04/28/25, documented a Brief Interview of Mental Status (BIMS) score of 15, indicating the resident's cognitive function was intact. R35's Psychosocial Well-Being Care Area Assessment (CAA), dated 04/28/25, documented depression as a disease and condition that may impede her ability to interact with others. It also listed the health problems of falls, pain, and fatigue as health status factors that may inhibit her social involvement. The Psychotropic Medication Use Care Area Assessment (CAA), dated 04/28/25, documented the resident was taking an antidepressant (a class of medications used to treat mood disorders). R35 exhibited signs of falls, depression, disturbances of balance, gait, positioning ability, and sedation manifested by short-term memory loss, decline in cognitive abilities, slurred speech, drowsiness, and little/no activity involvement. R35's Care Plan dated 02/06/25 documented she was on a medication regime with potential reactions and adverse side effects. The intervention dated 02/06/25 listed duloxetine (a medication used to treat depression and anxiety) and listed the black box warning for monitoring. R35's EHR documented an order dated 01/27/25 for duloxetine. R35's EHR lacked evidence R35, or her representative, received education and/or informed consent with regards to the bupropion HCL or citalopram use including reason for use, expected therapeutic benefits, and potential risks and side effects. During an interview on 06/10/25 at 03:24 PM, Administrative Nurse D reported that the facility did not have consent for psychotropic medications. Administrative Nurse D stated that she thought the consent was only needed if the facility started new psychotropic medications, not for residents who were currently taking psychotropic medications when they admitted to the facility. The facility policy for Psychotropic Medication, approved 03/2025, included: The facility will administer psychotropic medications, including anti-anxiety/hypnotic, antipsychotic, and antidepressant medication, appropriately to ensure the appropriate use, evaluation, and monitoring. The policy also indicated that the facility should inform the resident, family, and/or representative of the benefits, risks, and alternatives for each medication prior to adding, discontinuing, or changing any psychotropic medication.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. The facility identified a census of 36 residents. The sample included 13 residents with two residents sampled for nutrition. Based on observation, interview, and record review, the facility failed to notify the physician of significant weight changes in Resident (R) 19 who had a significant weight. This deficient practice also had the potential to negatively affect the resident's physical well-being and nutritional status. Findings: - R19's Electronic Medical Record (EMR) revealed the following diagnoses: dementia (a progressive mental disorder characterized by failing memory and confusion) with agitation. R19's 03/17/25 admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of three, indicating severely impaired cognition. The MDS recorded R19 ' s weight was 136 pounds, and she had no known weight loss. She consumed a regular textured diet with no eating or swallowing concerns. The 03/17/25 Cognitive Loss / Dementia (CAA) documented R19 admitted to the facility after having a month-long stay at a behavioral health facility to address medications to limit her aggression and attain a better quality of life. She had increased forgetfulness and was unable to live with family helping at home. The CAA further noted R19 often asked where she was and why she was in the facility. R19's 06/09/25 Quarterly MDS documented a BIMS score of three. The MDS documented R19 had a significant weight loss and weighed 120 pounds. R19 was independent with eating. R19's Care Plan dated 03/25/25 documented R19 made her own food choices. She was on a liberalized geriatric diet with texture as tolerated. R19 had a goal that her nutritional needs would be met, and dietary risks would be avoided during her stay. Interventions for R19 on 03/25/25 documented she liked to have a cup of coffee first thing in the morning and asked for it throughout the day. She may prefer to have small portions. R19 came to the dining room to have meals, and staff may have to cue her when it was time for meals. She did not drink milk but tolerated it in food. She ordered her meals and fed herself after it was set up. The plan directed staff to show R19 how to get snacks, offer her snacks and fluids throughout the day, and encourage her to drink fluids. The plan noted staff weighed her and recorded her weight on Monday mornings. R19's EMR recorded an admission weight on 03/06/25 of 135 pounds. R19's Physician's Orders noted a liberalized geriatric diet with texture as tolerated, ordered on 03/06/25. R19 ' s Progress Note by the registered dietician (RD) dated 03/07/25 at 12:14 PM documented R19 liked most foods. The RD noted that given the limited history she received, it was likely that R19 had lost weight over the past four to five years and was at risk for continued weight loss. (continued on next page)

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	17E534	A. Building B. Wing	06/11/2025

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R19's EMR recorded a weight on 03/31/25 of 127.5 pounds but lacked evidence the physician was notified. R19 ' s Progress Note from the RD dated 05/29/25 at 12:53 PM documented R19 had limited meal intake documented. With only 14 meals charted during the previous two weeks; intakes ranged from zero to less than 75%. The RD documented most meals documented indicated the resident consumed less than 26 % of meals. Staff reported R19 preferred to sleep late in the morning and even then, often preferred to remain in her room. She was more likely to come out of her room in the afternoon and she may sit in the lobby and have a snack or go to the dining room. Staff was able to encourage R19 to go to the dining room at around noon on that day. Staff assisted R19 with ordering a meal. Staff offered alternate meals, but R19 declined all suggestions, stating I'm just not hungry. I want to go back to my room and lie down. The RD documented she also attempted to encourage R19 to stay and offered the resident a milkshake and other dessert items, R19 continued to say she was not hungry. The RD noted R19's charting showed R19 had a bowel movement two days previous two weeks. The note recorded R19 had a significant weight loss and based on what staff reported and what R19 said, the resident may benefit from a trial of an appetite stimulant. At that time, it appeared R19 was at risk for continued weight loss. R19's EMR recorded a weight on 06/02/25 of 119.5 pounds but lacked evidence staff notified R19's physician notification of the loss. During an observation on 06/09/25 at 03:35 PM, R19 lay in bed with the door closed and her eyes closed. The blinds were closed, and it was dark in her room. During an observation on 06/11/25 at 12:15 PM, Certified Nurse Aide (CNA) O assisted R19 to the scale from her room. R19 stopped every couple of steps and turned to CNA O and asked where they were and where they were going then said, Okay. and proceeded to take a few more steps. CNA O directed R19 to stand on the scale. R19's weight was 120 pounds. During an interview on 06/11/25 at 08:17 AM, CNA O stated that R19 was independent with her care. She usually got up for lunch and supper and goes right back to bed; R19 liked to sleep. During an interview on 06/11/25 at 08:31 AM, Licensed Nurse (LN) G said when a resident had weight loss, staff would usually get an order from the doctor for Ensure (liquid nutritional supplement) or a protein shake, or a higher calorie meal. The registered dietician also makes recommendations for medications like an appetite stimulant. LN G said she did not know why R19's RD recommendations were not followed or faxed to the provider. She said she would verify the provider was not notified and notify him now if needed. During an interview on 06/11/25 at 08:43 AM, Administrative Nurse D stated the RD gave her a list of residents with weight loss weekly and let the nurses know the recommendations. The nurse would then talk to the doctor about the recommendations and get orders. During an interview on 06/12/25 at 03:41 PM, Consultant HH stated she was not notified of R19's weight loss until 06/11/25 and she ordered health shakes to start with. Consultant HH stated she expected to be notified of weight loss by fax immediately or on the next rounding day. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy Attica Long Term Care Weight Policy, dated 05/2024, included: The nursing director will notify the physician of significant weight loss.

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	17E534	A. Building B. Wing	06/11/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 36 residents with 13 residents sampled, including two residents reviewed for activities of daily living (ADL). Based on observation, interview, and record review, the facility failed to provide nail care for Resident (R)23 which placed the resident at risk for skin issues. Findings included: - R23's Electronic Medical Record (EMR) included the following diagnoses: dementia (a progressive mental disorder characterized by failing memory and confusion) and weakness (lacking strength). R23's Annual Minimum Data Set (MDS), dated [DATE], documented the staff assessment for cognition revealed moderately impaired cognition. She was dependent on staff for personal hygiene. Review of the Functional Abilities Care Area Assessment (CAA), dated 08/19/24, documented the resident required staff assistance with all activities of daily living (ADL). R23's Quarterly MDS, dated 03/17/25, documented the staff assessment for cognition revealed moderately impaired cognition. She was dependent on staff for personal hygiene. She had no limitation in range of motion (ROM) and was dependent on staff for mobility in her wheelchair and personal hygiene. R23's Care Plan, revised 03/25/25, instructed staff the resident was dependent on staff for all ADLs. On 06/09/25 at 08:13 AM, R23 sat in her wheelchair. Her fingernails were long, jagged, and dirty. On 06/09/25 at 02:51 PM, R23's fingernails remained long, jagged, and dirty. On 06/10/25 at 09:49 AM, R23 participated in a group activity. Her fingernails remained long, jagged, and dirty. On 06/10/25 at 08:13 AM, Certified Nurse Aide (CNA) M stated staff cut and cleaned R23's fingernails on her shower days. On 06/10/25 at 10:10 AM, CNA MM stated R23 was dependent on staff for all ADLs, including fingernail care. On 06/10/25 at 08:37 AM, Administrative Nurse D stated she expected staff to ensure R23's fingernails were smooth and clean. The facility did not provide a policy for nail care.

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	17E534	A. Building B. Wing	06/11/2025

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 36 residents with 13 residents sampled, including two residents reviewed for activities. Based on observation, interview, and record review the facility failed to implement an ongoing, resident-centered activity program for Resident (R)12, to meet his interests and preferences. This placed the resident at risk of boredom and isolation. Findings included: - R12's Electronic Medical Record (EMR) revealed a diagnosis of dementia (a progressive mental disorder characterized by failing memory and confusion). R12's Annual Minimum Data Set (MDS), dated [DATE], documented the staff assessment for cognition revealed moderately impaired cognition. The MDS recorded it was somewhat important for him to have books, newspapers, and magazines to read, and he enjoyed listening to music he liked and to participate in religious practices. It was very important for him to keep up with the news and to do his favorite activities. He had no impairment in functional range of motion (ROM) and was able to ambulate independently. The Activity Care Area Assessment (CAA), dated 12/09/24, did not trigger. R12's Quarterly MDS, dated 03/10/25, documented the staff assessment for cognition revealed moderately impaired cognition. He had no impairment in functional ROM and was able to ambulate independently. R12's Care Plan for activities of daily living (ADL), revised 03/19/25, instructed staff to direct him to events, as needed. R12's EMR revealed an Activity Assessment, dated 03/05/25, which documented the resident enjoyed listening to music and finding places to sit and lie down. R12's EMR from 05/11/25 through 06/09/25 revealed the resident had an activity on 05/11/25 which lasted 15 minutes, and an activity on 05/14/25 which lasted 120 minutes. The EMR lacked evidence of further activity events. On 06/09/25 at 09:37 AM, R12 sat in a recliner in the front commons area. The TV was turned on to a sitcom however the resident was not watching TV. Observation revealed no other activities were taking place at that time. On 06/09/25 at 02:37 PM, R12 sat in a recliner in the front commons area. The TV was turned to a game show however the resident was not watching TV. Observation revealed no other activities were taking place at that time. On 06/10/25 at 08:23 AM, Certified Nurse Aide (CNA) P stated R12 enjoyed talking. CNA P was unsure of any other activities the resident enjoyed. (continued on next page)

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	17E534	A. Building B. Wing	06/11/2025

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/10/25 at 08:23 AM, CNA Q stated R12 enjoyed one-to-one activity; staff documented all activities in his EMR. On 06/10/25 at 11:23 AM, Licensed Nurse (LN) G stated the activities in the dementia unit were different than the activities in the rest of the facility. LN G was unsure of activities R12 enjoyed. On 06/10/25 at 08:30 AM, Administrative Nurse D confirmed there were no other activities documented for R12. The facility policy for Life Enhancement and Activity Programming, approved 09/2022, included: Activities will be provided for all residents based on the comprehensive assessment and care plan and the preferences of each resident. An activity will be an endeavor intended to enhance the resident's sense of well-being and to promote physical, cognitive, and emotional health. Documentation will include participation in an activity rather than attendance.

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	17E534	A. Building B. Wing	06/11/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** - R23's Electronic Medical Record (EMR) included the following diagnoses: dementia (a progressive mental disorder characterized by failing memory and confusion) and weakness (lacking strength). R23's Annual Minimum Data Set (MDS), dated [DATE], documented the staff assessment for cognition revealed moderately impaired cognition. She was dependent on staff for wheelchair mobility. Review of the Functional Abilities Care Area Assessment (CAA), dated 08/19/24, documented the resident required staff assistance with all activities of daily living (ADL). R23's Quarterly MDS, dated 03/17/25, documented the staff assessment for cognition revealed moderately impaired cognition. She was dependent on staff for wheelchair mobility. R23's Care Plan, revised 03/25/25, instructed staff the resident was dependent on staff for wheelchair mobility. On 06/09/25 at 08:13 AM, Certified Nurse Aide (CNA) M propelled the resident in her wheelchair. The resident's right shoed foot was off the foot pedal and skimmed the floor during transport. The resident's left foot remained on the foot pedal. On 06/10/25 at 12:11 PM, CNA MM propelled the resident from the front commons area to her room in her wheelchair. The resident's shoed feet were between the foot pedals of the wheelchair, skimming the floor. On 06/09/25 at 08:13 AM, CNA M stated that R23's feet did not always stay on the foot pedals of her wheelchair. On 06/10/25 at 12:11 PM, CNA MM confirmed that R23's feet did not always stay on the foot pedals of her wheelchair. On 06/10/25 at 08:37 AM, Administrative Nurse D stated she expected staff to ensure R23's feet stayed on the foot pedals of their wheelchairs during transport, to avoid injury. The facility did not provide a policy for wheelchair positioning including foot pedals. The facility reported a census of 36 residents with 13 residents selected for review. Based on observation, interview, and record review, the facility failed to identify and implement meaningful resident-centered fall prevention interventions to prevent falls for Resident (R) 36. The facility further failed to ensure R14 and R23 had wheelchair pedals when staff propelled them in the wheelchair. This placed the residents at risk for falls and avoidable accidents. Findings included: (continued on next page)

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	06/11/2025

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- R36's Electronic Medical Records (EMR) documented R36 had the following diagnoses that included a history of fractures and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R36's 05/12/25 admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 99, indicating R36 was unable to answer the questions. The MDS documented per staff interview, R36 had memory impairment; she did not know the staff, where her room was, or that she was in a nursing home. R36 was on hospice services. R36 had fallen in the month prior to admission, falls within the last six months, and a fall resulting in a fracture. The 05/12/25 Falls Care Area Assessment (CAA) documented R36 had a fall with a hip fracture that required a surgical repair prior to admission. R36 was at risk for falls due to a history of falling, unsteadiness on her feet, and confusion. The CAA also documented R36 had behaviors of anxiety and trying to throw herself on the floor. The 05/12/25 Cognitive Loss/Dementia CAA documented R36 was confused and repeatedly asked the same question. Staff need to monitor her as she does not notify them of her needs. R36's Care Plan documented on 05/01/25 that R36 was at risk for falls with a history of falls. The plan noted R36 stood unassisted even with education and would stand again within minutes of the last redirection. It directed staff to monitor R36 for needs and help to meet them to prevent falls from occurring. Staff were directed to orient her to her call light for assistance and keep her walkways clean and clutter-free to prevent falls from occurring. R36's Care Plan documented the intervention dated 05/02/25 after R36's fall in the facility which directed staff to remind R36 to push the call light and wait for staff to come and help her. The plan lacked further interventions to address and prevent falls. R36's Progress Note dated 05/02/25 at 03:20 AM documented at 01:45 AM R36 was seated on the floor. R36 stated that she was sitting on the edge of her bed and decided to get up to get the Bible from her bedside table. She lost her balance and fell. R36 hit her head and received a skin tear below her chin on the right side. R36 reported some pain to the right chin and had a bump to the back of her head. Staff assisted R36 off the floor and walked to her recliner. R36's Event Report dated 05/02/25 documented the call light was on and within reach. The report noted the plan of care was to educate R36 to use the call light for help and wait for help to get something in her room. During an observation on 06/09/25 at 09:03 AM R36 sat in her recliner, in her room. R36 wore regular socks, but no shoes. During an observation on 06/09/25 at 03:38 PM, R36 was scooting forward in the recliner reaching for items on the shelf in front of her. During an interview on 06/11/25 at 08:17 AM, Certified Nurse Aide (CNA) O stated that R36 tried to get up without assistance. CNA O said R36 sometimes used her call light and said staff placed a soft pad call light under R36's hip so it would go off when she tried to get up. (continued on next page)

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	17E534	A. Building B. Wing	06/11/2025

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/11/25 at 08:31 AM, Licensed Nurse (LN) G stated R36 gets up without waiting for staff. LN G said when a resident falls, the nurse looks for the root cause of the fall and places an appropriate intervention. LN G said the intervention to reeducate R36 was not an appropriate intervention for her. During an interview on 06/11/25 at 08:43 AM, Administrative Nurse D stated when a resident falls, staff discuss the falls in the monthly quality assurance meeting to ensure the interventions are appropriate. Administrative Nurse D said the nurse along with the restorative nurse and the CNAs came up with appropriate interventions based on the root cause of the fall. Administrative Nurse D said R36 was sometimes able to use her call light but often got up without assistance. The facility's policy Attica Long Term Care Fall Prevention Protocol dated 05-2021, documented on the day of admission, each resident will be assessed for fall risk by a licensed nurse. When a resident falls, a root cause analysis will be developed to identify trends and interventions. The fall is documented in the care plan with interventions to prevent further falls based on the determined causal factors at the time of the initial fall follow-up. The resident will be assessed and documented on every shift for the next 72 hours including the response to the current interventions. - R14's Electronic Medical Record (EMR) documented diagnoses that included dementia (a progressive mental disorder characterized by failing memory and confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel). R14's 09/23/24 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of three, which indicated severely impaired cognition. R14 required substantial to maximal assistance with wheelchair mobility. R14's Cognitive Loss / Dementia (CAA) documented she had advancing dementia and varying cognitive levels. The CAA documented R14 had dementia, and her cognition continued to decline over time. R14's 03/17/25 Quarterly MDS documented a BIMS of two which indicated severely impaired cognition. R14 required substantial to maximal assistance with wheelchair mobility and was dependent on staff for transfers. R14's Care Plan included an intervention dated 12/29/22 which documented R14 used a wheelchair, and she propelled herself a bit, but staff propelled her to specific destinations. The plan directed staff to cue R14 to pick up her feet when staff pushed her in the wheelchair and to watch to be sure she did so. During an observation on 06/09/25 at 12:53 PM, R14 was at the back door, yelling for help to get outside. Certified Nurse Aide (CNA) JJ began pushing R14's wheelchair without foot pedals. When asked, CNA JJ stated staff were not supposed to push residents in their wheelchairs without foot pedals, but R14 usually self-propelled so she did not have foot pedals on her wheelchair. CNA JJ said staff were to take the foot pedals off the wheelchair when the resident self-propelled and put them back on when staff assisted the resident. CNA JJ looked for R14's foot pedals but did not find them. R14 then stated she would propel herself, and CNA JJ walked beside her wheelchair. (continued on next page)

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	06/11/2025

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/11/25 at 08:17 AM, CNA O stated that stated staff should always use foot pedals when assisting residents in a wheelchair. During an interview on 06/11/25 at 08:31 AM, Licensed Nurse (LN) G stated residents were to have the foot pedals off when they were self-propelling, but staff should always place foot pedals on staff was propelling the chair. During an interview on 06/11/25 at 08:43 AM, Administrative Nurse D stated all residents should have foot pedals on their wheelchairs when being assisted in a wheelchair for safety. The facility did not provide a policy for wheelchair positioning including foot pedals.

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	17E534	A. Building B. Wing	06/11/2025

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Attica Long Term Care Facility	302 N Botkin Attica, KS 67009

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. The facility identified a census of 36 residents. The sample included 13 residents with two residents sampled for nutrition. Based on observation, interview, and record review, the facility failed to provide care and services, which included supplemental nutrition and failed to follow the Registered Dietician (RD) recommendations to maintain acceptable parameters of nutritional status for Resident (R) 19. As a result of the facility failures, R19 had a significant unintended weight loss of 11.48 percent (%) over three months. This deficient practice also placed the resident at risk for malnutrition and further weight loss. Findings included: - R19's Electronic Medical Record (EMR) revealed the following diagnoses: dementia (a progressive mental disorder characterized by failing memory and confusion) with agitation. R19's 03/17/25 admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of three, indicating severely impaired cognition. The MDS recorded R19's weight was 136 pounds, and she had no known weight loss. She consumed a regular textured diet with no eating or swallowing concerns. The 03/17/25 Cognitive Loss / Dementia (CAA) documented R19 admitted to the facility after having a month-long stay at a behavioral health facility to address medications to limit her aggression and attain a better quality of life. She had increased forgetfulness and was unable to live with family helping at home. The CAA further noted R19 often asked where she was and why she was in the facility. R19's 06/09/25 Quarterly MDS documented a BIMS score of three. The MDS documented R19 had a significant weight loss and weighed 120 pounds. R19 was independent with eating. R19's Care Plan dated 03/25/25 documented R19 made her own food choices. She was on a liberalized geriatric diet with texture as tolerated. R19 had a goal that her nutritional needs would be met, and dietary risks would be avoided during her stay. Interventions for R19 on 03/25/25 documented she liked to have a cup of coffee first thing in the morning and asked for it throughout the day. She may prefer to have small portions. R19 came to the dining room to have meals, and staff may have to cue her when it was time for meals. She did not drink milk but tolerated it in food. She ordered her meals and fed herself after it was set up. The plan directed staff to show R19 how to get snacks, offer her snacks and fluids throughout the day, and encourage her to drink fluids. The plan noted staff weighed her and recorded her weight on Monday mornings. R19's EMR recorded an admission weight on 03/06/25 of 135 pounds. R19's Physician's Orders noted a liberalized geriatric diet with texture as tolerated, ordered on 03/06/25. R19's EMR lacked further orders related to nutrition. R19's Progress Note by the RD dated 03/07/25 at 12:14 PM documented R19 liked most foods. The RD noted that given the limited history she received, it was likely that R19 had lost weight over the past four to five years and was at risk for continued weight loss. (continued on next page)

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	17E534	A. Building B. Wing	06/11/2025

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

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F 0692 Level of Harm - Actual harm Residents Affected - Few	R19's EMR recorded a weight on 03/31/25 of 127.5 lbs. but lacked evidence the physician was notified. R19's Progress Note from the RD dated 05/29/25 at 12:53 PM documented R19 had limited meal intake documented. With only 14 meals charted during the previous two weeks; intakes ranged from zero to less than 75%. The RD documented most meals documented indicated the resident consumed less than 26 % of meals. Staff reported R19 preferred to sleep late in the morning and even then, often preferred to remain in her room. She was more likely to come out of her room in the afternoon and she may sit in the lobby and have a snack or go to the dining room. Staff was able to encourage R19 to go to the dining room at around noon on that day. Staff assisted R19 with ordering a meal. Staff offered alternate meals, but R19 declined all suggestions, stating I'm just not hungry. I want to go back to my room and lie down. The RD documented she also attempted to encourage R19 to stay and offered the resident a milkshake and other dessert items, R19 continued to say she was not hungry. The RD noted R19's charting showed R19 had a bowel movement two days previous two weeks. The note recorded R19 had a significant weight loss and based on what staff reported and what R19 said, the resident may benefit from a trial of an appetite stimulant. At that time, it appeared R19 was at risk for continued weight loss. R19's RD Progress Note dated 06/09/25 at 06:14 PM documented R19 had a significant weight loss. The note documented nine meals were charted in the previous week and there was no chewing or swallowing difficulty noted. Staff noted R19 was sleeping a lot, and when staff woke her for meals, she only wanted a sandwich out of the snack refrigerator. Staff further noted when they gave R19 a sandwich, she would take one bite and go back to sleep. At night staff attempted to give R19 a snack (sandwich, chips, ice cream). The note documented R19 occasionally went to the dining room, but only wanted a dessert. R19's clinical record lacked evidence staff implemented non-pharmacological interventions to address weight loss. The record lacked documentation related to nutritional supplement intake. R19's EMR recorded a weight on 06/02/25 of 119.5 pounds but lacked evidence staff notified R19's physician of the weight loss. During an observation on 06/09/25 at 03:35 PM, R19 laid in bed with the door closed and her eyes closed. The blinds were closed, and it was dark in her room. During an observation on 06/11/25 at 12:15 PM, Certified Nurse Aide (CNA) O assisted R19 to the scale from her room. R19 stopped every couple of steps and turned to CNA O and asked where they were and where they were going then said, Okay. and proceeded to take a few more steps. CNA O directed R19 to stand on the scale. R19's weight was 120 pounds. On 06/11/25 at 08:17 AM, CNA O stated R19 was independent with her care. She usually got up for lunch and supper and went right back to bed. CNA O reportedR19 liked to sleep. (continued on next page)

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	17E534	A. Building B. Wing	06/11/2025

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Attica Long Term Care Facility	302 N Botkin Attica, KS 67009

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 06/11/25 at 08:31 AM, Licensed Nurse (LN) G stated R19 had weight loss. She said she tried to give R19 a protein shake but confirmed it was not documented. LN G said staff were able to document supplements with the meal's documentation. LN G said R19 sometimes went to the dining area to eat, then back to her room to the toilet, and she went back to bed while she was in her room. LN G said when a resident had weight loss, staff would usually get an order from the doctor for Ensure (liquid nutritional supplement), a protein shake, or a higher-calorie meal with fortified foods. LN G said the RD also made recommendations for medications like an appetite stimulant. LN G said she did not know why R19's RD recommendations were not followed or faxed to the provider. She said she would verify the provider was not notified and notify him now if needed. On 06/11/25 at 08:43 AM, Administrative Nurse D stated the RD came in once a week to address weight loss. Administrative Nurse D said the facility staff looked at the list and decided if the loss was planned, if the resident had edema, or what the problem was. Administrative Nurse D said the RD gave her a list of residents with weight loss weekly and let the nurses know the recommendations. The nurse would then talk to the doctor about the recommendations and get orders. Administrative Nurse D stated the facility staff was trying to figure out the problem with R19 and addressing medication concerns to lessen R19's sleeping all the time. During an interview on 06/11/25 at 10:04 AM, Consultant GG stated she charted the residents' weight loss, and talked to the staff for input. Consultant GG said she gave recommendations to the nurse for them to relay to the doctor and get orders. She said she was unsure if it always got done. Consultant GG said she met quarterly with the providers to discuss weight loss. She said she suggested nutrition shakes for R19 and was aware staff could document the supplements and shakes provided, and confirmed they should document them. Consultant GG was unsure if shakes were documented for R19. On 06/12/25 at 03:41 PM, Consultant HH stated she was not notified of R19's weight loss until 06/11/25 and she ordered health shakes to start with. Consultant HH stated she expected to be notified of weight loss by fax immediately or on the next rounding day. The facility policy Attica Long Term Care Weight Policy dated 05/2024 included: Care Plan Teams will meet on Tuesday to discuss weight. Documentation on weight changes will be documented. The nursing staff will notify the physician of needed medical intervention. Nursing staff documents decisions for supplements. The nursing director will notify the physician of significant weight loss.

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	17E534	A. Building B. Wing	06/11/2025

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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. The facility reported a census of 36 residents. The sample included 13 residents. Based on interviews, record reviews, and observation, the facility staff failed to implement adequate and acceptable infection control practices related to hand hygiene and laundry services. This deficient practice placed the residents at risk for infections. Findings included: - During an observation on 06/09/25 at 03:36 PM, Dietary CC delivered clean laundry to the resident rooms of the 300 hallway and did not sanitize hands before or after delivering clean laundry to each room. During an observation on 06/10/25 at 12:50 PM, Certified Nurse Aide (CNA) M wiped a resident's buttock with gloved hands. Upon completion, CNA M did not change gloves or complete hand hygiene before placing a clean brief on the resident. During an interview on 06/10/25 at 09:08 AM, Administrative Nurse D reported that hand sanitizing should be done whenever staff went in or out of rooms regardless of the situation. During an interview on 06/10/25 at 01:05 PM, CNA M stated that she had dirty gloves on when she placed the clean brief on the resident. During an interview on 06/10/25 at 01:43 PM, Dietary BB reported that whoever is delivering clean laundry should wash or hand sanitize their hands before entering or exiting a resident's room. During an interview on 06/10/25 at 02:49 PM, Housekeeping/Maintenance U reported that whoever delivered laundry should wash or hand-sanitize their hands prior to entering and delivering laundry to any resident and upon exiting the resident's room. During an interview on 06/11/25 at 08:48 AM, Administrative Nurse E reported that hands were to be sanitized before handling any clothes and before and after entering a room and/order delivering laundry. Facility policy Attica Long Term Care Hand Hygiene, dated 02/2025, indicated that all staff members would comply with the current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines. The policy further indicated that staff would perform hand hygiene practices before and after contact with inanimate objects including medical equipment in the immediate vicinity of the resident. The policy further indicated that staff would Change gloves when moving from a contaminated body site to a clean body site and they would decontaminate hands after removing gloves with appropriate hand hygiene. - During an observation on 6/10/25 at 01:50 PM observation revealed a working sink at the end of the clean linen folding counter with hand soap, hand sanitizer, and a funnel sitting around the sink. The clean linen folding counter had two containers that held numerous items including Kleenexes. Further observation revealed a dirty clothes cart with dirty linen sitting against the counter. (continued on next page)

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	17E534	A. Building B. Wing	06/11/2025

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 06/10/25 at 01:55 PM a dusty bar of soap hung from the ceiling in the laundry washing and folding room and there was an air conditioning unit above the clean linen folding counter with dirty vents blowing towards the clean linen counter. During an interview on 06/11/25 at 08:39 AM, Administrative Staff A stated that each department staff was expected to clean their own area. During an interview on 06/11/25 at 08:41 AM, Administrative Nurse E reported that there should be nothing but clean linen on the clean linen processing area. The facility did not provide a policy related to laundry and/or processing clean linens.

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	17E534	A. Building B. Wing	06/11/2025

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

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F 0921 Level of Harm - Potential for minimal harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. The facility reported a census of 36 residents. The sample included 13 residents. Based on interviews, record reviews, and observation, the facility failed to ensure a safe environment in all areas of the facility including the laundry area. This deficient practice created the risk of an unsanitary environment. Findings included: - During an observation on 06/10/25 at 01:50 PM the clean clothes folding counter in the laundry washing and folding area had a patched hole three feet long and six inches wide that was patched with a piece of plain plywood. The observation also revealed several chipped areas in the folding counter. During an observation on 06/10/25 at 02:07 PM the clean linen storage closet had several ceiling tiles with broken areas that created large gaps and there was a large hole in one that had a plastic cover that did not entirely cover the hole, leaving gaps. During an interview on 06/11/25 at 08:23 AM, Housekeeping/Maintenance V reported that there was a repair request system that allowed staff to submit repair requests. Maintenance V also stated that he maintained a working list of maintenance items with resident related items as top priority. During an interview on 06/11/25 at 08:39 AM, Administrative Staff A reported that a work order should have been submitted to make or replace the broken counter for the clean linen processing area. Administrative Staff A also stated that ceiling tiles should be clean and fully intact. During an interview on 06/11/25 at 08:41 AM, Administrative Nurse E reported the linen processing area should have been clean and fully intact. The facility policy Attica Long Term Care Planned Preventative Maintenance Policy, dated 10/2019, indicated a preventative maintenance program has been implemented to promote the maintenance of fixtures and equipment in a state of good repair and condition. Routine inspections promote safety and aid in keeping fixtures and equipment in good working order and operating in accordance with the manufacturer's guidelines. The facility policy Attica Long Term Care Maintenance Checklist by Priority, dated 06/2019, indicated weekly checks of the kitchen and laundry to inspect for repairs as needed.