STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175201	A. Building B. Wing	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Downs Care and Rehab	1218 Kansas Street Downs, KS 67437

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(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to store, distribute, and serve food by professional standards for food service safety in the facility's kitchen. The facility failed to label, seal, and date food stored in the refrigerator/freezer and dry storage area. The facility also failed to consistently log freezer/refrigerator temperatures. Findings included:- On 04/13/26 at 08:10 AM, observation in the kitchen revealed the following:A white upright freezer had approximately 1/4 inch (in) ice buildup along the inside of the freezer and the shelves.The refrigerator located in the kitchen had a plastic bag with unlabeled, undated sliced yellow cheese.The March Freezer/refrigerator temperature logs lacked documentation of the readings for the following freezers and refrigerators in the morning and evening:1. Chest freezer located in dry storage on 05,06,10,11,14,15,17,19,21, and 23-31/262. A white stand-up freezer on 7,8,14, 15,18, 21, 253. A double door refrigerator on 7,8,15, 18, 21, 224. A single door refrigerator on 6, 7, 8, 21The April freezer/refrigerator temperature logs lacked documentation of the readings for the following freezers and refrigerators in the morning and evening:A double door freezer on 4, 5The ice machine located in the area between the kitchen and storage room had a plastic lid and a metal object on the floor behind it, and a plastic green drinking cup sitting on top of the drain underneath it.Eight (15.5-pound (lb.) plastic jugs of used cooking grease with numerous different sizes of grayish-black substances on their top. The dry storage area had the following:An approximately 1/4 full (5 lb. package of undated pasta Labello egg noodles.An approximately 1/4 full (4.5 lb.) package of unlabeled, undated, unsealed [NAME] noodles. Approximately 3/4 package of undated strawberry gelatin.An approximately 3/4 bag of unsealed buttermilk pancake. On 04/13/26 at 08:20 AM, Dietary Staff (DS) CC verified the above findings and stated she would ask the dietary manager what to do with the findings when she arrived at the facility for her shift. On 04/14/26 at 01:30 PM, the Dietary Manager (DM) stated staff should label and date all food placed in dry storage, refrigerator, or freezer when received, and if open, make sure they are sealed, labeled, and dated with the open date. The facility's Dietary Purchases, Receipt and Storage Policy, revised 01/21/26, documented all products would be labeled with the date received in the facility. Frozen foods stored in the freezer, and the temperature would be maintained at 0 to -10 degrees Fahrenheit (F). Produce is stored in the refrigerator, and the temperature would be maintained at 38-44 degrees F. Dairy products would be stored in the refrigerator, and the temperature would be maintained at 35 to 40 degrees F. The facility's Monitoring of Refrigerators and Freezers Policy, revised 01/21/26, documented all refrigerators/freezers would be cleaned on a weekly basis and as necessary for spills. Refrigerators that are accessible to elders and used by multiple elders and/ or families would contain only food that is sealed in an airtight container that had not been inside an elder's room. All food items would be labeled with the contents of the container and the date it was placed in the refrigerator. A temperature log would be completed. The Certified Dietary Manager/designee is responsible for monitoring temperatures and appropriate logging of temperatures, and appropriate discarding from refrigerators/freezers containing food items. All temperature logs will be maintained in the environmental services office for two weeks.

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 implement adequate infection control practices when staff failed to change gloves during incontinent care for Resident (R) 26. 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 for R11 and R44's and failed to ensure personal protective equipment (PPE-gowns and gloves) was readily available for use for R11 and R44, who shared a room, cares. Staff also failed to provide appropriate complete urinary catheter care for R44. Additionally, the facility failed to have a complete water management plan to prevent the spread of Legionella and other waterborne bacteria. Findings included:1. On 06/23/2026 at 12:05 PM, observation revealed R26 sat in a wheelchair in the hall. Certified Nurse Aide (CNA) N asked R26 if she needed to use the restroom, and she stated Yes. CNA M propelled R26 into R26's bathroom, and CNA N followed. Both applied gloves, CNA N cued R26 to stand using the grab bar on the wall, both assisted R26 in pivoting to the toilet, and CNA N pulled down the resident's pants and incontinent brief. R26 reported she was done, CNA M cued R26 to stand using the bars on the wall, while she assisted her by holding onto a gait belt. CNA N provided perineal (private area) care to the resident, then, with the same soiled gloves, pulled up R26's pants, pulled down her blouse, and touched her gait belt when assisting R26 to pivot turn into a wheelchair, then removed and discarded her gloves.On 06/23/2026 at 12:15 PM, CNA N verified she had not changed her gloves after providing R2 perineal care and stated she should have.2. On 06/22/2026 at 09:30 AM, observation revealed a lack of EBP signage for R11 and R44's and lacked the necessary PPE supplies. Observation revealed a lack of PPE supplies in the 100 hall, on the back of the room door, or in their closets.On 06/23/2026 at 03:30 PM, observation revealed CNA N brought PPE supplies down the hall from the other side of the facility to R44's room door entrance and CNA N and donned a gown, applied gloves, and entered R44's room. R44 sat in a wheelchair facing his bed. CNA N asked R44 if it was ok if she provided urinary catheter care, and he replied, Sure. Observation revealed R44 transferred himself to his bed, pulled down his pants and incontinent brief, CNA N took a washcloth, which hung on a metal bar by the sink, and applied soap on the washcloth. Further observation revealed CNA N used the soaped washcloth and wiped the catheter tubing from the connection site on the urinary catheter bag upwards to the insertion site. CNA N, with the same washcloth, wiped R44's groin area on both sides, then stated she was not going to finish the care because R44 had a bath that morning.On 06/23/2026 at 03:30 PM, CNA N said she knew R44 had EBP because she knew he had a urinary catheter and all residents with one were to be on EBP. CNA N verified there was no signage on the door or PPE supplies available by the door, in the closet, or behind the door, and stated that is why she brought them from the other side of the facility.On 06/23/2026, at 03:45 PM, CNA O stated she was unaware R11 or R44 were on EBP until CNA N brought her a gown and gloves to put on before providing catheter care. She said she had only recently become a CNA.On 06/24/2026, Administrative Nurse D verified R11 and R44's room lacked EBP signage and stated it should have EBP signage on the door, and PPE should be on the backside of the room door, in their closet, or at the aide charting desk in the middle of the hall. Administrative Nurse D stated staff should change gloves between dirty and clean and should provide urinary catheter care starting at the insertion site of the tubing down to the connection site and use a clean wipe or wash cloth for each perineal area cleansed.3. On 06/23/2026 at 08:30 AM, a review of the facility's water management plan revealed a lack of a complete plan, which included the building's water systems' use text or flow-diagrams for identification and control measures. The plan lacked documentation regarding flushing of stagnant areas of the facility's water system.On 06/23/2026 at 8:59 AM, Administrative Staff A and Maintenance Staff (MS) U verified the facility lacked a complete water management plan. Administrative Staff A stated that the prior maintenance staff took the information with them when they left, and MS U was working on it.The facility's Perineal Care Policy, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	revised 10/2023, instructed staff when providing perineal care to wash and dry hands thoroughly, put on gloves, wash and rinse the urethral area, thoroughly dry the perineum, discard disposable items into designated containers, and remove and discard gloves, then wash and dry hands thoroughly.The facility's Indwelling Urinary Catheters Policy, revised 06/22, instructed staff to use PPE when performing urinary catheter care. The policy instructed staff to follow the following steps when providing catheter care: For a male, use a washcloth with warm water and soap to cleanse around the meatus. Cleanse the glans using circular strokes from the meatus outward. Change the position of the washcloth with each cleansing stroke. With a clean washcloth, rinse with warm water using the above technique. Return the foreskin to its normal position. Use a clean washcloth with warm water and soap to cleanse and rinse the catheter from the insertion site to approximately four inches outward.The facility's EBP Policy, revised 04/2025, documented that appropriate precautions would be taken when caring for individuals known or suspected to have an infection or colonization with a multidrug-resistant organism and requires EBP. The use of PPE refers to the use of a gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. The use of gown and gloves for high-contact resident care activities is indicated when contact precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices, regardless of MDRO colonization, as well as for residents with MDRO infection or colonization.The facility's Water Management, Legionella Testing Policy, revised 10/2022, documented that the facility would handle and maintain its water supply in accordance with recommendations of the CDC, the Healthcare Infection Control Practices Advisory Committee, and the FDA. The facility would demonstrate its measures to minimize its risk of Legionella and other opportunistic pathogens in the building water system through a documented water management program.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, record review, and interview, the facility staff failed to treat Resident (R) 11 with dignity when staff ambulated beside R11 down the hall to the dining room with wet pants. Findings included:- On 06/23/2026 at 12:00 PM, R11 self-propelled in a wheelchair out of his room and started down the hall. Certified Nurse Aide (CNA) O stopped the resident and asked if he wanted to walk the rest of the way to the dining room, and R11 replied, Yes, no one came and got me for lunch. CNA O instructed the resident to wait while she went to get his walker from his room. CNA O returned with the walker and gait belt, applied the gait belt around R11's waist, assisted him to stand, and took hold of the walker. Observation revealed R11's pants were wet from the buttocks to the top of his waist. CNA O continued assisting R11 towards the dining room when the staff asked her if R11's pants were wet. CNA O touched R11's buttock area and stated yes, then asked R11 if he wanted to change his pants before going to the dining room, and he replied: I'd better. Observation revealed R11 turned around with his walker, and the front area from the waist down to the groin area was wet.On 06/23/2026 at 12:10 PM, CNA O verified R11 was incontinent of urine.On 6/23/2026 at 12:20 PM, Administrative Nurse D stated that staff should change the residents' clothing when wet.Upon request, the facility did not provide a dignity policy

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure an appropriate indication or a documented physician rationale, which included the unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the continued use of Resident (R)7's and R39's antipsychotic (a medication used to treat any major mental disorder characterized by a gross impairment testing) medication. Findings included:1.R7's Electronic Medical Record (EMR) included diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion with agitation including verbal and physical aggression, wandering and hoarding), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin,) and atherosclerotic heart disease (narrowing or blockage of the arteries that supply blood to the heart muscle). R7's Annual Minimum Data Set (MDS), dated [DATE], recorded R7 had severely impaired cognition. The MDS recorded R7 required staff supervision with most activities of daily living (ADL). The MDS recorded the resident received antipsychotic medication during the observation period. The Psychotropic Drug Use Care Area Assessment (CAA), dated 03/27/2026, recorded R7 received antipsychotic medication and had diagnosis of depression and dementia with behavioral disturbance. R7's Care Plan, dated 06/23/2026, recorded the nurse would administer medications as prescribed and monitor for side effects and effectiveness. The care plan documented Seroquel (antipsychotic) had a Black Box Warning that stated it was not approved for dementia-related psychosis, and there could be increased mortality in the elderly on antipsychotic treatment for dementia. The Physician's Order, order dated 03/11/2026, directed the staff to administer Seroquel XR oral tablet extended release 50 milligrams (mg), one tablet at bedtime for a diagnosis of dementia with other behavioral disturbance. R7's EMR lacked documentation of nonpharmacological approaches that were attempted but unsuccessful for behavioral management and lacked evidence of a physician's rationale including risk versus benefits for the Seroquel. On 06/23/2026 at 08:10 AM, observation revealed R7 sat at the dining room table and License Nurse (LN)G, administered the residents' morning medication. 2. R39's Electronic Medical Record recorded diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), major depressive disorder, and hallucinations. R39's Quarterly Minimum Data Set (MDS), dated [DATE], recorded R39 had moderately impaired cognition. The MDS recorded R39 was dependent with most activities of daily living (ADL). The MDS recorded the resident received antipsychotic medication during the observation period. The MDS documented that the R39 did not have hallucinations. The Psychotropic Drug Use Care Area Assessment (CAA), dated 11/03/2025, recorded R39 received antipsychotic medication and had a diagnosis of hallucinations. R39's Care Plan, dated 05/12/2026, recorded the nurse would administer medications as prescribed and monitor for side effects and effectiveness. The care plan documented R39 received Seroquel (antipsychotic) for Alzheimer's disease and had a Black Box Warning that stated -not approved for dementia-related psychosis, and there could be increase mortality in the elderly on antipsychotic treatment for dementia. The Physician's Order, order dated 02/19/2026, directed the staff to administer Seroquel 25 milligrams (mg), one tablet at bedtime for diagnosis of Alzheimer's disease with hallucinations. R39's's EMR lacked documentation of nonpharmacological approaches that were attempted but unsuccessful for behavioral management and lacked evidence of a physician's rationale including risk versus benefits for the Seroquel. On 06/23/26 at 07:30 AM, observation revealed R39 in a wheelchair in her room and License Nurse (LN)G, administered the residents' morning medication On 06/24/2026 at 08:30 AM, Administrative Nurse D verified R7 and R39 received Seroquel and stated the facility would contact the physician for appropriate documentation for the residents on antipsychotic medications. The facility's Psychoactive Medications policy dated 04/2025 recorded the resident would only receive (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	psychoactive medications or other approved medications that have an effect on the brain activity when necessary to treat conditions for which they are indicated and effective and would not be used for discipline or for convenience of the staff. The policy recorded psychoactive medication ordered would have behavioral symptoms that present a danger to the resident or others and the expression or indication of distress that are significant distresses to the resident. The policy documented what were the goals of the therapy, the attempted behavioral interventions attempted prior to starting the medication that did not relieve the medical symptom which were presenting a danger or significant distress and a description of why alternative non-pharmacological treatments are not clinically contraindicated, including the rationale for how this conclusion was reached.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure the Consult Pharmacist identified and reported the lack of appropriate indication or required physician documentation for Resident (R)'7 and R39's use of an antipsychotic (a class of medication used to treat any major mental disorder characterized by a gross impairment testing) medication. Findings included:1. R7's Electronic Medical Record (EMR) included diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion with agitation including verbal and physical aggression, wandering and hoarding), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin,) and atherosclerotic heart disease (narrowing or blockage of the arteries that supply blood to the heart muscle). R7's Annual Minimum Data Set (MDS), dated [DATE], recorded R7 had severely impaired cognition. The MDS recorded R7 required staff supervision with most activities of daily living (ADL). The MDS recorded the resident received antipsychotic medication during the observation period. The Psychotropic Drug Use Care Area Assessment (CAA), dated 03/27/2026, recorded R7 received antipsychotic medication and had diagnosis of depression and dementia with behavioral disturbance. R7's Care Plan, dated 06/23/2026, recorded the nurse would administer medications as prescribed and monitor for side effects and effectiveness. The care plan documented Seroquel (antipsychotic) had a Black Box Warning that stated it was not approved for dementia-related psychosis, and there could be increased mortality in the elderly on antipsychotic treatment for dementia. The Physician's Order, order dated 03/11/2026, directed the staff to administer Seroquel XR oral tablet extended release 50 milligrams (mg), one tablet at bedtime for a diagnosis of dementia with other behavioral disturbance. R7's EMR lacked documentation of nonpharmacological approaches that were attempted but unsuccessful for behavioral management and lacked evidence of a physician's rationale including risk versus benefits for the Seroquel. Pharmacist Consultant reviews on 3/03/26, 04/08/26, and 05/07/26 did not request an approved diagnosis or indication for the use of R7's Seroquel. On 06/23/2026 at 08:10 AM, observation revealed R7 sat at the dining room table and License Nurse (LN)G, administered the residents' morning medication. 2. R39's Electronic Medical Record recorded diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), major depressive disorder, and hallucinations. R39's Quarterly Minimum Data Set (MDS), dated [DATE], recorded R39 had moderately impaired cognition. The MDS recorded R39 was dependent with most activities of daily living (ADL). The MDS recorded the resident received antipsychotic medication during the observation period. The MDS documented that the R39 did not have hallucinations. The Psychotropic Drug Use Care Area Assessment (CAA), dated 11/03/2025, recorded R39 received antipsychotic medication and had a diagnosis of hallucinations. R39's Care Plan, dated 05/12/2026, recorded the nurse would administer medications as prescribed and monitor for side effects and effectiveness. The care plan documented R39 received Seroquel (antipsychotic) for Alzheimer's disease and had a Black Box Warning that stated -not approved for dementia-related psychosis, and there could be increased mortality in the elderly on antipsychotic treatment for dementia. The Physician's Order, order dated 02/19/2026, directed the staff to administer Seroquel 25 milligrams (mg), one tablet at bedtime for diagnosis of Alzheimer's disease with hallucinations. R39's's EMR lacked documentation of nonpharmacological approaches that were attempted but unsuccessful for behavioral management and lacked evidence of a physician's rationale, including risk versus benefits for the Seroquel. Pharmacist Consultant reviews on 3/03/26, 04/08/26, and 05/07/26 did not request an approved diagnosis or indication for the use of 39's Seroquel. On 06/23/26 at 07:30 AM, observation revealed R39 in a wheelchair in her room and License Nurse (LN)G, administered the residents' morning medication On 06/24/2026 at 08:30 AM, Administrative Nurse D verified R7 and (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R39 received Seroquel and stated the facility would contact the physician for appropriate documentation for the residents on antipsychotic medications. The facility's Psychoactive Medications policy dated 04/2025, recorded the resident would only receive psychoactive medications or other approved medications that have an effect on the brain activity when necessary to treat conditions for which they are indicated and effective and would not be used for discipline or for convenience of the staff. The policy recorded psychoactive medication ordered would have behavioral symptoms that present a danger to the resident or others and the expression or indication of distress that are significant distresses to the resident. The policy documented what were the goals of the therapy, the attempted behavioral interventions attempted prior to starting the medication that did not relieve the medical symptom which were presenting a danger or significant distress and a description of why alternative non-pharmacological treatments are not clinically contraindicated, including the rationale for how this conclusion was reach

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, record review, and interview, the facility failed to ensure a medication error rate not greater than five percent (%) when errors were observed for Resident (R) 7, resulting in an error rate of 5.13 percent (%). Findings included: - R7's Physician order, dated 03/11/2026, instructed staff to administer aspirin delayed release 81 milligrams (mg); one tablet a day for atherosclerotic heart disease. R7's Physician order, dated 03/12/2026, instructed staff to administer Glipizide (oral medication used to lower blood sugar) XL- extended release (ER), 2.5 mg, one tablet a day for diabetes mellitus. R7's Electronic Medical Record lacked an order to crush the delayed/extended-release medications. On 06/23/2026 at 08:10 AM, observation revealed Licensed Nurse (LN) G crushed R7's pills, including the delayed/extended-release aspirin and Glipizide, and mixed the medication with pudding. LN G administered one spoonful of the medication, and the resident ingested all the medications. On 06/23/2026 at 08:15 AM, LN G stated R7 liked to take her medications with pudding, and staff crushed them, so she was able to take them easier. On 06/24/2026 at 08:30 AM, Administrative Nurse D verified the delayed or extended-release medication should not be crushed and said they should be administered whole due to the extended release of the medication over time. Administrative Nurse D stated she had administered medication to R7 in the past and had never crushed her medication before administration. The facility's Medication Administration policy, dated June 2025, recorded during medication administration, facility staff should take all measures required by the facility policy and applicable law, including, but not limited to the following: Facility staff should crush oral medications only in accordance with pharmacy guidelines as set forth in Resource: Oral dosage Forms that Should Not Be Crushed, and/or facility policy. Exceptions to Should Not Crush medications may occur when physician orders are documented in the medical record including a statement explaining why crushing the medication will not adversely affect the resident.