STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175306	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manor of the Plains	200 Campus Drive Dodge City, KS 67801

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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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. The facility reported a census of 32 residents. The facility identified five Certified Nurse Aides (CNA) employed over the 12 the month period. Based on interview and record review, the facility failed to complete an annual performance review at least once every 12 months for two of the five CNA reviewed, to ensure adequate appropriate cares and services provided to the residents of the facility. Findings included:- Review of CNA personnel files revealed the following:CNA II, hired on 06/20/24, lacked an annual performance evaluation. Certified Medication Aide (CMA) R hired 11/17/23lacked an annual performance evaluation. During an interview on 09/11/25 at 12:09 PM, Administrative Staff A reported she expected 100 percent compliance to have the annual performance evaluations completed annually. The facility did not provide a policy on annual performance evaluations.

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 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. The facility reported a census of 32 residents, one main kitchen and one satellite kitchen. Based on observation, record review, and interview, the facility failed to prepare and serve food under sanitary conditions to prevent the potential for food borne bacteria. Findings included:- During a second tour of the satellite kitchen on 09/10/25 at 04:40 PM, observation revealed Dietary Staff DD removed a container of lettuce from the refrigerator with gloved hands. Wearing the same gloves, Dietary Staff DD opened a cabinet door, removed bowls from the shelf, and closed the door. With the same soiled gloves, Dietary Staff DD removed the lid from the lettuce container and grabbed a handful of lettuce from the container twice to fill two bowls with lettuce, then turned on the faucet handle, rinsed the lettuce off under water, and shut the faucet handle off. Still wearing the same gloves, Dietary Staff DD squeezed the lettuce and placed it back into each bowl. Dietary Staff DD removed the gloves and applied a new pair of gloves without performing hand hygiene. Dietary Staff DD then opened a drawer, removed a small black plastic container from the drawer, opened the bag of shredded cheese, placed the small black container into the bag, and scooped out the shredded cheese. Dietary Staff poured salad dressing into a small black plastic container from a measuring cup, rinsed out the container in the sink, removed her gloves, and applied a new pair of gloves without performing hand hygiene.During an observation on 09/10/25 at 04:50 PM, Dietary Staff DD removed tomatoes and a jar of pickles from the refrigerator using gloved hands. She removed her gloves and applied new gloves without performing hand hygiene. Dietary Staff DD cut up tomatoes, removed the lid from the pickles, and reached into the pickle jar with the same gloved hand and removed several sliced pickles and placed them on the plate with the tomatoes. Additionally, Dietary Staff DD removed the lid from the lettuce container, grabbed a handful of lettuce with her gloved hand, turned on the faucet, rinsed the lettuce, shut off the faucet, squeezed the lettuce of excess water, and placed the lettuce on the plate with tomatoes and pickles. Dietary Staff DD then removed her gloves and applied a new pair of gloves without performing hand hygiene.During an interview on 09/10/25 at 05:10 PM, Dietary Staff DD reported that she usually used hand sanitizer when she removed her gloves and confirmed she had not washed her hands or used hand sanitizer when she removed her gloves. Dietary Staff DD reported she would normally use a utensil to remove the food items from the containers.During an interview on 09/10/25 at 05:20 PM, Certified Dietary Manager BB stated that she expected staff to perform hand hygiene every time gloves were removed from the hands and to utilize utensils when removing food from containers. Additionally, Certified Dietary Manager BB stated that she expected staff not to use the same gloves that touched surfaces of the kitchen to touch food.During an interview on 09/11/25 at 12:24 PM, Administrative Staff A stated she expected the kitchen staff to serve all food in a sanitary manner.The facility's policy Use of Gloves dated 03/2020, documented to wash hands thoroughly prior to putting on gloves and when changing into a fresh pair of gloves. Gloves are to be changed when changing from one task to another.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. The facility reported a census of 32 residents. Five Certified Nurse Aide (CNA) staff who worked in the facility for more than 12 months were reviewed for the required in-service training. Based on interview and record review, the facility failed to develop, implement, and permanently maintain an in-service training program for CNA staff with the required topics and no less than 12 hours per year. Findings included:- Review of CNA personnel files revealed the following:CNA P, who was hired for the facility on 09/13/22, lacked abuse, neglect, and exploitation (ANE), social media training, and dementia (progressive mental disorder characterized by failing memory, confusion) training. CNA P's total hours were not calculated for the 12 hours required.CNA Q, who was hired 02/14/24, lacked ANE and social media training. CNA Q's total hours were not calculated for the 12 hours required.CNA II, who was hired 06/20/24, lacked ANE and social media training. CNA II's total hours were not calculated for the 12 hours required.During an interview on 09/11/25 at 12:09 PM, Administrative Staff A reported he expected the staff to have the required education and the required 12 hours annually.The facility did not provide a policy for CNA staff required for in-service and annual training hours.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. The facility reported a census of 32 residents; 12 residents were sampled for advanced directives (a written document, which indicates the medical decisions for health care professionals when the person could not make their own decisions). Based on interview and record review, the facility failed to ensure two resident's advanced directives were thoroughly completed when Resident (R) 38 had a do not resuscitate (DNR- or no code, a legal document or order that means the person does not desire resuscitative measures) order but not signed DNR form. Additionally, R4's DNR lacked a witness signature. Findings included:- Review of R4's Physician Order in the Electronic Medical Record (EMR) recorded an order for DNR, date ordered 11/04/24.Review of R4's EMR on 09/09/2025 at 12:45 PM, DNR signed by R4 on 11/01/24 and by the physician on 10/31/24. The DNR form lacked a witness signature. R38's Physician Order in the EMR recorded an order for DNR, date ordered 09/05/25.R38's EMR lacked a signed DNR form.During an observation on 09/11/25 at 09:40 AM, a red dot was noted on the name tag of R38's room.During an observation on 09/11/25 at 09:45 AM, a red dot was noted on the name tag of R4's room.During an interview on 09/11/25 at 09:35 AM, Administrative Nurse F reported that Social Service Designee (SSD) X would complete the advanced directive forms, and a nurse would place the order in the EMR, once the advanced directive paperwork was completed. Administrative Nurse F reported a red dot on any resident's name plate outside of their room meant the resident was a DNR. Administrative Nurse D confirmed R38 did not have a completed DNR form.During an interview on 09/11/25 at 10:15 AM, SSD X reported R4's DNR form was incomplete as it did not have a witness signature. SSD X stated she thought R38 had a DNR, but confirmed she could not locate a signed DNR form for R38 in a file or in EMR.The facility's Advanced Directive, dated 10/11/21, documented residents at all levels of living are provided with written information to exercise their legal rights: to make health care decisions, to refuse treatment, and to make Advance Directives. Advance Directives and Physician Orders will be reviewed by the resident/representative and the care plan team at least annually.

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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. The facility reported a census of 32 residents. There were 12 residents selected for review which included five residents reviewed for unnecessary medications. Based on observation, interview, and record review, the facility failed to ensure that Resident (R) 21's as-needed (PRN) antianxiety (a class of medications that calm and relax people) medication had the required 14-day stop date or a specified duration with a physician's rationale to support the extended use. Findings included:- R21's Electronic Health Record (EHR) revealed diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).R21's 09/26/24 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of three, which indicated severely impaired cognition. The MDS recorded R21 had behaviors, including refusal of care for one day. The MDS documented R21 required total assistance with most activities of daily living (ADL). The MDS recorded R21 received antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), antidepressant (a class of medications used to treat mood disorders), and antianxiety (a class of medications that calm and relax people) medications. The 09/27/24 Psychotropic Drug Use Care Area Assessment (CAA) documented R21 triggered secondary to the use of psychotropic med to manage a psychiatric condition. A licensed nurse would monitor side effects every shift, and the physician would be notified of any abnormal findings. A pharmacist consultant would review medications monthly, and the physician would review medications with each visit. Contributing factors included a history of depression. Risk factors included increased falls, impaired balance, and potential for adverse effects of medication. The care plan would be reviewed to monitor the effectiveness of psychotropic medication and any adverse effects of the medication.R21's 06/26/25 Quarterly MDS documented a BIMS score of zero, which indicated severely impaired cognition. The MDS recorded R21 had no depression or behaviors during the lookback period. The MDS documented R21 received antipsychotic, antianxiety, and antidepressant medications. R21's Care Plan instructed staff R21 would receive PRN lorazepam (antianxiety medication) cream for agitation, dated 11/14/24. R21's Physician's Orders documented an order for lorazepam cream 1 milligram (mg)/ 1 milliliter; give 2 mg/ 2 ml topically to the wrist every four hours PRN for dementia with agitation dated 11/01/24. The order lacked a stop date.R21's Medication Regimen Review (MRR) dated 08/11/25 documented there was no stop date for the PRN Ativan (lorazepam) noted.R21's Medication Administration Record (MAR), dated 04/01/25 through 04/30/25, had a documented order as needed psychotropic medication - physician communication review required for as needed compound lorazepam cream every 6 months. Last completed 04/09/24. Notify both Administrative Nurse D and Administrative Nurse E by email that this is due for review. For unspecified dementia of unspecified severity with agitation. Due on 04/10/2025 in the morning every 6 months starting on the 10th. The MAR lacked the initials indicating it was completed.R21's Concern and Assessment dated 04/07/25, documented by the practitioner, noted R21 was on compounded lorazepam cream 1mg/1ml every four hours as needed for unspecified dementia and reoccurred behaviors, which required a 14-day review, separate from the actual prescription. An extended end date can be chosen if you perform the review and document the rationale for the extended use, and notate the end date. Rationale for extended use progressive dementia with behaviors. Review every six months.During an observation on 09/09/25 at 03:58 PM, a nurse assisted R21 to the lobby area. R21 received a cookie and a drink from the staff. During an interview on 09/10/25 at 12:03 PM, Certified Nurse Aide (CNA) N reported R21 could be resistant to care at times and said staff would reapproach her as needed.During an interview on 09/11/25 at 08:43 AM, Consultant Pharmacist JJ reported that he would review the residents' EHR to verify a stop date for PRN psychotropic medications. Consultant Pharmacist JJ reported that Administrative Nurse F would handle all the (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stop dates that were required for PRN psychotropic medications, and that is why he did not document on the Monthly Medication Regimes. He also stated he had not realized there was no stop date for the PRN compound lorazepam until he reviewed the EHR during the interview. During an interview on 09/11/25 at 09:10 AM, Administrative Nurse F reported that R21's compound lorazepam had a stop date in the last EHR, but confirmed there was no stop date in the current EHR that the facility started to use on 11/01/24. She reported that she would keep a binder of all PRN psychotropic medications, which was reviewed every six months. Administrative Nurse F said the review dates would be the stop date.The facility's policy Psychoactive Psychopharmacological Medications dated 02/03/25, documented psychotropic medications used on as needed basis must have a diagnosed specific condition and indication for as needed use documented in the resident's medical record and is subject to the limitations as noted: As needed orders for psychotropic medications, excluding antipsychotics, shall be limited to no more than 14 days, unless the attending physician or prescribing practitioner believes it is appropriate to extend the order beyond the 14 days.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. The facility reported a census of 32 residents. The sample included 12 residents with one resident reviewed for activities of daily living (ADLs). Based on observation, interviews, and record review the facility failed to offer and provide assistance with grooming of facial hair for Resident (R) 25, who participated in her hygiene activities but needed staff assistance. Findings included:- R25's Electronic Health Record (EHR) revealed diagnoses of macular edema (swelling in a part of the retina that causes blurry or wavy vision, dull colors, and vision loss) and Meniere's disease (a chronic progressive disease of the inner ear, characterized by recurrent episodes of dizziness, progressive hearing loss, and ringing of the ears).R25's 01/20/25 admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. The MDS documented R25 required maximal assistance with most AD, which included transfer, bathing, dressing, and footwear. The MDS documented R25 required supervision with personal hygiene.The 01/27/25 Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) documented the CAA triggered secondary to R25's assistance required in ADLs, impaired balance and transition during transfers, and functional impairment in activity. The CAA noted contributing factors included generalized weakness and decreased safety awareness, and risk factors included further ADL decline. The care plan would be initiated and reviewed to improve and maintain the current ADL status and functional ability.R25's 07/17/25 Quarterly MDS documented a BIMS score of 10, which indicated moderately impaired cognition. The MDS documented R25 was independent with all ADLs, except she required supervision with ambulation.R25's Care Plan, revised on 05/28/25, directed staff to provide one-person assistance with bathing and showering.R25's Care Plan lacked any documentation for personal hygiene assistance or preferences for R25.R25's Personal Hygiene Task reviewed from 08/09/25 through 09/09/25 documented R25 was independent with the ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands.During an observation and interview on 09/09/25 at 02:00 PM, R25 was in her room, self-propelling around in her wheelchair. She had several long facial hairs on her face, approximately one-half inch long. R25 reported that she did not know that she had long facial hairs and stated she did not like having facial hair. R25 seemed a bit confused and repeated the same questions three times. R25 reported she completed her own care, and the staff did not need to do anything for her.During an observation on 09/10/2025 at 10:05 AM, R25 was in activity doing morning exercise. She still had several long facial hairs on her face.During an interview on 09/11/25 at 10:15 AM, Social Service Designee (SSD) X reported the residents would let the facility staff know their preference for facial hair removal. SSD X reported if a resident had impaired cognition, the family member or responsible party would give that preference information to the facility staff, and all preferences would be care planned.During an interview on 09/11/2025 at 10:43 AM, Administrative Nurse E stated he expected the staff to assist residents with facial hair removal and address this on scheduled bath days. Administrative Nurse E reported facial hair preferences would be on the care plan, and R25 really would not refuse showers. Administrative Nurse E reported that R25 believed she would be more independent than she really was.During an interview on 09/11/2025 at 01:16 PM, Certified Nurse Aide (CNA) S reported R25 received her showers on Monday and Thursday during second shift and reported R25 might refuse to have facial hair removed, it depended on the approach. CNA S reported that R25 could not see well, which is why she wore her glasses and head visor when she was not in her room.During an interview on 09/11/2025 01:22 PM, Administrative Nurse D stated she expected staff to remove unwanted facial hair on shower days or as needed, and it should be care planned. The facility did not provide a policy for ADLs.

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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. The facility reported a census of 32 residents; the sample included 12 residents with four residents reviewed for accidents. Based on observation, interview, and record review, the facility failed to follow the care planned interventions to prevent falls for Resident (R) 1 and R7. Findings included:- R1's Electronic Medical Records (EMR) documented diagnoses that included right femur (thigh bone) fracture, hypertension (HTN-elevated blood pressure), and narcolepsy (a sleep disorder marked by excessive sleepiness during the day or recurring, uncontrollable episodes of sleep during normal waking hours, usually with sudden, temporary episodes of muscle weakness). R1's 03/06/25 admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of two, indicating severe cognitive impairment. The MDS documented R1 had falls and a fall that resulted in a fracture within the last month prior to admission.R1's 03/06/25 Falls Care Area Assessment (CAA) documented R1 required assistance for activities of daily living (ADLs) and impaired balance during transfers. The CAA noted contributing factors included generalized weakness and decreased safety awareness, and risk factors include further ADL decline, falls, and pain. R1's 06/06/25 Quarterly MDS documented R1 had a BIMS score of 15, indicating intact cognition. The MDS documented R1 had two or more noninjury falls. The MDS documented R1 was dependent on staff assistance with wheelchair mobility; R1 did not walk and required substantial to maximal assistance with transfers. R1's Care Plan dated 05/29/25 documented that R1 was at risk for falls due to walking and balance problems. The care plan was updated following a fall during a transfer on 06/16/25, and instructed staff to use two staff members for all transfers. R1's Care Plan was updated following a fall on 07/10/25 for staff to use a body pillow on the bed to prevent falls. R1's Incident Note on 07/19/25 at 10:45 PM, documented R1 had a fall off the bed onto the floor. The note documented R1's body pillow was not in use as it was on the other bed in the room. During an interview on 09/09/25 at 10:53 AM, R1 reported he fell out of bed several times due to being restless and tossing and turning when he slept.On 09/11/25 at 9:00 AM, Certified Nurse Aide (CNA) M assisted R1 to his room and removed the foot pedals from the wheelchair. CNA M locked the wheelchair, applied the gait belt around R1's waist, retrieved the walker, and placed it in front of him. CNA M removed the arm from the wheelchair and stood in front of the walker, then pulled R1 forward to help him stand. R1 stood with his knees bent, and CNA M encouraged him several times to stand straight and to turn. R1 was unsteady but was able to slide his feet a small bit to turn a little. R1 began falling, and staff assisted R1 to turn a bit more and plop into his recliner. CNA M then assisted R1 to sit properly in the recliner. On 09/11/25 at 9:08 AM, CNA M stated R1 was at risk for falls and had been found on the floor several times at night. CNA M said R1 also had several falls from staff not transferring him properly. CNA M said she was not aware of any special instructions on the care plan for transferring R1. CNA M reported staff follow the care plan to know how to take care of the residents, and when someone falls, their care plan was updated by the MDS nurse. On 09/11/25 at 01:48 PM, Administrative Nurse D stated that when there was a fall, the administrative staff sat down as a group the following morning and investigated the fall to come up with an appropriate intervention. Administrative Nurse D said the MDS nurse put the intervention into the care plan and communicated it to the staff, and the staff were expected to follow the care plan.The facility's policy Falls dated 11/01/24, documented the residents will be identified for risks of falls and interventions implemented to reduce the risk of falls. The quality assurance nurse will review fall interventions and update as needed.- R7's Electronic Medical Records (EMR) documented diagnoses that included vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), generalized muscle weakness, and osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain). R7's 03/16/25 Significant Change Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of nine, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicating moderate cognitive impairment. The MDS documented R7 had two or more noninjury falls and one fall with an injury that was not severe.R7's 03/16/25 Falls Care Area Assessment (CAA) documented R7 required assistance for activities of daily living (ADLs) and impaired balance during transfers. The CAA noted contributing factors included generalized weakness and decreased safety awareness, and risk factors included further ADL decline, falls, and pain. R7's 06/16/25 Quarterly MDS documented R7 had a BIMS score of seven, indicating severe cognitive impairment. The MDS documented R7 had no falls. The MDS documented R7 required substantial to maximal assistance for wheelchair mobility. R7's Care Plan dated 11/19/24 documented R7 was at risk for falls due to her age, dementia, balance problems, and history of falling. The plan instructed staff to ensure her four-wheeled walker was in her reach. The plan was updated following a fall on 12/06/24 to include placing a Dycem (a non-slip mat used for stabilization and gripping to prevent slipping) in R7's chair and wheelchair. On 09/10/25 at 12:55 PM, Certified Nurse Aide (CNA) N and CNA O assisted R7 to her room in her wheelchair. They removed the wheelchair pedals and applied a gait belt around R7's waist. The two staff, one on each side, lifted R7 to a standing position, and she slowly moved her feet with difficulty. CNA N and CNA O assisted R7 to turn and lowered her into her recliner. They moved the wheelchair against the wall on the other side of the room. The walker was against another wall. Observation revealed the recliner, and the wheelchair did not have a Dycem in it. On 09/10/25 at 12:59 PM, CNA O reported that staff follow the care plan for all R7's care, and if there was a new intervention, staff can look at the profile that pulls from the care plan. CNA O said she was aware the R7 was a fall risk and stated that staff put the wheelchair away for R7, so she does not attempt to get up; staff listen for her to call and do frequent checks on her. CNA O said she was not aware that the care plan documented a Dycem should be in the wheelchair and the recliner, or that staff should keep R7?s walker within reach. On 09/11/25 at 09:08 AM, CNA M reported staff follow the care plan to know how to take care of the residents. CNA M said when someone falls the care plan was updated by the MDS nurse and the MDS nurse told the charge nurse what the update was, and the charge nurse told the other staff. On 09/11/25 at 01:48 PM, Administrative Nurse D stated that when there was a fall, the administrative staff sat down as a group the following morning and investigated the fall to come up with an appropriate intervention. Administrative Nurse D said the MDS nurse put the intervention into the care plan and communicated it to the staff, and the staff were expected to follow the care plan.The facility's policy Falls dated 11/01/24, documented the residents will be identified for risks of falls and interventions implemented to reduce the risk of falls. The quality assurance nurse will review fall interventions and update as needed.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. The facility reported a census of 32 residents; the sample included 12 residents with one resident reviewed for tube feeding (administration of nutritionally balanced liquefied foods or nutrients though a tube). Based on observation, interviews, and record review, the facility failed to ensure Resident (R) 38,a resident who did not eat or drink, had a physician's order for the type of enteral feed formula to be administered through R38's gastrostomy tube (G-tube: tube surgically placed through an artificial opening into the stomach) and/or assessment and direction from the Registered Dietician (RD) until six days after admission.Findings included:- R38's Electronic Health Record (EHR) documented diagnoses which included partial intestinal obstruction, malignant neoplasm of colon (the tendency of a medical condition, especially tumors, to become progressively worse, most familiar as a characteristic of cancer), and severe calorie protein nutrition.R38's 09/08/25 admission Minimum Data Set (MDS) not completed at time of survey but included a 09/09/25 Brief Interview for Mental Status (BIMS) score of 12, which indicated moderately impaired cognition.R38's 09/03/25 Base Line Care Plan documented staff were to provide tube feeding of Jevity 1.5 (liquid nutrition with fiber providing complete nutrition).R38's Hospital Discharge Orders dated 09/03/25 lacked a tube feeding/diet order.The Physician Order documented enteral feed order every night shift, open system container or gravity feeding - change feeding administration set daily; label the formula container, syringe and administration set with resident's name, date, time, and nurse's initials, date ordered 09/03/25 and date discontinued 09/09/25.R38's Physician Orders lacked an order for Jevity 1.5 or any enteral feeding solution.The Physician Orders dated 09/03/25 lacked nothing per mouth order (NPO).R38's Department of Clinical Nutrition: Nutrition Assessment dated 09/09/25 at 01:32 PM by the RD documented a diet order for enteral feedings; 45 milliliter (ml)/hour gravity, Jevity 1.5. The assessment noted R38 was NPO, and receiving tube feedings via gravity.During an observation on 09/09/25 at 11:10 AM, R38 was in her bed. She reported she had just returned from a appointment with her doctor. Observation revealed a tube feeding bag connected to a feeding pump, the bag was labeled with a date and time the enteral feeding was hung. No other information was written on the enteral feeding bag. R38 reported she did not know how much of the enteral feeding she would receive and reported the nurse would be back soon to reconnect her feeding to her feeding tube.During an observation on 09/09/25 at 11:45 AM, R38 had the enteral tube feeding connected to her feeding tube: the rate of the enteral feed was set a 45ml/hr.During an interview on 09/10/25 at 08:54 AM, Licensed Nurse (LN) G reported that the physician order would let the nurses know what type of enteral feed was to be administered when the feed was via the pump. LN g reviewed the discontinued order in EHR and reported the order did not state what type of enteral feed or amount to be administered. LN G reported that the night shift nurse would start the tube feeding as it was continuous. During an interview on 09/10/25 at 04:00 PM Administrative Nurse D reported that questions regarding the 09/09/25 assessment should be directed to the Registered Dietician. Administrative Nurse D reported she realized on 09/09/25 that R38's tube feeding orders were missing the type and amount of feeding to be administered and R38's orders had changed to a bolus feeding so all the orders are correct now.During an interview on 09/11/25 at 10:00 AM, Consultant RD KK reported that she expected a nutritional assessment to be completed within 72 hours after a resident admitted with a tube feeding.During an interview on 09/11/25 at 12:28 PM, Administrative Staff A stated she expected the nutritional assessment for R38's tube feeding to be completed before R38 was admitted and reported that she had sent the Registered Dietician emails that contained the nutritional notes from the hospital.The facility's policy Clinical Nutrition Department Responsibilities dated 01/2025 documented the Registered Dietitian Nutritionist (RDN) would assess the nutritional status of those patients/residents identified at risk, and will communicate information that impacts care to the health care team.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175306	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manor of the Plains	200 Campus Drive Dodge City, KS 67801

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. The facility identified a census of 32 residents. The sample included 12 residents including five residents reviewed for unnecessary medications. Based on record review, interview and observation, the facility failed to act upon blood sugar monitoring for Resident (R) 7 when staff administered insulin (a hormone that lowers the level of glucose in the blood) that should have been held per physician ordered parameters. Findings included:- R7's Electronic Medical Record (EMR) revealed a diagnosis of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin).R7's 03/16/25 Significant Change Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of nine, indicating moderate cognitive impairment. The MDS documented R7 had a diagnosis of diabetes and took insulin every day. R7's 06/16/25 Quarterly MDS documented R7 had a BIMS score of seven, indicating severe cognitive impairment. The MDS documented R7 had a diagnosis of diabetes and took insulin every day.R7's Physician's Order noted an order for Humalog (fast-acting insulin); inject eight units after meals related to diabetes mellitus. Notify the physician for blood sugar over 350 milligrams(mg) per deciliter(dl) or less than 60 mg/dl. Hold Humalog for blood sugars under 100 mg/dl or for refusal of meals; ordered 03/14/25. R7's Physician's Order noted an order to check blood sugar fasting and two hours after meals; start date 11/01/24. R7's August 2025 Medication Administration Record (MAR) revealed the following dates when R7's blood sugar was below 100 mg/dl, but the Humalog insulin was administered:08/01/25, R7's fasting blood sugar was 94 mg/dl, Humalog was given after breakfast. 08/09/25, R7's 01:00 PM blood sugar was 91 mg/dl, Humalog was given after supper. 08/10/25, R7's fasting blood sugar was 92 mg/dl, Humalog was given after breakfast. 08/12/25, R7's 10:00 AM blood sugar was 88 mg/dl, Humalog was given after lunch. 08/18/25, R7's fasting blood sugar was 99 mg/dl, Humalog was given after breakfast. 08/25/25, R7's fasting blood sugar was 97 mg/dl; Humalog was given after breakfast. 08/28/25, R7's 10:00 AM blood sugar was 98 mg/dl, Humalog was given after lunch. On 09/11/25 at 09:48 AM, Administrative Nurse F stated R7's blood sugars are taken fasting at around 07:30 and two hours after meals, and staff use those blood sugar readings to determine if they would hold or give the insulin after R7 ate. Administrative Nurse F said staff would follow the parameters given by the doctor. On 09/11/25 at 01:48 PM, Administrative Nurse D stated that she expected staff to take the blood sugar fasting and two hours after meals as ordered, and after the meal, the nurse was to give or hold the insulin according to the parameters in the order.The facility's Medication Administration policy reviewed 02/03/25 documented medications are administered as prescribed in accordance with good nursing principles and practices.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175306	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manor of the Plains	200 Campus Drive Dodge City, KS 67801

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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 0851 Level of Harm - Potential for minimal harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. The facility reported a census of 32 residents. Based on interview and record review, the facility failed to electronically submit accurate staffing information through Payroll-Based Journaling (PBJ). Findings included:- The PBJ Staffing Data Report for Fiscal Year (FY) 2025 Quarter 1 (October 1 - December 31) documented the facility did not have Licensed Nurse (LN) coverage 24 hours a day on the following dates:10/13/24, 1020/24, 12/1/24, 12/08/24 and 12/24/24Review of the Daily Nurse Staffing Form and Payroll Data Sheets indicated the days listed above were covered with the required LN coverage 24 hours each day. On 09/11/25 at 10:14 AM, Administrative Staff A reported the Regional Human Resources people would compete the PBJ report. Administrative Staff A said she expected the PBJ to be reported accuratelyThe facility did not provide a policy for Payroll Based Journal