STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175566	A. Building B. Wing	10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Plains Skilled Nursing by Americare	331 NE State Road 61 Pratt, KS 67124

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The facility reported a census of 51 residents. The sample included six residents who were reviewed for abuse. Based on observation, interview, and record review, the facility failed to ensure residents remained free from resident-to-resident abuse when, on 09/03/25 at approximately 05:00 AM, Resident (R)1 wandered into R2's room and struck R2, a cognitively and physically impaired resident, in the head. Findings included:-R1's Electronic Health Record (EHR) documented diagnoses that included unspecified dementia (a progressive mental disorder characterized by failing memory and confusion).R1's 07/28/25 admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of eight, which indicated moderately impaired cognition. The assessment documented R1 had physical behavioral symptoms directed towards others, rejection of care, and wandering behaviors that occurred one-to-three days during the look-back period.The 07/28/25 Behavioral Symptoms Care Area Assessment (CAA) documented R1 had wandering behaviors with rejection of care. The CAA documented risk factors included invading others' space and disruptions during activities and in the common areas.R1's 08/19/25 Significant Change Minimum Data Set was incomplete.R1's Care Plan dated 07/29/25 documented R1 wandered aimlessly and directed staff to develop a rapport and trust with R1 through regular visitation. The plan directed staff to anticipate R1's needs by following his physical or non-verbal indicators of discomfort and distress and follow up as indicated. Review of R1's EHR Progress Notes revealed the following: On 09/03/25 at 07:52 AM, Licensed Nurse (LN) G documented on 09/03/25 at 05:00 AM, staff heard someone yelling and found R1 in R2's room. R2's wife reported R1 had hit her and was trying to hit R2. LN G documented R2 nodded his head to indicate yes and rubbed the left side of his forehead when asked if R1 had hit him. LN G documented R2 had a red area on the left side of his forehead. LN G documented Administrative Staff A ordered one-on-one observation of R1.On 09/05/25 at 11:45 AM, LN I documented R1 left the facility with facility staff and his wife to go to a behavioral health unit (BHU).On 09/29/25 at 05:15 PM, LN I documented R1 arrived at the facility via Emergency Medical Services (EMS) from the hospital.The facility's investigation documented on 09/03/25 at 05:00 AM, staff heard yelling from R2's room and entered to find R1 swinging (fists) at R2's wife. Staff were able to remove R1 from R2's room and returned R1 to his room. The nurse assessed R2 and found a red mark on his upper left forehead without swelling or bruising.LN G's undated and unnotarized Witness Statement documented on 09/03/25, someone was yelling down the hall, and R1 was found in R2's room. R2's wife was present and reported R1 had hit her and said she was unsure if R1 had struck R2. R2 nodded yes when asked if R1 had hit him and rubbed the left side of his forehead. LN G documented R2 appeared to have a red area on the left side of his forehead. LN G also documented R1 was violent with staff and struck staff. LN G notified Administrative Staff A and was instructed to notify EMS and Law Enforcement Officers (LEO). Administrative Staff A ordered one-on-one observation for R1.Certified Nurse Aide (CNA) M's undated and unnotarized Witness Statement documented on 09/03/25 at an unknown time, she and CNA O heard yelling and went to investigate. Upon entering R2's room, R1 was standing between the bed and the wall with his arm up like he was ready to swing at R2; R2's wife was shielding him from R1. Staff removed R1 from R2's room, and R1 became violent and punched CNA M and kicked CNA O. CNA O's undated and unnotarized Witness Statement documented on 09/03/25 at an unknown time, she and CNA M heard yelling and went to investigate. R1 was observed with his arm up as if to hit R2, and R2's wife was attempting to block R1. Staff removed R1 from R2's room, and R1 became violent and punched CNA M and kicked CNA O.Administrative Staff B's undated and unnotarized Witness Statement documented on 09/03/25 at approximately 05:15 PM, she helped complete a care plan in R2's room and did not notice any marks on R2.Administrative Staff A's undated and unnotarized Witness Statement documented on 09/03/25 at an unknown time; no injuries were observed on R2's face or arms.Social Services X's undated and unnotarized Witness Statement documented on 09/03/25 at an unknown time; no injuries were observed on R2.Administrative Staff A's undated and unnotarized Witness Statement documented on 09/05/25 at 12:45 PM, LN I reported to Administrative Staff A that R2 had a black eye. Administrative Staff A documented that she and Activity Z went to R2's room and did not observe any bruising, swelling, or redness in R2's eyes or face.Administrative Nurse D's undated and unnotarized Witness Statement documented on 09/03/25 and 09/05/25 at unknown times, she looked at R2's face and did not see any bruising.Activity Z's unnotarized Witness Statement, dated 09/05/25 at 12:30 PM, documented she went with Administrative Staff A to R2's room to provide informational materials to R2's wife, and R2 did not have swelling, redness, or

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility reported a census of 51 residents. The sample included six residents who were reviewed for abuse. Based on observation, interview, and record review, the facility failed to report an allegation of resident-to-resident abuse to the State Agency, as required. (Refer to F600) Findings included:- Review of R1's EHR Progress Notes revealed the following: On 09/03/25 at 07:52 AM, Licensed Nurse (LN) G documented on 09/03/25 at 05:00 AM, staff heard someone yelling and found R1 in R2's room. R2's wife reported R1 had hit her and was trying to hit R2. LN G documented R2 nodded his head to indicate yes and rubbed the left side of his forehead when asked if R1 had hit him. LN G documented R2 had a red area on the left side of his forehead. LN G documented Administrative Staff A ordered one-on-one observation of R1. The facility's investigation documented on 09/03/25 at 05:00 AM, staff heard yelling from R2's room and entered to find R1 swinging (fists) at R2's wife. Staff were able to remove R1 from R2's room and returned R1 to his room. The nurse assessed R2 and found a red mark on his upper left forehead without swelling or bruising. LN G's undated and unnotarized Witness Statement documented on 09/03/25, someone was yelling down the hall, and R1 was found in R2's room. R2's wife was present and reported R1 had hit her and said she was unsure if R1 had struck R2. R2 nodded yes when asked if R1 had hit him and rubbed the left side of his forehead. LN G documented R2 appeared to have a red area on the left side of his forehead. LN G notified Administrative Staff A and was instructed to notify EMS and Law Enforcement Officers (LEO). Administrative Staff A ordered a one-on-one observation for R1. Certified Nurse Aide (CNA) M's undated and unnotarized Witness Statement documented on 09/03/25 at an unknown time, she and CNA O heard yelling and went to investigate. Upon entering R2's room, R1 was standing between the bed and the wall with his arm up like he was ready to swing at R2; R2's wife was shielding him from R1. Staff removed R1 from R2's room, and R1 became violent and punched CNA M and kicked CNA O. CNA O's undated and unnotarized Witness Statement documented on 09/03/25 at an unknown time, she and CNA M heard yelling and went to investigate. R1 was observed with his arm up as if to hit R2, and R2's wife was attempting to block R1. Staff removed R1 from R2's room, and R1 became violent and punched CNA M and kicked CNA O. Administrative Staff A's undated and unnotarized Witness Statement documented on 09/03/25 at an unknown time; no injuries were observed on R2's face or arms. Administrative Staff A's unnotarized and undated Witness Statement documented on 09/08/25 at an unknown time, R2's wife reported to Consultant GG that she wanted to report to LEO and requested charges be filed against R1. Administrative Staff A went into the room and met with R2's wife, who requested to speak to LEO. Administrative Staff A called the police, and a LEO met with R2's wife. During an observation on 10/01/25 at 01:00 PM, R1 rested on his bed in his room with family present. During an interview on 10/01/25 at 12:25 PM, R2's wife reported R1 entered R2's room four times that she knew of before the incident on 09/03/25. R2's wife stated she was able to redirect R1 out of R2's room without incident, but on the morning of 09/03/25, she was awakened by R1 entering the room; R1 interlaced his fingers, raised his hands above his head, and tried to strike R2. R2's wife said she placed her arms and body between R2 and R1 and started yelling for help, and R1 struck her prior to staff responding and removing R1. R2's wife stated that at the time of the incident, she was unsure if R1 had struck R2, but confirmed facial bruising later developed. During an interview on 10/01/25 at 01:15 PM, CNA P reported that when she came to work on the morning of 09/03/25, R2 had bruising on his face near his eye. CNA P said Administrative Staff A spoke with staff to convince them that nothing happened to R2. During an interview on 10/01/25 at 02:40 PM, Administrative Staff A said that if resident-to-resident abuse was observed or suspected, the expectation was for staff to separate, ensure the safety of the residents, provide aid as necessary, and notify the nurse. The nurse was expected to call the building administration, the resident's physician, LEO, EMS, and the residents' representatives. If there was any suspicion that any resident struck another resident, the nurse should also collect written witness statements from the staff. If the incident was willful abuse, then a report would be filed with the State Agency (SA). Administrative Staff A stated on the morning of 09/03/25, she received a call from the nurse who reported R1 entered R2's room and struck R2 and R2's wife. Administrative Staff A confirmed LEO and EMS were notified. Administrative Staff A stated she had not reported the incident to the SA as required. The facility's Abuse, Neglect and Exploitation Policy and Procedure policy, dated 05/2023, documented that the Administrator would notify the SA within 24 hours of the incident unless the incident met the definition of a crime against a person or resulted in serious bodily injury, then the report would be made to LEO and SA no later than two hours after

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility reported a census of 51 residents. The sample included six residents who were reviewed for abuse. Based on observation, interview, and record review, the facility failed to initiate protective actions to prevent the opportunity for additional resident-to-resident abuse, as required. On 09/03/25 at approximately 05:00 AM, Resident (R)1 wandered into R2's room and struck R2, a cognitively and physically impaired resident, in the head. R1 was placed on one-on-one observation by facility staff; however, R1 continued to wander into other resident's rooms with the potential to harm other residents on the unit. (Refer to F600) Findings included:- R1's Electronic Health Record (EHR) documented diagnoses that included unspecified dementia (a progressive mental disorder characterized by failing memory and confusion).R1's 07/28/25 admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of eight, which indicated moderately impaired cognition. The assessment documented R1 had physical behavioral symptoms directed towards others, rejection of care, and wandering behaviors that occurred one to three days during the look-back period. The 07/28/25 Behavioral Symptoms Care Area Assessment (CAA) documented R1 had wandering behaviors with rejection of care. The CAA documented risk factors included invading others' space and disruptions during activities and in the common areas. R1's 08/19/25 Significant Change Minimum Data Set was incomplete.R1's Care Plan dated 07/29/25 documented R1 wandered aimlessly and directed staff to develop a rapport and trust with R1 through regular visitation. The plan directed staff to anticipate R1's needs by following his physical or non-verbal indicators of discomfort and distress and follow up as indicated. R1's EHR Progress Notes revealed a note dated 09/03/25 at 07:52 AM, by Licensed Nurse (LN) G, which documented on 09/03/25 at 05:00 AM, staff heard someone yelling and found R1 in R2's room. R2's wife reported R1 had hit her and was trying to hit R2. LN G documented R2 nodded his head to indicate yes and rubbed the left side of his forehead when asked if R1 had hit him. LN G documented R2 had a red area on the left side of his forehead. LN G documented Administrative Staff A ordered one-on-one observation of R1. In a progress note dated 09/03/25 at 10:11 PM, LN G documented that the resident received one-on-one observation and had wandered in and out of other residents' rooms. R1 became violent and shattered the lid of a toilet tank.In a note dated 09/05/25 at 11:45 AM, LN I documented R1 left the facility with facility staff and his wife to go to a behavioral health unit (BHU).Review of the facility's investigation revealed documentation of one-on-one observation of R1 from 09/03/25 through 09/04/25.During an observation on 10/01/25 at 01:00 PM, R1 rested on his bed in his room with family present. During an interview on 10/01/25 at 02:40 PM, Administrative Staff A said that if resident-to-resident abuse was observed or suspected, the expectation was for staff to separate, ensure the safety of the residents, provide aid as necessary, and notify the nurse. The nurse was expected to call the building administration, the resident's physician, LEO, EMS, and the residents' representatives. If there was any suspicion that any resident struck another resident, the nurse should also collect written witness statements from the staff. If the incident was willful abuse, then a report would be filed with the State Agency (SA). Administrative Staff A stated on the morning of 09/03/25, she received a call from the nurse who reported R1 entered R2's room and struck R2 and R2's wife. Administrative Staff A confirmed LEO and EMS were notified, but not the State Survey Agency. Administrative Staff A reported R1 was placed on one-on-one observation by Administrative Staff A until 08:00 AM, when R1's wife arrived and assumed one-on-one observation until she left at 06:00 PM. Staff then provided one-on-one observation if R1's wife was not present until R1 was transferred to a BHU. The facility's Abuse, Neglect and Exploitation Policy and Procedure policy, dated 05/2023, documented that he facility will take steps to prevent mistreatment while the investigation is underway. Residents who allegedly mistreated another resident will be removed from contact with the resident during the course of the investigation. The resident suspected of elder-to-elder abuse will be provided supervision by staff until the physician, family, and facility management staff assess and provide treatment options to stop any further aggressive, abusive behavior by the elder. The accused resident's condition shall be immediately evaluated to determine the most suitable therapy, care approaches, and placement, considering his or her safety, as well as the safety of other residents and employees of the facility.