STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E451	A. Building B. Wing	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dawson Place	208 W Prout Street Hill City, KS 67642

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. The facility had a census of 36 residents. The sample included 12 residents. Based on observation, interview, and record review, the facility failed to ensure adequate daily nursing staff were always available to meet the needs of the residents who resided in the facility.Findings included:- The Facility Assessment, revised 06/23/25, documented the general approach to staffing was to ensure the facility had sufficient staff to meet the needs of the residents at any given time. The nursing staff were evaluated at the beginning of each shift and adjusted as needed (PRN) at the beginning of each shift and adjusted PRN to meet the care needs and acuity of the resident population.Review of the nursing daily staffing schedules from 07/01/24 to 09/29/24 revealed on 08/10/24 and 09/21/24 a lack of licensed nurse coverage 24 hours a day.On 10/21/25 at 08:37 AM, Administrative Staff A stated she was responsible for completing the daily nurse staffing schedules. Administrative Staff A stated Administrative Nurse D worked on the days above in the missing time slot. Administrative Staff A revealed Administrative Nurse D was salary and did not clock in, so the facility had no documentation to verify Administrative Nurse D worked during the missing time slots.The facility's Staffing, Sufficient and Competent Nursing Policy, revised August 2022, documented licensed nurses and certified nursing assistants would be available 24 hours a day, seven days a week to provide competent resident care services.

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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. The facility had a census of 36 residents. The sample included 12 residents. Based on observation, interview, and record review, the facility failed to provide the services of a full-time certified dietary manager for the 36 residents who resided in the facility and received their meals from the kitchen. Findings included:- On 10/20/25 at 08:20 AM, observation revealed that dietary staff in the kitchen prepared the breakfast meal. On 10/20/25 at 08:30 AM, Dietary Staff BB verified she was not a certified dietary manager. Dietary Staff BB stated the facility had five residents with a mechanical soft diet. On 10/22/25 at 01:00 PM, Administrative Staff A verified Dietary Staff BB was not certified.The facility's Dietician policy, undated, documented that a qualified, competent, and skilled dietician would help oversee the food and nutrition services in the facility. A food and nutrition services manager will oversee the production, storage, and delivery of food. The dietician will work closely with the food and nutrition service manager and clinical staff. Dietary managers who are not yet certified may document the clinical record only after receiving documented training from the facility's licensed dietician on appropriate documentation standards and regulatory requirements. Documentation must be reviewed by the supervising dietician to ensure clinical accuracy and compliance with federal and state regulations. If a dietician is not employed full-time (35 or more hours per week), a director of food and nutrition services would be designated. That individual would be a Certified Dietary Manager, or be a certified service manager, or be nationally certified in food service management and safety, or have an associate's or higher degree in food service management from an accredited institution. Have 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and have completed a course of study in food safety and management, no later than October 1, 2023. That includes topics integral to managing dietary operations, including, but not limited to, foodborne illness, sanitization, and food purchasing and receiving, and meet state requirements for food service or dietary managers. The Dietary manager should receive frequent scheduled consultation from a qualified dietician or qualified professional.

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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 had a census of 36 residents. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food by professional standards for food service safety in the facility's kitchen. Findings included:- On 10/21/25 at 11:30 PM, during food preparation, observation revealed the following:1. Three overhead fluorescent light fixtures, four feet by 12 inches with two light bulbs in each fixture, located directly above the food preparation area, and three overhead fluorescent light fixtures, four feet by 18 inches with four light fixtures, located above the dishwashing area and hot food preparation area with grey hanging lint.2. Three 24-inch by 24-inch air vent grills located above the cooking stove and food prep area, covered with brownish grease/sticky substance and gray fuzzy substance blowing directly on the food preparation and stove cooking area.3. One 24-inch by 24-inch, exhaust vent located above the dishwashing area, grills covered with brownish/black sticky grease substance and black fuzzy substance.4. Continued observation revealed multiple fire suppression spigots with metal pipes connected to the system, covered with brownish, fuzzy grey substance on the pipes and spigot area.On 10/21/25 at 11:35 AM, Dietary Staff BB verified the dirty register grills, dirty exhaust vent, and fuzzy substance on the fire suppression pipes and spigots. Dietary Staff BB verified she had worked at the facility for three months and was unsure who was responsible for the cleaning of the exhaust vent, register grills, and fire suppression spigots and pipes. On 10/21/25 at 11:45 AM, Maintenance Staff U verified the overhead fluorescent lights that were covered with grey lint, the fire suppression pipes, and spigots covered with a fuzzy grey substance, and the dirty registered grills. The facility's Sanitization policy, dated November 2022, documented the food service area is maintained in a clean and sanitary manner. The policy documents all kitchen and dining areas were kept clean, free from garbage, rodents, and insects. The policy documented the equipment, food contact surfaces, and utensils are cleaned and sanitized using heat or chemical sanitizing solutions

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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 identified a census of 36 residents. The sample included 12 residents. The facility had four residents required to be on enhanced barrier precautions (EBP- interventions designed to reduce the transmission of multi-drug-resistant organisms (MDRO- microorganisms, primarily bacteria, that have developed resistance to multiple antibiotics) during high contact resident care activities). Based on observation, interview, and record review, the facility failed to ensure that EBP signage was posted in or near the residents' rooms, which communicated the types of precautions and the personal protective equipment (PPE) required before performing resident cares. Findings included:- On the initial tour of the facility on 10/20/25 at 08:20 AM, four residents had PPE inside their rooms. Resident (R) 8, R11, R17, and R19 rooms had evidence of PPE in the room, but lacked signage inside or outside of the rooms that indicated that a resident was on EBP.On 10/20/25, a list of the residents on EBP was requested and provided by Administrative Nurse E. The list documented that R8, R11, R17, and R19 were on EBP.On 10/22/25 at 08:28 AM, Administrative Nurse E stated that residents on EBP had a yellow sticker on the trim outside the door. Administrative Nurse E stated each of the residents on EBP had the PPE supplies available in the room, and the floor nurses made care staff aware of who was on the EBP. Administrative Nurse E further stated that the residents should have a sign in their room with info on the EBP and what PPE should be worn.On 10/22/25 at 11:30 AM, Administrative Nurse D stated that the residents on EBP did have the yellow stickers outside of their rooms to indicate they were on EBP. Administrative Nurse D stated that one of the resident's family had an issue with the dignity aspect of the PPE being in the rooms of resident. Administrative Nurse D stated that she informed and educated the family on the need for EBP and the PPE access. Administrative Nurse D stated she was not certain about the signage aspect, but would review information about the EBP and would ensure that signage would be obtained and placed in the residents' rooms.The facility policy Enhanced Barrier Precautions dated December 2024, documented EBP is utilized to prevent the spread of MDROs to residents. Standard precautions apply to the care of all residents regardless of suspected or confirmed infection or colonization status. Staff are trained prior to caring for residents on EBPs. Signs are posted on the door or wall outside the residents' room, which communicate the type of precautions and PPE required.

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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** The facility had a census of 36 residents. The sample included 12 residents, with five reviewed for unnecessary medications. 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 antipsychotic (a medication used to treat any major mental disorder characterized by a gross impairment testing) medication. Findings include: - R7's Electronic Medical Record (EMR) recorded diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), depression (a mood disorder that causes persistent feelings of sadness), and sleep apnea (a disorder of sleep characterized by periods without respirations).R7's Quarterly Minimum Data Set (MDS) dated [DATE] recorded R7 had severely impaired cognition. The MDS recorded R7 required staff assistance with most activities of daily living (ADL). The MDS recorded the resident received antipsychotic and antidepressant (a class of medications used to treat mood disorders) medication during the observation period.The Psychotropic Drug Use Care Area Assessment (CAA) dated 04/28/25 recorded R7 received Seroquel (antipsychotic medication) 50 milligrams (mg) every night and documented a diagnosis of insomnia and dementia. The CAA documented the diagnosis was not approved. R7's Care Plan dated 10/13/25 recorded R7 had impaired cognitive function/impaired thought process due to dementia, and staff would cue, reorient, and supervise as needed. The care plan documented staff would administer medications as ordered and monitor for side effects and effectiveness.The Physician's Order, initial order date 04/22/25, directed the staff to administer Seroquel 50 mg, one tablet, at bedtime for a day for the diagnosis of insomnia. The Physician Order, dated 10/07/25, directed staff to administer Risperdal (antipsychotic medication) 0.5 mg, one tablet, two times a day for the diagnosis of dementia with agitation. R7's EMR lacked a documented physician rationale, which included the unsuccessful attempts for nonpharmacological symptom management and a risk versus benefits statement for the Seroquel and Risperdal use.R7's Pharmacy Review, dated 05/12/25, documented the resident received Seroquel 50 mg at bedtime and requested the provider for a diagnosis for the use of the antipsychotic medication. The pharmacist documented antipsychotic use for the behavior of dementia shows a 35 percent increase in mortality and a 50 percent increase in hospitalization. Continued review of the pharmacist's request revealed the physician documented No change. Review of the pharmacist review after 05/12/25 until the present revealed the pharmacist had not addressed the continued inaccurate diagnosis for the antipsychotic medication use.On 10/21/25 at 08:15 AM, observation revealed R7 sat in a wheelchair, dressed in street clothes and nicely groomed, in the dining room. Continued observation revealed the resident ambulated independently to his room and started talking to his roommate about getting out of the facility, and did not know how much longer he could stay here, and did not know what to do. On 10/21/25 at 11:20 AM, observation revealed Certified Medication Aide (CMA) R administered the residents' noon medications.On 10/20/25 at 02:05 PM, Administrative Nurse D verified the resident received Seroquel, with a diagnosis of insomnia. Administrative Nurse D verified the diagnosis was inappropriate for the medication and would contact the provider for the appropriate diagnosis for the medication use.On 10/22/25 at 11:30 AM, Administrative Nurse D verified the resident received Risperdal, with the diagnosis of dementia, and verified the diagnosis was inappropriate for the medication and would contact the provider for the appropriate diagnosis for the medication use. The facility's Psychotropic Medication Use dated February 2025, documented residents do not receive psychotropic medications that are not clinically indicated and necessary to treat a specific condition documented in the medical record. Psychotropic medication is any medication that affects brain activity associated with mental processes and behavior. Medications in (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications, anti-psychotics, antidepressants, anti-anxiety medications, and hypnotic and sedatives. Adequate indications for use refer to the identified, documented clinical rational for administering medication that is based on an assessment of the resident's condition and therapeutic goals, a determination that non-pharmacological interventions are clinical contraindicated, and manufactures recommendations, clinical practice guidelines, clinical standards of practice, medication references, clinical studies, or evidenced based review articles that support the us of the medications. The clinical rationale for the use of psychotropic medication, or a change from one type of psychotropic to another, is documented in the medical record. Diagnosis alone does not necessarily warrant the use of antipsychotic medication. If a psychiatric diagnosis is part of the rationale for the use of the psychotropic medication, there will be sufficient supporting documentation that the resident meets the criteria for that diagnosis.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 36 residents. The sample included 12 residents, with two residents reviewed for hospitalization. Based on observation, interviews, and record review, the facility failed to provide a written notification of transfer to Resident (R) 5 or their representative for all applicable transfers/discharges. The facility failed to ensure the written notification of transfers given to R5 had the required information. The facility further failed to notify the State Long Term Care Ombudsman (LTCO) of transfers/discharges for R5. Findings included:- R5's Electronic Medical Record (EMR) documented diagnoses of overactive bladder (a condition characterized by frequent, sudden, and uncontrollable urge to urinate, often accompanied by urinary incontinence), chronic kidney disease (a condition where the kidneys gradually lose their ability to filter waste products and excess fluid from the blood), malignant neoplasm (the tendency of a medical condition, especially tumors, to become progressively worse, most familiar as a characteristic of cancer) of the urethra (small tubular structure that drains urine from the bladder), benign prostatic hyperplasia (BPH- non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency, and urinary tract infections) urinary incontinence, and hypertension (HTN- elevated blood pressure). The Quarterly Minimum Data Set (MDS) dated 09/10/25 documented R5 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The Functional Abilities Care Area Assessment (CAA) dated 12/31/24 documented R5 needed assistance with his self-care and mobility, and had chronic pain. R5's Care Plan dated 09/29/25 documented R5 had bladder incontinence and a history of urinary tract infections. Staff would encourage the resident to drink fluids during the day to promote a prompted voiding response. The care plan directed staff to have the resident clean the peri-area with each incontinent episode. The Nurses' Note dated 08/19/25 at 08:00 PM documented the nurse was called to the resident's room and noted R5 to be pale, shaking and had a temperature of 103.6 degrees (normal 96.4 to 98.5 degrees), blood pressure of 120/60 (normal blood pressure less than 120/80), heart rate of 108 (normal 60 -100 beats per minute), and oxygen saturation of 90% (normal between 95-100). R5 complained of back pain, was incontinent of loose stool. The primary care physician was notified of the resident's condition, and R5 was transferred to the hospital. R5 was unable to stand and a sit-to-stand lift with two staff members was utilized to transfer R5 to the wheelchair, and then to the hospital. The Hospital Note dated 08/19/25 documented R5 had a diagnosis of sepsis (a life-threatening systemic reaction that develops due to infections that cause inflammation throughout the entire body) from a diagnosed urinary tract infection and was admitted to the hospital. The Nurses' Note dated 08/22/25 at 09:43 AM documented R5 returned to the facility accompanied by the hospital nurse. Upon request, the facility was unable to provide a written notification of transfer and bed hold acknowledgment for R5's transfer to the hospital on [DATE]. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon request, the facility was unable to provide documentation of LTCO notification for R5's transfer to the hospital on [DATE] and returned to the facility on [DATE]. On 10/21/25 at 10:45 AM, R5 ambulated from his room to the bathroom, which is located down the hall from his room. R5 ambulated with a walker and aide beside him, dressed in street clothes. On 10/20/25 at 02:10 PM, Administrative Staff A stated she sent a transfer notification to the Ombudsman if the resident was discharged from the facility to home or to another facility, but did not send the notification if the resident was transferred to the hospital since she started at the facility a year and a half ago. Administrative Staff A stated she would contact the LTCO and get guidance on the procedure for discharges. On 10/21/25 at 03:10 PM, Social Services X stated the facility did not have a written notification of transfer for R5's transfer to the hospital an 08/19/25. The facility's Transfer and Discharge policy, dated March 2025, documented the residents or residents' representatives were notified of an impending transfer or discharge and the reason for the move in writing and in a language and manner they understand. A copy of the notice is sent to the Office of the State Long-Term Ombudsman, the Notice of Facility Bed-Hold, and the policies. The notice of transfer is given as soon as it is practicable, but before the transfer or discharge. The resident and representative are notified in writing of the specific reason for transfer or discharge, the effective date of discharge or transfer, the specific location, and an explanation of the resident's rights to appeal the transfer or discharge to the state.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 36 residents. The sample size included 12 residents, who were reviewed for care plans. Based on observation, interview, and record review, the facility failed to ensure that Resident (R) 3's care plan was revised and interventions implemented to direct staff on resident care for her insulin pump (a small, computerized device that delivers insulin through a thin tube inserted under the skin).Findings included:- R3's Electronic Medical Record (EMR) documented diagnoses of Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), bipolar disorder (a major mental illness that caused people to have episodes of severe high and low moods), and diabetes mellitus (DM- when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin).R3's Annual Minimum Data Set (MDS) dated [DATE], documented R3 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. R3 required maximal assistance from staff for her activities of daily living (ADL). R3 received insulin (a hormone that lowers the level of glucose in the blood) regularly.R3's Functional Abilities Care Area Assessment (CAA) dated 12/10/24 documented she had a diagnosis of Parkinson's disease. R3 required extensive assistance with all ADLs except eating. R3 required the use of a sit-to-stand lift (specialized medical devices designed to assist individuals with limited mobility in transitioning from a seated to a standing position). R3 had diabetes and had an insulin pump. R3 used a wheelchair to assist with mobility and was usually dependent on staff to propel the wheelchair.R3's Care Plan, revised on 07/17/25, directed staff that she had depression related to her Parkinson's disease. The care plan directed staff that R3's medications would be reviewed by the pharmacist consultant monthly, by the physician every 60 days, and both as needed. The care plan directed staff to give R3 her diabetic medications as ordered by the doctor and monitor and document for side effects and effectiveness. R3's care plan lacked staff direction for cares related to the use of her insulin pump. R3's Order Summary of the EMR documented an order dated 03/18/25 for a MiniMed insulin pump, basal rate is monitored and adjusted by the physician at the endocrinology clinic.On 10/21/25 at 08:15 AM, R3 sat in her wheelchair at the dining table to eat breakfast with other residents.On 10/22/25 at 10:06 AM, Administrative Nurse E stated that R3's insulin pump was preprogrammed and set by the endocrinologists (a medical doctor who specializes in diagnosing and treating hormone-related diseases and conditions). Administrative Nurse E stated that yes, the information about the insulin pump should be on the care plan and would be added today.On 10/22/25 at 11:30 AM, Administrative Nurse D stated that she had been working on improving the care plans and that R3's care plan should have included interventions regarding the insulin pump. Administrative Nurse D stated that R3's care plan had been revised today to address the use of the insulin pump and how staff should care for R3 with its use.The facility's policy Care Plans, Comprehensive Person-Centered dated March 2022, documented the interdisciplinary team (IDT) in conjunction with the resident and his/her family or legal representative, developed and implemented a comprehensive, person-centered care plan for each resident. The care plan interventions were derived from a thorough analysis of the information gathered as part of the comprehensive assessment. Assessments of residents are ongoing, and care plans are revised as information about the residents and their conditions changes. The IDT reviews and updates the care plan: when there has been a significant change in the resident's condition; when the desired outcome was not met; when the resident has been readmitted to the facility from a hospital stay; and at least quarterly, in conjunction with the required quarterly assessment.

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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** The facility had a census of 36 residents. The sample included 12 residents, with five reviewed for unnecessary medication. Based on observation, interview, and record review, the facility's consultant Pharmacist failed to obtain an approved indication for use for Seroquel (antipsychotic -class of medications used to treat psychosis and other mental emotional conditions) for Resident (R) 7, and Risperdal (antipsychotic) for R7, and failed to have monthly pharmacy Medication Regimen Reviews (MRR) for R3 and R4. Findings included:- R7's Electronic Medical Record (EMR) recorded diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), depression (a mood disorder that causes persistent feelings of sadness), and sleep apnea (a disorder of sleep characterized by periods without respirations). R7's Quarterly Minimum Data Set (MDS) dated [DATE] recorded R7 had severely impaired cognition. The MDS recorded R7 required staff assistance with most activities of daily living (ADL). The MDS recorded R7 received antipsychotic and antidepressant (a class of medications used to treat mood disorders) medication during the observation period. The Psychotropic Drug Use Care Area Assessment (CAA) dated 04/28/25 recorded R7 received Seroquel 50 milligrams (mg) every night and documented a diagnosis of insomnia and dementia. The CAA documented the diagnosis was not an approved diagnosis. R7's Care Plan dated 10/13/25 recorded R7 had impaired cognitive function and impaired thought process due to dementia, and staff would cue, reorient, and supervise R7 as needed. The care plan documented staff would administer medications as ordered and monitor for side effects and effectiveness. The Physician's Order, initial order date 04/22/25, directed the staff to administer Seroquel 50 mg, one tablet, at bedtime for a day for the diagnosis of insomnia. The Physician Order dated 10/07/2, directed staff to administer Risperdal 0.5 mg, one tablet, two times a day for the diagnosis of dementia with agitation. R7's EMR lacked a documented physician rationale, which included the unsuccessful attempts for nonpharmacological symptom management and a risk versus benefits statement for the Seroquel and Risperdal use. R7's Pharmacy Review, dated 05/12/25, documented R7 received Seroquel 50 mg at bedtime and requested the provider for a diagnosis for the use of the antipsychotic medication. The pharmacist documented antipsychotic use for the behavior of dementia shows a 35 percent increase in mortality and a 50 percent increase in hospitalization. Continued review of the pharmacist's request revealed the physician documented No change. Review of the pharmacist review after 05/12/25 until the present revealed the pharmacist had not addressed the continued inaccurate diagnosis for the antipsychotic medication use. On 10/21/25 at 08:15 AM, observation revealed R7 sat in a wheelchair, dressed in street clothes and nicely groomed, in the dining room. Continued observation revealed R7 ambulated independently to his room and started talking to his roommate about getting out of the facility, and did not know how much (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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	longer he could stay here, and did not know what to do. On 10/21/25 at 11:20 AM, observation revealed Certified Medication Aide (CMA) R administered the residents' noon medications with no concerns identified. On 10/20/25 at 02:05 PM, Administrative Nurse D verified the resident received Seroquel, with a diagnosis of insomnia. Administrative Nurse D verified the diagnosis was inappropriate for the medication and would contact the provider for the appropriate diagnosis for the medication use. Administrative Nurse D verified the pharmacist had not identified and recommended a CMS appropriate diagnosis for R7's Seroquel and Risperdal. On 10/22/25 at 11:30 AM, Administrative Nurse D verified the resident received Risperdal, with the diagnosis of dementia and verified the diagnosis was inappropriate for the medication. Administrative Nurse D stated she would contact the provider for the appropriate diagnosis for the medication use. The facility's Medication Regimen Review policy dated May 2019 documented the consulting pharmacist reviews the medication regimen of each resident at least monthly. The consulting pharmacist performs a medication review regimen (MRR) for every resident in the facility receiving medication. The goal of the MRR is to promote positive outcomes while minimizing adverse consequences and potential risks associated with medication. The MRR involves a thorough review of the resident's medical record to prevent, identify, report, and resolve medication-related problems, medication errors, and other irregularities. The medication regimen and associated treatment goals involve collaboration with the resident, the resident representative, interdisciplinary team. The MRR includes a review of the resident's stated preferences, the comprehensive care plans, and information provided about the risks and benefits of the medication. Within 24 hours of the MRR, the consulting pharmacist provides a written report to the attending physician for each resident identified as having a non-life-threatening medication irregularity. The report contains the resident's name, the name of the medication, the identified irregularity, and the pharmacist's recommendation. The attending physician documents in the medical record that the irregularity has been reviewed and what, if any, action was taken to address it. The facility's Psychotropic Medication Use dated February 2025, documented residents do not receive psychotropic medications that are not clinically indicated and necessary to treat a specific condition documented in the medical record. Psychotropic medication is any medication that affects brain activity associated with mental processes and behavior. Medications in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications, anti-psychotics, antidepressants, anti-anxiety medications, and hypnotic and sedatives. Adequate indications for use refer to the identified, documented clinical rational for administering medication that is based on an assessment of the resident's condition and therapeutic goals, a determination that non-pharmacological interventions are clinical contraindicated, and manufactures recommendations, clinical practice guidelines, clinical standards of practice, medication references, clinical studies, or evidenced based review articles that support the us of the medications. The clinical rationale for the use of psychotropic medication, or a change from one type of psychotropic to another, is documented in the medical record. Diagnosis alone does not necessarily warrant the use of antipsychotic medication. If a psychiatric diagnosis is part of the rationale for the use of the psychotropic medication, there will be sufficient supporting documentation that the resident meets the criteria for that diagnosis. - R3's Electronic Medical Record (EMR) documented diagnoses of Parkinson's disease (slowly (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E451	A. Building B. Wing	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dawson Place	208 W Prout Street Hill City, KS 67642

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), bipolar disorder (a major mental illness that caused people to have episodes of severe high and low moods), and diabetes mellitus (DM- when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin). R3's Annual Minimum Data Set (MDS) dated [DATE], documented R3 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. R3 required maximal assistance from staff for her activities of daily living (ADL). R3 received insulin (a hormone that lowers the level of glucose in the blood) regularly. R3's Functional Abilities Care Area Assessment (CAA) dated 12/10/24 documented she had a diagnosis of Parkinson's disease. R3 required extensive assistance with all ADLs except eating. R3 required the use of a sit to stand lift (specialized medical devices designed to assist individuals with limited mobility in transitioning from a seated to a standing position). R3 had diabetes and had an insulin pump (a small computerized device that delivers insulin through a thin tube that goes under your skin). R3 used a wheelchair to assist with mobility and was usually dependent on staff to propel the wheelchair. R3's Care Plan revised on 07/17/25 directed staff that she had depression related to her Parkinson's disease. The care plan directed staff that R3's medications would be reviewed by the pharmacist consultant monthly, by the physician every 60 days and both as needed. The care plan directed staff to give R3 her diabetic medications as ordered by the doctor and monitor and document for side effects and effectiveness. A review of the Consultant Pharmacist's month regimen review (MRR) revealed the facility lacked documentation/record of R3's medication review for the months of September 2024, November 2024, December 2024, January 2025, and March 2025. On 10/21/25 at 08:15 AM, R3 sat in her wheelchair at the dining table eat breakfast with other residents. On 10/20/25 at 01:15 PM, Administrative Nurse D stated she had the emails with the physician responses for the MRRs but did not print them out and keep them in a binder and was not able to find all of them for R3. Administrative Nurse D stated that staff had just recently started to scan the MRRs into the EMR. The facility's policy Medication Regimen Reviews dated May 2019, documented the CP performed a MRR for every resident in the facility receiving medication. MRRs are done upon admission and at least monthly thereafter, or more frequently if indicated. The CP provides the director of nursing services and the medical director a written, signed, and dated copy of all MRRs. Copies of the MRR reports, including physician responses, were maintained as part of the permanent medical record. - R4's Electronic Medical Record (EMR) documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), hypertension (HTN- elevated blood pressure), atrial fibrillation (rapid, irregular heartbeat), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). R4's Significant Change Minimum Data Set (MDS) dated [DATE] documented she had a Brief Interview for Mental Status (BIMS) score of four, which indicated severely impaired cognition. R4 (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	required partial assistance with her activities of daily living (ADL). R4 received an antidepressant (a class of medications used to treat mood disorders) and an anticoagulant (a class of medications used to prevent the blood from clotting) regularly. R4's Psychotropic Drug Use Care Area Assessment (CAA) dated 04/18/25 documented she receives Zoloft (an antidepressant medication) for depression. R4's daughter had passed. R4 participated in most group activities. R4 has had a decline in her cognitive status, behaviors, and mobility. R4's episodes and symptoms of depression were monitored every shift. R4's Care Plan last revised on 10/07/25 directed staff to administer medications as ordered and to monitor for side effects and effectiveness. The care plan directed staff that her medications would be reviewed by the pharmacist consultant monthly, by a physician every 60 days, and by both as needed. A review of R4's Consultant Pharmacists (CP) monthly medication regimen review (MMR) from August 2024 to present revealed the facility was unable to provide documentation of the CP MMR for the months of September to December 2024, as well as January and February 2025. On 10/22/25 at 08:10 AM, R4 sat in her wheelchair at the dining table eating breakfast with other residents. On 10/20/25 at 01:15 PM, Administrative Nurse D stated she had the emails with the physician responses for the MRRs, but did not print them out or keep them in a binder, and she was not able to find all of them for R4. Administrative Nurse D stated that staff had just recently started to scan the MRRs into the EMR. The facility's policy Medication Regimen Reviews dated May 2019 documented the CP performed an MRR for every resident in the facility receiving medication. MRRs were done upon admission and at least monthly thereafter, or more frequently if indicated. The CP provides the director of nursing services and the medical director with a written, signed, and dated copy of all MRRs. Copies of the MRR reports, including physician responses, are maintained as part of the permanent medical record.

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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 had a census of 36 residents. Based on the interview and record review, the facility failed to submit complete and accurate staffing information through Payroll Based Journaling (PBJ) as required. Findings included:- The PBJ report provided by the Centers for Medicare & Medicaid Services (CMS) for Fiscal Year (FY) Quarter 4 2024 (July 1- September 30) indicated the facility had no licensed nurse coverage 24 hours a day on the following dates: 07/07/24, 07/27/24, 07/28/24, 08/11/24, and 09/29/24.Review of the facility's daily nursing staff coverage revealed the facility had licensed nurse coverage 24 hours a day on the above dates, and revealed the facility had adequate licensed nurse coverage.On 10/21/25 at 08:37 AM, Administrative Staff A stated the human resource staff was responsible for submitting the PBJ during that period of time, and she no longer worked for the facility.The facility's Reporting Direct Care Staffing Information (PBJ) Policy, revised May 2024, documented that complete and accurate direct care staffing information would be reported electronically to the Centers for Medicaid, Medicare Services (CMS) through the PBJ system in a uniform format specified by CMS.