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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR OF THE PLAINS	200 CAMPUS DRIVE , DODGE CITY, Kansas, 67801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The following citations represent the findings of a Health Recertification Survey and complaint survey regarding allegations of complaint 2605989. The 2567 was sent electronically on 09/25/25.	F0000		
F0578 SS = D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance	F0578		

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 reverse for further 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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F0578 SS = D	Continued from page 1 directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by: 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	F0578		

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F0578 SS = D	Continued from page 2 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.	F0578		
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . .	F0605		

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F0605 SS = D	Continued from page 3 §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F0605		

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F0605 SS = D	Continued from page 4 §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: 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,	F0605		

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F0605 SS = D	Continued from page 5 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	F0605		

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F0605 SS = D	Continued from page 6 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 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	F0605		

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F0605 SS = D	Continued from page 7 to extend the order beyond the 14 days.	F0605		
F0676 SS = D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is NOT MET as evidenced by:	F0676		

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F0676 SS = D	Continued from page 8 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	F0676		

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F0676 SS = D	Continued from page 9 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.	F0676		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F0689		

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F0689 SS = D	Continued from page 10 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: 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	F0689		

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F0689 SS = D	Continued from page 11 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.	F0689		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR OF THE PLAINS	200 CAMPUS DRIVE , DODGE CITY, Kansas, 67801

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F0689 SS = D	Continued from page 12 - 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, 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	F0689		

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F0689 SS = D	Continued from page 13 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.	F0689		
F0693 SS = D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent	F0693		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0693 SS = D	Continued from page 14 complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is NOT MET as evidenced by: 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	F0693		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR OF THE PLAINS	200 CAMPUS DRIVE , DODGE CITY, Kansas, 67801

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F0693 SS = D	Continued from page 15 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.	F0693		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0693 SS = D	Continued from page 16 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.	F0693		
F0730 SS = F	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(e)(7) §483.35(e)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is NOT MET as evidenced by: 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.	F0730		
F0757 SS = D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-	F0757		

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F0757 SS = D	Continued from page 17 §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is NOT MET as evidenced by: 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	F0757		

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F0757 SS = D	Continued from page 18 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.	F0757		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary	F0812		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR OF THE PLAINS	200 CAMPUS DRIVE , DODGE CITY, Kansas, 67801

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F0812 SS = F	Continued from page 19 CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: 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.	F0812		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR OF THE PLAINS	200 CAMPUS DRIVE , DODGE CITY, Kansas, 67801

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F0812 SS = F	Continued from page 20 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.	F0812		

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F0812 SS = C	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an	F0812 F0851		

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F0851 SS = C	Continued from page 22 agency. §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is NOT MET as evidenced by: 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 12/24/24 Review 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 accurately The facility did not provide a policy for Payroll Based Journal	F0851		
F0947 SS = F	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must-	F0947		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR OF THE PLAINS	200 CAMPUS DRIVE , DODGE CITY, Kansas, 67801

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F0947 SS = F	Continued from page 23 §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is NOT MET as evidenced by: 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,	F0947		

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

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F0947 SS = F	Continued from page 24 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.	F0947		