STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B029001	A. BUILDING: _____ B. WING _____	R 03/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RL DODGE CITY I, LLC	2800 6TH STREET DODGE CITY, KS 67801

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{S 000}	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey for correction order 19-36 of the above named facility conducted on 3/19/19 and 3/20/19. Revised 2567 sent to facility 4/5/19	{S 000}		
{S5028} SS=E	26-42-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the home as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation. This REQUIREMENT is not met as evidenced by:	{S5028}		

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

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{S5028}	Continued From page 1 KAR 26-42-101 (f)(3)(C)(E)(F) The facility reported a census of 8 residents. The sample included 3 residents. Upon request licensed nurse/operator A reported 2 incidents of alleged abuse/neglect since the last survey conducted on 2/20/19. Based on observation, interview and record review licensed nurse/operator A failed to have evidence of a thorough investigation for 2 of 2 reports (#1157 and #1163), failed to report within 24 hours as required and failed to submit 1 of 2 (#1157) investigation reports to the state agency within 5 days as required. Findings included: - Record review for resident #1157 revealed an admission date of 9/12/18 with diagnoses of Alzheimer's, normal pressure shunt placement, hypothyroidism and high cholesterol. The admission functional capacity screen (FCS) dated 9/12/18 identified the resident with short-term and long-term memory deficit, impaired memory recall and decision making. He/she needed physical assistance with all activities of daily living expect eating which required supervision. He/she had unsteadiness on his/her feet, used a walker to stand and a wheelchair for mobility. Under the comments section licensed nurse/operator A wrote 100% wheelchair, utilized the walker only to hang on to, to help stand. The negotiated service agreement/health care services (NSA/HCS) dated 9/12/18 directed staff to provide assistance of 2 staff for bathing, dressing, toileting and transfer using the walker only to stand. He/she was non-ambulatory and	{S5028}		

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{S5028}	Continued From page 2 used a wheelchair for mobility. Medical equipment used included hospital bed, wheelchair and walker. The NSA/HCS did not reflect the use of a mechanical lifting recliner. An amendment dated 10/8/18 may use body alarm for resident safety at bedtime continuously. An amendment dated 2/01/19 directed staff the resident received hospice care, used a hospital bed with staff to transfer the resident with a lift and 2 staff to get out of bed PRN (as needed). An amendment dated 2/14/19 directed discontinue walker, wheelchair assist of 1, heel protectors while in bed or recliner. Body alarm continuous while in bed, bed in lowest position when in bed, fall mat next to bed while resident in bed ... Review of certified staff care tool for this resident revealed directions to assist the resident with a mechanical lift and 2 staff to transfer from 1 surface to another, to use a body alarm continuous when in bed, bed in lowest position and fall mat. Review of the nursing notes revealed an entry dated 2/27/19 at 5:00 PM by licensed nurse/operator A - resident up in recliner in his/her room at 4:40 PM watching TV, when staff walked into the resident's room and found him/her lying face down on the floor directly in front of the recliner. This nurse was in the house and immediately assessed resident for injury ... the resident had bilateral skin tears over anterior hands that were cleaned and dressed. The body alarm was not in place when resident fell. Body alarm promptly placed, and staff educated on importance of the body alarm ... The note did not include any information related to how staff had positioned the resident in the recliner, whether the recliner feet were elevated and if the resident had the control for the mechanical lift recliner.	{S5028}		

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{S5028}	Continued From page 3 On 3/19/19 upon request to review the investigation for the alleged neglect reported to the state agency regarding the fall on 2/27/19, licensed nurse/operator A provided 3 pages of a document titled Incident Report, an email report to the state agency dated 3/05/19 at 7:27 AM and a response from the state agency to send a copy of the investigation report to a named state employee/manager. Review of the Incident Report revealed pre-typed page(s) with places to be marked if applicable, a section with 4 lines for a witness statement, a section for nurse assessment, notifications and interventions to put in place. The documents did not include the state agency required reporting form, any supporting documents (FCS, NSA/HCS, nursing notes, nursing assessments, physician notification/orders), no written/notarized statements by the staff on duty at the time. The entire document was written in the same handwriting. The section for witness statement identified certified staff B was doing rounds to check on all resident and went into the resident room and found him/her face first on the floor. The notation did not include any information about when the resident was placed in the recliner, how the resident was positioned in the recliner and whether the resident had the control for the mechanical lift recliner. The intervention included licensed nurse/operator A counseled staff, home health and hospice providers on making sure the body alarm was in place at all times. The reporting email dated 3/05/19 at 7:27 AM (6 days after the incident) included 1 paragraph with approximately the same information as in the nursing note and the state agency did not receive	{S5028}		

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{S5028}	Continued From page 4	{S5028}		

a final investigation report within 5 working days as required and no summary to include if the allegation was substantiated or not.

Observation on 3/19/19 at 2:35 PM revealed certified staff C and D entered the resident's room to provide care. The resident rested in bed, was able to help staff when turning from side to side and used the bed rail to hold on to. He/she had movement of his/her legs and crossed the right foot over the left ankle. He/she had full movement of his/her arms/hands. The recliner in the room facing the TV was a mechanical lift chair and the controller laid on the floor but within possible reach should the resident be in the recliner. The recliner had a pocket on the right side of the chair.

Interview with certified staff C on 3/19/19 at 2:35 PM revealed he/she was not on duty at the time of the incident. He/she said the control for the lift chair was usually put in the pocket after staff raised the feet for the resident to recline. He/she confirmed the resident could reach the control within the pocket and probably from the floor.

Interview on 3/19/19 at 3:39 PM with licensed nurse/operator A confirmed he/she did not complete and/or have evidence of a thorough investigation into this incident of alleged neglect. He/she confirmed not analyzing or determining how staff positioned the resident in the recliner, how staff found the recliner if it was in the upright position (lifted) and whether the cognitively impaired resident had access to the control for the mechanical lift chair. He/she confirmed no final report of an investigation was sent to the state agency.

Licensed nurse/operator A failed to report an

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{S5028}	Continued From page 5 incident of possible neglect within 24 hours as required, failed to have evidence of a thorough investigation for this resident's fall reported as possible neglect and failed to submit the investigation report to the state agency within 5 days as required. - Record review for resident #1163 revealed an admission date of 2/21/19 with diagnoses of CVA (cerebral vascular accident-stroke), hemiparesis, seizure disorder, hyperlipidemia and hyperthyroidism. The admission functional capacity screen (FCS) dated 2/21/19 identified the resident with short-term and long-term memory deficit, impaired memory recall and decision making. He/she needed physical assistance with bathing and dressing, supervision with toileting and independent to transfer and walk. He/she was at risk for falls with no assistive devices and had wandering behavior. The fall risk assessment dated 2/21/19 had a score of 10 with 10 or above represents a high risk. The negotiated service agreement/health care service (NSA/HCS) dated 2/18/19 indicated staff would provide 1 staff assist with bathing and dressing and the resident was independent with transfers and mobility. The resident required routine night checks, bed in lowest position had not fallen but was at risk. An amendment dated 2/25/19 indicated staff would toilet the resident every 2 hours. Review of the certified staff care tool (no date) revealed staff to assist the resident with bathing and dressing, toilet every 2 hours and identified	{S5028}		

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{S5028}	Continued From page 6	{S5028}		

the resident with a risk for falls. Additional information included resident was mostly non-verbal and not understandable when he/she does speak. He/she wanders around to exits and doors - monitor for elopement risk ... he/she would have separation anxiety from family after visits.

Review of the nursing notes revealed an entry by licensed nurse/operator A dated 3/08/19 at 10:15 PM - staff called this nurse to inform him/her of the resident being very unsteady on his/her feet and trying to continuously walk around. Staff expressed concern for the resident falling. The nurse spoke with a family member who declined evaluation at the emergency room and indicated the resident had a urinary tract infection (UTI) in the past when he/she had these symptoms. The nurse asked for a family member to come stay with the resident for his/her safety and directed staff to try to obtain a urine sample for testing. The note indicated family arrived within 30 minutes and stayed the night.

The next note dated 3/09/19 at 10:00 AM indicated staff called licensed nurse/operator A at 9:18 AM to report finding the resident on the floor next to his/her bed. Staff checked on the resident 10 minutes prior and noted him/her to be asleep in the bed. The nurse came to the facility and evaluated the resident for injury and noted he/she was still unsteady on his/her feet, agitated and combative. The resident had a skin tear on top of the right side of the head, 2 abrasions on the front of the head, an abrasion above the right eyebrow and one over the right elbow. The note does not indicate whether a family member was present or not. The nurse wrote he/she called a family member to report the fall and the family member did not want the resident to go to the emergency

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{S5028}	Continued From page 7	{S5028}		

room ... later, licensed nurse/operator A called the physician and received order for an antibiotic to treat possible UTI.

On 3/19/19 upon request to review the investigation for the alleged neglect reported to the state agency regarding the fall on 3/09/19, licensed nurse/operator A provided 3 pages of a document titled Incident Report, an email report to the state agency dated 3/11/19 at 4:33 PM (2 days after the incident).

Review of the Incident Report revealed pre-typed page(s) with places to be marked if applicable, a section with 4 lines for a witness statement, a section for nurse assessment, notifications and interventions to put in place. The documents did not include the state agency required reporting form, any supporting documents (FCS, NSA/HCS, nursing notes, nursing assessments, physician notification/orders), no written/notarized statements by the staff on duty at the time. The section for witness statement identified certified staff C wrote he/she went in to check on the resident and he/she was on the floor, very unsteady on his/her feet, was lying down prior to incident. The incident report indicated the fall happened on 3/09/19 at 9:15 AM. The report section for when was resident last seen/checked was blank. The report did not indicate when the resident was last toileted, had something to eat or drink or provision of any other care needs.

Observation on 3/19/19 at 1:30 PM revealed the resident ambulated about the facility independently with a steady gait. At 3:37 PM the resident walked independently with certified staff C following him/her to the resident's room and directed him/her to the bathroom. Certified staff C needed to provide verbal cueing and hand guide

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{S5028}	Continued From page 8 maneuvering for the resident to sit on the toilet. Interview on 3/19/19 at 3:39 PM with licensed nurse/operator A confirmed he/she did not complete and/or have evidence of a thorough investigation into this incident of alleged neglect. Licensed nurse/operator A failed to report an incident with possible neglect within 24 hours as required and failed to have evidence of a thorough investigation for this resident's fall reported as possible neglect.	{S5028}		
{S5155} SS=D	26-42-204 (a) Health Care Services (a) The administrator or operator in each home plus shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-42-204 (a) The facility reported a census of 8 residents. The sample included 3 residents. Based on observation and record review licensed nurse/operator A failed to provide or coordinate the provision of necessary health care services to meet the needs of each resident and in accordance with the functional capacity screening and the negotiated service agreement for 2 of 3	{S5155}		

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{S5155}	Continued From page 9 sampled residents (#1163 and #1201) regarding elopement risk. Findings included: - Record review for resident #1163 revealed an admission date of 2/21/19 with diagnoses of CVA (cerebral vascular accident-stroke), hemiparesis, seizure disorder, hyperlipidemia and hyperthyroidism. The admission functional capacity screen (FCS) dated 2/21/19 identified the resident with short-term and long-term memory deficit, impaired memory recall and decision making. He/she needed physical assistance with bathing and dressing, supervision with toileting and independent to transfer and walk. He/she was at risk for falls with no assistive devices and had wandering behavior. The elopement risk assessment dated 2/21/19 identified the resident with impaired cognition and oblivious to his/her own safety needs with a history of wandering. The resident moved independently without assistive devices, not in acceptance of facility placement and wanted to go home. The resident had separation anxiety from family and will try to follow them out the door. The negotiated service agreement/health care service (NSA/HCS) dated 2/18/19 indicated staff would provide 1 staff assist with bathing and dressing and the resident was independent with transfers and mobility. The resident required routine night checks, bed in lowest position had not fallen but was at risk and had wandering behavior. The section for management of behavioral symptoms was marked with pre-typed	{S5155}		

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{S5155}	Continued From page 10 standard interventions of redirection, distraction or music therapy, management of elopement risk/monitor doors and exits, orient to person/place/time as needed. The NSA/HSP did not address the resident's desire to go home and that he/she had separation anxiety and would attempt to follow family out the door with need for increased staff supervision following family visits. An amendment dated 2/25/19 indicated staff would toilet the resident every 2 hours. Review of the certified staff care tool (no date) revealed staff to assist the resident with bathing and dressing, toilet every 2 hours and identified the resident with a risk for falls. Additional information included resident was mostly non-verbal and not understandable when he/she does speak. He/she wanders around to exits and doors - monitor for elopement risk ... he/she would have separation anxiety from family after visits (these interventions were not included in the NSA/HCS). Review of the nursing notes revealed licensed nurse/operator A wrote on 2/21/19 at 1:00 PM resident admitted today from a behavioral unit. Resident has severe cognitive impairment from a stroke and brain surgery 1 year ago. Resident walks independently and does wander around the facility frequently going to the front door. Resident is unable to focus words or talk in sentences. He/she unable to follow or comprehend commands ... no agitated or aggressive behaviors at this time but does get frustrated when he/she realizes the doors are locked. On 2/25/19 at 4:30 PM licensed nurse/operator A wrote resident starting to settle in ... continues to wander and an elopement risk. He/she goes to the front and back doors frequently to check if the doors are locked ...	{S5155}		

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{S5155}	Continued From page 11 Frequent observations on 3/19/19 between 1:30 PM and 3:45 PM revealed the resident ambulated and wander aimlessly about the facility independently with a steady gait. Interview on 3/19/19 at 3:39 PM with licensed nurse/operator A confirmed the NSA/HCS only identified the residents wandering behavior and did not have specific interventions for the resident to address the attempts at the doors, separation anxiety and following family out the door after visits. He/she confirmed the certified staff care tool was not part of the health care service plan or the resident's record but merely a quick guide for staff to use. Licensed nurse/operator A failed to provide or coordinate the provision of necessary health care services to meet the needs of each resident and in accordance with the functional capacity screening and the negotiated service agreement for the resident regarding elopement risk.	{S5155}		