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 _____	03/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RL DODGE CITY I, LLC	2800 6TH STREET DODGE CITY, KS 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) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey at the above named assisted living facility conducted on 3/26,27/2018.	S 000		
S5015 SS=F	26-42-101(c) Administration Position Description (c) Administrator and operator position description. Each licensee shall adopt a written position description for the administrator or operator that includes responsibilities for the following: (1) Planning, organizing, and directing the home; (2) implementing operational policies and procedures for the home; and(3) authorizing, in writing, a responsible employee who is 18 years old or older to act on the administrator ' s or operator's behalf in the absence of the administrator or operator. This REQUIREMENT is not met as evidenced by: KAR-26-42-101 (c)(3) The facility reported a census of 8 residents. The sample included 3 residents. Based on interview the facility failed to have written authorization of a responsible employee 18 years old or older to act on the administrator's/operator's behalf in their absence. Findings included: - During an interview on 3/27/18 at 8:00 AM administrative nursing staff A reported that operator B was still the current operator since he/she just completed the operators course. Staff A did not think they had anything in writing stating that he/she was authorized to make	S5015		

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

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S5015	Continued From page 1 decision on the operators behalf. At approximately 9:00 AM administrative nursing staff A provided a typed note and reported he/she spoke with operator B and was told to type up something and staff B would signed it when he/she arrived at the facility today. The facility failed to have written authorization of a responsible employee 18 years old or older to act on the behalf of the operator in his/her absence.	S5015		
S5105 SS=E	26-42-202 (a) Negotiated Service Agreement a) The administrator or operator of each home plus shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-42-202(a)(1)(2) The facility reported a census of 8 residents. The sample included 3 residents. Based on interview	S5105		

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S5105	Continued From page 2 and record review the operator failed to ensure designated staff included podiatry services the resident received and who provided that service for 2 (#327 and #328) of 3 residents. Findings included: - Review of resident # 327's record revealed an admission dated of 8/13/17 with diagnoses of hyperlipidemia, chronic renal failure, chronic heart failure, chronic obstructive pulmonary disease, prostate cancer with bone metastasis, and hypertension. Review of the resident's functional capacity screen dated 8/13/17 revealed the resident needed assistance with bathing and dressing and had impaired vision. Review of the negotiated service agreement dated 8/13/17 lacked identification the resident received podiatry services and who provided that service. - Review of resident # 328's record revealed an admission dated of 9/1/17 with diagnoses of hypothyroidism, arthritis, macular degeneration, type 2 diabetes, and diverticulosis. Review of the functional capacity screen dated 8/21/17 revealed the resident required supervision with bathing and was independent in other activities of daily living. Review of the negotiated service agreement dated 8/21/17 revealed it lacked identification the resident received podiatry services and who provided that service. During an interview on 3/27/18 at 9:20 AM	S5105		

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S5105	Continued From page 3 administrative nursing staff A stated both residents (#327 and #328) should have had podiatry services and who provided the service on their negotiated service agreement. The operator failed to ensure designated staff included podiatry service and who provided the service in the negotiated service agreement.	S5105		
S5192 SS=F	26-42-206 (e) Food Preparation (e) Food shall be prepared using safe methods that conserve the nutritive value, flavor, and appearance and shall be served at the proper temperature. (1) Food used by facility staff to serve to the residents, including donated food, shall meet all applicable federal, state, and local laws and regulations.(2) Food in cans that have significant defects, including swelling, leakage, punctures, holes, fractures, pitted rust, or denting severe enough to prevent normal stacking or opening with a manual, wheel-type can opener, shall not be used. (3) Food provided by a resident ' s family or friends for individual residents shall not be required to meet federal, state, and local laws and regulations. This REQUIREMENT is not met as evidenced by: KAR 26-42-206 (e) The facility reported a census of 8 residents. The sample included 3 residents. Based on interview and record review the facility failed to develop a system to ensure foods were cooked and held at the proper temperature.	S5192		

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S5192	Continued From page 4 Findings included: - Observation during tour of the facility on 3/26/18 of the food temperature log for March 2018 revealed 12 out of 25 days lacked evidence staff checked the temperature of the food prior to serving the meal. It also revealed only the main meat had a temperature reading beside it and not the side dishes and cold foods checked prior to serving. Review of the February 2018 temperature log revealed 1 day without the temperature of the main meat food. The February log also did not include the temperatures of any side dishes and cold foods prior to serving. During an interview on 3/26/18 at 3:15 PM administrative nursing staff A reported staff served the food directly from the stove, to the plate, then to the resident. Staff A reported he/she expected staff to temp at least 2 food items each meal. The operator failed to ensure designated staff monitored the temperature of food to ensure staff served it to residents at the proper temperature.	S5192		
S5325 SS=D	26-42-205 (l) Medication Regimen Review Frequency (l) Medication regimen review. A licensed pharmacist or licensed nurse shall conduct a medication regimen review at least quarterly for each resident whose medication is managed by the home and each time the resident experiences any significant change in condition.	S5325		

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S5325	Continued From page 5 This REQUIREMENT is not met as evidenced by: KAR 26-42-205 (l) The facility reported a census of 8 residents. The sample included 3 residents. Based on interview and record review the operator failed to ensure 1 (#327) of 3 residents whose medications were managed by the home had a pharmacist or licensed nurse conduct a medication regimen review at least quarterly. Findings included: - Review of resident # 327's record revealed an admission dated of 8/13/17 with diagnoses of hyperlipidemia, chronic renal failure, chronic heart failure, chronic obstructive pulmonary disease, prostate cancer with bone metastasis, and hypertension. Review of the resident's functional capacity screen dated 8/13/17 revealed the resident could not manage his/her medications and treatments. Review of the negotiated service agreement dated 8/13/17 revealed the homes staff would manage the resident's medications and treatments. Review of the resident's record revealed the pharmacist completed a medication regimen review on 8/16/17, 9/29/17, and 1/13/18. During an interview on 3/26/18 at 3:20 PM administrative nursing staff A reported the home switched pharmacies recently in part because they could not get the pharmacy to come to the	S5325		

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S5325	Continued From page 6 facility. Staff A stated that was the reason for the gap in getting quarterly reviews done between September 2017 and January 2018. The operator failed to ensure a pharmacist completed a medication regimen review quarterly.	S5325		
S5327 SS=E	26-42-205 (l) (2) Medication Regimen Review Variance Report (l) (2) The licensed pharmacist or licensed nurse shall notify the medical care provider upon discovery of any variance identified in the medication regimen review that requires immediate action by the medical care provider. The licensed pharmacist shall notify a licensed nurse within 48 hours of any variance identified in the resident ' s regimen review that does not require immediate action by the medical care provider and specify a time within which the licensed nurse must notify the resident ' s medical care provider. The licensed nurse shall seek a response from the medical care provider within five working days of the medical care provider ' s notification of a variance. This REQUIREMENT is not met as evidenced by: KAR 26-42-205 (l)(2) The facility reported a census of 8 residents. The sample included 3 residents. Based on interview and record review the operator failed to ensure designated staff notified the medical provider of any variance identified in the medication regimen review and failed to receive a response related to the variance for 3 (#326, #327, #328) of 3 residents.	S5327		

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S5327	Continued From page 7 Findings included: - Review of resident # 327's record revealed an admission dated of 8/13/17 with diagnoses of hyperlipidemia, chronic renal failure, chronic heart failure, chronic obstructive pulmonary disease, prostate cancer with bone metastasis, and hypertension. Review of the resident's functional capacity screen dated 8/13/17 revealed the resident could not manage his/her medications and treatments. Review of the negotiated service agreement dated 8/13/17 revealed the homes staff would manage the resident's medications and treatments. Review of the resident's record revealed the pharmacist completed a medication regimen review on 8/16/17, 9/29/17, and 1/13/18. Review of the medication regimen review log revealed on 1/13/18 the pharmacist made recommendations related to metabolic panel (blood testing) and directed staff to see the report for recommendations. Review of the resident's medical record lacked evidence staff notified the medical provider of pharmacist recommendations or got a response from the medical provider related to the recommendations. - Review of resident # 328's record revealed an admission dated of 9/1/17 with diagnoses of hypothyroidism, arthritis, macular degeneration, type 2 diabetes, and diverticulosis.	S5327		

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S5327	Continued From page 8 Review of the functional capacity screen dated 8/21/17 revealed the resident needed supervision to manage medications and treatments. Review of the negotiated service agreement dated 8/21/17 revealed the resident self-administered his/her own medications with some staff supervision. Review of the pharmacy regimen review log revealed on 1/13/18 the pharmacist recommended to decrease the resident's diazepam from 5 milligrams to 2 milligrams at bed time for sleep and directed staff to see report for recommendations. Review of the resident's medical record lacked evidence staff notified the medical provider of pharmacist recommendations or got a response from the medical provider related to the recommendations. - Review of resident #326's record revealed an admission dated of 10/29/17 with diagnoses of hypertension, esophageal reflux, hypothyroidism, anxiety, depression, chronic pain, and constipation. Review of the functional capacity screen dated 10/29/17 revealed the resident could not manage his/her own medications or treatments. Review of the negotiated service agreement dated 10/29/18 revealed the home's staff would manage and administer the resident's medications and treatments. Review of the pharmacy regimen review log revealed on 1/13/18 the pharmacist recommended clarify basic metabolic panel	S5327		

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S5327	Continued From page 9 (blood testing) to be done if not done in the office and directed staff to see the report for recommendations. Review of the resident's medical record lacked evidence staff notified the medical provider of pharmacist recommendations or got a response from the medical provider related to the recommendations. During an interview on 3/27/18 at 8:50 AM administrative nursing staff reported he/she went back through the pharmacist emails and found recommendations attached to a secure document. Staff A stated he/she would sent those recommendations to the medical provider today. The operator failed to ensure designated staff notified the medical provider of any variance identified in the medication regimen review and received a response related to the variance.	S5327		