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 _____	11/28/2023

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 represent the findings of a resurvey for the above named Home Plus facility conducted on 11/27/23 and 11/28/23.	S 000		
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)(3) The facility reported a census of nine residents with three residents included in the sample. Based on interview, and record review the operator failed to ensure the "Negotiated Service Agreement" (NSA) was fully developed on what triggered in the "Functional Capacity Screen" (FCS) for resident (R)101 and R102.	S5105		

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

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S5105	Continued From page 1 Findings included: - R101's medical record revealed the resident moved into the facility on 04/20/19 with diagnoses glaucoma. The 04/10/23 FCS identified R101 sometimes understood others and triggered for wandering. The 04/10/23 NSA did not address R101's communication or wandering. On 11/28/23 at 10:46 AM Administrative Nurse A acknowledged R101's NSA did not address communication or wandering. The operator failed to ensure R101's NSA was fully developed to include all items that triggered in the FCS. - R102's medical record revealed the resident moved into the facility on 10/31/22 with a diagnosis of dementia. The 10/30/23 FCS identified R102 had difficulty with both short-term and long-term memory, memory recall and decision-making, and sometimes understood others. The FCS failed to identify the use of a bed assist device. The 10/30/23 NSA did not address R102's impaired cognition, and communication and did not address the use of a bed assist device. On 11/28/23 at 11:22 AM Administrative Nurse A stated the NSA did not address cognition or communication and did not include anything	S5105		

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S5105	Continued From page 2 concerning the use of a bed assist device. The operator failed to ensure R102's NSA was fully developed to include all items that triggered in the FCS and a description of the services R102 received.	S5105		
S5126 SS=D	26-42-202 (h) NSA Signatures (h) Each individual involved in the development of the negotiated service agreement shall sign the agreement. The administrator or operator shall ensure that a copy of the initial agreement and any subsequent revisions are provided to the resident or the resident's legal representative. This REQUIREMENT is not met as evidenced by: KAR 26-42-202(h) The facility had a census of nine residents. Three residents were included in the sample. The facility failed to ensure each individual involved in the development of the "Negotiated Service Agreement" (NSA) signed the agreement for resident (R)102. Findings included: - R102 admitted to the facility on 10/31/22 with a diagnosis of dementia. The 10/30/23 "Functional Capacity Screen" (FCS) revealed R102 had difficulty with short-term and long-term memory loss,	S5126		

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S5126	Continued From page 3 memory/recall and decision making. The 10/30/23 NSA did not include the signature of the nurse/operator and R102's legal representative. On 11/28/23 at 08:30 AM Administrative Nurse A stated the NSA was not signed by herself or R102's family member. The operator failed to ensure the NSA was signed by all parties involved in the development of the NSA.	S5126		
S5195 SS=F	26-42-206 (f) (g) Facility Food Storage (f) Staff shall store all food under safe and sanitary conditions. Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving. (g) Each home shall maintain at least a three-day supply of food to meet the requirements of the planned menus. This REQUIREMENT is not met as evidenced by: KAR 26-42-206 (f) The facility had a census of nine residents. All nine residents ate food prepared in the same kitchen. The operator failed to ensure food items were stored under safe and sanitary conditions by the failure to ensure foods stored in the refrigerators were kept at 41 degrees Fahrenheit (F) or lower according to Food Safety Guidelines.	S5195		

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S5195	Continued From page 4 Findings included: Review of the 2023 "Fridge/Refrigerator Temperature" log revealed documentation was missing for 11/05/23, 11/12/23, 11/19/23, and 11/26/23. On 11/28/23 at approximately 11:15 AM Administrative Nurse A confirmed there were no refrigerator and freezer temperatures documented for the month of November 2023. According to the Kansas Department of Agriculture "Focus on Food Safety" revised August 2017, "Cold foods must be maintained at an internal temperature of 41F or below." "Date mark foods appropriately, cover foods after completely cooled, cover foods to maintain cold holding temperature." The operator failed to ensure food items were stored under safe and sanitary conditions by failing to document refrigerator/freezer temperatures.	S5195		
S5240 SS=F	26-42-105 (a) Resident Records (a) The administrator or operator of each home plus shall ensure the maintenance of a record for each resident in accordance with accepted professional standards and practices. (1) Designated staff shall maintain the record of each discharged resident who is 18 years of age or older for at least five years after the discharge of the resident. (2) Designated staff shall maintain the record of	S5240		

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S5240	Continued From page 5	S5240		

each discharged resident who is less than 18 years of age for at least five years after the resident reaches 18 years of age or at least five years after the date of discharge, whichever time period is longer.

This REQUIREMENT is not met as evidenced by:
KAR 26-42-105(a)

The facility reported a census of nine residents. The sample included three residents. Based on record review and interview for three sampled residents (R)101, R102, and R103 the operator failed to ensure documentation on residents in accordance with accepted professional standards and practices.

Findings included:

- Review of R101's medical record revealed he was admitted to the facility on 04/20/19 with a diagnosis of glaucoma.

Review of R101's medical records revealed it lacked documentation of nursing notes past 09/05/23. There was no documentation of assessments completed, no vital signs and no updated documentation of R101's fall that occurred on 11/24/23.

On 11/28/23 at 11:11 AM Administrative Nurse A stated she did not have a policy on nursing documentation but was always told to at least complete a monthly nursing note unless there was a significant event. Administrative Nurse A

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S5240	Continued From page 6	S5240		

stated she was behind on her charting.

The operator failed to ensure documentation in R101's medical records were completed in accordance with professional standards and practices.

- Review of R102's medical record revealed she was admitted to the facility on 10/31/22 with a diagnosis of dementia.

Review of R102's medical records revealed the last nursing notes documentation was completed on 07/29/23. There was no documentation of assessments completed, and no vital signs.

On 11/28/23 at 08:30 AM Administrative Nurse A stated vital signs and weights were completed on a weekly basis but kept in a different folder separate from the medical records. Administrative Nurse A stated she completed rounds at least once a week or if a significant event but did not document weekly assessments unless there was a significant event, or the doctor needed to be contacted.

The operator failed to ensure documentation in R102's medical records were completed in accordance with professional standards and practices.

- Review of R103's medical record revealed she was admitted to the facility on 01/20/21 with a diagnosis anxiety.

Review of R103's medical record revealed the last nurses note was documented on 06/15/22. There were no follow-up nursing assessments

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S5240	Continued From page 7 documented since R103 was admitted on 01/20/21 and no vital signs were included in R103's medical records. On 11/28/23 at 11:32 AM Administrative Nurse A stated she did not have a policy on nursing documentation, was told to document a nursing note at least monthly or if there was a significant event. Administrative Nurse A stated she was behind on her charting. The operator failed to ensure documentation in R103's medical records were completed in accordance with professional standards and practices.	S5240		
S5312 SS=E	26-42-205 (g) (2) Medication Labeling (g) (2) Each prescription medication container shall have a label that was provided by a dispensing pharmacist or affixed to the container by a dispensing pharmacist in accordance with K.A.R. 68-7-14. This REQUIREMENT is not met as evidenced by: KAR 26-42-205 (g)(2) The facility reported a census of nine residents. Based on observation and interview the operator failed to ensure each prescription medication container had a label provided by a dispensing pharmacist affixed to the container. Findings included:	S5312		

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S5312	Continued From page 8 - Observation on 11/28/23 at 01:34 PM revealed the facility's medication cart contained the following prescription medications which were not labeled with a resident's full name: Resident (R)104: One bottle of Systane eye drops R101: One bottle of Latanoprost eyedrops One tube of Nystatin Cream The operator failed to ensure each prescription medication container had a label provided by a dispensing pharmacist affixed to the container.	S5312		