STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B070004	A. BUILDING: _____ B. WING _____	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUBLE RANCH	509 WESTERN HEIGHTS OVERBROOK, KS 66524

(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 represent the findings of a resurvey for the above named home plus conducted on 02/26/24.	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)(2) The facility reported a census of seven residents with three included in the sample. Based on interview and record review the administrator failed to ensure the "Negotiated Service Agreements" (NSA) for Residents (R) 1 and R2 described the services provided based on their "Functional Capacity Screens" (FCS) and R2's "NSA" identified an outside provider.	S5105		

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

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S5105	Continued From page 1 Findings included: - Record review for R1 revealed an admission date of 12/12/23 with diagnoses of Alzheimer's disease and hemiplegia affecting right dominant side. The 12/12/23 "FCS" identified R1 was unable to perform management of treatments; had short-term memory, memory/recall, and decision-making cognitive difficulties; was sometimes understandable and usually understood others during communication; and was marked for falls and impaired vision. The 12/12/23 "NSA" for R1 failed to identify the services provided for management of treatments, cognitive difficulties, communication, falls, and impaired vision. - Record review for R2 revealed an admission date of 10/21/21 with a diagnosis of dementia. The 10/02/23 "FCS" identified R2 was marked for falls and impaired vision. The 10/02/23 "NSA" for R2 failed to identify the services provided for falls and impaired vision. The "NSA" further failed to identify the outside hospice provider and describe services they provided. On 02/26/24 at approximately 04:35 PM Administrative Nurse B confirmed R1's "NSA" failed to describe services provided for treatments, cognitive difficulties, communication, falls, and impaired vision. She confirmed R2's	S5105		

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S5105	Continued From page 2 "NSA" failed to describe the services provided for impaired vision and falls. R2 received services provided by hospice which her "NSA" failed to identify and describe. The administrator failed to ensure the "NSA" for R1 and R2 described the services provided based on their "FCS" and R2's "NSA" identified an outside provider.	S5105		
S5215 SS=F	26-42-104 (d) Disaster and Emergency Preparedness Education (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the home ' s emergency management plan; (2) education of each resident upon admission to the home regarding emergency procedures; (3) quarterly review of the home ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-42-104(d)(3) The facility reported a census of seven residents. Based on interview and record review the administrator failed to provide reviews of the	S5215		

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S5215	Continued From page 3 facility's emergency management plan every quarter with staff and residents. Findings included: - Review of the facility's emergency management plan revealed lack of evidence of documentation a review was conducted during the fourth quarter of 2023. On 02/26/24 at approximately 03:49 PM Administrative Staff A confirmed the facility's emergency management plan lacked evidence of documentation a review was completed during the fourth quarter of 2023. The administrator failed to provide quarterly reviews of the facility's emergency management plan with staff and residents.	S5215		