STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B029002	A. BUILDING: _____ B. WING _____	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RL DODGE CITY 2 LLC	2800 6TH AVE STE #2 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 represent the findings of a resurvey for the above named Home Plus facility conducted on 08/14/24 and 08/15/24.	S 000		
S5085 SS=D	26-42-201 (c) Functional Capacity Screen Reassessment (c) Designated staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: 5085 KAR 26-42-201(c)(1) The facility reported a census of 12 residents. The sample included three residents. Based on observation, interview, and record review the operator failed to ensure designated staff completed a "Functional Capacity Screen" (FCS) at least once every 365 days for resident (R)103. Findings included: - R103's medical record revealed she moved into the facility on 05/30/23. The most current FCS available in R101's medical records was dated 05/30/23 with no documentation to show a FCS was completed	S5085		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B029002	A. BUILDING: _____ B. WING _____	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RL DODGE CITY 2 LLC	2800 6TH AVE STE #2 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
S5085	Continued From page 1 since this date. On 08/15/24 at 11:46 AM Administrative Nurse A stated that she had not completed R103's annual FCS within 365 days. The operator failed to ensure designated staff completed a FCS for R103 at least once every 365 days.	S5085		
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: 5105 KAR 26-42-202(a)(1) The facility reported a census of 12 residents with three residents included in the sample. Based on interview, and record review the operator failed to	S5105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B029002	A. BUILDING: _____ B. WING _____	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RL DODGE CITY 2 LLC	2800 6TH AVE STE #2 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
S5105	Continued From page 2	S5105		

ensure the "Negotiated Service Agreement" (NSA) was fully developed based on the resident's "Functional Capacity Screen" (FCS), service needs, and preferences for resident (R)101 and R103.

Findings included:

- R101's medical record revealed he moved into the facility on 08/08/24 with a diagnosis of dementia.

The 08/08/24 FCS identified R101 had difficulty with short-term memory, long-term memory, memory/recall and decision-making.

The 08/08/24 NSA did not address what services staff provided concerning R101's cognitive impairments.

On 08/15/24 at 11:42 AM Administrative Nurse A stated R101's NSA did not address how staff were to address his impaired cognition.

The operator failed to ensure R101's NSA was fully developed to include all items that triggered in the FCS.

- R103's medical record revealed she moved into the facility on 05/30/23 with a diagnosis of Lewy bodies dementia.

The 05/30/23 FCS identified R103 was sometimes understandable when she communicated with others and sometimes understood what others communicated to her.

The 05/30/23 NSA did not address what staff were to do concerning R103's communication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B029002	A. BUILDING: _____ B. WING _____	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RL DODGE CITY 2 LLC	2800 6TH AVE STE #2 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
S5105	Continued From page 3 deficits. On 08/15/24 at 11:46 AM Administrative Nurse A acknowledged the annual NSA did not include what staff were to do concerning R103's communication deficits.. The operator failed to ensure R103's NSA was fully developed to include all items that triggered in the FCS.	S5105		
S5116 SS=D	26-42-202 (d) NSA revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements: (1) At least once every 365 days;(2) following any significant change in condition, as defined in K.A.R. 26-39-100; (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant; and (4) if requested by the resident or the resident ' s legal representative, staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. This REQUIREMENT is not met as evidenced by: 5116 KAR 26-42-202(d)(1) The facility reported a census of 12 residents with three residents included in the sample. Based on interview, and record review the operator failed to ensure the "Negotiated Service Agreement"	S5116		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B029002	A. BUILDING: _____ B. WING _____	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RL DODGE CITY 2 LLC	2800 6TH AVE STE #2 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
S5116	Continued From page 4 (NSA) was review and revised as needed at least once every 365 days for resident (R)103. Findings included: - Record review for resident (R)103 revealed an admission date of 05/30/23. R103's Admission NSA was completed on 05/30/23 and an annual NSA was not completed until 08/15/24. On 08/15/24 at 11:46 AM Administrative Nurse A stated that she completed the annual NSA but not until 08/15/24 and acknowledged that it was not completed within 365 days of the previous NSA. The operator failed to ensure designated staff revised the NSA at least once every 365 days.	S5116		
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: 5126 KAR 26-42-202(h) The facility had a census of 12 residents. Three residents were included in the sample. The operator failed to ensure each individual involved	S5126		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B029002	A. BUILDING: _____ B. WING _____	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RL DODGE CITY 2 LLC	2800 6TH AVE STE #2 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
S5126	Continued From page 5 in the development of the "Negotiated Service Agreement" (NSA) signed the agreement for resident (R)101. Findings included: - R101 admitted to the facility on 08/08/24. The 08/08/24 NSA revealed R101 was severely cognitively impaired, and the NSA was not signed by R101's legal representative. On 08/15/24 at 11:42 AM Administrative Nurse A acknowledged R101's NSA was not signed by his legal representative upon admission. The operator failed to ensure R101's NSA was signed by his legal representative.	S5126		
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.	S5192		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B029002	A. BUILDING: _____ B. WING _____	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RL DODGE CITY 2 LLC	2800 6TH AVE STE #2 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
S5192	Continued From page 6 This REQUIREMENT is not met as evidenced by: 5192 KAR 26-42-206 (e) The facility had a census of 12 residents. All 12 residents ate food prepared in the same kitchen. The operator failed to ensure food items were served at the proper temperature. Findings included: - On 08/14/24 at approximately 12:30 PM during an observation of the kitchen revealed incomplete documentation of food temperatures. Review of the food menus with food temperature documentation revealed the following: The April Menu lacked food temperature documentation for: 04/26/24, 04/28/24, 04/29/24, 04/30/24. The May Menu lacked food temperature documentation for: 05/11/24 - 05/31/24 a total of 21 days. On 08/14/24 at 12:30 PM Administrative Nurse A stated she expected staff to document food temperatures for each meal. According to the Kansas Department of Agriculture "Focus on Food Safety" revised August 2017, hot foods must be maintained at an internal temperature of 135 Fahrenheit (F) or higher and cold foods must be maintained at an internal temperature of 41 F or below. The operator failed to ensure food items were	S5192		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B029002	A. BUILDING: _____ B. WING _____	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RL DODGE CITY 2 LLC	2800 6TH AVE STE #2 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
S5192	Continued From page 7 served at the proper temperature.	S5192		
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: 5195 KAR 26-42-206 (f) The facility had a census of 12 residents. All 12 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. Findings included: - On 08/14/24 at approximately 12:30 PM during an observation of the kitchen revealed the lack of documentation of refrigerator and freezer temperatures. On 08/14/24 at 12:30 PM Administrative Nurse A stated she expected staff to document refrigerator and freezer temperatures on a regular basis.	S5195		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B029002	A. BUILDING: _____ B. WING _____	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RL DODGE CITY 2 LLC	2800 6TH AVE STE #2 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
S5195	Continued From page 8 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." The operator failed to ensure food items were stored under safe and sanitary conditions by failing to document refrigerator/freezer temperatures.	S5195		
S5230 SS=F	26-42-207 (b)(5)(6) (c) Infection Control Policies (b)(5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; (c) Each administrator or operator shall ensure the home ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. This REQUIREMENT is not met as evidenced by: 5320 KAR 26-42-207(c) The facility reported a census of seven residents. Based on interview and record review for three residents and five new employee records, the administrator failed to ensure the facility remained	S5230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B029002	A. BUILDING: _____ B. WING _____	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RL DODGE CITY 2 LLC	2800 6TH AVE STE #2 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
S5230	Continued From page 9	S5230		

in compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in KAR 26-39-105.

Findings included:

- Review of five newly hired staff records revealed the following:
Certified Medication Aide (CMA) B's employee record revealed a hire date of 01/24/24 and provided a TB skin test (TST) dated 12/23/23 from the local health department. The facility failed to ensure a follow-up TST was completed within seven days of employment.

Certified Nurse Aide (CNA) C's employee record revealed a hire date of 03/19/24. A two-step TST was administered on 03/19/24 but failed to read it and failed to ensure the second step of the two-step TB skin test was administered one to three weeks after the first step was completed.

CNA D's employee record revealed a hire date of 06/05/24. CNA D's personnel records documented a TB screening questionnaire was completed on 08/08/24 which was not within seven days of hire, and the facility failed to ensure the first step of the two-step TB skin test was administered within seven days of hire and failed to ensure the second step of the TB skin test was administered 1-3 weeks after the first step was completed.

CNA E's employee record revealed a hire date of 03/29/24. The facility completed a TB symptom screening questionnaire, but it was not dated. The facility failed to ensure the first step of the two-step TB skin test was administered within seven days of hire and failed to ensure the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B029002	A. BUILDING: _____ B. WING _____	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RL DODGE CITY 2 LLC	2800 6TH AVE STE #2 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
S5230	Continued From page 10 second step of the TB skin test was administered 1-3 weeks after the first step was completed. The June 2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented, "Each new resident and new employee shall have an initial TB symptom screen that includes the components of the TB symptom questionnaire within seven days of residency or employment ...Each new ...employee shall receive a two-step TST ...within 7 days of ...employment ...If a new employee provides satisfactory documentation of receiving a single TST within 6 months prior to employment that read not positive, the employee shall only be required to have a single TST within 7 days of employment." The operator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in KAR 26-39-105 regarding newly hired employees.	S5230		
S5258 SS=F	26-42-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff records shall contain the following information: (1) Evidence of licensure, registration, certification, or a certificate of successful completion of a training course for each employee performing a function that requires specialized education or training; (2) supporting documentation for criminal background checks of facility staff and contract staff, excluding any staff licensed or registered by a state agency, pursuant to K.S.A. 39-970 and amendments thereto; (3) supporting documentation from the Kansas	S5258		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B029002	A. BUILDING: _____ B. WING _____	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RL DODGE CITY 2 LLC	2800 6TH AVE STE #2 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
S5258	Continued From page 11	S5258		

nurse aide registry that the individual does not have a finding of having abused, neglected, or exploited a resident in an adult carehome; and (4) supporting documentation that the individual does not have a finding of having abused, neglected, or exploited any resident in an adult care home, from the nurse aide registry in each state in which the individual has been known to work as a certified nurse aide.

This REQUIREMENT is not met as evidenced by:
5258
KAR 26-42-102(d)(1)(2)

The facility reported a census of 12 residents. Based on interview and record review, the operator failed to ensure two of five newly hired employees records included evidence of verification with the nurse aide registry was completed prior to staff employment, and the operator failed to ensure one of five newly hired employee records included evidence a criminal background check was completed in a timely manner.

Findings included:

- Review of employee files conducted on 08/14/24 revealed the following:
Certified Medication Aide (CMA) B was hired on 01/24/24. Documentation revealed a criminal background check was completed by the Kansas Bureau of Investigations (KBI) on 06/25/24, five months after the date of hire.

Certified Nurse Aide (CNA) C was hired on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B029002	A. BUILDING: _____ B. WING _____	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RL DODGE CITY 2 LLC	2800 6TH AVE STE #2 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
S5258	Continued From page 12 03/19/24. Documentation revealed a verification with the nurse aide registry was completed on 04/11/24, 23 days after being hired. CMA G was hired on 03/19/24. Documentation revealed a verification with the nurse aide registry was completed on 04/11/24, 23 days after being hired. The operator failed to ensure verification with the nurse aide registry were completed prior to staff employment and criminal background checks of newly hired staff were completed in a timely manner.	S5258		
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: 5312 KAR 26-42-205 (g)(2) The facility reported a census of 12 residents. Based on observation the operator failed to ensure each prescription medication container had a label provided by a dispensing pharmacist affixed to the container. Findings included: - Observation on 08/14/24 at 12:02 PM revealed	S5312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B029002	A. BUILDING: _____ B. WING _____	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RL DODGE CITY 2 LLC	2800 6TH AVE STE #2 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
S5312	Continued From page 13 the medication cart contained the following prescription medication containers which were not labeled with a resident's full name: Resident (R)105: Two Albuterol Sulfate Inhalation Aerosol inhalers One tube of Fluocinonide Cream R106: One bottle of Systane Lubricant Eye Drops R108: One Albuterol Sulfate Inhalation Aerosol R109: One bottle of Fluticasone Propionate nasal spray One tube of Clotrim/Betameth cream The operator failed to ensure each prescription medication container had a label provided by a dispensing pharmacist affixed to the container.	S5312		
S5313 SS=E	26-42-205 (g) (3) Over the counter medication (g) (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and the medication container.	S5313		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B029002	A. BUILDING: _____ B. WING _____	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RL DODGE CITY 2 LLC	2800 6TH AVE STE #2 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
S5313	Continued From page 14 This REQUIREMENT is not met as evidenced by: 5313 KAR 26-42-205(g)(3) The facility reported a census of 12 residents. Based on observation the operator failed to ensure a licensed pharmacist or licensed nurse placed the full name of the resident on the original package of over-the-counter medications. Findings included: - Observation on 08/14/24 at 12:02 PM revealed the medication cart contained the following over-the counter medications which were not labeled with a resident's full name: Resident (R)101: One bottle of Good Neighbor Pharmacy Vitamin D3 One bottle of Nature's Truth B-12 1,000 micrograms One bottle of Tylenol PM R104: One bottle of Equate Stool Softener Two bottles of Equate Pain Reliever One large bottle of Equate Pain Reliever R105: Two large bottle of Kroger Vitamin C 500 milligrams. R107: One bottle of Equate Advanced Eye Health Complex	S5313		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B029002	A. BUILDING: _____ B. WING _____	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RL DODGE CITY 2 LLC	2800 6TH AVE STE #2 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
S5313	Continued From page 15 The following medications were labeled as "Stock" medications: One bottle of Equate Allergy Relief One bottle of Good Neighbor Pharmacy Melatonin The operator failed to ensure all over-the-counter medications were labeled with the resident's full name.	S5313		