| 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 _____ | 10/01/2024 |

| 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<br><br>The following citations represent the findings of a resurvey with complaints (#190876 and #190507) at the above named home plus facility conducted on 10/01/24. | S 000 | | |
| S5080 SS=D | 26-42-201 (a) (b) Functional Capacity Screen on Admission<br><br>(a) On or before each individual ' s admission to a home plus, a licensed nurse, a licensed social worker, or the administrator or operator shall conduct a screening to determine the individual ' s functional capacity and shall record all findings on a screening form specified by the department. The administrator or operator may integrate the department ' s screening form into a form developed by the home, which shall include each element and definition specified by the department.<br>(b) A licensed nurse shall assess any resident whose functional capacity screening indicates the need for health care services.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-42-201 (a)<br><br>The census equaled 10 residents. The sample included 3 residents. Based on observation, record review and interview for 1 of 3 sampled Residents (R)3, the facility failed to ensure designated facility staff conducted a screening on or before admission to the assisted living facility to determine the resident's functional capacity. | S5080 | | |

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 |
|---|---|---|---|
| | B029001 | A. BUILDING: _____ B. WING _____ | 10/01/2024 |

| 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 |
|---|---|---|---|---|
| S5080 | Continued From page 1<br><br>Findings included:<br><br>- R3's "Medical Record" revealed she admitted to the facility on 12/15/23 with diagnoses of dementia and arthritis.<br><br>The "Functional Capacity Screen" (FCS) dated 12/15/23 recorded the resident required physical assistance with bathing and toileting and had impaired short-term and long-term memory, impaired memory/ recall and impaired decision making.<br><br>The "FCS" failed to address dressing, transfer, walk/ mobility, eating, meal preparation, transportation, shopping, use of telephone, laundry, housekeeping, management of medications and medical treatment, money management, bladder incontinence, communication, current or recent problems and risks, mobility appliances/ devices and support.<br><br>The resident's "Negotiated Service Agreement/ Health Care Services" dated 12/15/23 recorded facility staff provided encouragement with eating, administered medications and provided weekly fingernail care. The "NSA/Health Care Services" failed to address bathing, dressing, toileting, transfer, walk/ mobility, incontinence, management of fall risk and management of behavioral symptoms.<br><br>Interview on 10/01/24 at 02:13 PM with Licensed Nurse B confirmed R3's FCS was not completed fully upon admission.<br>Observation on 10/01/24 at 11:00 AM revealed R3 wandering around the facility and ambulating by self. | S5080 | | |

| 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 _____ | 10/01/2024 |

| 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 |
|---|---|---|---|---|
| S5080 | Continued From page 2<br><br>Facility's "Nursing Functional Capacity Screen & Negotiated Service Agreement with Care Plan Policy" (no date) recorded, "On or before each individual's admission, a licensed nurse, a licensed social worker, or the administrator or operator shall conduct a screening to determine the individual's functional capacity and shall record all findings on a screening form specified by the department."<br><br>The facility failed to ensure designated facility staff conducted a screening on or before admission to the assisted living facility to determine the resident's functional capacity for R3. | S5080 | | |
| S5085 SS=E | 26-42-201 (c) Functional Capacity Screen Reassessment<br><br>(c) Designated staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements:<br>(1) At least once every 365 days;<br>(2) following any significant change in condition as defined in K.A.R. 26-39-100; and<br>(3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-42-201 (c) (1)<br><br>The census equaled 10 residents. The sample included 3 residents. Based on record review and interview, the facility failed to ensure designated facility staff conducted a screening at least once every 365 days to determine each resident's | S5085 | | |

| 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 _____ | 10/01/2024 |

| 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 |
|---|---|---|---|---|
| S5085 | Continued From page 3 | S5085 | | |

functional capacity for Resident (R)1 and R2.

Findings included:

- R1's "Medical Record" revealed she admitted to the facility on 03/17/22 with diagnoses of diabetes mellitus type II, hypoxia, congestive heart failure and atrial fibrillation.

R1's most recent "Functional Capacity Screen" (FCS) dated 03/17/22 recorded the resident was independent with eating and management of medications and treatments and required physical assistance with bathing, dressing, toileting, transfers and walk/mobility. The FCS further recorded R1 was continent of urine and used a walker and wheelchair for mobility.

R1's "Medical record" lacked completion of a FCS since admission on 03/17/22.

Interview on 10/01/24 at 02:13 PM with Licensed Nurse (LN) B confirmed the record lacked a FCS every 365 days for R1 and further confirmed R1 currently required physical assistance from staff for management of medications and treatments, was at risk for falls/ unsteadiness and used a lift for transfers.

- R2's "Medical Record" revealed she admitted to the facility on 01/20/20 with diagnoses of depression and GI upset.

R2's most recent "Functional Capacity Screen" (FCS) dated 01/10/22 recorded the resident was independent with transfer, walk/ mobility and eating, required physical assistance required for bathing, dressing, toileting, and was unable to manage medications and treatments. The FCS recorded R2 was occasionally incontinent, had

| 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 _____ | 10/01/2024 |

| 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 |
|---|---|---|---|---|
| S5085 | Continued From page 4<br>impaired short-term and long-term memory, impaired memory/ recall and impaired decision making. R2 usually understandable/ sometimes understood, was at risk for falls/ unsteadiness and was socially inappropriate/ disruptive behaviors.<br><br>R2's "Medical record" lacked completion of a FCS since 01/10/22.<br><br>Interview on 10/01/24 at 02:13 PM with Licensed Nurse (LN) B confirmed the record lacked a FCS every 365 days for R2.<br><br>Facility's "Nursing Functional Capacity Screen & Negotiated Service Agreement with Care Plan Policy" (no date) recorded, "(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."<br><br>The facility failed to ensure designated facility staff conducted a screening at least once every 365 days to determine each resident's functional capacity for R1 and R2. | S5085 | | |
| S5105 SS=D | 26-42-202 (a) Negotiated Service Agreement<br><br>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 | S5105 | | |

| 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 _____ | 10/01/2024 |

| 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 |
|---|---|---|---|---|
| S5105 | Continued From page 5<br>following information:<br>(1) A description of the services the resident will receive;<br>(2) identification of the provider of each service; and<br>(3) identification of each party responsible for payment if outside resources provide a service.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-42-202 (a) (1) (2) (3)<br><br>The facility reported a census of 10 residents. The sample included 3 residents. Based on record review and interview for 1 sampled resident (R)1, Operator/ Licensed Nurse (LN) A failed to ensure the Negotiated Service Agreement (NSA) completed for residents who required health care services identified a description of the services the resident received, identified the provider of each service and identified each party responsible for payment if outside resources provided a service.<br><br>Findings included:<br><br>- R1's "Medical Record" revealed she admitted to the facility on 03/17/22 with diagnoses of diabetes mellitus type II, hypoxia, congestive heart failure and atrial fibrillation.<br><br>R1's most recent "Functional Capacity Screen" (FCS) dated 03/17/22 recorded the resident was independent with eating and management of medications and treatments and required physical assistance with bathing, dressing, toileting, transfers and walk/mobility. The FCS further recorded R1 was continent of urine and used a walker and wheelchair for mobility. | S5105 | | |

| 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 _____ | 10/01/2024 |

| 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 |
|---|---|---|---|---|
| S5105 | Continued From page 6<br><br>The resident's most recent "Negotiated Service Agreement/ Health Care Servies" dated 03/17/22 recorded facility staff assisted R1 with bathing, dressing, toileting and administered medications and treatments and further recorded assistance of two staff was provided to get R1 out of bed and assistance of one staff was provided any other time. The "NSA/Health Care Services" recorded R1 was ambulatory and used a walker and wheelchair.<br><br>A "Amended Negotiated Service Agreement/ Health Service Plan" dated 06/29/22 recorded R1 was able to get out of bed by self and sit in wheelchair, toilet self and assistance of one staff member was needed for showers.<br><br>The NSA lacked description of services provided by physical therapy, the provider of services and party responsible for payment of services.<br><br>Signed physician's order dated 08/27/24 recorded home health physical therapy to evaluate and treat R1 for back pain.<br><br>Interview on 10/01/24 at 02:13 PM with Licensed Nurse (LN) B confirmed R1's NSA lacked a description of services provided by physical therapy, the provider of physical therapy and party responsible for payment of physical therapy.<br><br>Facility's "Negotiated Service Agreement/ Health Care Plan Policy" dated 2014 recorded, "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." | S5105 | | |

| 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 _____ | 10/01/2024 |

| 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 |
|---|---|---|---|---|
| S5105 | Continued From page 7<br><br>Operator/ LN A failed to ensure the NSA completed for residents who required health care services identified a description of the services the resident received, identified the provider of each service and identified each party responsible for payment if outside resources provided a service. | S5105 | | |
| S5116 SS=E | 26-42-202 (d) NSA revisions<br><br>(d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements:<br>(1) At least once every 365 days;(2) following any significant change in condition, as defined in K.A.R. 26-39-100;<br>(3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant; and<br>(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.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-42-202 (d) (1)<br><br>The facility reported a census of 10 residents. The sample included 3 residents. Based on record review and interview for 2 Residents (R)1 and R2, Operator/ Licensed Nurse (LN) A failed to ensure the review, and if necessary, revision of the Negotiated Service Agreement (NSA) at least once every 365 days. | S5116 | | |

| 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 _____ | 10/01/2024 |

| 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 |
|---|---|---|---|---|
| S5116 | Continued From page 8<br><br>Findings included:<br><br>- R1's "Medical Record" revealed she admitted to the facility on 03/17/22 with diagnoses of diabetes mellitus type II, hypoxia, congestive heart failure and atrial fibrillation.<br><br>R1's most recent "Functional Capacity Screen" (FCS) dated 03/17/22 recorded the resident was independent with eating and management of medications and treatments and required physical assistance with bathing, dressing, toileting, transfers and walk/mobility. The FCS further recorded R1 was continent of urine and used a walker and wheelchair for mobility.<br><br>R1's most recent "Negotiated Service Agreement/ Health Care Services" dated 03/17/22 recorded facility staff assisted R1 with bathing, dressing, toileting and administered medications and treatments and further recorded assistance of two staff was provided to get R1 out of bed and assistance of one staff was provided any other time. The "NSA/Health Care Services" recorded R1 was ambulatory and used a walker and wheelchair. No home health agency was listed as providing cares.<br><br>A "Amended Negotiated Service Agreement/ Health Service Plan" dated 06/29/22 recorded R1 was able to get out of bed by self and sit in wheelchair, toilet self and assistance of one staff member was needed for showers.<br><br>Record lacked a NSA completed since 03/17/22.<br><br>Interview on 10/01/24 at 02:13 PM with LN B confirmed R1's records lacked a NSA completed at least once every 365 days and further | S5116 | | |

| 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 _____ | 10/01/2024 |

| 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 |
|---|---|---|---|---|
| S5116 | Continued From page 9 | S5116 | | |

confirmed the current NSA was not accurately reflected for walk/mobility and the use of an outside provider.

Interview and observation on 10/01/24 at 01:19 PM revealed two certified staff members reposition R1 in her recliner. R1 stated facility staff assisted her with bathing dressing, toileting and transfer. R1 stated she was unable to walk and used the wheelchair or sit to stand lift with staff assistance.

- R2's "Medical Record" revealed she admitted to the facility on 01/20/20 with diagnoses of depression and GI upset.

R2's most recent "Functional Capacity Screen" (FCS) dated 01/10/22 recorded the resident was independent with transfer, walk/ mobility and eating, required physical assistance required for bathing, dressing, toileting, and was unable to manage medications and treatments. The FCS recorded R2 was occasionally incontinent, had impaired short-term and long-term memory, impaired memory/ recall and impaired decision making. R2 usually understandable/ sometimes understood, was at risk for falls/ unsteadiness and was socially inappropriate/ disruptive behaviors.

R2's "Negotiated Service Agreement/ Health Care Services" dated 01/10/22 recorded one facility staff assisted with bathing, dressing, toileting, cut up food and administered medications and treatments. The "NSA/ Health Care Services" further recorded R2 was independent with transfer and walk/ mobility, was occasionally incontinent and redirection, distraction and re-orientation was used by facility staff.

| 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 _____ | 10/01/2024 |

| 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 |
|---|---|---|---|---|
| S5116 | Continued From page 10<br>Record lacked a NSA completed since 01/10/22.<br><br>Interview on 10/01/24 at 02:13 PM with LN B confirmed R2's records lacked a NSA completed at least once every 365 days.<br><br>Facility's "Nursing Functional Capacity Screen & Negotiated Service Agreement with Care Plan Policy" (no date) recorded, "Each administrator or operator shall ensure the review, and if necessary, revision of each negotiated service agreements according to the following requirements: (1) At least once every 365 days."<br><br>Operator/ LN A failed to ensure the review, and if necessary, revision of the Negotiated Service Agreement (NSA) at least once every 365 days for R1 and R2. | S5116 | | |
| S5192 SS=E | 26-42-206 (e) Food Preparation<br><br>(e) Food shall be prepared using safe methods that conserve the nutritive value, flavor, and appearance and shall be served at the proper temperature.<br>(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.<br>(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 |
|---|---|---|---|
| | B029001 | A. BUILDING: _____ B. WING _____ | 10/01/2024 |

| 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 |
|---|---|---|---|---|
| S5192 | Continued From page 11<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-42-206 (e)<br><br>The census equaled 10 residents. The sample included 3 residents. Based on record review, interview and observation for all residents living in the facility and receiving meal services, Operator/ Licensed Nurse (LN) A failed to ensure the facility staff served food at the proper temperature.<br><br>Findings included:<br><br>- During the initial tour of the facility's kitchen on 10/01/24 at 11:08 AM with LN B, facility food temperature monitoring logs were requested and "September 2024 Menu" was obtained from LN B.<br><br>Record lacked breakfast, lunch and dinner food temperatures for the following dates: 09/01/24, 09/16/24, 09/18/24, 09/19/24, 09/20/24, 09/21/24, 09/23/24, 09/25/24, 09/26/24, 09/28/24, 09/29/24 and 09/30/24.<br><br>Interview on 10/01/24 with LN B confirmed food temperature monitoring logs were not completed daily.<br><br>Interview on 10/01/24 at 02:48 PM with LN confirmed all ten residents eat meals at the facility.<br><br>Observation on 10/01/24 at 12:15 PM revealed residents eating lunch time meal in the dining room of the facility.<br><br>Kansas Department of Agriculture Food Safety guidelines records hot food must be maintained | S5192 | | |

| 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 _____ | 10/01/2024 |

| 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 |
|---|---|---|---|---|
| S5192 | Continued From page 12<br>at a temperature of 135 degrees Fahrenheit or above, cold foods at 41 degrees Fahrenheit or below.<br><br>Facility's "3.12 Infection/ Exposure Control Policy" (no date) recorded, "Staff will check and record internal temperatures no a log prior to serving coked food to residents. The log will be kept in the kitchen at all times."<br><br>For all residents of the facility, Operator/ LN A failed to ensure facility staff served food at the proper temperature. | S5192 | | |
| S5195 SS=E | 26-42-206 (f) (g) Facility Food Storage<br><br>(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.<br>(g) Each home shall maintain at least a three-day supply of food to meet the requirements of the planned menus.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-42-206 (f)<br><br>The census equaled 10 residents. The sample included 3 residents. Based on record review, interview and observation for all residents receiving meal services, Operator/ Licensed Nurse (LN) A failed to ensure the facility staff stored all food under safe and sanitary conditions.<br><br>Findings included: | S5195 | | |

| 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 _____ | 10/01/2024 |

| 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 |
|---|---|---|---|---|
| S5195 | Continued From page 13<br>- Observation during the initial tour on 10/01/24 at 11:08 AM revealed a kitchen containing food/drinks.<br><br>Observation of the "fridge/ freezer temperature log" revealed the following dates were missing temperature recordings for September 2024: 09/07/24, 09/08/24, 09/22/24, 09/25/24.<br><br>Interview on 10/01/24 with LN B confirmed the September 2024 temperature monitoring logs were missing the above dates.<br><br>Observation of the pantry in the kitchen revealed one cereal box, which was not sealed.<br><br>Interview on 10/01/24 with LN B confirmed food was to be sealed once opened.<br><br>Facility's "3.12 Infection/ Exposure Control Policy" (no date) recorded, "Thermometers will be used to maintain appropriate temperatures in refrigeration and freezing. Staff will check and record refrigerator and freezer temperatures once daily and note and adjustment required."<br><br>For all residents of the facility, Operator/ LN A failed to ensure the facility staff stored all food under safe and sanitary conditions. | S5195 | | |
| S5215 SS=F | 26-42-104 (d) Disaster and Emergency Preparedness Education<br><br>(d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following:<br>(1) Orientation of new employees at the time of employment to the home ' s emergency management plan; | S5215 | | |

| 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 _____ | 10/01/2024 |

| 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 |
|---|---|---|---|---|
| S5215 | Continued From page 14<br>(2) education of each resident upon admission to the home regarding emergency procedures;<br>(3) quarterly review of the home ' s emergency management plan with employees and residents; and<br>(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.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-42-104 (d) (3) (4)<br><br>The census equaled 10 residents. The sample included 3 residents and review of 5 newly hired employee records. Based on record review and interview, Operator/ Licensed Nurse (LN) A failed to ensure disaster and emergency preparedness by ensuring the performance of quarterly review of the facility's entire "Emergency Management Plan" with residents and staff and an annual emergency drill with staff and residents to include an evacuation of the residents to a secure location.<br><br>Findings included:<br><br>- Review of the facility "Emergency Management Plan" revealed the plan contained procedures to manage potential emergencies and disasters including fire, flood, severe weather, tornado, explosion, natural gas leak, lack of electrical, or water service, and missing residents.<br><br>Facility failed to provide quarterly reviews of the emergency management plan with residents and staff for the first quarter of 2024. | S5215 | | |

| 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 _____ | 10/01/2024 |

| 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 |
|---|---|---|---|---|
| S5215 | Continued From page 15<br><br>Facility failed to perform an annual emergency drill since last survey conducted with all residents and the minimum number of staff on duty at one time that included an evacuation of all residents to a secure location.<br><br>Interview on 10/01/24 at 12:57 PM with Licensed Nurse (LN) B confirmed unable to locate an emergency management plan review completed with residents and staff for the first quarter of 2024 and further confirmed unable to locate an emergency drill conducted with all residents and the minimum number of staff at one time.<br><br>Operator/ LN A failed to ensure disaster and emergency preparedness by the failure to ensure the performance of quarterly reviews of the facility's entire emergency plan with residents and staff and an annual emergency drill with staff and residents to include an evacuation of the residents to a secure location. | S5215 | | |
| S5230 SS=F | 26-42-207 (b)(5)(6) (c) Infection Control Policies<br><br>(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;<br>(6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting;<br>(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. | S5230 | | |

| 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 _____ | 10/01/2024 |

| 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 |
|---|---|---|---|---|
| S5230 | Continued From page 16<br><br>This REQUIREMENT is not met as evidenced by:<br>K.A.R 26-42-207 (c)<br><br>The census totaled 10 residents. The sample included 3 residents and review of 5 newly hired employees. Based on record review and interview for 3 of 3 sampled Residents (R)1, R2 and R3 and 4 of 5 sampled staff (Certified Medication Aide (CMA) C, CMA D, Certified Nurse Aide (CNA) E and CNA F, the facility failed to ensure compliance with the State Agency's tuberculosis (TB) guidelines.<br><br>Findings included:<br><br>- R1's "Health Record" revealed she admitted to the facility on 03/17/22 and the record lacked completion of an annual TB questionnaire completed since 03/17/22.<br><br>R2's "Health Record" revealed she admitted to the facility on 01/20/20 and the record lacked completion of an annual TB questionnaire completed since 02/28/22.<br><br>R3's "Health Record" revealed she admitted to the facility on 12/15/23. R3's first step of TB testing was administered on 12/15/23 and read 12/30/23, fifteen days later. R3's record lacked completion of a TB questionnaire completed on admission.<br><br>- Review of CMA C's employee record revealed they hired onto the facility on 01/27/24. CMA C's first step of TB testing and TB questionnaire was completed on 08/30/24, approximately 7 months | S5230 | | |

| 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 _____ | 10/01/2024 |

| 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 |
|---|---|---|---|---|
| S5230 | Continued From page 17<br>after being hired by the facility.<br><br>- Review of CMA D's employee record revealed they hired onto the facility on 07/19/24. CMA D's first step of TB testing was completed on 09/13/24, approximately 2 months after being hired by the facility. CMA D's TB questionnaire was completed on 08/21/24, approximately 1 month after being hired.<br><br>- Review of CNA E's employee record revealed they hired onto the facility on 01/25/24. CNA E's first step of TB testing was completed on 08/18/24, approximately 7 months after being hired by the facility.<br><br>- Review of CNA F's employee record revealed they hired onto the facility on 06/11/24. CNA F's record lacked completion of TB testing upon hire. CNA F's TB questionnaire was completed on 08/21/24, approximately 2 months after being hired.<br><br>Interview on 10/01/24 at 01:00 PM with Licensed Nurse (LN) B confirmed TB testing was not completed upon hire for CMA C, CMA D, CNA E and CNA F.<br><br>Interview on 10/01/24 at 02:13 PM with LN B confirmed TB testing was no completed correctly upon hire for R3 and further confirmed record lacked completion of an annual TB questionnaire for R1 and R2 since 2022.<br><br>Facility's "Tuberculosis Testing Policy and Procedure" policy (no date) recorded, "[Facility name] shall skin test all new residents and employees as soon as the residency or employment begins (within 7 days) using the 2-step tuberculin skin test or blood assay for | S5230 | | |

| 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 _____ | 10/01/2024 |

| 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 |
|---|---|---|---|---|
| S5230 | Continued From page 18<br><br>Mycobacterium tuberculosis (BAMT) ... Procedure for Tuberculin Skin Testing: a.) The first skin test shall be read within 48-72 hours of its administration ...The second skin test shall be read within 48-72 hours of its administration. Any skin test not read within 72 hours shall be repeated."<br><br>The facility failed to ensure compliance with the State Agency's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105, which had the potential to affect all residents. | S5230 | | |
| S5245 SS=F | 26-42-105 (b) Resident Records Confidential<br><br>(b) Each administrator or operator shall ensure that all information in each resident's record, regardless of the form or storage method for the record, is kept confidential, unless release is required by any of the following:<br>(1) Transfer of the resident to another health care facility;<br>(2) law;<br>(3) third-party payment contract; or<br>(4) the resident or legal representative of the resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-42-105 (b)<br><br>The census equaled 10 residents. The sample included 3 residents. Based on interview and observation for all residents, Operator/ License Nurse (LN) A failed to ensure that all information | S5245 | | |

| 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 _____ | 10/01/2024 |

| 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 |
|---|---|---|---|---|
| S5245 | Continued From page 19<br>in each resident's record, regardless of the form or storage method for the record, is kept confidential.<br><br>Findings included:<br><br>- On 10/01/24, Licensed Nurse (LN) B provided a "Resident Roster", which included 10 residents. Four residents were noted as wander risks.<br><br>Observation during the initial tour on 10/01/24 at 11:23 AM revealed 10 unsecured resident records in a cabinet in the hallway of the facility. The records were easily accessed.<br><br>Interview on 10/01/24 at 11:23 AM with LN B confirmed the records were unsecured.<br><br>Facility's "Policy and Procedure Notice Privacy Dissemination" (no date) recorded, "The nursing facility is required to: maintain the privacy of your health information."<br><br>For all residents of the facility, Operator/ LN A failed to ensure that all information in each resident's record, regardless of the form or storage method for the record, is kept confidential. | S5245 | | |
| S5251 SS=E | 26-42-105 (f) (11) Resident Records Documentation of Incidents<br><br>(f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action. | S5251 | | |

| 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 _____ | 10/01/2024 |

| 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 |
|---|---|---|---|---|
| S5251 | Continued From page 20<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-42-105 (f) (11)<br><br>The census totaled 10 residents. The sample included 3 residents and 2 focused record review residents. Based on record review and interview for 2 focused record review residents (R)4 and R5, Operator/Licensed Nurse (LN) A failed to ensure documentation of all incidents, and indications of illness or injury including date, time of occurrence, action taken and results of the action.<br><br>Findings included:<br><br>- Review of R4's medical record revealed she admitted to the facility on 02/08/22 with diagnosis of hypertension, dyspnea, glaucoma, major depressive disorder and osteoarthritis.<br><br>R4's most recent "Functional Capacity Screen" (FCS) dated 02/08/22 recorded the resident was independent with eating, required physical assistance with bathing, dressing, toileting, transfer and walk/ mobility, and was unable to perform management of medications and treatments. The FCS recorded the resident was occasionally incontinent, had short and long-term memory impairment, memory/recall impairment, impaired decision making and was sometimes understandable/ sometimes understood communication. The FCS further recorded the resident was at risk for falls/unsteadiness, had impaired vision, and used a wheelchair and walker for mobility.<br><br>Record lacked a FCS completed annually since 02/08/22. | S5251 | | |

| 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 _____ | 10/01/2024 |

| 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 |
|---|---|---|---|---|
| S5251 | Continued From page 21<br><br>R4's most recent "Negotiated Service Agreement/ Health Care Services" dated 02/08/22 recorded facility staff assisted with bathing, dressing, toileting, transfer, walk/mobility, eating and administered medications. Facility staff completed routine night checks and reoriented R1 to person, place and time as needed.<br><br>Record lacked a Negotiated Service Agreement completed since 02/08/22.<br><br>Review of R4's "Incident Report" dated 01/08/24 revealed she fell onto her left side while transferring from wheelchair to chair with certified staff.<br><br>Record lacked documentation of a nurse assessment at the time of the fall, parties notified including family and physician, injuries sustained from the fall, interventions/ treatment plan to prevent fall from reoccurring and results of interventions implemented.<br><br>Interview on 10/01/24 at 02:50 PM with LN B confirmed there was no documentation from a licensed nurse after R4 fell that included full assessment of R4, parties notified, injuries and interventions or treatment plan. LN B further confirmed she was unable to verify if a licensed nurse assessment R4 at the time of her fall.<br><br>- Review of R5's medical record revealed she admitted to the facility on 01/20/21 with diagnosis of chronic back pain, anxiety, depression and restless leg syndrome.<br><br>R5's most recent "Functional Capacity Screen" (FCS) dated 01/15/23 recorded the resident was independent with dressing, toileting, transfer, | S5251 | | |

| 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 _____ | 10/01/2024 |

| 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 |
|---|---|---|---|---|
| S5251 | Continued From page 22 | S5251 | | |

walk/ mobility and eating, required supervision with bathing and was unable to perform transfer and management of medications and treatments. The FCS recorded the resident had short and long-term memory impairment, memory/recall impairment, impaired decision making and was sometimes understandable/ usually understood communication. The FCS further recorded the resident was at risk for wandering and was socially inappropriate/ disruptive behavior. The FCS identified R5 used a walker for mobility.

Record lacked a FCS completed annually since 01/15/23.

R5's most recent "Negotiated Service Agreement/ Health Care Services" dated 01/15/23 recorded the resident received physical assistance with bathing and medication and treatment administration. The "Negotiated Service Agreement/ Health Care Services" further recorded facility staff redirected, distracted, managed elopement risk/ monitored doors and exits and reoriented R5.

Record lacked a Negotiated Service Agreement completed since 01/15/23.

Review of R5's "Incident Report" dated 01/10/24 revealed she had an unwitnessed fall in her room.

Record lacked documentation of nurse assessment at the time of the fall, parties notified including family and physician, injuries sustained from the fall, interventions/ treatment plan to prevent fall from reoccurring and results of interventions implemented.

Interview on 10/01/24 at 02:50 PM with LN B confirmed there was no documentation from a

| 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 _____ | 10/01/2024 |

| 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 |
|---|---|---|---|---|
| S5251 | Continued From page 23<br>licensed nurse after R5 fell that included a full assessment of R5, parties notified, injuries and interventions or treatment plan. LN B further confirmed she was unable to verify if a licensed nurse assessment R5 at the time of her fall.<br><br>Facility's "3.20 Resident Fall Procedure" policy (no date) recorded, "in the event of a resident fall, the aide will immediately contact a nurse. If the fall occurs after business hours a [facility name] on call nurse is contacted. The aide will remain with the resident in the position the resident was found, while the nurse asks the aide questions regarding the fall. If the resident has hit their head the nurse will complete an on-site assessment to determine if further attention is needed. If the resident shows indication of any pain or injury, the nurse will either complete an on-site assessment or may directly send the resident to the hospital. After the assessment the nurse will give the aide further instructions as needed ... the nurse will notify the resident's family and primary care provider of any fall at the time of occurrence."<br><br>Operator/LN A failed to ensure designated staff documented all incidents, symptoms, and other indications of illness including the date and time of occurrence, action taken, and results of the action. | S5251 | | |
| S5300 SS=F | 26-42-205 (d) (1-2) Facility Administration of Medications<br><br>(d) Home administration of resident ' s medications. If a home is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care | S5300 | | |

| 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 _____ | 10/01/2024 |

| 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 |
|---|---|---|---|---|
| S5300 | Continued From page 24<br>provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met:<br>(1) Only licensed nurses and medication aides shall administer and manage medications for which the home has responsibility.<br>(2) Medication aides shall not administer medication through the parenteral route.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-42-205 (d)<br><br>The census equaled 8 residents. The sample included 3 residents. Based on record review and interview for 3 Residents (R)1, R2 and R3, Operator/Licensed Nurse (LN) A failed to ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider's written order.<br><br>Findings included:<br><br>- R1's "Medical Record" revealed she admitted to the facility on 03/17/22 with diagnoses of diabetes mellitus type II, hypoxia, congestive heart failure and atrial fibrillation.<br><br>R1's most recent "Functional Capacity Screen" (FCS) dated 03/17/22 recorded the resident was independent with management of medications and treatments.<br><br>The resident's most recent "Negotiated Service Agreement/ Health Care Services" dated 03/17/22 recorded facility staff administered | S5300 | | |

| 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 _____ | 10/01/2024 |

| 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 |
|---|---|---|---|---|
| S5300 | Continued From page 25 | S5300 | | |

medications and treatments.

Review of R1's September 2024 medication administration record (MAR) revealed the following:

"All Day Relief 220 mg [milligrams] 1 tablet by mouth once daily; Aspirin [nonsteroidal anti-inflammatory drug] enteric coated 81 mg by mouth once daily; Docusate Sodium [stool softener] 100 mg by mouth 2 times a day; Eliquis [blood thinner] 5 mg by mouth 2 times a day; Escital Opram 5 mg by mouth every day; Ferosul [supplement] 325 mg by mouth once daily, Furosemide [diuretic] 40 mg by mouth every morning; Hydrochlorothiazide [diuretic] 25 mg by mouth once daily; Metformin [diabetic drug] 1,000 mg by mouth 2 times a day; Oxygen with concentrator 2 liters continuous; Simvastatin 20 mg by mouth once daily and Vitamin D3 1,000 units take 2 tablets by mouth daily." Medications signed off as administered daily from 09/01/24 through 09/30/24.
"Lorazepam [benzodiazepine] 1 mg by mouth at bedtime as needed" and "MiraLAX [laxative] 1 capful in liquid and drink by mouth daily as needed."
"Methocarbamol [muscle relaxant] 750 mg by mouth 3 times a day as needed." Medication signed off as administered on 09/01/24, 09/04/24, 09/05/24, 09/09/24, 09/10/24, 09/11/24. 09/12/24, 09/13/24, 09/14/24, 09/15/24, 09/16/24, 09/17/24, 09/20/24, 09/23/24, 09/26/24 and 09/29/24.

Record lacked current signed physician orders for the above listed medications.

Interview on 10/01/24 at 02:13 PM with LN B confirmed she did not have current signed physician orders for the above listed medications

| 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 _____ | 10/01/2024 |

| 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 |
|---|---|---|---|---|
| S5300 | Continued From page 26<br>in R1's "Medical Record."<br><br>The September 2024 MAR further recorded, "Tramadol 50 mg by mouth every 6 hours as needed." Medication was signed off as administered twice on 09/29/24 and once on 09/30/24.<br><br>"Physician Order Sheet" dated 08/23/24 recorded, "Hold Tramadol for now."<br><br>- R2's "Medical Record" revealed she admitted to the facility on 01/20/20 with diagnoses of depression and GI upset.<br><br>R2's most recent "Functional Capacity Screen" (FCS) dated 01/10/22 recorded the resident was unable to manage medications and treatments.<br><br>The resident's most recent "Negotiated Service Agreement/ Health Care Services" dated 01/10/22 recorded one facility staff administered R2's medications and treatments.<br><br>Review of R2's September 2024 medication administration record (MAR) recorded the following:<br>"Aspirin [nonsteroidal anti-inflammatory drug] enteric coated 81 mg [milligrams] by mouth every day with food and Vitamin C [supplement] 500 mg by mouth every day." Medications signed off as administered daily by certified staff on 09/12/24, 09/16/24, 09/21/24 and 09/22/24. Medication was not administered all other days in September.<br><br>Record lacked current signed physician orders for the above listed medications.<br><br>Interview on 10/01/24 at 02:13 PM with LN B confirmed she did not have current signed | S5300 | | |

| 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 _____ | 10/01/2024 |

| 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 |
|---|---|---|---|---|
| S5300 | Continued From page 27 | S5300 | | |

physician orders for the above listed medications in R2's "Medical Record."

- R3's "Medical Record" revealed she admitted to the facility on 12/15/23 with diagnoses of dementia and arthritis.

The "Functional Capacity Screen" (FCS) dated 12/15/23 failed to identify level of needs for management of medications and treatments.

The resident's "Negotiated Service Agreement/ Health Care Services" dated 12/15/23 recorded facility staff administered R3's medications.

Review of R3's September 2024 medication administration record (MAR) recorded the following:
"Lorazepam 1 mg [milligram] by mouth 3 times a day; Melatonin [supplement] 10 mg by mouth daily; and Quetiapine 25 mg by mouth daily."
Lorazepam and Melatonin were signed off as administered daily from 09/01/24 through 09/30/24. Quetiapine was signed off as administered daily from 09/19/24 through 09/30/24.

Record lacked current signed physician orders for the above listed medications.

Interview on 10/01/24 at 02:13 PM with LN B confirmed she did not have current signed physician orders for the above listed medications in R3's "Medical Record."

Facility's "3.14 Medication Administration Policy" (no date) recorded, "All medications that are administered by the home will be administered in accordance with the medical care provider's written order."

| 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 _____ | 10/01/2024 |

| 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 |
|---|---|---|---|---|
| S5300 | Continued From page 28<br><br>Operator/LN A failed to ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider's written order. | S5300 | | |