

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B046083	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/24/2025
NAME OF PROVIDER OR SUPPLIER ROCOCO HEALTHCARE SERVICES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 741 N NELSON ROAD OLATHE, KS 66061		
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S 000	INITIAL COMMENTS The following represents the findings of a resurvey with attached complaint 187265, 188361, and 193902 at the above named home plus facility conducted on 04/24/25.	S 000		
S5029 SS=F	26-42-101 (g) Availability of policies and procedures (g) Availability of policies and procedures. Each administrator or operator shall ensure that policies and procedures related to resident services are available to staff at all times and are available to each resident, legal representatives of residents, case managers, and families during normal business hours. A notice of availability shall be posted in a place readily accessible to residents. This REQUIREMENT is not met as evidenced by: KAR 26-42-101(g) The facility reported a census of 12 residents. Based on observation and interview the administrator failed to ensure a notice of the availability of the facility's policies and procedures was posted in a place accessible to all residents. Findings included: - Observation on 04/24/25 at approximately 09:02 AM during the initial tour revealed an availability notice of the facility's policies and procedures was not posted. On 04/24/25 at approximately 12:15 PM	S5029		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S5029	Continued From page 1 Administrative Staff A confirmed a notice of the availability of the facility's policies and procedures was not posted. The administrator failed to ensure a notice of the availability of the facility's policies and procedures was posted in a place accessible to all residents.	S5029		
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) The facility reported a census of 12 residents with three included in the sample. Based on interview, observation, and record review the administrator failed to ensure the Negotiated	S5105		

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S5105	Continued From page 2 Service Agreement (NSA) for Residents (R)1 and R2 described the services they received based on their Functional Capacity Screens (FCS). Findings included: - Record review for R1 revealed an admission date of 03/12/24 with a diagnosis of dementia. The 03/09/25 FCS identified R1 was unable to perform bathing, dressing, toileting, transfers, walking/mobility, eating, and management of medications and treatments; was incontinent of bladder; had short term memory, long term memory, memory/recall, and decision-making difficulties; was rarely or never understood or understandable with communication; and was marked at risk for falls. The 03/13/23 (most recent) Negotiated Service Agreement/Health Care Service Plan is the facility's combined NSA/HSP which documented staff provided complete assistance with bathing, dressing, toileting, transfers, and walking/mobility; offered choices for dressing and meals, offered choices, cues and reminders throughout the day, redirection and engagement for cognition; administered medications and treatments; and staff assisted with transfers to reduce falls. The NSA/HSP failed to describe the services she received for eating and communication. Observation on 04/24/25 at 12:48 PM R1 was assisted to eat every bite by CNA B. On 04/24/25 at approximately 01:30 PM CNA B stated R1 responded verbally on occasion and to	S5105		

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S5105	Continued From page 3 communicate with her staff talks close to her ear. - Record review for R2 revealed an admission date 11/20/23 with diagnoses of neurocognitive disorder with Lewy bodies, depression, anxiety, and insomnia. The 11/04/24 FCS identified R2 required supervision with eating, transfers, and walking/mobility; was unable to perform bathing, dressing, toileting, or management of medications and treatments; was incontinent; had difficulty with short term memory, long term memory, memory/recall, and decision making; was sometimes understood and sometimes could understand when communicating; and had a problem of wandering, falls, and impaired decision making. The 11/04/24 NSA failed to describe the services he received for eating, communication, or wandering. Observation on 04/24/25 at 12:21 PM Certified Nurse Aide (CNA) B repeated self twice when talking to resident. Observation on 04/24/25 at 12:48 PM R2's visitor assisted to eat by putting food on fork, giving cues, and prompting for next bite or drink. Observation on 04/24/25 at 01:25 PM Administrative Staff A asked R2 twice if he wanted to walk. She talked to R2 by getting close to ear and speaking clearly. On 04/24/25 at approximately 01:28 PM CNA B stated R2 requires questions or prompts	S5105		

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S5105	Continued From page 4 repeated multiple times most of the time. CNA B stated that when R2 wanders, staff questions his needs. On 04/24/25 at approximately 02:02 PM Administrative Staff A confirmed R1 and R2's NSAs failed to describe the services provided based on their FCS. The facility's "Negotiated Service Agreement and Health Services Plan Policy and Procedures" dated 10/20/22 explained each resident would have an NSA developed according to the FCS including services that meet the resident's needs. The administrator failed to ensure the NSA for R1 and R2 described the services provided based on their 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.	S5116		

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S5116	Continued From page 5 This REQUIREMENT is not met as evidenced by: KAR 26-42-202(d)(1) The facility reported a census of 12 residents with three residents included in the sample review. Based on interview and record review, the administrator failed to ensure designated staff reviewed and if necessary, revised the "Negotiated Service Agreement" (NSA) for Resident (R)1 every 365 days. Findings included: - Record review for R1 revealed an admission date of 03/12/24 with a diagnosis of dementia. The 03/09/25 Functional Capacity Screen (FCS) identified R1 was unable to perform bathing, dressing, toileting, transfers, walking/mobility, eating, and management of medications and treatments; was incontinent of bladder; had short term memory, long term memory, memory/recall, and decision-making difficulties; was rarely or never understood or understandable with communication; and was marked at risk for falls. The 03/13/23 (most recent) Negotiated Service Agreement/Health Care Service Plan (NSA/HSP) is the facility's combined NSA/HSP which documented staff provided complete assistance with bathing, dressing, toileting, transfers, and walking/mobility; offered choices for dressing and meals for cognition; administered medications and treatments; and staff assisted with transfers to reduce falls.	S5116		

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S5116	Continued From page 6 The NSA/HSP failed to describe the services she received for eating and communication. R1's record lacked evidence of documentation of an NSA since 03/13/23 which was 406 days prior to survey. On 04/24/25 at approximately 12:42 PM Administrative Staff A confirmed R1's record lacked evidence of documentation an NSA/HSP was completed at least every 365 days. The facility's "Negotiated Service Agreement and Health Services Plan Policy and Procedures" dated 10/20/22 explained the NSA will be developed at least every 365 days. The administrator failed to ensure designated staff reviewed and if necessary, revised the NSA for R1 every 365 days.	S5116		
S5190 SS=F	26-42-206 (d) Dietary Services (d)(1) Menu plans shall be available to each resident on at least a weekly basis. This REQUIREMENT is not met as evidenced by: KAR 26-42-206(d)(1) The facility reported a census of 12 residents. Based on observation and interview, the administrator failed to ensure the menu was available to all residents on at least a weekly basis.	S5190		

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S5190	Continued From page 7 Findings included: - Observation on 04/24/25 at 09:31 AM revealed a weekly menu was not made available to all residents. On 04/24/25 at 09:33 AM Administrative Staff A confirmed a weekly menu was not made available to all residents. The facility's "Dietary Services Policy and Procedures" dated 10/20/23 explained that menus were posted for resident viewing at least a week at a time. The administrator failed to ensure a weekly menu was available to all residents.	S5190		
S5195 SS=F	26-42-206 (f) (g) Facility Food Storage (f) Staff shall store all food under safe and sanitary conditions. Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving. (g) Each home shall maintain at least a three-day supply of food to meet the requirements of the planned menus. This REQUIREMENT is not met as evidenced by: KAR 26-42-206(f) The facility reported a census of 12 residents. The facility had a kitchen where food was stored, prepared, and served to all residents. Based on	S5195		

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S5195	Continued From page 8 observation and interview the administrator failed to ensure food items were stored under safe conditions. Findings included: - Observation on 04/24/25 at 09:10 AM revealed two refrigerators in the kitchen contained food items for all residents. Refrigerator space number one contained the following food items: One opened 44-ounce bottle of Heinz ketchup, undated. One opened 10-ounce bottle of Great Value sweet relish, undated Three squeeze containers of Daisy sour cream with best by date 09/29/24. Four eight-ounce packages of Philadelphia cream cheese with best by date 02/15/25. One bottle of Sunsweet prune juice, opened 03/31/25 with label that read to discard ten days after opening. Refrigerator space number two contained the following food items: One bottle of Daiya blue cheese dressing with best by date 03/09/25. One package of Member's Mark 160 slice American cheese, undated, unsealed, and parts were hard and discolored. On 04/24/25 at approximately 09:33 AM Administrative Staff A verified food items were undated, unsealed and/or past date of use. The facility's "Dietary Services Policy and Procedures" dated 10/20/23 explained that foods	S5195		

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S5195	Continued From page 9 were stored under safe conditions. The August 2024 Kansas Department of Agriculture's "Focus on Food Safety" booklet page 21 documented foods must be marked with use by date if commercially processed and the original container is opened. Foods may be held under refrigeration for seven days once opened. The administrator failed to ensure food items were stored under safe conditions.	S5195		
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)(4) The facility reported a census of 12 residents. Based on interview and record review the	S5215		

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S5215	Continued From page 10 administrator failed to ensure disaster and emergency preparedness by ensuring an annual evacuation drill was completed and quarterly review of the facility's emergency management plan with all staff and residents for the first quarter of 2025. Findings included: - Record review on 04/24/25 revealed the lack of documentation of facility's emergency management plan with residents and staff for the first quarter of 2025. - Record review of on 04/24/25 revealed the lack of documentation of facility's evacuation since last survey in 2023. On 04/24/25 at approximately 09:52 AM Administrative Staff A confirmed reviews of the facility's emergency management plan with staff and residents was not conducted in the first quarter of 2025, and a full evacuation was not conducted since last survey. The facility's "Disaster Preparedness" policy dated 10/20/23 explained the policies and procedures were reviewed with residents quarterly. The operator conducted an annual evacuation drill with staff and resident which includes evacuation of residents to a secure location. The administrator failed ensure disaster end emergency preparedness by ensuring an annual evacuation drill was completed and quarterly review of the facility's emergency management plan with all staff and residents.	S5215		

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S5245 SS=F	26-42-105 (b) Resident Records Confidential (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: (1) Transfer of the resident to another health care facility; (2) law; (3) third-party payment contract; or (4) the resident or legal representative of the resident. This REQUIREMENT is not met as evidenced by: KAR 26-42-105(b) The facility reported a census of 12 residents with three included in the sample. Based on interview and record review the administrator failed to ensure all information in each resident's record was kept confidential. Findings included: - Observation on 04/24/25 at 09:05 AM revealed an open closet including medical records for all residents. On 04/24/25 at approximately 09:22 AM Administrative Staff A confirmed the closet door is left open and not locked which includes the residents' medical records. The administrator failed to ensure all information	S5245		

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S5245	Continued From page 12 in each resident's record was kept confidential.	S5245		
S5315 SS=F	26-42-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the home in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the home in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the home. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration.	S5315		

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S5315	Continued From page 13 This REQUIREMENT is not met as evidenced by: KAR 26-42-205(h)(1) The facility reported a census of 12 residents. Based on observation and interview the administrator failed to ensure facility staff stored non-controlled medications within a locked medication room, cabinet, or medication cart. Findings included: - Observation on 04/24/25 at 09:05 AM revealed an open closet including a refrigerator which stored medications for residents. Inside the refrigerator were four boxes of unopened latanoprost 0.0005%, 2.5 milliliter eye drop medications and two zippered bags of bisacodyl 10 milligram, five suppositories. On 04/24/25 at approximately 09:22 AM Administrative Staff A confirmed the closet door is left open and not locked which includes a refrigerator that stores refrigerated medications. The facility's Medication Storage Policy and Procedures" implemented 02/02/23 explained all non-controlled medications were stored in the medication room, cabinet, or cart under a single lock. The administrator failed to ensure facility staff stored non-controlled medications within a locked medication room, cabinet, or medication cart.	S5315		

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S5335	Continued From page 14	S5335		
S5335 SS=F	28-39-437 Construction (a) Each home-plus facility shall be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public. (b) All new construction, renovation, remodeling, and changes in building use in existing buildings shall comply with building and fire codes, ordinances, and regulations enforced by city, county, and state jurisdictions, including the state fire marshal. This REQUIREMENT is not met as evidenced by: KAR 28-39-437(a) The facility reported a census of 12 residents. Based on observation and interview the administrator failed to ensure the building was maintained to protect the health and safety of the residents by ensuring all chemicals were stored within a locked area. Findings included: - Observation on 04/24/25 at approximately 09:02 AM revealed the laundry door was unlocked. A one-gallon container of laundry detergent was on the floor and read, "Keep out of reach of children." Observation on 04/24/25 at 12:32 PM revealed Certified Nurse Aide D entered laundry without using key. Laundry detergent located on floor. On 04/24/25 at 09:20 AM Administrative Staff A confirmed chemical was not in a locked area and	S5335		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B046083	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/24/2025
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(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
S5335	Continued From page 15 her expectation was for the door to be locked. The administrator failed to ensure the building was maintained to protect the health and safety of the residents by ensuring all chemicals were stored within a locked area.	S5335		