Kansas Department on Aging

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 _____	04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RL DODGE CITY 1 LLC	2800 6TH AVENUE 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 an abbreviated survey with review of facility reports #194916 and 198453 at the above home plus conducted on 04/07/26 and 04/08/26.	S 000		
S5026 SS=J	26-42-101 (f) (1) Staff Treatment of residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: 5026 KAR 26-42-101(f)(1)B) The facility reported a census of seven residents with four residents identified as at risk for wandering. Based on observation, record review and interview, the Operator failed to ensure the safety of residents who had severe cognitive impairment when care staff left a spray bottle of cleaning chemical on the countertop in the main kitchen unsecured. On 04/03/2026, Resident (R) 102 ingested an unknown amount of cleaning chemical from a bottle that was left unsecured and unmonitored by facility staff . R102 required hospital treatment which placed the resident in	S5026		

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

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S5026	Continued From page 1 immediate jeopardy. Findings included: - Review of R102's medical record revealed that he moved into the facility on 12/08/23 with a diagnosis of dementia (a progressive mental disorder characterized by failing memory, and confusion.) Review of R102's "Functional Capacity Screen" (FCS) dated 07/13/25 revealed R102 was independent with transfers and mobility and had impaired short-term memory, impaired long-term memory, impaired memory recall, and impaired decision-making abilities. R102 was sometimes able to make himself understood and he sometimes understood others. R102 was marked for wandering. Review of R102's combined "Negotiated Service Agreement" (NSA) / "Health Care Services Plan" (HCSP) dated 07/13/25 documented staff provided redirection or distraction and removed R102 from situations if able. Review of R102's "Amended Negotiated Service Agreement" dated 08/08/25 documented for safety of resident secondary to dementia, no lock on room door, kitchen access will be limited by the use of safety gates as well as a safety latch to the knife drawer and chemical cabinet, the laundry room will have keypad entry, exit door codes will not be given to the resident. Review of the undated facility "Witness Statement" completed and signed by "Certified	S5026		

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S5026	Continued From page 2	S5026		

Medication Aide" (CMA) B documented that she had just redirected R102 from trying to take down a chair from the dining room table. While she was guiding R102 somewhere else another resident with an alarm had gotten up, CMA B went to assist that resident to sit down and looked back at R102 and observed him drinking the cleaning chemical. CMA B rushed over to R102 and removed the cleaning chemical into the kitchen and proceeded to call the nurse on call.

Review of the facility provided, surveillance system dated/timed, video footage revealed the following events, which occurred on 04/03/26:
At 05:05 PM "Certified Medication Aide" (CMA) B obtained a spray bottle of cleaning solution from the kitchen counter near the door leading to the back storage room. CMA B cleaned an area on the bar countertop where a resident had sat and then left the spray bottle on the upper counter in front of the main kitchen sink.

At 06:15 PM "Certified Nurse Aide" (CNA) D obtained the spray bottle from the bar counter by the sink and proceeded to the dining room table and sprayed the table to clean it.

At 06:17 PM CMA F was observed wiping the dining room table using the bottle of cleaning solution that was left on the dining table.

At 06:22 PM CMA F placed the spray bottle on the corner of the bar counter closest to the medication cart.

At 07:37 PM R102 sat at the bar counter with the spray bottle located near him. Both CNA D and

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S5026	Continued From page 3 CNA E were in the vicinity but did not ensure the spray bottle was secured out of the reach of R102. At 08:28 PM R102 took the spray bottle over to the bar countertop by the sink and took the sprayer mechanism off the bottle and started to reach over the counter and appeared to try and get something from the dish drainer located next to the main kitchen sink. CNA E moved the dish drainer out of the reach of R102 but failed to notice and remove the opened spray bottle of cleaning solution that was directly in front of R102. At 08:30 PM R102 picked up the spray bottle and took it to the dining room table and proceeded to try and remove a chair from the top of the table. At 08:32 PM CMA B was seen assisting another resident in the living room within view of the dining room when she witnessed R102 drinking from the opened chemical spray bottle. CMA B rushed over to R102 and took the bottle from him and proceeded to call the on-call nurse to report the incident. Review of the facility provided video footage revealed the bottle of cleaning solution was unsecured for a total of 3.5 hours with only intermittent use by staff. On 04/07/26 at 11:29 AM CMA B stated she saw the spray bottle of cleaning solution was left out but did not think much about it. CMA B stated that it was an expectation that staff stored chemicals in a locked cabinet under the kitchen sink or in a locked cabinet in a locked storage	S5026		

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S5026	Continued From page 4	S5026		

room. CMA B also stated it was the expectation that staff had possession of chemicals at all times when using them but had witnessed staff leave cleaning chemicals unattended if they had to attend to a resident needing assistance.

Review of R102's hospital records revealed R102 was brought to the Emergency Department after ingesting approximately one and a half ounces of cleaning solution. R102 was noted to be tachycardic (increased heart rate) and agitated and was administered an antianxiety medication, after which R102 became hypoxic (low blood oxygen level) and was admitted to the hospital for observation with telemetry.

On 04/07/26 at 04:00 PM Administrative Nurse A stated it was her expectation that chemicals be stored in a locked cabinet when not being used or in staff possession when in use.

Review of the undated "Policy for Barriers to Access" documented regulation required staff to lock any cabinet, drawer or door that could hold items that may be harmful to residents. There are locks on the knife drawer, chemical cabinets, medication cabinets and laundry rooms.

On 04/08/26 at 04:09 PM Administrative Nurse/Operator was notified that R102 had been placed in immediate jeopardy on 04/03/26 when care staff failed to properly secure or be in possession of a toxic cleaning chemical when they left the bottle within reach of R102.

The removal plan was accepted on 04/08/26 at 04:38 PM and included the following interventions:

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S5026	Continued From page 5 Teachable Moment sent out on the communication application "Band App" to all employees on April 6, 2026. All staff to read and sign in acknowledgement of teachable moment. New chemical storage policy initiated. Staff members immediately involved received 1:1 counseling related to unsecured chemicals. Mandatory staff meeting set for Thursday, April 9th to present findings of the investigation. Present teachable moment and ensure all staff have signed the form in acknowledgement. Present new Chemical Storage Policy.	S5026		