STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175207	A. Building B. Wing	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunporch of Dodge City	501 W Beeson Road Dodge City, KS 67801

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 40 residents with four residents included in the sample. Based on observation, interview and record review, the facility failed to ensure one resident, Resident (R) 1 was assessed for safety related to bed rail use. Additionally, the facility failed to obtain or provide evidence of informed consent from R1 or his representative prior to the use of bed rails. Findings included:R1's Electronic Health Record (EHR) documented diagnoses that included vascular dementia (a progressive mental disorder characterized by failing memory and confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), delirium (sudden severe confusion, disorientation, and restlessness) and major depressive disorder (MDD - a major mood disorder that causes persistent feelings of sadness). R1's 12/30/25 Annual Minimum Data Set (MDS) documented that a Brief Interview of Mental Status (BIMS) interview could not be completed because the R1 is never or rarely understood. The staff assessment documented memory problems and severely impaired cognition. R1's 12/30/25 Cognitive Loss/Dementia Care Area Assessment (CAA) documented severe cognitive impairment and memory problems. R1's Care Plan, reviewed 03/17/26, documented R1 had an alteration in musculoskeletal status related to broken bones in the left wrist/forearm, and on 02/09/26, the facility replaced R1's bed to be one without bed rails, initiated on 02/13/26. R1?s EHR under the Assessments tab revealed no risk assessment for bed rail use since his admission to the facility on [DATE]. On 03/17/26 at 10:20 AM, R1 rested in a Geri-chair (a recliner on wheels that can be pushed around like a wheelchair, usually with a removable tray) in his room in a reclined position and eyes closed. R1's left wrist was in a splint with the forearm supported by a pillow. R1's bed did not have bed rails attached. On 03/17/26 at 11:00 AM, Administrative Nurse D provided a list of residents in the facility and identified that 25 residents' beds had at least one bed rail attached. Administrative Nurse D stated that prior to the incident on 02/08/26, which involved R1, no nursing bed rail safety assessments had been conducted since she was hired by the facility. On 03/17/26 at 11:17 AM, Maintenance U stated he did not have inspection logs specific to bed rails, but he performed a monthly facility assessment that included all safety-related items, such as ensuring bed rails were securely fastened to the bed frame of all applicable beds. Maintenance U stated that if nursing personnel identified a bed rail that needed to be removed, he would have it removed the same day as it was requested. On 03/17/26 at 11:34 AM, Maintenance U provided inspection logs for weekly checks from 09/06/25 to 03/07/26 except for the week of 10/11/25. Maintenance U highlighted the inspection instruction to check the full facility for safety and fall risks and rooms for extension cords, rolling chairs, floor mats, and any trip hazards. The inspection logs did not specify inspection of bed rails. On 03/17/26 at 11:45 AM, Administrative Nurse D stated that the facility had no nursing safety assessment for the bed rails on R1's bed. Administrative Nurse D also confirmed that the facility had not obtained informed consent from R1 or his representative prior to R1 being in a bed with bed rails. On 03/17/26 at 01:10 PM, Administrative Nurse D stated her expectation was for a nursing bed rail assessment to be performed on admission, (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	quarterly, annually, and as needed if a significant change occurred. Additionally, Administrative Nurse D stated the facility should obtain informed consent from the resident or the resident's representative prior to use of bed rails, and the consent should be reviewed at least annually. Administrative Nurse D stated that bedrails should only be used when absolutely necessary and only to assist the resident in increasing their independence by assisting the resident with bed mobility or transfers into or out of the bed. On 03/17/26 at 01:15 PM, Administrative Staff A stated maintenance personnel should ensure the good working order of bed rails. Additionally, Administrative Staff A stated that prior to the incident with R1 on 02/08/26, the facility did not have a nursing safety assessment process related to bed rails. Administrative Staff A stated her expectation was for Administrative Nurse D or her designee to perform a bed rail safety assessment on admission, quarterly, and as needed if any changes occurred. The facility's Bed Safety and Bed Rails policy, dated 08/2022 documented the use of bed rails or side rails was prohibited unless the criteria for use have been met that included attempts to use alternatives, interdisciplinary team (IDT - a team of facility staff consisting of members of various departments including but not limited to; dietary, nursing, maintenance, therapy, etc.) evaluation, resident assessment and informed consent. The assessment would determine potential risks to the resident that included accident hazards, restricted mobility, and psychosocial outcomes.