STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175444	A. Building B. Wing	03/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richmond Healthcare & Rehab Center	340 E South Street Richmond, KS 66080

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility documented a census of 49 residents. The sample included three residents. Based on observation, interviews, and record review, the facility failed to respond to speech therapy recommendations for dietary changes and a swallow study result recommendation for Resident (R) 1.Findings included:- R1's Electronic Medical Record (EMR) documented diagnoses of cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), Alzheimer's Disease with late onset (progressive mental deterioration characterized by confusion and memory failure), generalized muscle weakness, dementia (progressive mental disorder characterized by failing memory, and confusion), and dysphagia (swallowing difficulty).R1's admission Minimum Data Set (MDS) dated [DATE] noted the Brief Interview for Mental Status (BIMS) assessment was documented as not assessed. The MDS recorded R1's short-term and long-term memory was not assessed. The MDS further documented R1's decision-making abilities were not assessed. The MDS documented R1 required partial to moderate assistance with eating, oral hygiene, upper body dressing, personal hygiene, transferring from seated to standing position, and chair to bed transfers.The Nutritional Status Care Area Assessment (CAA) dated 01/02/26 documented R1 was recently hospitalized with a primary diagnosis of cerebral infarction. The CAA documented R1 was prescribed a Consistent Carbohydrate Diet (CCHO - a diet plan designed to manage blood sugar levels by keeping the amount of carbohydrates consumed at each meal consistent) and a Low Concentrated Sweets (LCS - a nutritional plan designed to manage blood sugar levels) diet of regular texture and consistency. The CAA documented R1 had poor appetite, but it was improving. The CAA documented R1 required partial to moderate assistance with eating. The CAA documented staff would monitor and document oral intake and nutritional changes. The CAA recorded any changes would be addressed with the dietician and physician.R1's 12/31/25 Care Plan documented R1 needed assistance with activities of daily living (ADL). R1's 12/31/25 Care Plan included the following fall interventions:12/31/25 - R1 required setup or clean-up assistance for eating.01/02/2026 - may crush medications and give together, except those on the do not crush list, unless authorized by the primary care provider (PCP).R1's 01/02/26 Care Plan documented R1 had a cerebral vascular accident that affected vision, mobility, and strength. The 01/02/26 Care Plan included the following fall interventions for R1:01/02/26 - directed staff to monitor intake to assure an adequate fluid intake to prevent dehydration. The intervention recorded If R1 was unable to eat, make sure diet was the correct consistency to facilitate safe swallowing. The intervention further recorded if R1 was unable to swallow, give enteral feeding (a medical method of delivering nutrition directly into the stomach or small intestine when a person cannot eat or drink enough by mouth) as ordered by the physician.01/02/26 - directed staff to monitor and document R1's ability to chew and swallow. If R1 presented problems, obtain order for speech therapy to evaluate and treat.R1's 01/02/26 Care Plan documented R1 had potential for diet and nutrition changes due to the new environment and recent admission to the center. The Care Plan documented R1 was at risk for weight loss, risk for swallowing problems, risk for chewing problems, and had recent acute hospital stay due to cerebral infarction. The 01/02/26 Care Plan included the following fall interventions for (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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1:01/02/26 - R1 had a diet order for a controlled carbohydrate/low concentrated sweet (CCHO/LCS) diet with regular texture and regular consistency.A Physician's Order with a start date of 12/30/25 and discontinue date of 02/12/26, documented a diet order of CCHO/LCS diet with regular texture and regular consistency for R1.R1's EMR lacked evidence of any other diet orders, or dietary changes for R1 during her stay in the facility from 12/30/25 to 02/04/26.A Speech Therapy Treatment Encounter Note dated 01/07/26 documented Speech language pathology (SLP) addressed dysphagia. R1 was seen at noon meal. The note documented R1 had an episode earlier in the week with significant coughing and difficulty swallowing meat. The note further documented nursing downgraded R1's diet to mechanical soft (foods that are physically altered to require minimal chewing, to assist those with swallowing issues). The note documented R1 demonstrated coughing and throat clearing with the ham and beans which were a mixed consistency. The note further documented R1 had no coughing with thin liquids or mechanical soft solids. The note documented R1 had a Flexible Endoscopic Evaluation of Swallowing (FEES - procedure used to evaluate how well a person swallows) study tomorrow (01/08/26).A Speech Therapy Treatment Encounter Note dated 01/08/26 documented R1 demonstrated some difficulty with thin liquids and did aspirate (when food, liquid, or saliva moves into the airway and lungs instead of being swallowed) a tic tac when she swallowed it whole with thin liquids and multiple pills at a time. The note documented SLP recommended R1's medications be crushed in puree (food blended into a smooth, pudding-like consistency that requires no chewing), until an official report was received and further review of the information was completed. A Flexible Endoscopic Evaluation of Swallowing (FEES) report for R1, dated 01/08/26, documented R1's current diet was mechanical soft solids and thin liquids. The report listed a recommendation of a Minced and Moist (modified diet with soft, moist, or finely minced food that requires minimal chewing) mechanical soft diet with thin liquids. The report recommended medications taken whole or cut in puree. The report recommended swallow strategies to keep R1 upright 90 degrees during and 60 minutes or more after meals and snacks. The report documented R1 required cues for double swallow for every bite and drink.A Speech Therapy Treatment Encounter Note, dated 01/15/26, documented R1 was discharged from all therapies due to unexpected exhaustion of insurance benefits. The note documented R1 had an altered diet of mechanical soft and thin liquids with pills crushed in puree. The note documented R1 required total supervision at meals for safety.Review of R1's EMR under the Misc tab revealed Licensed Nurse (LN) G uploaded R1's swallow study results into R1's EMR on 01/09/26. R1's EMR lacked evidence that R1's provider was notified of the results of the swallow study. R1's EMR lacked evidence of a physician's response to the swallow study results for R1.On 03/23/26 at 03:04 PM, Administrative Nurse D stated R1 typically ate by herself but needed prompting from staff. She stated staff helped R1 with her meals some, but did not recall any staff ever having to feed R1. Administrative Nurse D stated she was unsure what happened with the swallow study recommendations and speech therapy recommendations. She stated she was unsure if the family or provider declined the recommendations. Administrative Nurse D stated normally when a recommendation or result comes in, the nurse reviews it, then medical records (LN G) would transcribe it and put in a note. She stated once it goes through the process, the end results would come to her for review to ensure everyone did what they were required along the way, so nothing was missed. She stated she did not recall reviewing the recommendations for R1's swallow study or the speech therapy recommendations otherwise she would have looked into it to find out why it did not go through.On 03/23/26 at 05:59 PM Administrative Nurse D stated normally, when a video swallow result came back, and there was a recommendation sent to the facility, the physician would have reviewed it and given an answer as to why they would make an order change or not. She stated sometimes the physician would sign the result directly and it would have been scanned in after. Administrative Nurse D stated LN G would have been the staff member who would have scanned the results into R1's EMR. She stated speech therapy may have scanned or sent it directly to LN G for her to upload. She stated speech therapy should have followed through and asked if LN G got the order or (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	recommendation for the diet change. Administrative Nurse D stated any order documentation would be forwarded to her as well so she could review them. Administrative Nurse D stated if any changes were made to R1's diet during her stay it would have shown up under the orders tab, even if it had been discontinued. Administrative Nurse D stated she did an in-service last month for issues like this with the nurses about documentation and orders. She stated floor nurses do not put in orders frequently and it was mostly done by LN G. She stated they covered in the in-service what residents are on antibiotics, orders, and expectations for better documentation. She stated she was unable to provide a sign-in sheet with LN G's signature for the in-service. She stated LN G did not attend the in-service and believed she was on vacation during that time. She stated the facility did not have a policy that was relevant to this situation and she was working on getting a policy put into place related to orders and recommendations.On 03/23/26 at 06:19 PM LN H stated orders, results, or recommendations make it to her, she would review them and then LN G scans them into the resident's EMR. She stated the nurses and the DON would have received a copy as well to ensure nothing was missed. She stated she was not sure but believed speech therapy notes with recommendations went to LN G as well. LN H stated the swallow study results would have been scanned by LN G and if there were any order changes the nurses and the DON would have received a copy of what had been changed. LN H stated the facility had an in-service about putting orders in the system. She stated she worked as an as-needed employee and was not at the in-service. She stated she was filled in when she returned by Administrative Nurse D. LN H stated if the swallow study results and recommendations were scanned into a resident's EMR under the Misc tab, she was unsure that there would have been any alert for her to know they came back. She stated if LN G uploaded the results, and did not tell the nurses about it, they would not have known if it needed to be reviewed. On 03/24/26 at 11:03 AM LN G stated she ensured physicians reviewed test results and that test results were uploaded or entered into the resident's EMRs. LN G stated if the speech therapist recommended dietary changes, then they would fill out a diet communication form as to what diet they recommend. She stated that form is then reviewed with or by the physician and the physician would then give the okay for the diet order. LN G stated she was not able to access any notes from the speech therapist, and the therapy director was good about communicating any changes that needed to be made. She stated the diet communication form would have been filed out by speech therapy and given to a nurse and dietary staff. She stated she would have then uploaded it under the miscellaneous (Misc) section of the resident's EMR. LN G stated after a physician was notified of a result or recommendation, she would have put in a progress note documenting the physician was notified. LN G stated she uploaded the swallow study for R1 on 01/09/26 and read the current diet was listed as mechanical soft on the swallow study report. She stated after she scanned the results in, she reviewed R1's orders and found R1's diet was entered as regular and not mechanical soft. LN G stated she contacted the provider and was told to continue R1's regular diet and he did not want to make any changes. LN G stated during that time there was no Director of Nursing (DON) or Assistant Director of Nursing (ADON) and she was interrupted before she put a response or notification progress note in R1's EMR. LN G stated she did not put the progress note in after contacting the provider about R1's swallow study results, or his response to the recommendations. LN G stated the provider did not give a rationale as to why he did not wish to make changes after she discussed the swallow study results with him. LN G stated she was unsure if the provider had seen or was aware of the information in the speech therapy notes and the speech therapist's recommendations. She stated she did not have access to that information and was not sure if the provider did either. LN G stated she did go over the swallow study results over the phone with the provider but was unsure if the provider had reviewed the results himself.No policy provided by the facility upon request.