STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N039004	A. BUILDING: _____ B. WING _____	08/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING INC	420 N 5TH ANTHONY, KS 67003

(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 a resurvey with complaints #162787 and #164179 at the above named facility conducted on 7/26,27,28,29/2021 and 8/2/2021 which resulted in the following deficiencies.	S 000		
S 185 SS=D	26-39-102 (d) Admission, Transfer, Discharge (d) The administrator or operator of each adult care home shall ensure that each resident is permitted to remain in the adult care home and is not transferred or discharged from the adult care home unless one of the following conditions is met: (1) The transfer or discharge is necessary for the resident's welfare, and the resident's needs cannot be met in the current adult care home. (2) The safety of other individuals in the adult care home is endangered. (3) The health of other individuals in the adult care home is endangered. (4) The resident has failed, after reasonable and appropriate notice, to pay the rates and charges imposed by the adult care home. (5) The adult care home ceases to operate. This REQUIREMENT is not met as evidenced by: KAR 26-39-102 (d)(1)(2)(3)(4) The facility reported a census of 15 residents. The sample included 3 resident's and 5 discharged residents. Based on interview and record review the operator failed to ensure 1 (#800) of 5 discharged residents were not discharged unless one of the following conditions were met: 1. necessary for resident's welfare and	S 185		

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
	N039004	A. BUILDING: _____ B. WING _____	08/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING INC	420 N 5TH ANTHONY, KS 67003

(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 185	Continued From page 1	S 185		

staff cannot meet the resident's needs; 2. safety of other individuals was endangered; 3. the health of other individuals was endangered; 4. the resident has failed to pay the rates and charges imposed by the facility; or 5. the care home ceases to operate.

Findings included:

- Review of resident #800's medical record revealed the resident admitted to the facility on 2-6-21 with diagnoses of restless leg syndrome, anxiety disorder, major depressive disorder, and difficulty walking.

Review of the admission functional capacity screen dated 2-6-21 revealed the resident required physical assistance with bathing, dressing, toileting, transfers, was unable to manage medications or medical treatments, had short term memory and memory recall deficit and had current or recent problems with falls and impaired decision-making.

Review of the functional capacity screen dated 3-31-21 revealed the resident was unable to manage bathing and dressing as compared to the functional capacity screen dated 2-6-21.

Review of the resident's negotiated service agreement dated 2-6-21 revealed the resident received services for a level 2 which was designed to accommodate resident's who needed maximum assistance with daily needs which could include assistance with dressing, showering, grooming, toileting, and medication management.

Review of the resident's health care service plan dated 2-6-21 revealed staff provided the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N039004	A. BUILDING: _____ B. WING _____	08/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING INC	420 N 5TH ANTHONY, KS 67003

(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 185	Continued From page 2	S 185		

her showers and dressed the resident in her choice of clothing. It identified staff prepared the resident her meals, did her laundry, cleaned her apartment, and administered the resident's medications and medical treatments as ordered by the physician. The health care service plan had no revisions from 2-6-21 thru discharge to identify the resident had declined in status and required more assistance.

Review of the resident's nurses notes included the following:
2-6-21 - documentation that the resident moved into the facility.
3-31-21- the resident had a fall without injury.
4-1-21 licensed nurse D documented she met with the family that the resident's needs more care than assisted living could provide for her.
4-14-21 - licensed nurse D documented meeting with family to reevaluate the resident's living arrangements at facility.
6-20-21 licensed nurse D documented the resident seemed to be needing more and more assistance with daily cares, wants to stay in bed, is non-compliant with treatments and drinking water as physician had directed. It included that staff visited with family that the resident is no longer a good fit for assisted living and that arrangements should be made to find another kind of facility which will meet her needs.
6-24-21 licensed nurse D documented meeting with family and resident to inform them of 30 day discharge notice explaining resident had fallen 2 times in the past couple of weeks, is calling for more help in getting around in her apartment and needs more help with her activities of daily living.

Review of the 30 day discharge notice dated 6-19-21 addressed to the resident identified the resident needed to find a facility that could better

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N039004	A. BUILDING: _____ B. WING _____	08/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING INC	420 N 5TH ANTHONY, KS 67003

(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 185	Continued From page 3 fit her needs and recommended a nursing home facility. It identified that being non-compliant was a major factor in giving the 30 day notice including: constantly refusing showers, not complying with skin treatments, and excessive call light use requiring increased help. The resident record lacked specifics as to what kind of increased help the resident required that the facility could not provide. During an interview on 7-28-21 at 4:11 PM operator A reported the resident would wait until right before the meal to call for help to get up and around and then she would refuse to come to the meal. The resident was alert and oriented and would refuse to get up to use the restroom, she would refuse to shower and follow the skin program that her physician had wanted for her. She refused to get out of bed for meals and was afraid she might choke. Operator A stated they had not completed a refusal of services with the resident and her family. The operator failed to ensure resident #800 was permitted to remain in the facility without being discharged unless specific conditions occurred according to state regulations.	S 185		
S 190 SS=E	26-39-102 (e) Admission, Transfer, Discharge (e) Before a resident is transferred or discharged involuntarily, the administrator or operator, or the designee, shall perform the following: (1) Notify the resident, the resident ' s legal representative, and if known, a designated family member of the transfer or discharge and the reasons; and (2) record the reason for the transfer or	S 190		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N039004	A. BUILDING: _____ B. WING _____	08/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING INC	420 N 5TH ANTHONY, KS 67003

(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 190	Continued From page 4 discharge under any of the circumstances specified in paragraphs (d) (1) through (4) in the resident ' s clinical record, which shall be substantiated as follows: (A) The resident's physician shall document the rationale for transfer or discharge in the resident ' s clinical record if the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met by the adult care home; (B) the resident's physician shall document the rationale for transfer or discharge in the resident ' s clinical record if the transfer or discharge is appropriate because the resident's health has improved sufficiently so that the resident no longer needs the services provided by the adult care home; and (C) a physician shall document the rationale for transfer or discharge in the resident ' s clinical record if the transfer or discharge is necessary because the health or safety of other individuals in the adult care home is endangered. This REQUIREMENT is not met as evidenced by: KAR 26-39-102 (e)(2)(A)(C) The facility reported a census of 15 residents. The sample included 3 residents and 5 discharged resident record reviews. Based on interview and record review of 4 (#100, #600, #800, #900) of 5 discharged residents who received a 30 day discharge notice, the operator failed to have the resident's physician document the rationale for transfer or discharge in the resident's medical record prior to discharge from the facility.	S 190		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N039004	A. BUILDING: _____ B. WING _____	08/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING INC	420 N 5TH ANTHONY, KS 67003

(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 190	Continued From page 5 Findings included: - Review of resident #100's medical record revealed he moved into the facility on 10-17-2020 with diagnoses of nervousness. Review of the resident's functional capacity screen dated 10-9-2020 revealed the resident was independent with activities of daily living, had some bladder incontinence, took no medications, and usually made self understood and understood others. Review of the resident's Negotiated service agreement dated 10-17-20 revealed the resident received housekeeping, laundry, meal services, otherwise the resident was independent with all health care service needs. Review of the resident's health care service plan dated 10-17-20 revealed the resident was independent in daily care needs, family assisted with financial and shopping matters. The resident's record lacked review/revision of the functional capacity screen, the negotiated service plan or health care service plan to identify the resident had a change in behaviors that were inappropriate to living in the facility. Review of a letter dated 5-28-21 which was addressed to the resident's DPOA revealed the facility gave the DPOA a 30 day notice to find other living arrangements for the resident. It noted in the NSA dated 10-17-20 the facility could give a notice in the event that a behavior that deems detrimental to the health, safety, or peaceful lodging to the resident or others. Review of a letter dated 7-14-21 sent to the	S 190		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N039004	A. BUILDING: _____ B. WING _____	08/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING INC	420 N 5TH ANTHONY, KS 67003

(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 190	Continued From page 6 resident and one to his DPOA, identified it served as a 30 day notice for discharge based on behaviors that the staff determined detrimental to the health, safety, or peaceful lodging to you or other residents. However, If another incident happens in the next 30 days that is detrimental to the health or safety of you or other residents, we again will notify the staff and ask to give a 3 day notice of discharge. Review of the resident's record included a letter to the physician that the resident had inappropriate behaviors. However, the record lacked a physicians documentation of the rationale for discharge being necessary because the health or safety of other individuals in the adult care home is endangered. - Review of resident # 600's medical record revealed she admitted into the facility with diagnoses of hypertension and anxiety. Review of the resident's functional capacity screen dated 6-15-21 revealed the resident needed physical assistance with bathing, and management of medications, had cognitive impairment and used a cane as an assistive device. Review of the resident's negotiated service agreement dated 6-21-19 identified the facility provided the resident "level 1" services which were designed to accommodate those residents determined to need light to moderate assistance. Services included supervision /occasional assistance with personal hygiene including showers, dressing grooming and medications assistance as well as housekeeping and laundry services.	S 190		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N039004	A. BUILDING: _____ B. WING _____	08/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING INC	420 N 5TH ANTHONY, KS 67003

(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 190	Continued From page 7 The resident's health care service plan dated 6-21-19 identified the staff assisted the resident with showers 2 times per week, stand by assistance with dressing, grooming, and administered the resident her medications. The residents record lacked addition revisions to the negotiated service agreement or health care service plan related to resident's needs. Review of a letter dated 7-25-19 to the resident's DPOA revealed the letter served as a 30 day discharge notice. It identified the resident's behavior issues were not acceptable at the facility. She had started lashing out, cussing, raising voice at other residents and staff, and had knocked a stack of papers of the desk. It identified the 30 day notice would begin July 26, 2019. The record included another letter to the resident's DPOA dated 11-2-19 that was a follow-up to the initial 30 day notice provided on 7-25-19. It identified the facility had tried to work things out with the physician and behavior issues but the behaviors had continued. It revealed the licensed nurse D spoke with DPOA and discussed the resident would no longer be able to stay at the facility. Operator A spoke with the resident's DPOA on 10-14-19 and explained he had 30 days to find placement. The residents record included a letter to the resident's medical provider that they had given the resident a 30 day notice to find another facility to better fit her needs and behaviors. However, the resident's record lacked physician documentation for the rational for discharge being necessary due to the resident's welfare and	S 190		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N039004	A. BUILDING: _____ B. WING _____	08/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING INC	420 N 5TH ANTHONY, KS 67003

(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 190	Continued From page 8	S 190		

needs cannot be met or if it is necessary because the health or safety of other individuals in the home is endangered.

- Review of resident #800's medical record revealed the resident admitted to the facility on 2-6-21 with diagnoses of resstless leg syndrome, anxiety disorder, major depressive disorder, and difficulty walking.

Review of the admission functional capacity screen dated 2-6-21 revealed the resident required physical assistance with bathing, dressing, toileting, transfers, was unable to manage medications or medical treatments - had short term memory and memory recall deficit and had current or recent problems with falls and impaired decision-making.

Review of the functional capacity screen dated 3-31-21 revealed the resident needed more assistance with bathing and dressing as compared to the functional capacity screen dated 2-6-21.

Review of the resident's negotiated service agreement dated 2-6-21 revealed the resident received services for a level 2 which was designed to accommodate resident's who needed maximum assistance with daily needs which could include assistance with dressing, showering, grooming, toileting, and medication management.

Review of the resident's nurses notes included the following:
4-1-21 licensed nurse D documented she met with the family that the resident's needs more care than assisted living could provide for her.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N039004	A. BUILDING: _____ B. WING _____	08/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING INC	420 N 5TH ANTHONY, KS 67003

(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 190	Continued From page 9	S 190		

The resident and family discussed ways the resident could remain in the facility and set goal for the resident regarding increasing her independence in some of her activities of daily living.
6-20-21 licensed nurse D documented the resident seemed to be needing more and more assistance with daily dares, wants to stay in bed, is non-compliant with treatments and drinking water as physician had directed. It included that staff visited with family that the resident is no longer a good fit for assisted living and that arrangements should be make to find another kind of facility which will meet her needs.

Review of the 30 day discharge notice dated 6-19-21 addressed to the resident identified the resident needed to find a facility that could better fit her needs and recommended a nursing home facility. Factors in decision included: constantly refusing showers, not complying with skin treatments, and excessive call light use requiring increased help.

Review of the resident's record lacked physician documentation for the rational for discharge related to the facility not able to meet the needs of the resident.

- Review of resident #900's medical record revealed the resident admitted to the facility on 3-17-19 with diagnoses of depression, abnormal gait and decubitus ulcer.

Review of the resident's functional capacity screen dated 3-17-19 revealed the resident required physical assistance with activities of daily living, could not manage his medications and treatments, and used gait poles to assist with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N039004	A. BUILDING: _____ B. WING _____	08/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING INC	420 N 5TH ANTHONY, KS 67003

(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 190	Continued From page 10	S 190		

transfers.

Review of the residents negotiated service agreement dated 3-17-19 revealed the resident received services for a level 2 which was designed to accommodate resident's who needed maximum assistance with daily needs which could include assistance with dressing, showering, grooming, toileting, and medication management.

Review of the resident's record lacked revision to the negotiated service agreement or health care service plan to identify the resident required increased assistance of staff to meet the resident's daily needs.

Review of the 30 day dismissal letter sent to the resident and his family dated 10-8-19 revealed the facility staff felt they could not meet the resident's needs so a 30 day notice is sent to allow you time to look for placement. It identified the resident's condition and level of assistance needed from staff varied from 1 to 2 staff daily. It is for the resident's safety that you need to find different placement at another nursing facility.

Review of the resident's record lacked documentation by the physician that the resident's transfer/discharge was necessary for the resident's welfare and the resident's needs cannot be met by the facility.

During an interview on 7-29-21 operator A reported either her or the nurse wrote letters to each physician for the residents who had received a 30 day notice and the reason why. Operator A stated she did not realize the physician needed to document rational for the discharges in the residents record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N039004	A. BUILDING: _____ B. WING _____	08/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING INC	420 N 5TH ANTHONY, KS 67003

(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 190	Continued From page 11 The operator failed to ensure the resident's physician documented the rationale for transfer or discharge in the resident's medical record specifically related to the facility not being able to meet the residents needs or the safety of other individuals in the facility was endangered.	S 190		
S 200 SS=E	26-39-102 (g) Written Discharge Notice Requirements (g) Each written transfer or discharge notice shall include the following: (1) The reason for the transfer or discharge; (2) the effective date of the transfer or discharge; (3) the address and telephone number of the complaint program of the Kansas department on aging where a complaint related to involuntary transfer or discharge can be registered; (4) the address and telephone number of the state long-term care ombudsman; and (5) for residents who have developmental disabilities or who are mentally ill, the address and telephone number of the Kansas advocacy and protection organization. This REQUIREMENT is not met as evidenced by: KAR 26-39-102 (g)(3)(4) The facility reported a census of 15 residents. The sample included 3 residents and 5 discharged resident record reviews. Based on interview and record review of 4 (#100, #600, #800, #900) of 5 discharged residents who received a 30 day discharge notice, the operator	S 200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N039004	A. BUILDING: _____ B. WING _____	08/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING INC	420 N 5TH ANTHONY, KS 67003

(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 200	Continued From page 12	S 200		

failed to ensure the notice included address and telephone number of the complaint program of the Kansas department for aging and disabilities where a complaint related to involuntary transfer or discharge could be filed and failed to included the address and telephone number of the state long-term care ombudsman.

Findings included:

- Review of resident #100's medical record revealed he moved into the facility on 10-17-2020 with diagnoses of nervousness.

Review of the resident's functional capacity screen dated 10-9-2020 revealed the resident was independent with activities of daily living, had some bladder incontinence, took no medications, and usually made self understood and understood others.

Review of the resident's Negotiated service agreement dated 10-17-20 revealed the resident received housekeeping, laundry, meal services, otherwise the resident was independent with all health care service needs.

Review of the resident's health care service plan dated 10-17-20 revealed the resident was independent in daily care needs, family assisted with financial and shopping matters.

Review of the resident's 30 day discharge notices dated 5-28-21 and 7-14-21 lacked the phone number and address for the Kansas complaint hotline and lacked the phone number and address for the state ombudsman.

- Review of resident # 600's medical record

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N039004	A. BUILDING: _____ B. WING _____	08/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING INC	420 N 5TH ANTHONY, KS 67003

(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 200	Continued From page 13 revealed she admitted into the facility with diagnoses of hypertension and anxiety. Review of the resident's functional capacity screen dated 6-15-21 revealed the resident needed physical assistance with bathing, and management of medications, had cognitive impairment and used a cane as an assistive device. Review of the resident's negotiated service agreement dated 6-21-19 identified the facility provided the resident "level 1" services which were designed to accommodate those residents determined to need light to moderate assistance. Services included supervision /occasional assistance with personal hygiene including showers, dressing grooming and medications assistance as well as housekeeping and laundry services. The resident's health care service plan dated 6-21-19 identified the staff assisted the resident with showers 2 times per week, stand by assistance with dressing, grooming, and administered the resident her medications. Review of the resident's 30 day notice dated 7-25-19 lacked the phone number and address for the Kansas complaint hotline and lacked the phone number and address for the state ombudsman. - Review of resident #800's medical record revealed the resident admitted to the facility on 2-6-21 with diagnoses of restless leg syndrome, anxiety disorder, major depressive disorder, and difficulty walking.	S 200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N039004	A. BUILDING: _____ B. WING _____	08/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING INC	420 N 5TH ANTHONY, KS 67003

(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 200	Continued From page 14	S 200		

Review of the admission functional capacity screen dated 2-6-21 revealed the resident required physical assistance with bathing, dressing, toileting, transfers, was unable to manage medications or medical treatments - had short term memory and memory recall deficit and had current or recent problems with falls and impaired decision-making.

Review of the functional capacity screen dated 3-31-21 revealed the resident needed more assistance with bathing and dressing as compared to the functional capacity screen dated 2-6-21.

Review of the resident's negotiated service agreement dated 2-6-21 revealed the resident received services for a level 2 which was designed to accommodate resident's who needed maximum assistance with daily needs which could include assistance with dressing, showering, grooming, toileting, and medication management.

Review of the resident's 30 day discharge notice dated 6-19-21 lacked the phone number and address for the Kansas complaint hotline and lacked the phone number and address for the state ombudsman.

- Review of resident #900's medical record revealed the resident admitted to the facility on 3-17-19 with diagnoses of depression, abnormal gait and decubitus ulcer.

Review of the resident's functional capacity screen dated 3-17-19 revealed the resident required physical assistance with activities of daily living, could not manage his medications

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N039004	A. BUILDING: _____ B. WING _____	08/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING INC	420 N 5TH ANTHONY, KS 67003

(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 200	Continued From page 15 and treatments, and used gait poles to assist with transfers. Review of the residents negotiated service agreement dated 3-17-19 revealed the resident received services for a level 2 which was designed to accommodate resident's who needed maximum assistance with daily needs which could include assistance with dressing, showering, grooming, toileting, and medication management. Review of the residents 30 day discharge notice dated 10-8-19 lacked the phone number and address for the Kansas complaint hotline and lacked the phone number and address for the state ombudsman. The operator failed to ensure each 30 day notice given to resident #100, #600, #800 and #900 included the address and phone number of the complaint program of the Kansas Department of aging and disabilities and the address and phone number of the state long-term care ombudsman.	S 200		
S3095 SS=D	26-41-202 (f) NSA Refusal of Service (f) If a resident or the resident's legal representative refuses a service that the administrator or operator, the licensed nurse, the resident's medical care provider, or the case manager believes is necessary for the resident's health and safety, the negotiated service agreement shall include the following: (1) The service or services refused; (2) identification of any potential negative outcomes for the resident if the service or services are not provided; (3) evidence of the provision of education to the	S3095		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N039004	A. BUILDING: _____ B. WING _____	08/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING INC	420 N 5TH ANTHONY, KS 67003

(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
S3095	Continued From page 16 resident or the resident ' s legal representative of the potential risk of any negative outcomes if the service or services are not provided; and (4) an indication of acceptance by the resident or the resident's legal representative of the potential risk. . This REQUIREMENT is not met as evidenced by: KAR 26-39-202 (f)(1)(2)(3)(4) The facility reported a census of 15 residents. The sample included 3 resident's and 5 discharged residents. Based on interview and record review the operator failed to ensure the negotiated service agreement (NSA) for 1 (#800) of 5 discharged residents included services the resident refused which the operator A and licensed nurse D believed necessary for the resident's health and safety. The NSA failed to identify the service (s) refused; identification of any potential negative outcomes for the resident related to refusal of services; evidence of providing education to the resident and/or the residents legal representative of the risks; and indication of acceptance by the resident or legal representative of such risks. Findings included: - Review of resident #800's medical record revealed the resident admitted to the facility on 2-6-21 with diagnoses of restless leg syndrome, anxiety disorder, major depressive disorder, and difficulty walking. Review of the admission functional capacity screen dated 2-6-21 revealed the resident	S3095		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N039004	A. BUILDING: _____ B. WING _____	08/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING INC	420 N 5TH ANTHONY, KS 67003

(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
S3095	Continued From page 17	S3095		

required physical assistance with bathing, dressing, toileting, transfers, was unable to manage medications or medical treatments, had short term memory and memory recall deficit and had current or recent problems with falls and impaired decision-making.

Review of the functional capacity screen dated 3-31-21 revealed the resident was unable to manage bathing and dressing as compared to the functional capacity screen dated 2-6-21.

Review of the resident's negotiated service agreement dated 2-6-21 lacked information regarding the resident's refusal to shower, refusal of skin treatments ordered by the physician, and refusal to drink water as physician directed.

Review of the resident's nurses noted revealed on 6-20-21 licensed nurse D documented the resident seemed to be needing more and more assistance with daily cares, wants to stay in bed, is non-compliant with treatments and drinking water as physician had directed.

Review of the 30 day discharge notice dated 6-19-21 addressed to the resident that being non-compliant was a major factor in giving the 30 day notice including: constantly refusing showers, not complying with skin treatments, and excessive call light use requiring increased help.

During an interview on 7-28-21 at 4:11 PM operator A confirmed the facility had not completed a refusal of services addendum to the NSA with the resident or her DPOA.

The operator failed to ensure resident #800 received a refusal of services addendum which identified the potential risks related to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N039004	A. BUILDING: _____ B. WING _____	08/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING INC	420 N 5TH ANTHONY, KS 67003

(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
S3095	Continued From page 18 resident's refusal of services as well as her and/or her DPOA's understanding of the risks and accepting responsibility for those risks.	S3095		
S3175 SS=E	26-41-205 (a) (1) Self Administration of Medication (a) Self-administration of medication. Any resident may self-administer and manage medications independently or by using a medication container or syringe prefilled by a licensed nurse or pharmacist or by a family member or friend providing this service gratuitously, if a licensed nurse has performed an assessment and determined that the resident can perform this function safely and accurately without staff assistance. (1) An assessment shall be completed before the resident initially begins self-administration of medication, if the resident experiences a significant change of condition, and annually. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(a) (1) The facility reported a census of 15 residents. The sample included 3 residents and 5 discharged resident reviews. Based on record review, and interview the operator failed to ensure a licensed nurse completed a self-administration medication assessment for 2 (#400 and #500) of 3 sampled residents who kept and self-administered medications and medical	S3175		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N039004	A. BUILDING: _____ B. WING _____	08/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING INC	420 N 5TH ANTHONY, KS 67003

(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
S3175	Continued From page 19 treatments Findings included: - Resident #400 moved into the facility on 4-27-19 with diagnoses of glaucoma, edema and anxiety. Review of the resident's functional capacity screen dated 4-27-21 revealed the resident could not manage her medications or medical treatments. Review of the negotiated service agreement (NSA) and health care service plan dated dated 4-27-21 revealed the resident received services for a level 1 which was designed to accommodate those residents determined to need light to moderate assistance which could include supervision or occasional assistance with personal hygiene, showering, dressing and medication assistance. It also identified the resident paid and additional amount for the optional service of medication set-up and administration. The negotiated service agreement failed to identify that the resident self-administered all of her cream and ointment treatments as well as failed to identify specifically that the staff dialed the resident's insulin pen and the resident self injected it. Review of a self medication assessment dated 4-27-20 identified that staff would apply dressing to the resident's coccyx howeever it did not identify an assessment of the resident's ability to self administer her medical treatments or her ability to self inject her insulin.	S3175		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N039004	A. BUILDING: _____ B. WING _____	08/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING INC	420 N 5TH ANTHONY, KS 67003

(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
S3175	Continued From page 20 - Review of resident #500 revealed he admitted to the facility on 12-1-2018 with diagnoses of diabetes, and coronary artery disease. Review of the residents functional capacity screen dated 3-17-21 revealed the resident needed supervision with activities of daily living and was independent with management of medications and medical treatments. Review of the residents negotiated service agreement dated 12-1-20 revealed the resident did not receive any "level of care" services for assisted living and did not receive services for medication management. Review of the residents self -administration assessment dated 12-1-20 lacked 4 different areas of assessment that were not completed and lacked a signature of the person who completed the assessment. During an interview on 7-28-21 at 11:33 AM the resident reported his son sest up his medications in the pill container and then he took them when he needed to. During an interview on 7-27-21 at 2:47 PM licensed nurse D reported a self -administration assessment needed to be done when a resident moved into the facility and then with their yearly assessment. The operator failed to ensure the licensed nurse completed a self-administration medication assessment for 2 resident's who kept and self-administered medications and medical treatments in their room.	S3175		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N039004	A. BUILDING: _____ B. WING _____	08/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING INC	420 N 5TH ANTHONY, KS 67003

(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
S3186	Continued From page 21	S3186		
S3186 SS=D	26-41-205 (b) Administration of Selected Medications (b) Administration of select medications. Any resident who self-administers medication may select some medications to be administered by a licensed nurse or medication aide. The negotiated service agreement shall reflect this service and identify who is responsible for the administration and management of selected medications. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (b) The facility reported a census of 15 residents. The sample included 3 residents and 5 discharge resident reviews. Based on record review and interview the operator failed to ensure 1 (#400) of 1 sampled resident record who self-administered some of their medications had a Negotiated Service Agreement that identified the responsible person for the administration and management of selected medications. Findings included: - Resident #400 moved into the facility on 4-27-19 with diagnoses of glaucoma, edema and anxiety. Review of the resident's functional capacity screen dated 4-27-21 revealed the resident could	S3186		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N039004	A. BUILDING: _____ B. WING _____	08/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING INC	420 N 5TH ANTHONY, KS 67003

(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
S3186	Continued From page 22	S3186		

not manage her medications or medical treatments.

Review of the negotiated service agreement (NSA) and health care service plan dated dated 4-27-21 revealed the resident received services for a level 1 which was designed to accommodate those residents determined to need light to moderate assistance which could include supervision or occasional assistance with personal hygiene, showering, dressing and medication assistance. It also identified the resident paid and additional amount for the optional service of medication set-up and administration. The negotiated service agreement failed to identify that the resident self-administered all of her cream and ointment treatments as well as failed to identify specifically that the staff dialed the resident's insulin pen and the resident self injected it.

Review of the residents July 2021 medications administration record revealed the resident self administered her Nystatin topical powder to skin twice a day, voltaren gel to knee as needed for pain and her antifungal cream to skin folds as needed.

During an interview on 7-28-21 at 9:46 AM the resident stated she tried to do most things herself which included putting on her medicated creams that are in her bathroom.

During an interview on 7-28-21 at 11:00 AM operator A confirmed the residents negotiated service agreement did not specify which medications / medical treatments the resident would do and the facility staff would do.

The operator failed to ensure a resident who

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N039004	A. BUILDING: _____ B. WING _____	08/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING INC	420 N 5TH ANTHONY, KS 67003

(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
S3186	Continued From page 23 self-administered some of their medications had a Negotiated Service Agreement that identified the responsible person for the administration and management of selected medications.	S3186		
S3280 SS=E	26-41-104 (d) Disaster and Emergency Preparedness (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 facility ' s emergency management plan; (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' 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 26-41-104(d)(3) The facility reported a census of 15 residents. Based on record review and interview for all facility employees, the administrator failed to ensure disaster and emergency preparedness by ensuring performance of quarterly review of the facility's emergency management plan with employees.	S3280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N039004	A. BUILDING: _____ B. WING _____	08/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING INC	420 N 5TH ANTHONY, KS 67003

(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
S3280	Continued From page 24 Findings included: - On 7-26-21 review of the emergency management notebook provided by certified staff B revealed reviews for residents quarterly but lacked quarterly reviews of the emergency management plan for staff since December of 2019. During an interview on 7-26-21 at 1:30 PM certified staff B stated she had gotten behind on doing the emergency management reviews with facility employees. The operator failed to emergency preparedness by reviewing the emergency management plan quarterly with all employees.	S3280		