STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N056012	A. BUILDING: _____ B. WING _____	06/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMPORIA PLACE	1200 W 12TH AVENUE EMPORIA, KS 66801

(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 citations represent the findings of a resurvey for the above named facility conducted on 6/18/18 and 6/19/18.	S 000		
S3101 SS=E	26-41-202 (h) NSA Signatures (h) Each individual involved in the development of the negotiated service agreement shall sign the agreement. The administrator or operator shall ensure that a copy of the initial agreement and any subsequent revisions are provided to the resident or the resident's legal representative. This REQUIREMENT is not met as evidenced by: KAR 26-41-202 (h) The facility census totaled 27 residents. The sample included 3 residents. Based on record review and interview for 3 of 3 residents (#701, #702 and #703) the Administrator failed to ensure the Negotiated Service Agreements were signed by all parties who participated on the day of the agreement. Findings included: - Review of the record for resident #701 revealed an admission date of 9/25/15 with diagnoses of: diastolic heart failure, osteoarthritis, hypertension, epilepsy, coronary artery disease, chronic kidney disease and chronic pain. Review of the significant change Functional Capacity Screen dated 1/31/18 indicated the resident needed physical assistance with bathing, management of medications and was at risk for	S3101		

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
	N056012	A. BUILDING: _____ B. WING _____	06/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMPORIA PLACE	1200 W 12TH AVENUE EMPORIA, KS 66801

(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
S3101	Continued From page 1	S3101		

falls.

Review of the Negotiated Service Agreement (NSA)/Health Service Plan (HSP) dated 3/1/18 indicated facility staff would manage the resident's medications, wound care and provide physical assistance of 1 staff with bathing. The NSA/HSP was not signed until 3/2/18 by the responsible party, administrator and licensed nurse.

Interview on 6/19/18 at 10:45 AM with licensed nurse C and administrator D confirmed the NSA lacked a signature on the day it was developed.

The Administrator failed to ensure the Negotiated Service Agreements were signed by all parties who participated on the day of the agreement.

- Record review for resident #702 revealed an admission dated of 3/31/17 with diagnoses of: hypothyroidism, cognitive impairment, ataxic gait, Parkinsonism, hypertension, dizziness, BPPV (benign paroxysmal positional vertigo), mild diastolic failure and anxiety.

The annual Functional Capacity Screen (FCS) dated 3/30/18 indicated the resident required physical assistance with bathing, medication management, had cognitive impairment with short-term memory/memory recall/decision making and was at risk for falls.

Review of the Negotiated Service Agreement (NSA)/Health Service Plan (HSP) dated 3/24/18 indicated staff would manage the resident's medications, the family or paid care giver would assist with bathing, staff would provide housekeeping and laundry services weekly. The resident had difficulty recalling the date and time

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N056012	A. BUILDING: _____ B. WING _____	06/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMPORIA PLACE	1200 W 12TH AVENUE EMPORIA, KS 66801

(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
S3101	Continued From page 2	S3101		

and was frequently repetitive with conversation. He/she could navigate to/from his/her apartment without staff assistance. The NSA lacked signatures of those who participated in the development on 3/24/18 and was not signed until 4/17/18 by the responsible party, administrator and licensed nurse.

Interview on 6/19/18 at 10:45 AM with licensed nurse C and administrator D confirmed the NSA lacked a signature on the day it was developed. Nurse D reported the responsible party lived out of town and the NSA was mailed for signature.

The Administrator failed to ensure the Negotiated Service Agreements were signed by all parties who participated on the day of the agreement.

- Record review for resident #703 revealed an admission date of 4/5/18 with diagnoses of: Parkinson's, dementia, diabetes mellitus, hypertension and chronic pain.

The admission Functional Capacity Screen (FCS) dated 4/5/18 indicated the resident needed physical assistance with bathing, dressing, toileting and supervision with transfers/walking/mobility. He/she had cognitive impairment and was at risk for falls.

The Negotiated Service Agreement (NSA)/Health Service Plan (HSP) dated 4/5/18 indicated staff would provide medication management, assistance with bathing, toileting, dressing/grooming and transfers/mobility/walking. He/she required staff assistance for an escort related to trouble with recalling day/date/time or where located. He/she needed reminders with guidance to and from his/her room about the community. The NSA was not signed until 4/7/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N056012	A. BUILDING: _____ B. WING _____	06/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMPORIA PLACE	1200 W 12TH AVENUE EMPORIA, KS 66801

(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
S3101	Continued From page 3 by the responsible party (who is also a resident of the facility), administrator and licensed nurse. Interview on 6/19/18 at 10:45 AM with licensed nurse C and administrator D confirmed the NSA lacked a signature on the day it was developed. The Administrator failed to ensure the Negotiated Service Agreements were signed by all parties who participated on the day of the agreement.	S3101		
S3165 SS=E	26-41-204 (d) Health Care Services (d) The negotiated service agreement shall contain a description of the health care services to be provided and the name of the licensed nurse responsible for the implementation and supervision of the plan. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(d) The facility reported a census of 27 residents. The sample included 3 residents. Based on record review and interview for 3 of 3 sampled residents (#701, #702, and #703) the administrator failed to ensure each resident's negotiated service agreement/health care service plan (NSA/HSP) contained the name of the licensed nurse responsible for the implementation and supervision of the health care service plan. Findings included: - Review of the record for resident #701 revealed an admission date of 9/25/15 with diagnoses of:	S3165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N056012	A. BUILDING: _____ B. WING _____	06/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMPORIA PLACE	1200 W 12TH AVENUE EMPORIA, KS 66801

(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
S3165	Continued From page 4	S3165		

diastolic heart failure, osteoarthritis, hypertension, epilepsy, coronary artery disease, chronic kidney disease and chronic pain.

Review of the significant change Functional Capacity Screen dated 1/31/18 indicated the resident needed physical assistance with bathing, management of medications and was at risk for falls.

Review of the Negotiated Service Agreement (NSA)/Health Service Plan (HSP) dated 3/1/18 indicated facility staff would manage the resident's medications, wound care and provide physical assistance of 1 staff with bathing. The NSA lacked the name of the licensed nurse responsible for implementation and supervision of the HSP.

Interview on 6/19/18 at 10:45 AM with licensed nurse C confirmed the NSA lacked the name of the licensed nurse responsible for implementation and supervision of the health care service plan.

The administrator failed to ensure this resident's negotiated service agreement/health care service plan (NSA/HSP) contained the name of the licensed nurse responsible for the implementation and supervision of the health care service plan.

- Record review for resident #702 revealed an admission dated of 3/31/17 with diagnoses of: hypothyroidism, cognitive impairment, ataxic gait, Parkinsonism, hypertension, dizziness, BPPV (benign paroxysmal positional vertigo), mild diastolic failure and anxiety.

The annual Functional Capacity Screen (FCS) dated 3/30/18 indicated the resident required physical assistance with bathing, medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N056012	A. BUILDING: _____ B. WING _____	06/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMPORIA PLACE	1200 W 12TH AVENUE EMPORIA, KS 66801

(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
S3165	Continued From page 5	S3165		

management, had cognitive impairment with short-term memory/memory recall/decision making and was at risk for falls.

Review of the Negotiated Service Agreement (NSA)/Health Service Plan (HSP) dated 3/24/18 indicated staff would manage the resident's medications, the family or paid care giver would assist with bathing, staff would provide housekeeping and laundry services weekly. The resident had difficulty recalling the date and time and was frequently repetitive with conversation. He/she could navigate to/from his/her apartment without staff assistance. The NSA lacked the name of the licensed nurse responsible for implementation and supervision of the HSP.

Interview on 6/19/18 at 10:45 AM with licensed nurse C confirmed the NSA lacked the name of the licensed nurse responsible for implementation and supervision of the health care service plan.

The administrator failed to ensure this resident's negotiated service agreement/health care service plan (NSA/HSP) contained the name of the licensed nurse responsible for the implementation and supervision of the health care service plan.

- Record review for resident #703 revealed an admission date of 4/5/18 with diagnoses of: Parkinson's, dementia, diabetes mellitus, hypertension and chronic pain.

The admission Functional Capacity Screen (FCS) dated 4/5/18 indicated the resident needed physical assistance with bathing, dressing, toileting and supervision with transfers/walking/mobility. He/she had cognitive impairment and was at risk for falls.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N056012	A. BUILDING: _____ B. WING _____	06/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMPORIA PLACE	1200 W 12TH AVENUE EMPORIA, KS 66801

(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
S3165	Continued From page 6 The Negotiated Service Agreement (NSA)/Health Service Plan (HSP) dated 4/5/18 indicated staff would provide medication management, assistance with bathing, toileting, dressing/grooming and transfers/mobility/walking. He/she required staff assistance for an escort related to trouble with recalling day/date/time or where located. He/she needed reminders with guidance to and from his/her room about the community. The NSA lacked the name of the licensed nurse responsible for implementation and supervision of the HSP. Interview on 6/19/18 at 10:45 AM with licensed nurse C confirmed the NSA lacked the name of the licensed nurse responsible for implementation and supervision of the health care service plan. The administrator failed to ensure this resident's negotiated service agreement/health care service plan (NSA/HSP) contained the name of the licensed nurse responsible for the implementation and supervision of the health care service plan.	S3165		
S3202 SS=E	26-41-205 (d) (4) Delegation of Medication Administration (4) Any licensed nurse may delegate nursing procedures not included in the medication aide curriculum to medication aides under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (d) (4) The facility census totaled 27 residents. The	S3202		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N056012	A. BUILDING: _____ B. WING _____	06/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMPORIA PLACE	1200 W 12TH AVENUE EMPORIA, KS 66801

(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
S3202	Continued From page 7	S3202		

sample included 3 residents. Based on record review and interview the facility failed to have evidence of additional training for certified medication aide (CMA) E and F to ensure the CMAs were competent and safe with duties delegated to check blood sugars and dial the dose for insulin pens.

Findings included:

- On 6/18/18 at 1:18 PM licensed nurse C reported certified medication aides (CMAs) were delegated to perform blood sugar testing and dialing of insulin pens for residents.

Review of the personnel file for CMA E on 6/18/18 revealed he/she began employment on 5/24/17. The record lacked documentation of additional training to allow this CMA to perform blood sugar testing and dialing of insulin pens for residents to administer.

Review of the personnel file for CMA F on 6/18/18 revealed he/she began employment on 2/20/17. The record lacked documentation of additional training to allow this CMA to perform blood sugar testing and dialing of insulin pens for residents to administer.

Interview on 6/18/18 at 12:57 PM with CMA B revealed he/she performed blood sugar testing on residents and would dial the insulin pen for the resident to administer.

Interview with licensed nurse C on 6/18/18 at 2:45 PM confirmed the facility did not have evidence of CMA E and CMA F being trained in blood sugar testing and dialing insulin pens.

The facility failed to have evidence of additional

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N056012	A. BUILDING: _____ B. WING _____	06/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMPORIA PLACE	1200 W 12TH AVENUE EMPORIA, KS 66801

(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
S3202	Continued From page 8 training for certified medication aides to ensure the CMAs were competent and safe with duties delegated regarding blood sugar checks and dialing the dose for insulin pens.	S3202		
S3211 SS=E	26-41-205 (g) (3) OVER THE COUNTER DRUGS (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and the medication container. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (g)(3) The facility reported a census of 27 residents. Based on record review, observation, and interview for all residents receiving facility management of medications, the administrator failed to ensure a licensed nurse or licensed pharmacist placed the full name of the resident on each over-the-counter (OTC) medication package or container in the only medication cart and medication room. This deficient practice affected 14 residents (#701, #703, #704, #705, #706, #707, #708, #709, #710, #711, #712, #713,	S3211		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N056012	A. BUILDING: _____ B. WING _____	06/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMPORIA PLACE	1200 W 12TH AVENUE EMPORIA, KS 66801

(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
S3211	Continued From page 9 #714 and #715). Findings included: - The facility resident roster identified 26 residents received facility management of medications. On 6/18/18 at 12:57 PM certified medication aide (CMA) B opened the only medication cart and then the only medication room. Observation revealed the following over-the-counter (OTC) medications for the residents were either not labeled at all or had first name only, last name only, initials or room number only: Resident #701 had 2 bottles/containers or packages of OTC medications Resident #703 had 1 bottle/container or package of OTC medications Resident #704 had 1 bottles/container or package of OTC medications Resident #705 had 1 bottle/container or package of OTC medications Resident #706 had 2 bottles/containers or packages of OTC medications Resident #707 had 3 bottles/containers or packages of OTC medications Resident #708 had 2 bottles/containers or packages of OTC medications Resident #709 had 4 bottles/containers or packages of OTC medications Resident #710 had 1 bottle/container or package of OTC medications Resident #711 had 1 bottle/container or package of OTC medications Resident #712 had 1 bottle/container or package of OTC medications Resident #713 had 1 bottle/container or package of OTC medications Resident #714 had 1 bottle/container or package	S3211		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N056012	A. BUILDING: _____ B. WING _____	06/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMPORIA PLACE	1200 W 12TH AVENUE EMPORIA, KS 66801

(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
S3211	Continued From page 10 of OTC medications Resident #715 had 2 bottles/containers or packages of OTC medications. There was also 1 bottle of Folic Acid 400 tablets with no name or identifiers. Within the cabinet in the medication room was 3 boxes of unit dose packages of Triple antibiotic ointment (144 packages per box) not labeled. CMA B reported the packages were for stock use when a resident needed first aid. Interview on 6/18/18 at 1:10 PM with CMA B revealed when the resident or family brings in the OTC medications he/she would write the room number on the bottle/container/package. Interview on 6/18/18 at 1:18 PM with licensed nurse C revealed the CMAs labeled the OTC bottles/containers/packages with a room number or name when the resident or family brings it in. The CMAs should check that the physician had ordered the OTC and if not alert the nurse. Review of the facility's medication administration policy dated 7/1/14 revealed medications and treatments are administered to residents in accordance with physician order, state laws and assisted living regulations. Review of the facility's Stock medication and supplies policy dated 7/1/14 revealed the community (facility) does not stock medications for resident use. Each resident must have their own medications on hand. The administrator failed to ensure a licensed nurse or licensed pharmacist placed the full name of the resident on each over-the-counter (OTC)	S3211		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N056012	A. BUILDING: _____ B. WING _____	06/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMPORIA PLACE	1200 W 12TH AVENUE EMPORIA, KS 66801

(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
S3211	Continued From page 11 medication package or container for which the facility managed his/her medications.	S3211		