STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B022001	A. BUILDING: _____ B. WING _____	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWO TIMBERS LLC	101 EAST VIRGINIA ST HIGHLAND, KS 66035

(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 the licensure resurvey for the above named facility conducted on 02/28/24.	S 000		
S5155 SS=D	26-42-204 (a) Health Care Services (a) The administrator or operator in each home plus shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-42-204(a) The facility reported a census of 12 residents with 3 included in the sample reviewed. Based on interview and record review, operator A failed to ensure a licensed nurse coordinated care to meet Resident (R) 1's, (R) 2's and (R) 3's needs for bed rail/assistive device. Findings included: - Record review for R1 revealed an admission date of 10/04/23 with a diagnosis of hypertension, chronic pain and tremors. The 10/04/23 "Functional Capacity Screen" (FCS) identified R1 required physical assistance	S5155		

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
	B022001	A. BUILDING: _____ B. WING _____	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWO TIMBERS LLC	101 EAST VIRGINIA ST HIGHLAND, KS 66035

(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
S5155	Continued From page 1	S5155		

with bathing, dressing, toileting, transfer, walking/mobility, staff managed medications, was incontinent of bladder and was at risk for falls/unsteadiness.

The 02/03/24 "Negotiated Service Agreement" (NSA) identified staff provided R1 bathing assistance two times a week, assistance with dressing, toileting, and bladder incontinence.

R1's record lacked evidence of documentation of a bedrail/assistive device assessment.

Observation on 02/28/24 at 11:15 AM in R1's room revealed a bed assistive device to both sides of the bed.

On 02/28/24 at approximately 02:10 PM operator A confirmed R1's records lacked evidence of documentation of using a bedrail/assistive device assessment.

- Record review for R2 revealed an admission date of 10/23/23 with a diagnosis of stroke.

The 10/23/23 "Functional Capacity Screen" (FCS) identified R2 required physical assistance with bathing, dressing, toileting, transfer, walking/mobility, staff managed medications, was incontinent of bladder and was at risk for falls/unsteadiness.

The 10/23/23 "Negotiated Service Agreement" (NSA) identified staff would provide R2 bathing assistance, dressing, toileting, transfers, walking/mobility, and bladder incontinence.

R2's record lacked evidence of documentation of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B022001	A. BUILDING: _____ B. WING _____	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWO TIMBERS LLC	101 EAST VIRGINIA ST HIGHLAND, KS 66035

(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
S5155	Continued From page 2 a bedrail/assistive device. Observation on 02/28/24 at 11:20 AM during entrance tour R2's room revealed a bed assistive device to the left side of the bed. On 02/28/24 at approximately 02:15 PM operator A confirmed R2's records lacked evidence of documentation of using a bedrail /assistive device. - Record review for R3 revealed an admission date of 12/01/23 with a diagnosis of hypertensive heart disease, acute pain to trauma and atrial fibrillation. The 02/05/24 "Functional Capacity Screen" (FCS) identified R3 required physical assistance with bathing, dressing, toileting, transfer, walking/mobility, staff managed medications, was incontinent of bladder and was at risk for falls/unsteadiness. The 02/05/24 "Negotiated Service Agreement" (NSA) identified staff would provide R3 bathing assistance, dressing, toileting, transfers, walking/mobility, and bladder incontinence. R3's record lacked evidence of documentation of a bedrail/assistive device. Observation on 02/28/24 at 11:40 AM during entrance tour R3's room revealed a bed assistive device to both sides of the bed. On 02/28/24 at approximately 02:30 PM operator	S5155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B022001	A. BUILDING: _____ B. WING _____	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWO TIMBERS LLC	101 EAST VIRGINIA ST HIGHLAND, KS 66035

(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
S5155	Continued From page 3 A confirmed R3's records lacked evidence of documentation of using a bedrail /assistive device. Operator A failed to ensure a licensed nurse coordinated care to meet R1's, R2's and R 3's needs for bedrail/assistive devices.	S5155		
S5215 SS=F	26-42-104 (d) Disaster and Emergency Preparedness Education (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 home ' s emergency management plan; (2) education of each resident upon admission to the home regarding emergency procedures; (3) quarterly review of the home ' 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 26-42-104(d)(3) The facility reported a census of 12 residents. Based on interview and record review the operator A failed to provide quarterly reviews of the facility's emergency management plans with staff and residents.	S5215		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B022001	A. BUILDING: _____ B. WING _____	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWO TIMBERS LLC	101 EAST VIRGINIA ST HIGHLAND, KS 66035

(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
S5215	Continued From page 4 Findings included: - On 02/28/24 at 11:30 AM dates and documentation of the facility's quarterly reviews of emergency management plans with residents and staff since the previous survey were requested from operator A. On 02/28/24 at approximately 03:10 PM operator A confirmed the reviews of the facility's emergency management plans with staff and residents was not conducted quarterly. Review of emergency management documentation revealed last quarterly review for resident and staff was "February 2022". Operator A failed to provide quarterly reviews of the facility's emergency management plans with staff and residents.	S5215		
S5230 SS=D	26-42-207 (b)(5)(6) (c) Infection Control Policies (b)(5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; (c) Each administrator or operator shall ensure the home ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105.	S5230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B022001	A. BUILDING: _____ B. WING _____	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWO TIMBERS LLC	101 EAST VIRGINIA ST HIGHLAND, KS 66035

(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
S5230	Continued From page 5 This REQUIREMENT is not met as evidenced by: KAR 26-42-207(c) The facility reported a census of 12 residents included with the sample. Based on record review and interview for Residents (R)1 and R2 and 4 sampled staff Certified Nurse Aide (CNA) D, CNA E, CNA F, CNA G, the facility failed to ensure compliance with the state Agency's tuberculosis department's tuberculosis (TB) guidelines. Findings included: - Record review for R1 revealed an admission date of 10/04/23 with a diagnosis of hypertension, chronic pain, tremors. The 10/26/23 first step TB skin test was read on 10/28/23 with negative results. R1's record lacked evidence of documentation of a second step TB skin test. - Record review for R2 revealed an admission date of 10/23/23 with a diagnosis of stroke. R2's record lacked evidence of documentation of a TB skin test. - Record review for R3 revealed an admission date of 12/01/23 with diagnoses of hypertensive heart disease, acute pain to trauma, atrial fibrillation.	S5230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B022001	A. BUILDING: _____ B. WING _____	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWO TIMBERS LLC	101 EAST VIRGINIA ST HIGHLAND, KS 66035

(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
S5230	Continued From page 6 R3's record lacked evidence of documentation of a TB skin test. Review of CNA D's employee record revealed a hire date of 12/08/23/23. CNA D's record lacked evidence of TB testing upon hire. Review of CNA E's employee record revealed a hire date of 11/15/23/23. CNA E's record lacked evidence of TB testing upon hire. Review of CNA F's employee record revealed a hire date of 05/23/23. CNA F's record lacked evidence of TB testing upon hire. The 04/30/23 first step TB skin test was read on 05/02/23 with negative results. CNA F's record lacked evidence of documentation of a second step TB skin test. Review of CNA G's employee record revealed a hire date of 01/08/24. CNA G's record lacked evidence of TB testing upon hire. The 09/11/23 first step TB skin test was read on 09/13/23 with negative results. CNA G's record lacked evidence of documentation of a second step TB skin test. On 02/28/24 at approximately 3:10 PM operator A confirmed R1's record lacked evidence of documentation of a second step TB skin test. On 02/28/24 at approximately 3:15 PM operator A confirmed R2's record lacked evidence of	S5230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B022001	A. BUILDING: _____ B. WING _____	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWO TIMBERS LLC	101 EAST VIRGINIA ST HIGHLAND, KS 66035

(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
S5230	Continued From page 7 documentation of a TB skin test. On 02/28/24 at approximately 3:25 PM operator A confirmed R3's record lacked evidence of documentation of a step TB skin test. On 02/28/24 at approximately 3:35 PM operator A confirmed CNA D's record lacked evidence of documentation of a TB skin test. On 02/28/24 at approximately 3:37 PM operator A confirmed CNA E's record lacked evidence of documentation of a TB skin test. On 02/28/24 at approximately 3:39 PM operator A confirmed CNA F's record lacked evidence of documentation of a second step TB skin test. On 02/28/24 at approximately 3:41 PM operator A confirmed CMA G's record lacked evidence of documentation of a second step TB skin test. The department's June 2013 "Tuberculosis (TB) Guideline for Adult Care Homes" documented Each new resident and employee shall have an initial TB symptom screen that includes the components of the Tuberculosis Symptom Screen Questionnaire and shall receive a two-step TST or an IGRA within 7 days of residency or employment. Each resident and employee shall have an annual TB symptom screen that includes the components of the Tuberculosis Symptom Screen Questionnaire. Operator A failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in KAR 26-39-105	S5230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B022001	A. BUILDING: _____ B. WING _____	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWO TIMBERS LLC	101 EAST VIRGINIA ST HIGHLAND, KS 66035

(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