STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B005001	A. BUILDING: _____ B. WING _____	03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELLINWOOD COUNTRY LIVING	302 N MAIN STREET ELLINWOOD, KS 67526

(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 at the above named home plus facility conducted on 03/20/24.	S 000		
S5215 SS=E	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 census equaled 8 residents. The sample included 3 residents and review of 4 newly hired employee records. Based on record review and interview, Operator/Certified Medication Aide (CMA) A failed to ensure disaster and emergency preparedness by ensuring the performance of quarterly review of the facility's entire "Emergency Management Plan" with staff.	S5215		

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
	B005001	A. BUILDING: _____ B. WING _____	03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELLINWOOD COUNTRY LIVING	302 N MAIN STREET ELLINWOOD, KS 67526

(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 1 Findings included: - Review of the facility "Emergency Management Plan" revealed the plan contained procedures to manage potential emergencies and disasters including fire, flood, severe weather, tornado, explosion, natural gas leak, lack of electrical, or water service, and missing residents. On 03/20/24, surveyor requested the facility's quarterly reviews of the emergency management plan with staff and facility failed to provide documentation. Interview on 03/20/24 at 03:34 PM with Licensed Nurse B confirmed unable to locate documented quarterly reviews of the emergency management plan with staff. The facility failed to provide a policy on disaster and emergency management reviews. Operator/CMA A failed to failed to ensure disaster and emergency preparedness by ensuring the performance of quarterly review of the facility's entire "Emergency Management Plan" with staff.	S5215		
S5230 SS=F	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	S5230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B005001	A. BUILDING: _____ B. WING _____	03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELLINWOOD COUNTRY LIVING	302 N MAIN STREET ELLINWOOD, KS 67526

(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 2 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. This REQUIREMENT is not met as evidenced by: KAR 26-42-207 (c) The census totaled 8 residents. The sample included 3 residents and review of 4 newly hired employees. Based on record review and interview for 3 sampled Residents (R)1, R2 and R3 and 3 newly hired employees (Certified Nurse Aide (CNA) C, CNA D and CNA E, the facility failed to ensure compliance with the State Agency's tuberculosis (TB) guidelines. Findings included: - R1's "Medical Record" revealed she admitted to the facility on 12/18/22 and the record lacked completion of TB testing and a TB questionnaire upon admission. Record further lacked completion of an annual TB questionnaire for 2023. R2's "Medical Record" revealed he admitted to the facility on 03/11/24 and the record lacked completion of TB testing and a TB questionnaire upon admission R3's "Medical Record" revealed she admitted to	S5230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B005001	A. BUILDING: _____ B. WING _____	03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELLINWOOD COUNTRY LIVING	302 N MAIN STREET ELLINWOOD, KS 67526

(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 3 the facility on 03/21/23 and the record lacked completion of TB testing and a TB questionnaire upon admission. - Review of CNA C's employee record revealed they hired onto the facility on 02/08/24. CNA C's first step of TB testing was completed on 02/22/24, 2 weeks after being hired to the facility. The record lacked evidence of completion of the second step of TB testing upon hire. Review of CNA D's employee record revealed they hired onto the facility on 02/08/24. CNA D's first step of TB testing was completed on 03/04/24, approximately 3.5 weeks after being hired to the facility. The record lacked evidence of completion of the second step of TB testing upon hire. Review of CNA E's employee record revealed they hired onto the facility on 01/17/24. CNA E's first step of TB testing was completed on 01/29/24, 12 days after being hired to the facility. The record lacked evidence of completion of the second step of TB testing upon hire. The record further lacked completed of a TB questionnaire upon hire. TB questionnaire was completed on 01/29/24, 12 days after being hired to the facility. Interview on 03/20/24 at 02:15 PM with Licensed Nurse (LN) B confirmed TB testing and a TB questionnaire was not completed upon admission for R1. Interview on 03/20/24 at 02:37 PM with LN B confirmed TB testing and a TB questionnaire was not completed upon admission for R2 and R3.	S5230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B005001	A. BUILDING: _____ B. WING _____	03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELLINWOOD COUNTRY LIVING	302 N MAIN STREET ELLINWOOD, KS 67526

(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 4 Interview on 03/20/24 at 02:41 PM with LN B confirmed TB testing was completed late for CNA C, CNA D and CNA E and further confirmed the second step of TB testing had not been completed for CNA C, CNA D and CNA E. Facility's TB policy (no date) recorded, "A health screening shall be performed on each employee no later than 7 days after employment ...TB testing on employees and residents as per state regulations: 1. TB testing (2-step) will be done on each new resident and employee, as soon as residency or employment begins, unless a documentation of a previous significant reaction can be provided." The facility failed to follow the State Agency's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105, which had the potential to affect all residents.	S5230		
S5313 SS=E	26-42-205 (g) (3) Over the counter medication (g) (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.	S5313		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B005001	A. BUILDING: _____ B. WING _____	03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELLINWOOD COUNTRY LIVING	302 N MAIN STREET ELLINWOOD, KS 67526

(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
S5313	Continued From page 5 This REQUIREMENT is not met as evidenced by: KAR 26-42-205 (g) (3) The census totaled 8 residents. The sample included 3 residents. Based on observation and interview for 1 sampled resident (R)1 and 3 non-sampled resident (R)4, R5 and R6, Operator/Certified Medication Aide (CMA) A failed to ensure licensed nurses or pharmacists placed the full name of the resident on each package of the resident's over the counter medication. Findings included: - Observation on 03/20/24 during the initial tour with Operator/CMA A revealed a locked medication cart in the dining room of the facility. The following over the counter medications were noted without first and last names: For R3, the cart contained one 12 oz (ounce) bottle of Cold and Flu Relief, For R4, the cart contained one bottle of 8HR (hour) Arthritis Pain Relief, For R5, the cart contained one box of Mucinex DM Max, For R6, the closet contained one box of Coricidin HBP (high blood pressure) Cough and Cold and one 12 oz bottle of Coricidin HBP Cough, Cold and Flu. Interview on 03/20/24 with Operator/CMA A confirmed the above listed medications were labeled without first and last names.	S5313		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B005001	A. BUILDING: _____ B. WING _____	03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELLINWOOD COUNTRY LIVING	302 N MAIN STREET ELLINWOOD, KS 67526

(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
S5313	Continued From page 6 "Facility Management of Medications" policy (no date) recorded, "9. Over the counter drugs ...A pharmacist or licensed nurse shall place the full name of the resident on the package if over-the-counter drugs are removed from the original manufacture's package." Operator/ CMA A failed to ensure licensed nurses or pharmacists placed the full name of residents on each package of the resident's over the counter medication.	S5313		