STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B044002	A. BUILDING: _____ B. WING _____	06/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KELLY HOUSE OF MERIDEN SOUTH	3566 62ND STREET MERIDEN, KS 66512

(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 represents the findings of a resurvey for the above named home plus facility conducted on 06/24/25.	S 000		
S5195 SS=F	26-42-206 (f) (g) Facility Food Storage (f) Staff shall store all food under safe and sanitary conditions. Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving. (g) Each home shall maintain at least a three-day supply of food to meet the requirements of the planned menus. This REQUIREMENT is not met as evidenced by: KAR 26-42-206(f) The facility reported a census of ten residents. The facility had a main kitchen where food was stored, prepared, and served to all residents. Based on observation and interview the administrator failed to ensure foods were stored under safe conditions. Findings included: - Observation on 06/24/25 at 10:45 AM revealed a refrigerator and three freezer spaces in the facility's main kitchen which contained food items for the residents. The chest freezer held one bag of opened and unsealed sweet potato fries.	S5195		

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
	B044002	A. BUILDING: _____ B. WING _____	06/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KELLY HOUSE OF MERIDEN SOUTH	3566 62ND STREET MERIDEN, KS 66512

(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
S5195	Continued From page 1 The refrigerator held the following food items: One zippered bag of roast beef dated 6/16 One zippered bag of cleaned and cut onion undated One opened and unsealed individual container of butterscotch pudding One 12 fluid ounce container of mayo with best by date of 2/25/25 Two opened and undated containers of French vanilla coffee creamer with labels that read to discard in 14 days The bottom drawer of refrigerator included two zippered bags of hamburger and one zippered bag of pork loin all dated "5/21". Liquid from meat were located in the bottom of the drawer. A drawer between upright freezer and refrigerator held drink mixes including one fruit punch and one orange punch, both opened and unsealed. Observation on 06/24/25 at 11:02 AM revealed a tall pantry cabinet which contained the following food items for the residents and their best by dates: Three dented 14-ounce cans of cranberry sauce, one read 12/31/24, two read 4/1/25 One 16 fluid ounce bottle classic Caesar dressing, 3/19/25 One 16 fluid ounce bottle coleslaw dressing, 6/17/25 On 06/24/25 at approximately 11:05 AM Certified Medication Aide (CMA) E confirmed the foods were either unsealed, undated, or past their best by date.	S5195		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B044002	A. BUILDING: _____ B. WING _____	06/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KELLY HOUSE OF MERIDEN SOUTH	3566 62ND STREET MERIDEN, KS 66512

(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
S5195	Continued From page 2 The August 2024 Kansas Department of Agriculture's "Focus on Food Safety" booklet page 15 described to store raw foods like beef, pork, and fish separately to prevent contamination. Page 21 explains that foods prepared on-site or commercially prepared must be date marked when prepared or when the original container was opened and held under refrigeration. A food storage policy was requested which the facility failed to provide. The administrator failed to ensure foods were stored under safe conditions.	S5195		
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 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:	S5230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B044002	A. BUILDING: _____ B. WING _____	06/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KELLY HOUSE OF MERIDEN SOUTH	3566 62ND STREET MERIDEN, KS 66512

(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 KAR 26-42-207(c) The facility reported a census of ten residents with three residents included in the sample. Based on interview and record review the administrator failed to ensure the facility remained in compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in KAR 26-39-105 for five of five newly hired staff. Findings included: - Record review for Certified Medication Aide (CMA) F revealed a hire date of 12/19/24 and failed to include a completed TB two-step test (TST). - Record review for CMA G revealed a hire date of 08/08/24 and failed to include a completed TB two-step test (TST). - Record review for Certified Nurse Aide (CNA) H revealed a hire date of 01/08/25. A first step of the TB two-step test (TST) was administered 05/07/25 and read 05/09/25. Her record failed to include a second step. - Record review for CNA I revealed a hire date of 12/24/24 and failed to include a completed TB two-step test (TST). - Record review for Unlicensed Staff J revealed a hire date of 12/30/24 and failed to include a completed TB two-step test (TST). On 06/24/25 at 11:08 AM Administrative Staff D confirmed all five sample staff's records lacked	S5230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B044002	A. BUILDING: _____ B. WING _____	06/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KELLY HOUSE OF MERIDEN SOUTH	3566 62ND STREET MERIDEN, KS 66512

(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 documentation of completed TB TST. The department's June 2013 "Tuberculosis (TB) Guideline for Adult Care Homes" documented each new employee shall receive a two-step TST or Interferon Gamma Release Assay within seven days of employment. A TB policy was requested which the facility failed to provide. The administrator failed to ensure the facility remained in compliance with the State Agency's tuberculosis guidelines for adult care homes adopted by reference in KAR 26-39-105, which had the potential to affect all residents.	S5230		
S5335 SS=F	28-39-437 Construction (a) Each home-plus facility shall be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public. (b) All new construction, renovation, remodeling, and changes in building use in existing buildings shall comply with building and fire codes, ordinances, and regulations enforced by city, county, and state jurisdictions, including the state fire marshal. This REQUIREMENT is not met as evidenced by: KAR 28-39-437(a) The facility reported a census of ten residents. Based on observation and interview the administrator failed to ensure the building was maintained to protect the health and safety of the	S5335		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B044002	A. BUILDING: _____ B. WING _____	06/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KELLY HOUSE OF MERIDEN SOUTH	3566 62ND STREET MERIDEN, KS 66512

(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
S5335	Continued From page 5 residents by ensuring all emergency exits were clear and walls were in good repair. Findings included: - Observation on 06/24/25 at 09:43 AM revealed the sunroom with door to east side was full of unused furniture blocking the ability to exit out the door. Observation of the floor plan revealed the sunroom door was labeled as an emergency exit. On 06/24/25 at 02:43 PM Certified Medication Aide E stated the sunroom has had furniture packed to where staff and residents could not exit safely for at least the last six months. She confirmed the sunroom door was an emergency exit. - Observation on 06/24/25 at approximately 09:40 AM in the north bathroom revealed a piece of rubber not secured to the wall between shower and toilet. The rubber allowed water and contaminants to harbor between rubber and wall. Observation on 06/24/25 at approximately 09:58 AM in the south bathroom revealed a missing piece of wall trim. The wall was unfinished and had the potential to grow harmful contaminants. On 06/24/25 at 02:43 PM Administrative Staff D stated tickets for repair were entered for the bathroom walls but were not entered correctly to ensure repairs were completed. She confirmed the bathroom walls were not repaired to protect the residents from injury or illness.	S5335		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B044002	A. BUILDING: _____ B. WING _____	06/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KELLY HOUSE OF MERIDEN SOUTH	3566 62ND STREET MERIDEN, KS 66512

(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
S5335	Continued From page 6 The administrator failed to ensure the building was maintained to protect the health and safety of the residents by ensuring all emergency exits were clear and walls were in good repair.	S5335		