| 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 _____ | 08/26/2025 |

| 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<br><br>The following citations represent the findings of the licensure resurvey for the above named home plus facility conducted on 08/26/25. | S 000 | | |
| S5171 SS=D | 26-42-204 (i) Health Care Services Standards of Practice<br><br>(i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-42-204 (i)<br><br>The census totaled 7 residents. The sample included 3 residents. Based on observation, interview and record review, Operator/ Certified Medication Aide (CMA) A failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services in accordance with acceptable standards of practice for the use of bed assistive devices, which met the needs of 1 of 3 sampled residents (R)2.<br><br>Findings included:<br><br>- The "Resident Roster" obtained on 08/26/25 at 10:15 AM from Operator/ CMA A identified one resident as having a bed assistive device (R2).<br><br>Record review for R2 revealed she admitted to the facility on 03/13/25 with diagnoses of hypothyroidism and generalized anxiety disorder.<br><br>R2's current "Functional Capacity Screen" (FCS) | S5171 | | |

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 _____ | 08/26/2025 |

| 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 |
|---|---|---|---|---|
| S5171 | Continued From page 1 | S5171 | | |

dated 03/13/25 recorded the resident required supervision with eating, physical assistance with bathing, dressing, toileting, transfers, walk/mobility and was unable to manage medications and treatments. The FCS recorded R2 had impaired short-term memory, memory/recall impairment, impaired decision-making skills and was understandable/ usually understood communication. R2 was at risk for falls/ unsteadiness, had impaired vision, was at risk for wandering and had socially inappropriate behavior.

The resident's "Negotiated Service Agreement/ Health Care Service Plan" (NSA/HCSP) dated 03/13/25 recorded staff assisted R2 with bathing, dressing, toileting, transfer, walk/mobility, eating and administered medications and treatments. The NSA/HCSP identified a walker used for mobility. The NSA/HCSP recorded facility staff completed nighttime safety checks and encouraged socialization.

The NSA failed to identify the use of a bed assistive device used for transfers.

Record review lacked any assessment of the resident to confirm the device was not a restraint, an assessment of the resident to determine the purpose of the bedrail/assistive device and the resident's ability to safely use the device, an assessment of the bedrail/assistive device to ensure the device was securely attached to the bed or bedframe and posed no risk for entrapment.

Observation on 08/26/25 at approximately 01:25 PM of R2's room revealed a bed assist device to

| 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 _____ | 08/26/2025 |

| 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 |
|---|---|---|---|---|
| S5171 | Continued From page 2<br>the left side of the bed. The bed assist device was secured to the bed.<br><br>Interview on 08/26/25 at 12:43 PM with Licensed Nurse B confirmed no safety checks or bed assistive device assessments were completed on R2.<br><br>The FDA (food and drug administration) Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated 3/10/06 listed 4 zones of greatest concern with specific measurements to reduce the risk of entrapment as follows:<br>Zone 1 within the rail should measure less than 4 and 3/4 inches<br>Zone 2 under the rail, between the rail supports or next to a single rail support should measure less than 4 and ¾ inches<br>Zone 3 between the rail and the mattress should measure less than 4 and 3/4 inches<br>Zone 4 under the rail at the ends of the rail should measure less than 2 and 3/8 inches.<br><br>Facility failed to provide a bed assistive device policy.<br><br>Operator/CMA A failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services in accordance with acceptable standards of practice which met the needs of R2 regarding use of a bed assistive device. | S5171 | | |
| S5192 SS=F | 26-42-206 (e) Food Preparation<br><br>(e) Food shall be prepared using safe methods that conserve the nutritive value, flavor, and | S5192 | | |

| 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 _____ | 08/26/2025 |

| 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 |
|---|---|---|---|---|
| S5192 | Continued From page 3 | S5192 | | |

appearance and shall be served at the proper temperature.
(1) Food used by facility staff to serve to the residents, including donated food, shall meet all applicable federal, state, and local laws and regulations.(2) Food in cans that have significant defects, including swelling, leakage, punctures, holes, fractures, pitted rust, or denting severe enough to prevent normal stacking or opening with a manual, wheel-type can opener, shall not be used.
(3) Food provided by a resident ' s family or friends for individual residents shall not be required to meet federal, state, and local laws and regulations.

This REQUIREMENT is not met as evidenced by:
KAR 26-42-206 (e)

The census equaled 7 residents. The sample included 3 residents. Based on record review, interview and observation for all residents receiving meal services, Operator/ Certified Medication Aide (CMA) A failed to ensure the facility staff served food at the proper temperature.

Findings included:

- Observation during the initial tour on 08/26/25 at 10:22 AM revealed a kitchen containing food/drinks. Food temperature monitoring logs were requested from Operator/ CMA A.

Observation on 08/26/25 at 02:14 PM of the "Food Temps" with Operator/ CMA A revealed the

| 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 _____ | 08/26/2025 |

| 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 |
|---|---|---|---|---|
| S5192 | Continued From page 4<br>following dates lacked lunch food temperatures: 08/09/25, 08/10/25, 08/11/25, 08/16/25 and 08/17/25.<br><br>Observation on 08/26/25 at 02:14 PM of the "Food Temps" revealed the following dates lacked supper food temperatures: 08/02/25, 08/06/25, 08/09/25, 08/10/25, 08/11/25, 08/12/25, 08/14/25, 08/16/25 and 08/17/25, 08/18/25, 08/19/25 and 08/21/25.<br><br>Interview on 08/26/25 at 02:14 PM with Operator/ CMA A confirmed the August 2025 "Food Temps" lacked temperatures for the above dates.<br><br>Interview on 08/26/25 at approximately 02:14 PM with Operator/ CMA A confirmed all seven residents ate meals at the facility daily.<br><br>Facility failed to provide a policy on monitoring food temperatures.<br><br>For all residents of the facility, Operator/ CMA A failed to ensure facility staff served food at the proper temperature. | S5192 | | |
| S5230 SS=F | 26-42-207 (b)(5)(6) (c) Infection Control Policies<br><br>(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;<br>(6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; | 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 _____ | 08/26/2025 |

| 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 5<br>(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.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-42-207 (c)<br><br>The census totaled 7 residents. The sample included 3 residents. Based on record review and interview for 1 Residents (R)2, the facility failed to ensure compliance with the State Agency's tuberculosis (TB) guidelines.<br><br>Findings included:<br><br>- R2's "Health Record" revealed she admitted to the facility on 03/13/25. R2's first step of TB testing was administered on 03/20/25 and read on 03/23/25. R2's record lacked evidence of completion of the second step of TB testing.<br><br>Interview on 08/26/25 at 01:55 PM with Licensed Nurse B confirmed unable to locate a second step of TB testing for R2.<br><br>Facility failed to provide a TB policy.<br><br>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 | 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 _____ | 08/26/2025 |

| 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<br>(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.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-42-205 (g) (3)<br><br>The census totaled 7 residents. The sample included 3 residents. Based on observation and interview for 1 resident (R)1 and 2 non-sampled residents (R)4 and R5, 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.<br><br>Findings included:<br><br>- Observation on 08/26/25 at 10:22 AM with Operator/ CMA A revealed a locked medication cart in the dining room. The following over the counter medications were noted without first and last names:<br><br>For R1, the cart contained one tube of | 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 _____ | 08/26/2025 |

| 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 7<br><br>Pain-Relieving Cream and one bottle of Acetaminophen (pain reliever),<br>For R4, the cart contained one bottle of Aspirin (non-steroidal anti-inflammatory drug),<br>For R5, the cart contained one bottle of Aspirin and one bottle of Tylenol (pain reliever),<br>Additionally, the cart contained one bottle of Milk of Magnesia (laxative), and Operator/ CMA was unable to verify whom the medication belonged to.<br><br>Interview on 08/26/25 at approximately 10:30 AM with Operator/ CMA A confirmed the above listed medications were without first and last names and further confirmed all over the counter medications were to be labeled with first and last names.<br><br>Facility failed to provide an over the counter medication policy.<br><br>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 | | |