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 _____	11/06/2025

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 represents the findings of a resurvey for the above named home plus facility conducted 11/05/25-11/06/25.	S 000		
S5085 SS=E	26-42-201 (c) Functional Capacity Screen Reassessment (c) Designated staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: KAR 26-42-201(c)(1)(2) The facility reported a census of 12 residents with three included in the sample. Based on interview and record review the operator failed to complete a Functional Capacity Screen (FCS) for Resident (R) 1 and R3 every 365 days and R1 following a significant change in condition. Finding included: - Record review for R1 revealed an admission date of 10/04/23 with a diagnosis of chronic respiratory failure. The 03/17/24 FCS identified R1 was unable to perform bathing, dressing, toileting, transfers,	S5085		

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 _____	11/06/2025

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
S5085	Continued From page 1	S5085		

mobility, eating, management of medications and treatments; had memory/recall and decision-making difficulties; and was at risk for falls, impaired vision, impaired hearing, and impaired decision-making.

Review of the local hospice agency "Plan of Care Order" documented R1 was admitted to hospice on 03/27/25.

R1's record lacked an FCS since 03/17/24 which was 233 days overdue for annual and not completed upon change in condition.

On 11/05/25 at 03:46 PM Administrative Staff A confirmed R1's record lacked evidence of documentation of an FCS for annual or significant change.

- Record review for R3 revealed an admission date of 01/13/24 with a diagnosis of dementia.

The 01/12/24 (admission) FCS identified R3 was unable to perform bathing, dressing, toileting, and management of medications and treatments; required physical assistance with transfers, mobility, eating; had short-term memory, long-term memory, memory/recall, and decision-making difficulties; and was at risk for falls and had impaired decision-making.

R3's record lacked an FCS since 01/12/24 which was 297 days overdue.

On 11/06/25 at 10:56 AM Administrative Staff A confirmed R3 did not have an updated FCS.

The operator failed to ensure an FCS was

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 _____	11/06/2025

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
S5085	Continued From page 2 completed for R1 and R3 every 365 days and for R1 following a significant change in condition.	S5085		
S5116 SS=E	26-42-202 (d) NSA revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements: (1) At least once every 365 days;(2) following any significant change in condition, as defined in K.A.R. 26-39-100; (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant; and (4) if requested by the resident or the resident ' s legal representative, staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. This REQUIREMENT is not met as evidenced by: KAR 26-42-202(d)(1)(2) The facility reported a census of 12 residents with three residents included in the sample. Based on interview and record review the operator failed to ensure the review of the Negotiated Service Agreement (NSA) for Residents (R) 1 and R3 following a significant change in condition and once every 365 days. Findings included: - Record review for R1 revealed an admission date of 10/04/23 with a diagnosis of chronic	S5116		

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 _____	11/06/2025

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
S5116	Continued From page 3 respiratory failure. The 03/17/24 FCS identified R1 was unable to perform bathing, dressing, toileting, transfers, mobility, eating, management of medications and treatments; had memory/recall and decision-making difficulties; and was at risk for falls, impaired vision, impaired hearing, and impaired decision-making. The most recent NSA was dated 03/17/24. Review of the local hospice agency "Plan of Care Order" documented R1 was admitted to hospice on 03/27/25. R1's record lacked an NSA since 03/17/24 which was 233 days overdue for annual and not completed upon change in condition. On 11/05/25 at 03:46 PM Administrative Staff A confirmed R1's record lacked evidence of documentation of an updated NSA for annual or significant change. - Record review for R3 revealed an admission date of 01/13/24 with a diagnosis of dementia. The 01/12/24 (admission) FCS identified R3 was unable to perform bathing, dressing, toileting, , management of medications and treatments; required physical assistance with transfers, mobility, eating; had short-term memory, long-term memory, memory/recall, and decision-making difficulties; and was at risk for falls and had impaired decision-making. The most recent NSA was dated 01/12/24.	S5116		

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 _____	11/06/2025

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
S5116	Continued From page 4 R3's record lacked an NSA since 01/12/24 which was 297 days overdue. On 11/06/25 at 10:56 AM Administrative Staff A confirmed R3 did not have an updated NSA. The operator failed to ensure the review and if necessary, revision of the NSA for R1 and R3 following a significant change in condition and once every 365 days.	S5116		
S5171 SS=F	26-42-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: KAR 26-42-204(i) The facility reported a census of 12 residents with three included in the sample. Based on observation and interview the operator failed to ensure medication administration was according to standard of practice. Findings included: - Observation on 11/05/25 at 01:25 PM revealed multiple medication cups with medications inside labeled with partial resident names. No medication cards were located with the medication cups. On 11/05/25 at 01:25 PM Administrative Staff A	S5171		

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 _____	11/06/2025

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
S5171	Continued From page 5 stated the medications are the residents' evening and bedtime medications. On 11/05/25 at 02:09 PM Certified Medication Aide C stated medications are set up in the mornings and on her 12-hour shift days she takes over the cart at 02:00 PM. On 11/06/25 at 12:20 PM Administrative Staff A confirmed she does not set up medications according to standard of practice. The Kansas Certified Medication Aide Curriculum page 169 instructed when medications are set up for a group of residents medication cards for each medication should be placed under the cup. The operator failed to ensure medication administration was according to standard of practice.	S5171		
S5192 SS=F	26-42-206 (e) Food Preparation (e) Food shall be prepared using safe methods that conserve the nutritive value, flavor, and 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	S5192		

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 _____	11/06/2025

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
S5192	Continued From page 6 required to meet federal, state, and local laws and regulations. This REQUIREMENT is not met as evidenced by: KAR 26-42-206(e) The facility reported a census of ten residents. Based on record review and interview the operator failed to ensure food was served at the proper temperature. Findings included: During initial tour temperature logs were requested. Review of a food temperature log located in the facility's binder revealed the no temperatures were logged since May of 2024. On 11/05/25 at approximately 01:22 PM Administrative Staff A confirmed the food temperature log lacked evidence of documentation food was served at proper temperature for each meal. Dietary guidelines for Americans 2005 recommended using a clean thermometer that measured the internal temperature of cooked food to make sure food is cooked to and held at proper temperatures and to keep food out of the "danger zone" (40 degrees Fahrenheit to 140 degrees Fahrenheit) where bacteria can multiply rapidly. The operator failed to ensure food was served at the proper temperature.	S5192		

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 _____	11/06/2025

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
S5195	Continued From page 7	S5195		
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 12 residents. Based on observation and interview the operator failed to ensure foods were stored under safe conditions. Findings included: - Observation on 11/05/25 at approximately 01:10 PM revealed a refrigerator and freezer was in the facility's main kitchen which contained food items for the residents. A temperature log was not present. Observation on 11/05/25 at 02:21 PM revealed four chest freezers in the basement. Freezers labeled "Freezer 2" and "freezer 3" with yellow note that says "4" did not have thermometers located inside. On 11/05/25 at approximately 02:30 PM Certified Medication Aide C confirmed the freezer spaces did not have thermometers.	S5195		

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 _____	11/06/2025

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
S5195	Continued From page 8 On 11/05/25 at approximately 01:22 PM Administrative Staff A stated the temperatures are checked and confirmed there were no temperature logs for the refrigerator or freezer spaces. The 2009 Food and Drug Administration "Food Code", section 3-501.12 read foods held under refrigeration should be at 41 degrees Fahrenheit (F) or less. The 2005 Food Safety Guidelines instructs refrigerator temperature at 40 degrees F and freezer temperatures at 0 degrees F. The operator failed to ensure foods were stored under safe conditions.	S5195		
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.	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 _____	11/06/2025

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 9 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 failed to provide quarterly reviews of the facility's emergency management plan with staff and residents. Findings included: - Review of the facility's emergency management plan quarterly reviews with residents and staff since the previous survey revealed the last review was completed in March of 2024. On 11/05/25 at 03:07 PM Administrative Staff A confirmed reviews of the facility's emergency management plan with staff and residents was not conducted quarterly. The operator failed to provide quarterly reviews of the facility's emergency management plan with staff and residents.	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
	B022001	A. BUILDING: _____ B. WING _____	11/06/2025

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 10 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 facility reported a census of 12 residents with three residents included in the sample. Based on interview and record review the operator 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 two of five newly hired staff and for Residents (R) 1 and R3. Findings included: - Record review for Certified Medication Aide (CMA) C revealed a hire date of 03/24/25. A first step of the TB two-step test (TST) was administered 11/11/24 and read 11/13/24, which was prior to hire. Her record failed to include a second step. Record review for Certified Nurse Aide (CNA) H revealed a hire date of 01/26/25. The employee record lacked documentation of TB testing. Review of R1's record revealed an admission date of 10/04/23 and with most recent TB	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 _____	11/06/2025

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 11 screening questionnaire completed 03/17/24. The record failed to include a current annual screening questionnaire. Review of R3's record revealed an admission date of 01/13/24 with the most recent TB screening questionnaire was completed on admission. The record failed to include a current annual screening questionnaire. On 11/05/25 at 03:35 PM CMA C confirmed she did not have a second step of the TB TST completed. On 11/05/25 at 03:18 PM Administrative Staff A confirmed CMA C, CNA H, R1, and R3's records lacked documentation required. 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 unless a completed TST documentation is provided from within six months prior to hire. Each resident and employee should have an annual TB symptom screen. The operator 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		
S5258 SS=F	26-42-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff records shall contain the following information:	S5258		

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 _____	11/06/2025

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
S5258	Continued From page 12 (1) Evidence of licensure, registration, certification, or a certificate of successful completion of a training course for each employee performing a function that requires specialized education or training; (2) supporting documentation for criminal background checks of facility staff and contract staff, excluding any staff licensed or registered by a state agency, pursuant to K.S.A. 39-970 and amendments thereto; (3) supporting documentation from the Kansas nurse aide registry that the individual does not have a finding of having abused, neglected, or exploited a resident in an adult carehome; and (4) supporting documentation that the individual does not have a finding of having abused, neglected, or exploited any resident in an adult care home, from the nurse aide registry in each state in which the individual has been known to work as a certified nurse aide. This REQUIREMENT is not met as evidenced by: KAR 26-42-102(d)(1)(2) The facility reported a census of 12 residents. Based on interview and record review the operator failed to ensure evidence of licensure or certification was completed for three of five sampled staff and criminal background checks were completed for five of five sampled staff upon hire. Findings included: - Record review for five employees revealed the following:	S5258		

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 _____	11/06/2025

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
S5258	Continued From page 13 Certified Nurse Aide (CNA) E's employee record revealed a hire date of 03/09/25. The employee's registry check was completed on 11/05/25 and her record lacked evidence of supporting documentation a criminal background check was completed. Certified Medication Aide (CMA) C's employee record revealed a hire date of 03/24/25. The employee record lacked a criminal background check. CNA F's employee record revealed a hire date of 04/06/25. The employee's registry check was completed on 11/05/25 and her record lacked evidence of supporting documentation a criminal background check was completed. CNA G's employee record revealed a hire date of 04/06/25. The employee's registry check was completed on 11/05/25 and her record lacked evidence of supporting documentation a criminal background check was completed. CNA H's employee record revealed a hire date of 01/26/25. The employee record lacked a criminal background check. On 11/05/25 at 03:18 PM Administrative Staff A confirmed staff records lacked evidence documentation that licensure or certification was completed for all three of the sampled staff and criminal background checks were completed for all sampled staff upon hire. The operator failed to ensure evidence of licensure or certification was completed for three	S5258		

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 _____	11/06/2025

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
S5258	Continued From page 14 of five sampled staff and criminal background checks were completed for five of five sampled staff upon hire.	S5258		
S5313 SS=F	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. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(g)(3) The facility reported a census of 12 residents. Based on observation and interview the operator failed to ensure a licensed pharmacist or licensed nurse placed the full names of the residents on the original packages of eighteen over-the-counter (OTC) medications. Findings included: - Observation on 11/05/25 at 01:25 PM revealed Certified Medication Aide (CMA) C unlocked and opened the medication cart where the	S5313		

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 _____	11/06/2025

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
S5313	Continued From page 15 medications for the residents were stored. The following over-the-counter medications were not labeled with residents' full names: One bottle cranberry 90 capsules One bottle century multivitamin supplement 100 tablets One bottle tums 750 milligram (mg), 60 tablets One box bismuth subsalicylate 262mg, 30 chewable tablets One bottle cranberry 4200 mg, 60 softgels One bottle preservision eye vitamins, 210 softgels One bottle acetaminophen 650 mg, 225 caplets One bottle polyethylene glycol 3350, 17.9 ounces One bottle fexofenadine 180 mg, 150 tablets One bottle melatonin 10 mg, 180 gummies One bottle ibuprofen 200 mg, 10 tablets One bottle acetaminophen 500 mg, 200 tablets One bottle acetaminophen 500 mg, 600 caplets One bottle eye health complex 210 minigels Two bottles vitamin D3 2000 international units, 400 softgels One bottle fexofenadine 180 mg, 55 tablets One bottle acetaminophen 500 mg, 500 tablets On 11/05/25 at approximately 02:12 PM CMA C confirmed the OTC medication were not labeled with residents' full names. The operator failed to ensure all OTC medications were labeled with the residents' full names.	S5313		
S5315 SS=E	26-42-205 (h) Medication Storage (h) Storage. Licensed nurses and medication	S5315		

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 _____	11/06/2025

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
S5315	Continued From page 16 aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the home in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the home in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the home. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(h)	S5315		

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 _____	11/06/2025

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
S5315	Continued From page 17 The facility reported a census of 12 residents. Based on observation and interview the operator failed to ensure that all medications and biologicals are stored in accordance with pharmacy and manufacturer recommendations or federal and state laws and regulations. Findings included: - Observation on 11/05/25 at approximately 01:50 PM of the medication cart revealed the following medications: One bottle viatmin D3 50 micrograms, 400 softgels with expiration date 10/24 One bottle calcium 500 milligrams, 60 tablets with expiration date 04/25 One bottle ranitidine 150 milligrams, 95 tablets with expiration date 02/16 One bottle acetaminophen 325 milligrams, 100 tablets with expiration date 09/25 On 11/05/25 at approximately 01:54 PM Certified Medication Aide C confirmed the medications were expired. The operator failed to ensure that all medications and biologicals are stored in accordance with pharmacy and manufacturer recommendations or federal and state laws and regulations.	S5315		
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.	S5335		

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 _____	11/06/2025

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
S5335	Continued From page 18 (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 12 residents. Based on observation and interview the operator failed to ensure the building was maintained to protect the health and safety of the residents by ensuring all chemicals were stored within a locked area. Findings included: - Observation on 11/05/25 at 01:20 PM revealed a lockable, undercounter cabinet below the kitchen sink that was unlocked. The following chemicals were inside with labels that read "Keep out of reach of children:" One spray bottle Murphy cleaning spray One aerosol can Zip disinfectant spray Two aerosol cans of Sparkle mirror and glass cleaner One spray bottle home bug spray One bottle Zep sanitizer spray One container heavy duty degreaser On 11/05/25 at approximately 01:23 PM Certified Medication Aide C confirmed chemicals were not in a locked area. - Observation on 11/05/25 at 02:16 PM revealed	S5335		

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 _____	11/06/2025

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
S5335	Continued From page 19 one aerosol can of air freshener in an unlockable bathroom cabinet with label that read "Keep out of reach of children:" On 11/05/25 at approximately 02:17 PM Certified Medication Aide C confirmed the chemical was not in a locked area. The operator failed to ensure the building was maintained to protect the health and safety of the residents by ensuring all chemicals were stored within a locked area.	S5335		
S5365 SS=F	28-39-437 Laundry Area (4) Laundry area. (A) If the facility processes laundry, the facility shall provide a work area with a one-way flow of laundry from a soiled area to a clean area. (B) The laundry area shall not be located in the same room where preparation and service of food occur. (C) Each facility shall store laundry in a manner that prevents odors and the spread of disease. This REQUIREMENT is not met as evidenced by: KAR 28-39-437 (e)(4)(A) The facility reported a census of 12 residents. Based on observation and interview the operator failed to ensure the facility laundry area used for all residents had a one-way flow from a soiled area to a clean area.	S5365		

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 _____	11/06/2025

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
S5365	Continued From page 20 Findings included: - Observation on 11/05/25 at 02:11 PM revealed the laundry area had two washers and two dryers set up in a washer, dryer, washer, dryer order. On 11/05/25 at 02:13 PM Certified Medication Aide (CNA) C confirmed the washer and dryer set up does not allow for a one-way flow from soiled to clean and all residents' laundry is completed in the same location. The operator failed to ensure the facility laundry area had a one-way flow from a soiled area to a clean area.	S5365		
S9999	Final Observations 9999 final observations S/S of E If the home plus admits residents with dementia, the administrator or operator shall ensure the provision of staff education, at orientation and at least annually thereafter, on the treatment and appropriate response to persons who exhibit behaviors associated with dementia. This requirement is not met as evidenced by: KAR 26-42-103(c) The facility reported a census of 12 residents. Based on interview and record review the operator failed to ensure staff orientation and in-service education for treatment and	S9999		

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 _____	11/06/2025

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
S9999	Continued From page 21	S9999		

appropriate response to persons who exhibit behaviors associated with dementia.

Findings included:

- Record review for R3 revealed an admission date of 01/13/24 with a diagnosis of dementia.

Requested record of dementia training for newly hired staff on 11/05/25 at 02:35 PM which the facility failed to provide.

On 11/05/25 at approximately 03:20 PM Administrative Staff A confirmed dementia training was not completed at hire with newly hired staff or with all staff at an in-service.

The operator failed to ensure staff orientation and in-service education for treatment and appropriate response to persons who exhibit behaviors associated with dementia.

KSA 39-928

Upon receipt of an application for license, the licensing agency with the approval of the state fire marshal shall issue a license if the applicant is fit and qualified and if the adult care home facilities meet the requirements established under this law. A license, unless sooner suspended or revoked, shall remain in effect upon filing by the licensee, and approval by the licensing agency and the state fire marshal or their duly authorized agents, of an annual report upon such uniform dates and containing such information in such form as the licensing agency prescribes and payment of an annual fee. It shall be posted in a conspicuous place in the adult

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 _____	11/06/2025

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
S9999	Continued From page 22 care home. Findings included: Department records revealed the facility failed to file and pay the 2020, 2021, 2022, 2023, 2024, and 2025 annual renewal licensing fees. Observation on 11/05/25 at 02:35 PM Administrative Staff A opened office door and pointed to the facility license located behind some boxes on top of a filing cabinet. Interview on 11/05/25 at 03:50 PM Administrative Staff A stated she was unaware of any missed license renewal but could not provide proof of completed renewal or fees paid. The facility failed to file and pay the 2020, 2021, 2022, 2023, 2024, and 2025 annual renewal licensing fees to the department and post the license in a conspicuous place as required by KSA 39-928.	S9999		