STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N011007	A. BUILDING: _____ B. WING _____	02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE AUTUMN PLACE	311 SOUTH EAST AVENUE COLUMBUS, KS 66725

(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 with complaints 190469, 190830 at the above named Residential Health Care Facility conducted on 02/02/26 and 02/03/26.	S 000		
S3085 SS=E	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: 3085 KAR 26-41-202(a)(1) The facility reported a census of 13 residents with three residents included in the sample with one abbreviated record review. Based on interview, and record review the operator failed	S3085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N011007	A. BUILDING: _____ B. WING _____	02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE AUTUMN PLACE	311 SOUTH EAST AVENUE COLUMBUS, KS 66725

(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
S3085	Continued From page 1	S3085		

to ensure the "Negotiated Service Agreement" (NSA) was fully developed based on the resident's "Functional Capacity Screen" (FCS), service needs, and preferences for Resident (R)102 , R103 and R104.

Findings included:

- R102's medical record revealed she moved into the facility on 04/07/21 with a diagnosis of macular degeneration.

The 02/01/25 FCS identified R102 was at risk for falls and had impaired vision.

The 02/01/25 NSA did not address what services staff provided R102 concerning her risk for fall or her impaired vision.

On 02/03/26 at 02:06 PM "Licensed Nurse" (LN) B confirmed R102's NSA did not address what services staff provided concerning falls or impaired vision.

The operator failed to ensure R102's NSA was fully developed to include all items that triggered on the FCS, her service needs, and preferences.

- R103's medical record revealed she moved into the facility on 06/16/25 with a diagnosis of heart failure.

The 06/16/25 FCS identified R103 had impaired vision and impaired hearing.

The 06/16/25 NSA did not address what services staff provided R103 concerning her impaired

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N011007	A. BUILDING: _____ B. WING _____	02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE AUTUMN PLACE	311 SOUTH EAST AVENUE COLUMBUS, KS 66725

(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
S3085	Continued From page 2 vision and impaired hearing. On 02/03/26 at 02:52 PM LN B confirmed R103's NSA did not address what services staff provided concerning her impaired vision and impaired hearing. The operator failed to ensure R103's NSA was fully developed to include all items that triggered on the FCS, her service needs, and preferences. - R104's medical record revealed she moved into the facility on 05/19/25 with a diagnosis of macular degeneration. The 05/19/25 FCS identified R104 triggered for falls/unsteadiness, impaired vision, impaired hearing and impaired decision making. The 05/19/25 NSA did not address what services staff provided R104 concerning falls/unsteadiness, impaired vision, impaired hearing and impaired decision making. On 02/03/26 at 02:39 PM LN B confirmed R104's NSA did not address what services staff provided concerning falls/unsteadiness, impaired vision, impaired hearing and impaired decision making. The operator failed to ensure R104's NSA was fully developed to include all items that triggered on the FCS, her service needs, and preferences.	S3085		
S3211 SS=E	26-41-205 (g) (3) OVER THE COUNTER DRUGS (3) A licensed nurse or medication aide may accept over-the-counter medication only in its	S3211		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N011007	A. BUILDING: _____ B. WING _____	02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE AUTUMN PLACE	311 SOUTH EAST AVENUE COLUMBUS, KS 66725

(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
S3211	Continued From page 3 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: 3211 KAR 26-41-205 (g)(3) The facility reported a census of 13 residents. Based on observation and record review, the operator failed to ensure a licensed pharmacist or licensed nurse placed the full name of the resident on the original package of "over the counter" (OTC) medications. Findings included: - Observation on 02/02/26 at 02:13 PM of the medication cart revealed the following OTC medications not labelled with the full name of the resident: Two- Three fluid ounce bottles of Foster and Thrive Saline Nasal Spray Two bottles of Spring Valley Calcium 600 milligrams (mg.) One bottle of Spring Valley Vitamin B12	S3211		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N011007	A. BUILDING: _____ B. WING _____	02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE AUTUMN PLACE	311 SOUTH EAST AVENUE COLUMBUS, KS 66725

(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
S3211	Continued From page 4 One bottle of Equate Stool Softener One bottle of Nature Made Fish Oil 1200 mg. One bottle of Equate eight-hour Arthritis Pain Relief Acetaminophen The undated "Medication Management" policy documented, "Over the counter drugs. The facility shall ensure that each over the counter drug delivered to the facility ...The pharmacist or licensed nurse shall place the full name of the resident on the package." The operator failed to ensure all OTC medications were labeled by a pharmacist or licensed nurse with the resident's full name.	S3211		