STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N039004	A. BUILDING: _____ B. WING _____	04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING INC	420 N 5TH ANTHONY, KS 67003

(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 Re-Licensure Survey for the above named Assisted Living Facility conducted on 04/07/26 and 04/08/26.	S 000		
S3092 SS=E	26-41-202 (d) Negotiated Service Agreement 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, facility 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 26-41-202 (d)(2) The facility reported a census of 14 residents(R). The sample included three residents. Based on observation, interview, and record review the executive director failed to ensure designated staff reviewed and revised the "Negotiated Service Agreement" for two (R4, R5) of three sampled residents when they had a significant change in service needs.	S3092		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S3092	Continued From page 1 Findings included: - Review of R4's record revealed she moved into the facility on 09/01/21 with a diagnosis of dementia. R4's "Functional Capacity Screen" dated 09/30/26 identified she needed physical assistance with all activities of daily living except for eating. She was unable to participate in management of her medications and medical treatments and had impaired cognition. R4's "Negotiated Service Agreement & Care Plan" dated 10/01/25 identified qualified staff would provide R4 assistance with activities of daily living and administer her medications and medical treatments. Staff would also provide choices and reminders throughout the day. This "Negotiated Service Agreement & Care Plan" had handwritten "1/9/26 [name] Hosp". The notation did not identify what services the company would be providing or include signatures of the facility Nurse and R5's/Legal Representative. Interview on 04/08/26 at 10:11 AM Certified Medication Aide D reported R4 received Hospice services and the Hospice staff provide bathing for the resident. Interview on 04/08/26 at 04:32 PM Administrative Staff A reviewed R4's "Negotiated Service Agreement & Care Plan" and reported she had written on the form the date she started Hospice Services. Administrative Staff A confirmed she had not truly revised R4's "Negotiated Service	S3092		

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S3092	Continued From page 2	S3092		

Agreement & Care Plan" to identify services Hospice would provide and failed to obtain signatures from the Nurse and Resident/Legal Representative.

The executive director failed to ensure designated staff reviewed and revised R4's "Negotiated Service Agreement & Care Plan" when R4 started on Hospice Services.

- Review of R5's record revealed she moved into the facility on 03/05/25 with a diagnoses diabetes mellites type II.

R5's admission "Functional Capacity Screen" dated 03/03/25 identified she was independent with all activities of daily living.

R5's admission "Negotiated Service Agreement & Care Plan" dated 03/05/25 identified she received physical therapy and occupation therapy through a local home health provider. However, R5's record did not include revisions of the "Negotiated Service Agreement & Care Plan" when the home health services discontinued on 04/24/25.

Interview on 04/08/26 at 11:02 AM Administrative Staff A confirmed she had not completed a revision of the "Negotiated Service Agreement & Care Plan" when home health discontinued services.

The executive director failed to ensure designated staff reviewed and revised R5's "Negotiated Service Agreement & Care Plan" as needed when she discontinued from home health services.

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S3166 SS=D	26-41-204 (e) Delegation of Duties (e) A licensed nurse may delegate nursing procedures not included in the nurse aide or medication aide curriculums to nurse aides or medication aides, respectively, under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(e) The facility reported a census of 14 residents. The sample included three residents. Based on interview and record review the administrator failed to ensure three of three Certified Medication Aides (CMA) were trained by a licensed nurse and delegated the nursing procedure for obtaining blood glucose checks according to the nurse practice act and amendments thereto. Findings included: - Interview on 04/08/26 at 09:17 AM Certified Medication Aide D reported there only resident who had insulin or blood sugar checks was R5. - Review of R5's record revealed she moved into the facility on 03/05/25 with a diagnosis of diabetes mellites type II. Her Record included blood sugar documentation for March 2026 and April 2026 completed by Certified Medication Aides (CMA) C, CMA F, and CMA I.	S3166		

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S3166	Continued From page 4 On 04/08/26 at approximately 10:45 AM surveyor requested delegation/competency checks for blood glucose monitoring for CMA C , CMA F, and CMA I. On 04/08/26 at approximately 04:20 PM Administrative Staff A confirmed the delegation / competency for blood glucose monitoring had not been completed. The executive director failed to ensure the Licensed Nurse delegated the nursing task of monitoring a resident's blood glucose, which is not included in the CMA curriculum, for three CMAs who had monitored R5's blood glucose.	S3166		
S3175 SS=D	26-41-205 (a) (1) Self Administration of Medication (a) Self-administration of medication. Any resident may self-administer and manage medications independently or by using a medication container or syringe prefilled by a licensed nurse or pharmacist or by a family member or friend providing this service gratuitously, if a licensed nurse has performed an assessment and determined that the resident can perform this function safely and accurately without staff assistance. (1) An assessment shall be completed before the resident initially begins self-administration of medication, if the resident experiences a significant change of condition, and annually.	S3175		

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S3175	Continued From page 5 This REQUIREMENT is not met as evidenced by: KAR 26-41-205(a)(1) The facility reported a census of 14 residents (R). The sample included three residents. Based on interview and record review the executive director failed to ensure a licensed nurse completed an assessment for self-administration of medications for one (R5) of three sampled residents prior to the residents self-injecting her insulin. Findings included: - Review of R5's record revealed she moved into the facility on 03/05/25 with a diagnoses diabetes mellites type II. R5's "Functional Capacity Screen" dated 03/03/25 identified she needed physical assistance with management of her medications and medical treatments. R5's "Functional Capacity Screen" dated 03/05/26 identified she needed physical assistance with management of her medications and medical treatments. R 5's "Negotiated Service Agreement" (NSA) dated 03/05/26 identified R3 needed qualified staff to administer medications, and she would self-inject her insulin. Review of R5's record only included one assessment for self-injection of her insulin completed on 03/15/26. R5's record lacked an	S3175		

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S3175	Continued From page 6 assessment to identify is she could safely and accurately self-inject her insulin when she first started self-injecting her insulin upon moving into the facility. Interview on 04/08/26 at 11:09 AM Administrative Staff A confirmed R5 had been self-injecting her insulin since moving into the facility. Administrative Staff A looked through R5's chart and confirmed staff did not complete an admission assessment for self injection of her insulin. The executive director failed to ensure a licensed nurse completed a self-administration assessment for R3 to ensure she could safely and accurately self-inject her insulin when she first started self-injecting her insulin.	S3175		
S3202 SS=D	26-41-205 (d) (4) Delegation of Medication Administration (4) Any licensed nurse may delegate nursing procedures not included in the medication aide curriculum to medication aides under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(d)(4) The facility reported a census of 14 residents. The sample included three residents. Based on interview and record review the executive director failed to ensure three of three Certified Medication Aides (CMA) were trained by a	S3202		

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S3202	Continued From page 7 licensed nurse and delegated the nursing procedure of preparing and dialing an insulin pen to the ordered dosage for a resident to then self-inject, which is not a part of the CMA curriculum. Findings included: - During an interview on 04/07/26 at approximately 01:47 PM Administrative Staff A reported R5 was the only resident in the facility who received insulin and staff prepared the pen and R5 self-injected it. - Review of R5's record revealed she moved into the facility on 03/05/25 with a diagnosis of diabetes mellites type II. Her Record included documentation of staff preparing her insulin pen for March 2026 and April 2026 completed by Certified Medication Aides (CMA) C, CMA F, and CMA I. On 04/08/26 at approximately 10:45 AM surveyor requested delegation/competency checks for preparing an insulin pen for a resident to self-inject for CMA C , CMA F, and CMA I. On 04/08/26 at approximately 04:20 PM Administrative Staff A confirmed the delegation/competency for preparing and insulin pen had not been completed. The executive director failed to ensure the Licensed Nurse delegated the nursing procedure of preparing and dialing the dosage of an insulin pen, which is not included in the CMA curriculum, for three of three CMAs who had prepared insulin pens for the resident to self-inject.	S3202		

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S3248 SS=F	26-41-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff records shall contain the following documentation: (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 care home; 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 have worked as a certified nurse aide. This REQUIREMENT is not met as evidenced by: KAR 26-41-102(d)(1)(2) The facility reported a census of 14 residents. Based on record review of three newly hired employees, the executive director failed to have evidence of Registry/Licensure verification for	S3248		

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S3248	Continued From page 9 two of three newly hired staff who required specialized education and training verified upon hire. The executive director also failed to ensure two of three newly hired staff had a criminal background check completed by the required department upon hire. These failures had the potential to affect all residents in the facility. The findings included: - Review of three of five newly hired employee files revealed the following: Certified Medication Aide (CMA) E hired on 04/26/25 failed to have evidence of a criminal background check completed through Kansas Department for Aging and Disabilities (KDADS) upon hire. Certified Nurse Aide (CNA) G hired on 03/09/26 failed to have evidence of completing a registry verification of her CNA certification and failed to have a criminal background check completed through KDADS. Interview on 04/07/26 at 03:21 PM Administrative Staff B confirmed she had not completed the criminal background checks because she had not been able to get in to complete them. Interview on 04/07/26 at 03:18 PM Administrative Staff A reviewed the employee records and confirmed CNA G did not have registry check in her file and CMA Fs was not done upon hire. The executive director failed to ensure designated staff conducted a registry check and criminal background check for verification of	S3248		

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S3248	Continued From page 10 certification and criminal history for CMA E and CNA G prior to working at the facility.	S3248		
S3261 SS=E	26-41-105 (f) (11) Resident Record Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action This REQUIREMENT is not met as evidenced by: KAR 26-41-105(f)(11) The facility reported a census of 14 residents(R). The sample included three residents. Based on interview and record review the executive director failed to ensure three (R3, R4, R5) of three sampled resident records contained documentation of all incidents, symptoms, and other indications of illness or injury, what staff did, and the results of action taken. Findings included: - R3 moved into the facility on 09/02/23 with a diagnosis of myelodysplastic (bone marrow cancer) and diabetes mellitus type II. R3's "Functional Capacity Screen" (FCS) dated 03/11/26 identified he was independent with bathing, dressing, toileting, transfers and needed physical assistance with walking/mobility and management of his medications.	S3261		

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S3261	Continued From page 11 R3s "Negotiated Service Agreement & Care Plan" dated 03/19/26 identified qualified staff would assist R3 with activities of daily living as needed and Hospice would assist with bathing. Qualified nursing staff would administer and manage his medications. Review of R3's Hospice notebook Included the following medication order changes: 03/25/26- order for Lasix 20 milligrams (mg) daily. 04/01/26 -order for Lorazepam (Antianxiety) 0.5 mg twice a day and Colace 100mg daily 04/06/26 - order to discontinue Lorazepam twice daily and just administer 0.5 mg daily in the morning and keep PRN orders. Review of R3's facility Nursing documentation lacked documentation that he had moved into the facility, had received any new medication orders, documentation of symptoms to indicate need for changes in medications, or results of new medications. On 04/07/26 at 03:42 PM surveyor requested for CMA I to print R3's progress notes from the laptop, and reported he did not have a file or notes in the computer. On 04/08/26 at 07:39 AM Administrative Staff A confirmed R3 did not have any nursing documentation in the record because she had not opened a "Record" for him in the laptop yet. The operator failed to ensure R3's record included documentation of all symptoms, incidents, illness, the action taken, and results of	S3261		

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S3261	Continued From page 12	S3261		

action take.

- Review of R4's record revealed she moved into the facility on 09/01/21 with a diagnosis of dementia.

R4's "Functional Capacity Screen" dated 09/30/26 identified she needed physical assistance with all activities of daily living except for eating. She was unable to participate in management of her medications and medical treatments and had impaired cognition.

R4's "Negotiated Service Agreement & Care Plan" dated 10/01/25 identified qualified staff would provide R4 assistance with activities of daily living and administer her medications and medical treatments. Staff would also provide choices and reminders throughout the day.

Review of R4's medical providers' orders included the following:
12/18/24 - new order for Zyrtec 10 mg at bedtime. Call if not better in one week.
02/09/25 - distal clavicle non-displaced fracture - apply sling on right shoulder, rest, ice, Tylenol for pain and follow up with primary care physician in one week.
12/10/25 - new order for Zyrtec 10mg daily for one week, call if not better in one week.
12/12/25 - new orders to discontinue Zyrtec and start Claritin 10 mg daily and Robitussin DM cough syrup daily as needed for cough.
12/12/25 - Robitussin tablets 20-400 mg four times a day as needed for cough.
12/18/25 - complaining of pain in right side. provider ordered pelvis and Lumbar x-ray.
12/23/25 - Norco 5mg one tablet three times a

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day for 1 week and check CT of Lumbar/Sacral area.
12/24/25 - physician notified R4 continues to complain of pain even with scheduled pain medication and physician responded that R4 likely has Sacral fracture.
01/09/26 - Hospital discharge orders with a hospital admission date of 12/29/25.

Review of R4's nursing documentation revealed the following documentation.
11/13/24 - resident had a fall and went to emergency room.
11/13/24 - returned with no injuries.
02/08/25 - resident had a fall in her room and complained of right shoulder pain. Resident sent to the emergency room.
02/09/25 - returned to facility with no apparent injuries.
02/10/25 - resident to wear arm sling due to stable right clavicle fracture.

R4's record failed to include nursing documentation to include new orders related to cold/cough symptoms, failed to follow up post fall, failed to follow up on medical treatment for symptoms, failed to include results of x-ray and CT scans completed because of resident complaining of pain. The record also failed to include documentation of the resident going to the hospital on 12/29/25, symptoms related to need for hospitalization, and documentation of her returning to the facility. It also failed to include documentation the resident received Hospice services when she returned from the hospital.

Interview on 04/08/26 at 07:39 AM Administrative

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Staff A reported she thought if a resident was on Hospice services the facility nurse did not need to document in the nurses' notes because Hospice documented in their notes.

Electronic Interview on 04/08/26 at 10:15 AM Licensed Nurse C reported she charted on residents when they go to doctor and have medication changes, but if a resident was on Hospice, staff would call Hospice and their nurse would document but when on hospice they usually call them and Hospice staff would document in their chart.

The executive director failed to ensure R4's record included documentation of all symptoms, incidents, illness, the action taken, and results of action related to falls, medication changes and hospital admission then return.

- Review of R5's record revealed she moved into the facility on 03/05/26 with a diagnosis of diabetes mellitus type II.

R5's "Functional Capacity Screen" dated 03/05/26 identified R5 was independent with activities of daily living, had bladder incontinence and required physical assistance of staff with management of his medications.

R5's "Negotiated Service Agreement & Care Plan" dated 03/25/26 identified staff needed to walk with her and qualified staff would manage and administer her medications.

Review of R5's nursing documentation included the following"
01/16/26 - noted order for insulin changed

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	N039004	A. BUILDING: _____ B. WING _____	04/08/2026

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S3261	Continued From page 15 04/01/25 - Cipro (antibiotic) 1 tablet every 12 hours for 6 doses. 06/16/25 - discontinue mealtime insulin continue with bedtime insulin. 01/06/26 - reduce Toujeo (insulin) to 12 units. 03/15/26 - resident complaining of chest pain when taking a deep breath with crackles in lower lungs. Nurse suggested she go see her provider tomorrow. The record lacked documentation of the day R5 moved into the facility, follow up how she tolerated changes in her insulin, and symptoms related to the start of an antibiotic and follow up post administration of it. It also lacked follow up documentation of R5's chest pain with breathing. Electronic Interview on 04/08/26 at 10:15 AM Licensed Nurse C reported she charted on residents when they go to doctor and have medication changes. The executive director failed to ensure R4's record included documentation of all symptoms, incidents, illness, the action taken, and results of action related to falls, medication changes and hospital admission then return.	S3261		
S3280 SS=F	26-41-104 (d) Disaster and Emergency Preparedness (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 facility ' s emergency management plan; (2) education of each resident upon	S3280		

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S3280	Continued From page 16 admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' 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 26-41-104(d)(3) The facility reported a census of 14 residents. Based on record review and interview for all employees and all residents, the executive director failed to ensure disaster and emergency preparedness by ensuring performance of quarterly reviews of the facility's emergency management plan with all facility staff and residents. Findings included: - Review of the emergency plan reviews for residents, and employees provided by Administrative Staff B on 04/07/26 lacked review of the emergency management plan for the 4th quarter of 2025 and the first quarter of 2026. Interview on 04/08/26 at 08:01 AM Administrative Staff B reported the person responsible for completing the quarterly reviews confirmed they had not been completed since 09/2025.	S3280		

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S3280	Continued From page 17 For Employees and Residents, the executive director failed to ensure the facility's emergency plan was reviewed quarterly.	S3280		
S3298 SS=F	26-41-206 (d) Food Preparation (d) Food preparation. 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 required to meet federal, state, and local laws and regulations. This REQUIREMENT is not met as evidenced by: KAR 26-41-206(d) The facility reported a census of 14 residents. Based on record review and interview, the executive director failed to ensure dietary staff prepared foods to the proper temperatures and in a way to ensure flavor, appearance and maintain proper serving temperature of food.	S3298		

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S3298	Continued From page 18 Findings included: Review of the Food Temperature logs revealed the following: December 2025: Breakfast 11 out of 31 days with no food temperatures. Lunch 16 out of 31 days without food temperatures. Supper 20 out of 31 days without food temperatures. January 2026: Breakfast and Lunch 1 out of 31 days without food temperatures. Supper 12 out of 31 days without food temperatures February 2026: Breakfast 1 out of 28 days without food temperatures. Lunch 2 out of 28 days without food temperatures. Supper 18 out of 28 days without food temperatures. March 2026: Breakfast 10 days out of 31 without food temperatures. Lunch 12 out of 31 days without food temperatures. Supper 15 out of 31 days without food temperatures. April 2026 log did not have a sheet but there were three days with temperatures written on the March log dated April. Interview on 03/18/26 at 03:30 PM dietary staff reviewed the food temperature logs and confirmed staff were to be temping and documenting the temperatures to ensure foods were prepared and served at appropriate temperatures. Interview on 04/07/26 at 01:24 PM Administrative Staff B reported day shift is better than evening shift at monitoring food temperatures. Administrative Staff B confirmed there were	S3298		

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S3298	Continued From page 19 multiple days that lacked food temperatures to ensure they were prepared and maintained proper temperature. Review of the dietary guidelines for Americans 2005 recommends checking the internal temperature of cooked food to make sure food is cooked to and held at an appropriate temperature and to keep food out of the "danger zone" (40 degrees F to 140 degrees F) where bacteria can multiple rapidly. The executive director failed to ensure dietary staff monitored food temperatures to ensure food was prepared and served at proper temperatures.	S3298		
S3310 SS=F	26-41-207 (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; and (c) Each administrator or operator shall ensure the facility ' 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	S3310		

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S3310	Continued From page 20 by: KAR 26-41-207(c) The facility reported a census of 14 residents (R). The sample included three residents and review of three newly hired employees' records. Based on interview and record review the executive director 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, three of three newly hired staff. Findings included: - Review of three newly hired employee records revealed the following: - Certified Medication Aide E hired on 04/26/25 had a TB Skin Test (TST) completed on 08/28/25, four months after hire dated and lacked evidence of a TB symptom screen or a second TST. - Certified Medication Aide F hired on 12/06/25; record lacked a TB symptom screen and only had a TST result page that said 06/04/25 - negative. It did not include a date the TST was administered, lacked a second TST. - Certified Nurse Aide G hired on 03/09/26 lacked a TB symptom screen completed upon hire. Interview on 04/08/26 at 07:38 AM Administrative Staff A reported she spoke with Nurse H and confirmed the TST, and questionnaires had not been completed.	S3310		

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S3310	Continued From page 21 Review of the "Tuberculosis (TB) Guidelines for Adult Care Homes" June 2013 revealed each new employee shall have two-step TST initiated within seven days of employment and a TB symptom screen completed that includes the components of the Tuberculosis Symptom Screen Review Questionnaire. The executive director failed to ensure new employees screened and tested for TB according to the TB guidelines adopted by the department.	S3310		