STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008008	A. BUILDING: _____ B. WING _____	07/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF AUGUSTA	1611 FAIRWAY STREET AUGUSTA, KS 67010

(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 the licensure resurvey for the above named facility conducted on 07/13/26 and 07/14/26.	S 000		
S3200 SS=E	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: K.A.R. 26 41-205 (d) The facility reported a census of 45 residents. The sample included 3 "Residents'". Based on observation and interview the Operator failed to ensure medications managed by the facility were administered to residents in accordance with professional standards of practice.	S3200		

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

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S3200	Continued From page 1 Findings included: - Observation on 07/13/26 at approximately 11:30 AM of the "First Floor" medication cart located on the first floor of the facility in the common hallway approximately 15 feet from the front entrance of the facility revealed the locking bolt was in the out position and the drawers freely opened and there were no staff present at the medication cart. Located in the top drawer in the center of the drawer was a clear plastic medication cup. On the medication cup it was handwritten "111" and it contained 5 pills. Next to the cup that had "111" handwritten on it was a stack of 3 medication cups. The first cup had "210" and it contained 2 orange pills. The second cup had handwritten on it was "209" and it contained 3 pills. The third cup had "213" handwritten on it and it contained 7 pills. Observation on 07/13/26 at approximately 11:40 AM "Certified Medication Aide" (CMA) A was observed walking to the facility dining room with the stack of 3 medication cups in her hand and she lifted the top cup from the stack to observe the number that was handwritten on the cup and she then proceeded to go to a resident. Interview on 07/13/26 at approximately 04:00 PM with facility Resource C confirmed the facility did not have a specific policy for passing medications. The facility staff were to follow the state guidelines. Operator B confirmed facility staff were not trained to prepare resident medications in advance. Review of the "Certified Medication Aide Curriculum" revised on 05/10/23 on page 165 revealed "All medications must be identified to point of administration. For medications removed	S3200		

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S3200	Continued From page 2 from a package or container with the prescription label, a medication card must be used which contains the resident's name, the name of the medication, the route of administration, special instructions for administration and time of administration. This card must be checked against the "Medication Administration Record" (MAR) before administering the medication to a resident". The Operator failed to ensure medications managed by the facility were administered to residents in accordance with professional standards of practice.	S3200		
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 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: K.A.R. 26 41-205 (g) (3) The facility reported a census of 45 residents.	S3211		

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S3211	Continued From page 3 The sample included 3 "Residents'". Based on observation and interview, the Operator failed to ensure a licensed pharmacist or the "Licensed Nurse" (LN) placed the full name of the resident on the "Over-the-Counter" (OTC) medication containers, bottle, or package. Findings included: - Observation on 07/13/26 at approximately 11:30 AM of the "First Floor" medication cart located on the first floor of the facility in the common hallway approximately 15 feet from the front entrance of the facility revealed the locking bolt was in the out position and the drawers freely opened and there were no staff present at the medication cart. The unlocked medication cart contained that contained the following OTC medications that lacked the full name of the resident: 1 container of Viactiv chews 690 milligrams 1 bottle of Nasal Spray Observation on 07/13/26 at approximately 12:15 PM of the facility's "Second Floor" medication cart revealed the locking bolt was in the out position and the drawers freely opened. The unlocked medication cart contained the following OTC medications that lacked the full name of the resident; 1 bottle of Anti Fungal Powder Interview on 07/13/26 at approximately 12:15 PM with Operator B confirmed all OTC medications were to have the full name of the resident on the bottle or package placed by the licensed pharmacist or the LN.	S3211		

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S3211	Continued From page 4 The Operator failed to ensure a licensed pharmacist or the LN placed the full name of the resident on the OTC medication containers, bottle, or package.	S3211		
S3215 SS=F	26-41-205 (h) Medication Storage (h) Storage. Licensed nurses and medication 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 facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility 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 facility. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration.	S3215		

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S3215	Continued From page 5 This REQUIREMENT is not met as evidenced by: K.A.R. 26 41-205 (h) (1) (4) The facility reported a census of 45 residents. The sample included 3 "Residents'". Based on observation and interview, the Operator failed to ensure all non-controlled medications were stored in a locked medication room, cabinet or medication cart. The Operator further failed to ensure the facility "Licensed Nurses" (LN)'s and "Certified Medication Aides'" (CMA)'s did not administer medications beyond the manufacturer's or pharmacy provider's recommended date of expiration. Findings included: - Observation on 07/13/26 at approximately 11:30 AM of the "First Floor" medication cart located on the first floor of the facility in the common hallway approximately 15 feet from the front entrance of the facility revealed the locking bolt was in the out position and the drawers freely opened and there were no staff present at the medication cart. Located in the top drawer of the medication cart on the left side of the drawer was a Novolog insulin pen that had approximately 250 units in the pen and lacked a date of when the pen was opened. Interview on 07/13/26 at approximately 11:35 AM with CMA A confirmed the Novolog insulin Pen lacked a date of when the insulin pen was opened. CMA A further confirmed the "First Floor" Medication cart was unlocked.	S3215		

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S3215	Continued From page 6 Observation on 07/13/26 at approximately 12:15 PM of the facility's "Second Floor" medication cart revealed the locking bolt was in the out position and the drawers freely opened. There were no staff present at the medication cart. Interview on 07/13/26 at approximately 12:15 PM with Operator B confirmed all facility medication carts were to be locked when the facility CMA's were not at the cart. Review of the Novolog manufacturer's recommendation instructed to throw the opened pen away after 28 days even if insulin remained in the pen. The Operator failed to ensure all non-controlled medications were stored in a locked medication room, cabinet or medication cart. The Operator further failed to ensure the facility LN's and CMA's did not administer medications beyond the manufacturer's or pharmacy provider's recommended date of expiration.	S3215		