STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N005007	A. BUILDING: _____ B. WING _____	C 09/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREDO SENIOR LIVING OF HOISINGTON	259 WEST 6TH STREET HOISINGTON, KS 67544

(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 Health Licensure Resurvey and Complaint survey regarding allegations in the following complaints: 198386, conducted on 09/02/26, 09/03/26, 09/08/26 and 09/09/26. The facility reported a census of 17 residents. The sample included four residents.	S 000		
S 190 SS=D	26-39-102 (e) Admission, Transfer, Discharge (e) Before a resident is transferred or discharged involuntarily, the administrator or operator, or the designee, shall perform the following: (1) Notify the resident, the resident ' s legal representative, and if known, a designated family member of the transfer or discharge and the reasons; and (2) record the reason for the transfer or discharge under any of the circumstances specified in paragraphs (d) (1) through (4) in the resident ' s clinical record, which shall be substantiated as follows: (A) The resident's physician shall document the rationale for transfer or discharge in the resident ' s clinical record if the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met by the adult care home; (B) the resident's physician shall document the rationale for transfer or discharge in the resident ' s clinical record if the transfer or discharge is appropriate because the resident's health has improved sufficiently so that the resident no longer needs the services provided by the adult care home; and (C) a physician shall document the rationale for transfer or discharge in the resident ' s clinical record if the transfer or discharge is necessary	S 190		

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
	N005007	A. BUILDING: _____ B. WING _____	C 09/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREDO SENIOR LIVING OF HOISINGTON	259 WEST 6TH STREET HOISINGTON, KS 67544

(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 190	Continued From page 1 because the health or safety of other individuals in the adult care home is endangered. This REQUIREMENT is not met as evidenced by: KAR 26-39-102 (e)(2)(C) Based on interview and record review the facility failed to provide physician documentation for the rationale for transfer or discharge in Resident (R)101's medical record prior to discharge from the facility. Findings included: - Review of R101's medical record revealed he moved into the facility on 08/04/24 with a diagnosis of dementia. Review of R101's "Functional Capacity Screen" (FSC) dated 10/21/24 identified R101 was at risk for wandering. The FCS did not identify R101 exhibited inappropriate behaviors. Review of R101's "Negotiated Service Agreement" (NSA) did not identify any services provided by staff related to R101 wandering into other residents' rooms, exit-seeking behaviors or what interventions were to be followed when R101 became angry or aggressive with staff and residents. Review of 101's records failed to find any documentation of the physician's rationale for discharge necessary because the facility was not able to provide services necessary to ensure the safety of R101 or provide for the safety of other	S 190		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N005007	A. BUILDING: _____ B. WING _____	C 09/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREDO SENIOR LIVING OF HOISINGTON	259 WEST 6TH STREET HOISINGTON, KS 67544

(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 190	Continued From page 2 individuals living and working in the adult care home. On 09/09/26 at 01:15 PM Administrative Staff A stated R101 exhibited exit-seeking behaviors, would get angry and aggressive with staff and residents, and urinated in numerous other places besides the toilet. Administrative Staff A stated it got to the point that staff could no longer offer the services required to keep R101 and other residents safe, so she informed R101's family member that placement in a more secure facility needed to be arranged for R101. Administrative Staff A confirmed there was no physician's rationale for discharged in R101's medical records. The "Discharge Policy" dated 2022 documented, "Prior to discharging a resident involuntarily, the residence will...Document in the resident's clinical record the reason for the discharge...The documentation shall be made by...The resident's physician when the transfer or discharge is appropriate for the resident's welfare and needs cannot be me by the residence ..." The facility failed to ensure prior to R101 being discharged, the resident's physician documented the rationale for transfer or discharge in the resident's medical record specifically related to the facility not being able to meet R101's needs and for the safety of other individuals in the facility.	S 190		
S3026 SS=J	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met:	S3026		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N005007	A. BUILDING: _____ B. WING _____	C 09/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREDO SENIOR LIVING OF HOISINGTON	259 WEST 6TH STREET HOISINGTON, KS 67544

(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
S3026	Continued From page 3 (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(1)(B) Based on observation, interview and record review, the facility failed to provide adequate supervision and ensure effective interventions were in place and followed to prevent cognitively impaired Resident (R)101 from exiting the facility without staff knowledge. These failures resulted in R101 exiting the facility on at least two occasions and being unaccounted for by staff for an unknown amount of time, which placed the resident at risk for further neglect and harm. Findings included: - R101's medical record revealed he moved into the facility on 08/05/24 with a diagnosis of dementia. The 10/21/25 "Functional Capacity Screen" (FCS) identified R101 was independent with transfers and mobility without the use of an assistive device, had severely impaired cognition and was identified to be at risk for wandering. The 10/22/25 "Negotiated Service Agreement" (NSA) documented staff would ensure R101 did not leave the community unattended. The NSA	S3026		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N005007	A. BUILDING: _____ B. WING _____	C 09/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREDO SENIOR LIVING OF HOISINGTON	259 WEST 6TH STREET HOISINGTON, KS 67544

(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
S3026	Continued From page 4	S3026		

lacked specific interventions in place to prevent R101 from leaving the community without staff knowledge.

Review of the 09/20/24 "Behavior Note" revealed R101 looked for his deceased wife, walked out the front door, and proceeded to walk down the street. Staff redirected R101 and brought him back into the facility.

Review of the 03/15/25 late entry "Behavior Note" revealed R101 was anxious and confused. He thought it was time to go to work and wandered into other residents' rooms asking for a truck.

Review of the 03/17/25 "Behavior Note" revealed staff reported R101 wandered out the front door in the middle of the night.

Review of the late entry 04/10/25 "Behavior Note" reported R101 paced around the facility and attempted to leave out the front door. R101 stated he needed to get the trailer and go to work.

Review of the late entry 11/13/25 "Behavior Note" reported R101 left through the front door and tried to cross the street to go home.

Review of the late entry 11/19/25 "Behavior Note" revealed R101 repeatedly attempted to exit the building. Staff had to provide one-on-one care to keep him from going outside.

Review of the late entry 11/24/25 "Behavior Note" revealed R101 was confused and agitated towards other residents and angry that he could not go to work.

Review of the late entry 01/20/26 "Behavior Note" revealed R101 was exit seeking, angry and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N005007	A. BUILDING: _____ B. WING _____	C 09/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREDO SENIOR LIVING OF HOISINGTON	259 WEST 6TH STREET HOISINGTON, KS 67544

(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
S3026	Continued From page 5	S3026		

aggressive towards other residents. Staff sat with R101 all day in order to keep him calm and in the building.

Review of the late entry 01/23/26 "Behavior Note" revealed R101 was very agitated and exit seeking and was hard to redirect.

Review of the late entry 02/24/26 "Behavior Note" revealed R101 said he had to go to work and could not stay any longer. R101 attempted to exit the building and was not easily redirected.

Review of the late entry 02/25/26 "Behavior Note" revealed R101 had been pacing and exit seeking. When staff attempted to redirect him from exiting the front door, R101 called her a (expletive).

Review of the late entry 02/27/26 "Behavior Note" revealed R101 was confused and agitated all day, exit seeking, and not easily redirected.

Review of the late entry 03/18/26 "Behavior Note" revealed the resident was very anxious, constantly attempted to exit the back door, and required staff to provide one-on-one attention in order to keep him in the building.

An observation on 09/02/26 at 10:00 AM revealed the front and rear doors to the facility were unlocked and were not alarmed. There was a group of fifteen residents attending a church service in the common area, but administrative or care staff were not observed in the common area until seventeen minutes later.

During an interview on 09/03/26 at 08:43 AM, R101's family member stated R101 was able to get out of the facility several times, but staff were aware of this and were able to catch up to him

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N005007	A. BUILDING: _____ B. WING _____	C 09/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREDO SENIOR LIVING OF HOISINGTON	259 WEST 6TH STREET HOISINGTON, KS 67544

(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
S3026	Continued From page 6	S3026		

and redirect R101 back into the building. However, this family member stated that on at least two occasions, R101 was able to exit the facility without staff knowledge and was missing for an unknown amount of time. In one instance on 11/20/25 (time unknown), the family member was in the backyard of R101's former home located a short distance down the street from the facility, hanging laundry when he looked up to find R101 standing there. The family member had R101 in the home for about five minutes when he noticed Certified Medication Aide (CMA) C drive down the street looking for R101. There was another time, the family member was not sure of the date, when he noticed Certified Nurse Aide (CNA) D walking down the street towards his house. CNA D stated R101 got out of the building again and wondered if he was with him. The family member stated R101 was not with him and then proceeded to get into his vehicle and found R101 several blocks south of the facility.

On 09/08/26 at 05:58 PM, CMA C stated R101 exhibited exit-seeking behaviors and was good at watching for opportunities to get out of the building. CMA C stated the facility was not a locked memory care unit. The doors were usually locked between 08:00-09:00 PM but did not prevent anyone from exiting the facility. CMA C stated R101 exited the facility at least twice without staff knowledge where staff had to go look for him. CMA C stated staff completed 30-minute safety checks, then 15-minute safety checks, had to keep R101 within sight at all times, and eventually staff had to provide one-on-one supervision to ensure R101 did not exit the facility. CMA C stated staff were not able to always keep R101 within sight, especially when staff were assisting other residents in their room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N005007	A. BUILDING: _____ B. WING _____	C 09/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREDO SENIOR LIVING OF HOISINGTON	259 WEST 6TH STREET HOISINGTON, KS 67544

(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
S3026	Continued From page 7 On 09/08/26 at 06:25 PM, CNA D stated R101 exhibited exit-seeking behaviors especially when he got antsy. CNA D stated R101 exited the facility without staff knowledge at least twice that she was aware of. CNA D stated one time she walked down the street towards R101's former residence and talked to R101's family member telling him that R101 got out of the facility again. R101's family member got into his vehicle to look for R101 and eventually found him. On 09/09/26 at 11:05 AM, CMA E stated R101 had severe dementia and attempted to exit the facility numerous times wanting to go home. CMA E stated staff were not always able to have eyes on R101 and there was at least one time when R101 got out of the facility and walked down the street to his former house. CMA E stated staff noticed R101 was missing and started to look for him inside and outside the building and were getting ready to call the police when R101's family member showed up to the facility with the resident. On 09/09/26 at 12:43, PM Licensed Nurse (LN) B stated R101 had severely impaired cognition and exhibited exit-seeking behaviors. LN B stated staff had to keep a close eye on R101 when church groups met as he would attempt to leave the facility with them after services. LN B stated there were times when R101 attempted to leave the facility, but staff were able to redirect R101 and get him back into the facility. LN B stated there was at least one time when R101 was able to leave the facility without staff knowledge and he ended up at his residence about five houses down the street from the facility. LN B stated door chimes had been installed to alert staff when someone entered or exited the building. Staff attempted to distract R101 by offering him snacks	S3026		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N005007	A. BUILDING: _____ B. WING _____	C 09/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREDO SENIOR LIVING OF HOISINGTON	259 WEST 6TH STREET HOISINGTON, KS 67544

(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
S3026	Continued From page 8	S3026		

and tried to entertain him. LN B stated the NSA did not include specific interventions staff used to ensure R101 did not leave the facility unattended.

On 09/09/26 at 01:15 PM, Administrative Staff A stated R101 exhibited exit-seeking behaviors frequently. Administrative Staff A stated staff witnessed R101 attempting to leave the facility and try to go home or look for his deceased wife, but staff were able to redirect him and prevent him from leaving. Administrative Staff A stated she believed R101 left the building without staff knowledge at least once when he walked to his former residence. Staff noticed R101 was missing and started looking for him when R101's family member brought him back to the facility.

The "Abuse, Neglect, and Exploitation Prevention" policy revised 2022 documented, "The purpose of this policy is to maintain as safe and secure an environment as possible for all residents...Neglect: Means the failure or omission by one's self, caretaker or another person to provide goods or services which are reasonably necessary to ensure safety and well-being and to avoid physical or mental harm or illness."

The facility failed to ensure cognitively impaired R101 was kept free from neglect by ensuring appropriate interventions were put into place and implemented by staff to help prevent R101 from leaving the facility unattended without staff knowledge placing R101 at risk for harm.

This Immediate Jeopardy was removed when the following actions were taken by the facility:
R101 was transferred to a secure facility on 03/19/26.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N005007	A. BUILDING: _____ B. WING _____	C 09/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREDO SENIOR LIVING OF HOISINGTON	259 WEST 6TH STREET HOISINGTON, KS 67544

(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
S3028	Continued From page 9	S3028		
S3028 SS=D	26-41-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the facility as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(3) Based on interview and record review the facility failed to report an allegation of abuse, neglect, or exploitation to the department within 24 hours	S3028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N005007	A. BUILDING: _____ B. WING _____	C 09/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREDO SENIOR LIVING OF HOISINGTON	259 WEST 6TH STREET HOISINGTON, KS 67544

(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
S3028	Continued From page 10 when staff did not report Resident (R)101 exited the facility without staff knowledge and went missing for an undisclosed amount of time. Findings included: - Review of (R)101's medical records revealed he was admitted to the facility on 08/05/24 with a diagnosis of dementia. The 10/21/25 "Functional Capacity Screen" (FCS) identified R101 was at risk for wandering. The 10/22/25 "Negotiated Service Agreement" (NSA) documented staff to ensure R101 did not leave the community unattended. On 09/09/26 at 01:15 PM Administrative Staff A stated she believed R101 exited the facility without staff knowledge at least one time when he ended up walking to his former residence down the street. Staff noticed R101 was missing and started looking for him when the resident's family member brought him back to the facility. Administrative Staff A stated this incident was not reported to the department because she did not know she was required to report it. Review of the "Abuse, Neglect, and Exploitation Prevention" policy revised 2022 documented, "All reported allegations concerning abuse, neglect, or exploitation of any resident shall be dealt with following Credo Senior Living policies and procedures...and shall be reported to the State Regulatory Department." The facility failed to report an allegation of abuse, neglect, or exploitation to the department within 24 hours.	S3028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N005007	A. BUILDING: _____ B. WING _____	C 09/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREDO SENIOR LIVING OF HOISINGTON	259 WEST 6TH STREET HOISINGTON, KS 67544

(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
S3055	Continued From page 11	S3055		
S3055 SS=F	26-41-101 (l) Survey Report (l) Survey report and plan of correction. Each administrator or operator shall ensure that a copy of the most recent survey report and plan of correction is available in a public area to residents and any other individuals wishing to examine survey results. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(l) Based on observation, the facility failed to ensure a copy of the most recent survey report was available in a public area for residents and any other individuals to examine. Findings included: - Observation on 09/02/26 at approximately 10:00 AM during the initial tour of the facility revealed there was no state survey results available for review. Staff searched for a notebook and located a white "State Survey" notebook kept in the executive director's office with the most recent survey available dated 03/12/2020. Staff located another black "Survey Notebook" in this office with the most recent survey available for review dated 06/23/22. The last survey of the facility was completed on 02/26/25. The facility failed to ensure a copy of the most recent survey results were available in a public area for anyone to review.	S3055		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N005007	A. BUILDING: _____ B. WING _____	C 09/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREDO SENIOR LIVING OF HOISINGTON	259 WEST 6TH STREET HOISINGTON, KS 67544

(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
S3105	Continued From page 12	S3105		
S3105 SS=D	26-41-202 (j) Negotiated Service Agreement Outside Resource (j) If a resident's negotiated service agreement includes the use of outside resources, the designated facility staff shall perform the following: (1) Provide the resident, 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, with a list of providers available to provide needed services; (2) assist the resident, if requested, in contacting outside resources for services; and (3) monitor the services provided by outside resources and act as an advocate for the resident if services do not meet professional standards of practice This REQUIREMENT is not met as evidenced by: KAR 26-41-202(j)(3) Based on interviews and record review, the facility failed to ensure designated staff monitored services provided by outside resources when nursing staff failed to ensure home health care providers documented assessments when monitoring previous wounds for Resident (R)102's feet. Findings included: - R102's medical record revealed she moved into the facility on 07/14/26 with a diagnosis of diabetes mellitus. A "Functional Capacity Screen" (FCS) was not	S3105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N005007	A. BUILDING: _____ B. WING _____	C 09/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREDO SENIOR LIVING OF HOISINGTON	259 WEST 6TH STREET HOISINGTON, KS 67544

(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
S3105	Continued From page 13 completed upon admission to the facility. The 07/14/26 "Negotiated Service Agreement" (NSA) did not identify R102 received services from a local home healthcare provider. Review of R102's medical records failed to locate any documentation from a local home health care provider. On 09/09/26 at 12:17 PM Licensed Nurse (LN) B stated R102 received services from a local home health care provider that came twice a week to monitor her feet to make sure old foot wounds did not reopen. LN B stated the home health care provider did not leave any progress notes but verbally reported to her. LN B confirmed she did not write any progress notes in R102's medical records to document any of these visits. The facility failed to ensure designated staff monitored the services provided by outside resources concerning R102.	S3105		
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	S3215		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N005007	A. BUILDING: _____ B. WING _____	C 09/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREDO SENIOR LIVING OF HOISINGTON	259 WEST 6TH STREET HOISINGTON, KS 67544

(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
S3215	Continued From page 14 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. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(h)(1) Based on observation and interview, the facility failed to ensure resident medications were securely stored when staff left the medication room door open and unattended with medications stored in unlocked cabinets. Findings included: - Observation on 09/02/26 at 10:00 AM found the medication room door was open and there were no nursing staff to be found for approximately 17 minutes. The resident medications were stored in individual baskets located in unlocked over-the-counter cabinets. There were also	S3215		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N005007	A. BUILDING: _____ B. WING _____	C 09/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREDO SENIOR LIVING OF HOISINGTON	259 WEST 6TH STREET HOISINGTON, KS 67544

(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
S3215	Continued From page 15 medication cards lying on the counter and on the floor. There was a group of 15 residents attending a church meeting in the common area located next to the medication room. On 09/09/26 at approximately 04:40 PM Administrative Staff A acknowledged the medication room was left unlocked and unattended when this surveyor arrived to the facility on the morning of 09/02/26. The facility failed to ensure medications were securely stored to ensure only licensed nurses and certified medication aides had access to stored medications.	S3215		
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	S3248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N005007	A. BUILDING: _____ B. WING _____	C 09/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREDO SENIOR LIVING OF HOISINGTON	259 WEST 6TH STREET HOISINGTON, KS 67544

(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
S3248	Continued From page 16 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: 26-41-102 (d)(1)(2) Based on interview and record review, the facility failed to ensure two of four newly hired employee records included evidence of timely verification of certification with the nurse aide registry and failed to ensure a criminal background check was completed for one of four newly hired staff. Findings included: - Review of employee files conducted on 09/03/26 revealed the following: " Certified Medication Aide " (CMA) H was hired on 06/11/26. The operator failed to provide a copy of a "Nurse Aide Registry Confirmation Notice" to indicate a certification check was completed prior to or the day of hire. "Certified Nurse Aide" (CNA) I was hired on 01/03/26. The operator failed to provide a copy of a "Nurse Aide Registry Confirmation Notice" to indicate a certification check was completed prior to or the day of hire and failed to complete a criminal background in a timely manner. On 09/03/26 at 12:24 PM Administrative Staff A stated she was unable to locate a Kansas Nurse Aide Registry check for CMA H and CNA I, and	S3248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N005007	A. BUILDING: _____ B. WING _____	C 09/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREDO SENIOR LIVING OF HOISINGTON	259 WEST 6TH STREET HOISINGTON, KS 67544

(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
S3248	Continued From page 17 stated she failed to complete a criminal background check for CNA I. The facility failed to ensure timely verifications of certification with the nurse aide registry and failed to ensure criminal background checks were completed for newly hired staff.	S3248		
S3261 SS=D	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) Based on interview and record review the facility failed to ensure qualified staff documented Resident (R)101's medical record contained documentation of all incidents, symptoms, and other indications of illness or injury when he eloped on 11/20/25. Findings included: - R101's medical record revealed he moved into the facility on 08/05/24 with a diagnosis of dementia. The 10/21/25 "Functional Capacity Screen" (FCS) identified R101 was independent with transfers	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N005007	A. BUILDING: _____ B. WING _____	C 09/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREDO SENIOR LIVING OF HOISINGTON	259 WEST 6TH STREET HOISINGTON, KS 67544

(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
S3261	Continued From page 18	S3261		

and mobility without the use of an assistive device, had severely impaired cognition and was identified to be at risk for wandering.

The 10/22/25 "Negotiated Service Agreement" (NSA) documented staff would ensure R101 did not leave the community unattended. The NSA lacked specific interventions in place to prevent R101 from leaving the community without staff knowledge.

On 09/02/26 at 08:43 AM R101's family member stated on 11/20/25 R101 had exited the facility without staff knowledge and walked down the street to his house and was found standing in the backyard by the family member as he hung laundry out to dry. The family member stated facility staff drove by his house, and he told them that R101 was with him and that he would return him to the facility.

Review of R101's medical records failed to locate documentation of the elopement, any investigation of this incident, and interventions put into place to ensure R101 was safe from eloping from the facility in the future.

On 09/09/26 at 12:43 PM Licensed Nurse B stated R101 had severely impaired cognition and exhibited exit-seeking behaviors. LN B stated R101 had a home about five houses down the street to the west of the facility and there was at least one time that she knew of where R101 exited the facility without staff knowledge and staff had to go look for him. LN B stated R101 had gone to his former house down the street and the son brought him back to the facility. LN B stated the staff reported this elopement to the operator but confirmed there was no documentation of this incident in R101's medical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N005007	A. BUILDING: _____ B. WING _____	C 09/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREDO SENIOR LIVING OF HOISINGTON	259 WEST 6TH STREET HOISINGTON, KS 67544

(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
S3261	Continued From page 19 record. The facility failed to ensure designated staff included documentation of all incidents, symptoms and other indications of illness or injury including the dated, time of occurrence, action taken, and results of the action.	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 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) Based on record review and interview for all residents and all facility employees, the facility failed to ensure disaster and emergency preparedness by ensuring performance of	S3280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N005007	A. BUILDING: _____ B. WING _____	C 09/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREDO SENIOR LIVING OF HOISINGTON	259 WEST 6TH STREET HOISINGTON, KS 67544

(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
S3280	Continued From page 20 quarterly reviews of the facility's emergency management plan with employees. Findings included: - On 09/03/26 Administrative Staff A failed to provide documentation that quarterly reviews of the emergency management plan were completed with employees for the third and fourth quarters of 2025. On 09/03/26 at 12:30 PM Administrative Staff A stated she was not able to find any record of quarterly reviews of the emergency management plan completed with employees for the third and fourth quarters of 2025. The facility failed to ensure reviews of the emergency management plan were completed on a quarterly basis with employees.	S3280		
S3320 SS=F	28-39-254 CONSTRUCTION (a) The assisted living facility or residential health care facility shall be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel and the public. (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. (c) New construction, modifications and equipment shall conform to the following codes and standards:	S3320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N005007	A. BUILDING: _____ B. WING _____	C 09/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREDO SENIOR LIVING OF HOISINGTON	259 WEST 6TH STREET HOISINGTON, KS 67544

(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
S3320	Continued From page 21 (1) Title III of the Americans with disabilities act, 42 U.S.C. 12181, effective as of January 26, 1992; and (2) "Food Service Sanitation Manual," health, education, and welfare (HEW) publication no. FDA 78-2081, as in effect on July 1, 1981. This REQUIREMENT is not met as evidenced by: KAR 28-39-254 (a) Based on observation, and interview, the facility failed to ensure staff secured all chemicals to maintain the safety of all residents, staff and visitors. Findings included: - An observation on 09/02/26 at 10:11 AM of an unlocked housekeeping cart revealed the following unlocked chemicals: One 32-ounce (oz.) spray bottle of Lima- A-Way One 24 oz. spray bottle of Oxi-Clean rug and carpet cleaner One 60 oz. bottle of Pine Sol Two 17.5 oz. spray cans of Raid Ant & Roach killer One 8 fluid (fl.) oz. spray can of WD-40 One 19 oz. spray can of Sprayaway glass cleaner One 19 oz. spray can of Great Value Disinfectant Spray	S3320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N005007	A. BUILDING: _____ B. WING _____	C 09/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREDO SENIOR LIVING OF HOISINGTON	259 WEST 6TH STREET HOISINGTON, KS 67544

(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
S3320	Continued From page 22 One 16 oz. spray bottle of Mr. Clean- Clean Freak One 22 fl. oz Resolve Upholstery and Multi-Fabric cleaner An observation on 09/02/26 at 12:23 PM of an unlocked supply closet had the following chemicals: Two containers of Comet with Bleach Cleanser Two 24 fl. oz. squeeze bottles of Lysol Power Clinging Gel One 19 oz. spray can of Sprayaway Glass Cleaner One 19 oz. spray can of Lysol Disinfectant Spray Three 16 fl. oz. spray bottles of Mr. Clean- Clean Freak Multi-Purpose Cleaner One 9.7 oz. spray can of Pledge Lemon Clean An observation on 09/02/26 at 01:58 PM revealed Dietary Staff G attempted to gain access to the supply closet, but the door was locked, and she did not have a key. An observation on 09/02/26 at 04:13 PM revealed Certified Medication Aide (CMA) E attempted to gain access to the supply closet but found the door was locked. CMA E left and returned later with a key. On 09/09/26 at approximately 04:40 PM Administrative Staff A stated she has told staff numerous times the supply closet needed to be locked at all times.	S3320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N005007	A. BUILDING: _____ B. WING _____	C 09/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREDO SENIOR LIVING OF HOISINGTON	259 WEST 6TH STREET HOISINGTON, KS 67544

(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
S3320	Continued From page 23 The facility failed to ensure staff kept chemicals locked out of reach for residents, staff and visitor safety.	S3320		