STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023024	A. BUILDING: _____ B. WING _____	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF EUDORA	2725 CHURCH ST EUDORA, KS 66025

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S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey with attached complaint numbers 197743 and 197389 for the above named facility conducted on 03/16/26 and 03/17/26.	S 000		
S3211 SS=F	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. Based on observation and interview the Operator failed to ensure the Licensed Pharmacist or the "Licensed Nurse" (LN) placed the full name of the resident on the "Over-the-Counter" (OTC) medication containers.	S3211		

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

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S3211	Continued From page 1 Findings included: - Observation on 03/16/26 at approximately 02:10 PM "Registered Nurse" (RN) B unlocked the "Assisted Living" (AL) medication cart, located on the west side of the facility, and revealed the following OTC medications that lacked the full name of the resident: 1 bottle of Centrum Men's Vitamins 1bottle of Zinc 50 milligrams 1 bottle of Areds Z Preser Vision Vitamins 1 bottle of Vitamin D3 1 bottle of Dex 4 Fast Acting Glucose Tablets Interview on 03/17/26 at approximately 04:40 PM with Operator A and Regional RN C confirmed all OTC medication containers were to be labeled by the LN or the Licensed Pharmacist with the full name of the resident. The Operator failed to ensure the Licensed Pharmacist or the LN placed the full name of the resident on the OTC medication containers.	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	S3215		

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S3215	Continued From page 2 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. 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'" (R)'s. Based on observation, interview, and record review, the Operator failed to ensure the facility's "Licensed Nurses" (LN)'s did not administer insulin beyond the manufacturer's or pharmacy provider's recommended date of expiration. The operator further failed to ensure the facility's "Certified Medication Aides'" (CMA)'s checked the insulin pens recommended date of expiration prior to	S3215		

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S3215	Continued From page 3	S3215		

dialing the insulin pens for the residents to self-administer their insulin. The Operator continued to fail to ensure all non-controlled medications managed by the facility were secured in a locked medication cart or medication room for R3.

Findings included:

- Observation on 03/16/26 at approximately 02:10 PM "Registered Nurse" (RN) B unlocked the "Assisted Living" (AL) medication cart, located on the west side of the facility, and revealed the following insulin pens that lacked the date the insulin pens were opened for use:

1 Lantus insulin pen that lacked the date the insulin pen was opened. The Lantus Pen was approximately half full.
1 Novolog insulin pen that lacked the date the insulin pen was opened. The Novolog pen was full.

Review of the Lantus Insulin pen manufacturers' recommendation revealed after 28 days the Lantus insulin pen should be thrown away even if the Lantus insulin pen contained insulin.

Review of the Novolog Insulin pen manufacturers' recommendation revealed after 28 days the Lantus insulin pen should be thrown away even if the Novolog pen contained insulin.

Interview on 03/17/26 at approximately 04:40 PM with Operator A and Regional RN C confirmed all Insulin pens were to be dated with a beyond use date.

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S3215	Continued From page 4 The Operator failed to ensure the facility's LN's did not administer insulin beyond the manufacturer's or pharmacy provider's recommended date of expiration. The operator further failed to ensure the facility's CMA's checked the insulin pens recommended date of expiration prior to dialing the insulin pens for the resident's to self-administer their insulin. - Record review for R3 revealed an admission date of 12/10/22 with diagnoses of cognitive communication deficit, other cerebral infarction, type two diabetes mellitus, aphasia following cerebral infarction, hypertensive heart disease with heart failure and glaucoma. Review of R3's combined "Functional Capacity Screen" (FCS) / "Negotiated Service Agreement" (NSA) dated 02/25/26 revealed R3 was independent with bathing, dressing, toileting, transferring, walking, mobility and eating. R3 lacked the ability to manage her own medications and medical treatments. R3 was cognitively intact and used a walker mobility device. The section titled "Management of Medications" revealed R3 required physical assistance to prepare her medications for administration. The section titled "Medications/Treatments/Durable Medical Equipment/Advance Directives" lacked documentation of R3 administering any of her own medications. The facility LN was instructed to delegate R3's medication administration to facility staff that was "certified/licensed" to administer medications. Observation on 03/17/26 at approximately 03:00 PM with Operator A of R3's bathroom revealed a	S3215		

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S3215	Continued From page 5 cabinet that had an upper and lower door that freely opened located in the southwest corner of the bathroom. In the upper cabinet were the following unsecured OTC medications: 1 bottle of Stool Softener 1 bottle of Colace 1 bottle of Acetaminophen 500 milligrams. Interview on 03/17/26 at approximately 04:40 PM with Operator A and Regional RN C confirmed all medications the facility managed were to be stored in the locked mediation cart or medication room. The Operator failed to ensure all non-controlled medications managed by the facility were secured in a locked medication cart or medication room for R3.	S3215		
S3320 SS=E	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		

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S3320	Continued From page 6 (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: K.A.R. 28-39-254 (a) The facility reported a census of 45 residents. 20 residents resided in the secured specialty unit. Based on observation and interview, the Operator failed to ensure the secured specialty unit was maintained to protect the health and safety of the cognitively impaired residents who resided in the secured specialty unit. Findings included: - Observation on 03/16/26 at approximately 02:30PM with Operator A, of the northeast hallway in the secured specialty unit revealed a housekeeping cart that was pushed into the doorway right in front of the secured exit door to the outside of the facility. On the top of the cart was a container of unsecured Sani Wipes with a purple top (a hospital-grad high alcohol disinfecting wipe). The cart was located approximately 10 feet behind the facility staff member, who was talking to a resident. Interview on 03/17/26 at approximately 04:20 PM	S3320		

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S3320	Continued From page 7 with Regional Registered Nurse C and Operator A confirmed all chemicals were to be secured in the secured specialty unit. The Operator failed to ensure the secured specialty unit was maintained to protect the health and safety of the cognitively impaired residents who resided in the secured specialty unit.	S3320		