STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE ASSISTED LIVING	440 N 4TH STREET CLEARWATER, KS 67026

(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 with attached complaint numbers 196488, 196196, and 193699, for the above named facility conducted on 11/17/25, 11/18/25, and 11/19/25.	S 000		
S 110 SS=E	26-39-103 (c) NOTICE OF RIGHTS AND SERVICES (c) Notice of rights and services. (1) Before admission, the administrator or operator shall ensure that each resident or the resident's legal representative is informed, both orally and in writing, of the following in a language the resident or the resident ' s legal representative understands: (A) The rights of the resident; (B) the rules governing resident conduct and responsibility; (C) the current rate for the level of care and services to be provided; and (D) if applicable, any additional fees that will be charged for optional services. (2) The administrator or operator shall ensure that each resident or the resident ' s legal representative is notified in writing of any changes in charges or services that occur after admission and at least 30 days before the effective date of the change. The changes shall not take place until notice is given, unless the change is due to a change in level of care. This STANDARD is not met as evidenced by: K.A.R. 26-39-103 (c) (1) (A) (B) (C) (D) The facility reported a census of 32 residents.	S 110		

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
	N087053	A. BUILDING: _____ B. WING _____	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE ASSISTED LIVING	440 N 4TH STREET CLEARWATER, KS 67026

(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 110	Continued From page 1 The sample included 3 "Residents'" (R)'s, and 3 focused reviews. Based on record review and interview the operator failed to provide in writing the resident rights, rules governing resident conduct and responsibility, the current rate for the level of care and services to be provided, and if applicable, any additional fees that would be charged for optional services for newly admitted R4 and R6. Findings included: - Record review for R4 revealed an admission date of 07/11/25 with diagnoses of emphysema, chronic obstructive pulmonary disease, pleural plaque with the presence of asbestos, hypertension, and anemia. Review of R4's "Functional Capacity Screen" dated 08/27/25 revealed R4 was independent with bathing, dressing, and toileting. R4 required supervision with transferring and walking/mobility. R4 was cognitively intact, he was able to make himself understood, and he understood others. R4 was at risk for falls and used no walking/mobility device. R4 lacked the ability to manage his own medications and medical treatments. Review of R4's combined and unsigned "Negotiated Service Agreement" (NSA)/"Health Service Plan" (HSP) identified R4 was fully independent with transferring with the use of a transfer pole, and R4 was fully independent with the use of a wheelchair. The section titled "Medication Management and Medical Treatment Management" lacked documentation of who was	S 110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE ASSISTED LIVING	440 N 4TH STREET CLEARWATER, KS 67026

(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 110	Continued From page 2	S 110		

responsible for the management and administration of R4's medications and medical treatments. Under the section titled "Fall Risk" R4 was documented not being at risk for falls.

R4's combined NSA/HSP lacked documentation of the outside hospice provider.

Review of the facility provided document titled "Move in Record" dated 07/11/25 revealed in the section titled "External Communities" section the name of the outside provider providing hospice care.

R4's record lacked documentation of R4 being provided in writing at the time of admission to the facility the resident rights, rules governing resident conduct and responsibility, the current rate for the level of care and services to be provided, and if applicable, any additional fees that would be charged for optional services.

Interview on 11/19/25 at approximately 01:00 PM with Operator A and Regional Licensed Nursing Home Administrator C confirmed R4's medical record lacked documentation in writing at the time of admission to the facility the resident rights, rules governing resident conduct and responsibility, the current rate for the level of care and services to be provided, and if applicable, any additional fees that would be charged for optional services.

- Record review for R6 revealed an admission date of 09/09/25 with diagnoses of atrial fibrillation, dementia, and hypertension.

Review of R6's FCS dated 09/05/25 revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE ASSISTED LIVING	440 N 4TH STREET CLEARWATER, KS 67026

(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 110	Continued From page 3	S 110		

she was independent with bathing, dressing, toileting, transferring, walking/mobility, and eating. She lacked the ability to manage her own medications and medical treatments. R6 was continent, cognitively intact, and able to make herself understood and she understood others. R6 had no current/recent problems or risks. R6 used no mobility device.

Review of R6's combined NSA/HSP dated 09/08/25 instructed facility staff to physically assist R6 with dressing and provide cues and reminders throughout the day for cognitive impairment. Under the section titled "Medication Management and Medical Treatment Management" R6 was documented as being independent.

R6's record lacked documentation of R6 being provided in writing at the time of admission to the facility the resident rights, rules governing resident conduct and responsibility, the current rate for the level of care and services to be provided, and if applicable, any additional fees that would be charged for optional services.

Interview on 11/19/25 at approximately 01:00 PM with Operator A and Regional Licensed Nursing Home Administrator C confirmed R6's medical record lacked documentation in writing at the time of admission to the facility the resident rights, rules governing resident conduct and responsibility, the current rate for the level of care and services to be provided, and if applicable, any additional fees that would be charged for optional services.

The operator failed to provide in writing the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE ASSISTED LIVING	440 N 4TH STREET CLEARWATER, KS 67026

(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 110	Continued From page 4 resident rights, rules governing resident conduct and responsibility, the current rate for the level of care and services to be provided, and if applicable, any additional fees that would be charged for optional services for newly admitted R4 and R6.	S 110		
S3060 SS=F	26-41-106 Community Governance (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the facilitation of the organization of at least one resident council, each of which shall meet at least quarterly to provide residents with a forum to provide input into community governance. (b) Each administrator or operator shall ensure the accommodation of the council process by providing space for the meetings, posting notices of the meetings, and assisting residents who wish to attend the meetings. (c) In order to permit a free exchange of ideas and concerns, each administrator or operator shall ensure that all meetings are conducted without the presence of facility staff, unless allowed by the residents. (d) Each administrator or operator shall respond to each written idea and concern received from the council, in writing, within 30 days after the meeting at which the written ideas and concerns were collected. The administrator or operator shall ensure that a copy of each written idea or concern and each response is available to surveyors. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-106 (c) (d)	S3060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE ASSISTED LIVING	440 N 4TH STREET CLEARWATER, KS 67026

(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
S3060	Continued From page 5 The facility reported a census of 32 residents. Based on record review and interview the Operator failed to ensure the Community Governance meetings were conducted without the presence of facility staff, unless allowed by the residents. The Operator further failed to show a copy of the written responses to the council addressing their concerns and ideas within 30 days of receiving the councils' written concerns and ideas. Findings included: - Record review of the facility provided binder titled "Resident Council" revealed a two-page document titled "Resident council Minutes". The Community Governance meetings were held on the following dates, with the following concerns, ideas and staff present: On 01/30/25 Resident concerns over the following: staff tardiness for their shifts, late medication passes, food not being warm when served, maintence issues, housekeeping not being performed, laundry not being done, showers not being received, and handwashing. Two staff members were listed by first name only and titles were not provided. Under the section titled "Old Business" it was handwritten "No old business". The document lacked acknowledgement from the residents allowing staff to be present at the meeting. The document further lacked a written response from the Operator over resident	S3060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE ASSISTED LIVING	440 N 4TH STREET CLEARWATER, KS 67026

(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
S3060	Continued From page 6 concerns. On 03/13/25 Under the section titled "Old Business" it was handwritten "No old business". In the section titled "Staff Members in Attendance", prior activities director M and prior Operator L were listed. Resident concerns included the residents request for a list of workers names and positions with pictures. The document lacked acknowledgement from the residents allowing staff to be present at the meeting. The document further lacked a written response from the Operator over resident concerns. On 04/17/25 In the section Titled "Old Business", the word "Old" was marked out, and the word "New" was handwritten in. The document lacked documentation of the follow up of the 03/13/25 meeting. In the section titled "Staff Members in Attendance", prior activities director M was listed. Resident concerns included the following: housekeeping not being done, laundry not being done, food concerns, and maintenance concerns. The document lacked acknowledgement from the residents allowing staff to be present at the meeting. The document further lacked a written response from the Operator over resident concerns.	S3060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE ASSISTED LIVING	440 N 4TH STREET CLEARWATER, KS 67026

(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
S3060	Continued From page 7 On 05/08/25 In the section titled "Staff Members in Attendance", prior activities director M was listed. In the section titled "Old Business" it was documented that "Housekeeping not making improvements", and there were continued maintence and dietary issues. Resident concerns included continued dietary issues, housekeeping issues, and maintenance issues. Resident did discuss "Resident Choice Meals". The document lacked acknowledgement from the residents allowing staff to be present at the meeting. The document further lacked a written response from the Operator over resident concerns and ideas. On 06/12/25 In the section titled "Staff Members in Attendance", prior activities director M was listed. In the section titled "Old Business" the issue of food not being hot when served, housekeeping not being performed and maintence issues were listed. In the section titled "New Business" there were dietary concerns, nursing availability at night concerns, staff member being rude to residents, housekeeping concerns, and maintenance concerns. The document lacked acknowledgement from the residents allowing staff to be present at the	S3060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE ASSISTED LIVING	440 N 4TH STREET CLEARWATER, KS 67026

(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
S3060	Continued From page 8	S3060		

meeting. The document further lacked a written response from the Operator over resident concerns and ideas.

On 07/10/25 In the section titled "Staff Members in Attendance", prior activities director M was listed.

In the section titled "Old Business" dietary issues, housekeeping and maintenance issues were listed.

In the section titled "New Business" it was reported that a staff member sat in the dining room on her phone, housekeeping concerns, dietary concerns, maintenance concerns, and resident ideas for upcoming "Resident choice Meals".

The document lacked acknowledgement from the residents allowing staff to be present at the meeting. The document further lacked a written response from the Operator over resident concerns and ideas.

On 08/14/25 In the section titled "Staff Members in Attendance", prior activities director M, Prior Operator E and "Certified Medication Aide" (CMA) N were listed.

The section titled "Old Business" lacked documentation.

Under the section titled "New Business" the following resident concerns and ideas were documented:
Medication administration time, resident privacy, infection control concerns, housekeeping

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE ASSISTED LIVING	440 N 4TH STREET CLEARWATER, KS 67026

(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
S3060	Continued From page 9	S3060		

concerns, more variety in foods served, maintenance concerns, and "Resident Choice Meals" discussed.
The document lacked acknowledgement from the residents allowing staff to be present at the meeting. The document further lacked a written response from the Operator over resident concerns and ideas.

On 09/11/25 in the section titled "Staff Members in Attendance", prior activities director M was listed.

The section titled "Old Business" lacked documentation.

In the section titled "New Business" resident voiced concerns over staffing, medication administration times, questions about some medications a resident receives, housekeeping concerns, dietary concerns, maintenance concerns, and residents discussed "Resident Choice Meals".

The document lacked acknowledgement from the residents allowing staff to be present at the meeting. The document further lacked a written response from the Operator over resident concerns and ideas.

On 10/13/25 In the section titled "Staff Members in Attendance", CMA N was listed.

The section titled "Old Business" lacked documentation and the second page that listed "New Business" was not attached.

Interview on 11/19/25 at approximately 01:30

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE ASSISTED LIVING	440 N 4TH STREET CLEARWATER, KS 67026

(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
S3060	Continued From page 10	S3060		

with Operator A and Licensed Nursing Home Administrator C confirmed the lack of documentation of an acknowledgement from the residents allowing a staff member to be present at their meetings. Operator A further confirmed the lack of documentation of the Operators written response to the Community Governances ideas and concerns.

Review of the facility provided policy titled "Resident Council" dated 10/21 revealed the following:

"4. The administrator will request to be present at Resident Council meetings."

"7. The "Quality Assurance and Performance Improvement" (QAPI) committee will review information and feedback from the Resident Council as part of their quality review. Issues documented on council response forms may be referred to the QAPI committee, if applicable (this issue is of serious natrue or if there is a pattern).

"8. All items of concern raised at Resident Council meetings will be answered in person or in writing by the Administratior at the next meeting".

The Operator failed to ensure the Community Governance meetings were conducted without the presence of facility staff, unless allowed by the residents. The Operator further failed to show a copy of the written responses to the council addressing their concerns and ideas within 30 days of receiving the councils' written concerns and ideas

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE ASSISTED LIVING	440 N 4TH STREET CLEARWATER, KS 67026

(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
S3171 SS=E	26-41-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-204 (i) The facility reported a census of 32 residents. The sample included 3 "Residents'" (R)'s, 4, 5, 6, and 3 focused reviews R's 1, 2, and 3. Based on observation, record review and interview, the operator failed to to provide healthcare services for R3 and R4 in accordance with professional standards of practice when the Operator failed to perform an assessment for R3 and R4 to confirm the bed assist devices were not a restraint, R3 and R4's ability to safely use the bed assist devices, an assessment to ensure the devices posed no risk for entrapment, and an assessment to ensure the devices were securely attached to the bedframe. The operator continued to fail to document the assessments for R3 and R4 in their medical record, and the Operator further failed to ensure the "Negotiated Service Agreements" (NSA)'s for R3 and R4 included a description of the bed assist devices, the purpose of the bed assist devices, and special instructions on use and monitoring of the bed assist devices. Findings Included:	S3171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE ASSISTED LIVING	440 N 4TH STREET CLEARWATER, KS 67026

(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
S3171	Continued From page 12 - Record review for R3 revealed an admission date of 11/23/22 with diagnoses of epileptic seizures, chronic obstructive pulmonary disease, major depressive disorders, anxiety, and cerebrovascular disease. Review of R3's "Functional Capacity Screen" (FCS) dated 09/08/25 revealed R3 was independent with bathing, dressing, toileting, eating, and transferring. R3's walking/mobility was not scored. R3 lacked the ability to manage her own medications and medical treatments. R3 had impaired short term memory, and she was able to make herself understood and she understood others. The comments section of R3's FCA lacked documentation of a bed assist device. Review of R3's combined "Negotiated Service Agreement" (NSA) /"Health Service Plan" (HSP) signed and dated 08/29/23 instructed facility staff to provide stand by assistance with bathing, and R3 used a wheelchair at all times. the section titled "Transfers" instructed facility staff that R3 was independent with transferring. R3's NSA/HSP lacked documentation of a description of the bed assist devices, the purpose of the bed assist devices, and special instructions on use and monitoring of the bed assist devices. Observation on 11/19/25 at approximately 10:45 AM of R3's bed revealed the head of the bed sat against the west wall of the room. On the North side of the bed slid under the mattress was an	S3171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE ASSISTED LIVING	440 N 4TH STREET CLEARWATER, KS 67026

(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
S3171	Continued From page 13	S3171		

inverted "U" shaped device that measured approximately 20 inches in height and 18 inches in width. There was an opening of approx. 17.5 inches in width from the inside of each leg of the inverted "U" shaped device. The device freely slid from under the mattress, and the device measured approximately 4 inches from the device to the mattress.

Interview on 11/19/25 at approximately 01:00 PM with Operator A confirmed R3's "Medical Record" lacked documentation for R3 to confirm the bed assist devices were not a restraint, R3's ability to safely use the bed assist devices, an assessment to ensure the devices posed no risk for entrapment, and an assessment to ensure the devices were securely attached to the bedframe. The operator continued to fail to document the assessments for R3 in her medical record.

- Record review for R4 revealed an admission date of 07/11/25 with diagnoses of emphysema, chronic obstructive pulmonary disease, pleural plaque with the presence of asbestos, hypertension, and anemia.

Review of R4's FCS dated 08/27/25 revealed R4 was independent with bathing, dressing, toileting, and eating. R4 required supervision with transferring, and walking/mobility. R4 lacked the ability to manage his own medications and medical treatments. R4 was continent and his cognition was intact. R4 was able to make himself understood and he understood others. R4 was a fall risk and used no mobility device.

The comments section of R4's FCA lacked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE ASSISTED LIVING	440 N 4TH STREET CLEARWATER, KS 67026

(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
S3171	Continued From page 14	S3171		

documentation of a bed assist device.

Review of R4's combined unsigned NSA/HSP dated 08/27/25 instructed facility staff to provide assistance for bathing. The section titled "Transfers" R4 was independent with transferring and had a "Transfer pole for transfers in/out of bed independently".

R4's NSA/HSP lacked documentation of a description of the bed assist devices, the purpose of the bed assist devices, and special instructions on use and monitoring of the bed assist devices.

Observation on 11/19/25 at approximately 10:30 AM of R4's bed revealed the head of the bed sat against the south wall of the room. On both sides of R4's bed there were bedrails that were rectangular in shape and measured approximately 32.5 inches in width, and 18.5 inches in width. There were eight tubular bars on the inside frame that measured less the 4 inches. The bed assist devices posed no risk for entrapment and were securely attached to the bed. The device on the east side of the bed was in the up position and the device on the west side of the bed was in the down position.

Interview on 11/19/25 at approximately 01:00 PM with Operator A confirmed R4's "Medical Record" lacked documentation for R4 to confirm the bed assist devices were not a restraint, R4's ability to safely use the bed assist devices, an assessment to ensure the devices posed no risk for entrapment, and an assessment to ensure the devices were securely attached to the bedframe. The operator continued to fail to document the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE ASSISTED LIVING	440 N 4TH STREET CLEARWATER, KS 67026

(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
S3171	Continued From page 15 assessments for R4 in his medical record. Review of the facility provided policy titled titled "Assistive Devices and Equipment" dated 10/21 revealed "3. Recommendations for th euse of devices and equipment are based on the comprehensive assessment and documented in the resiident care plan". The FDA (food and drug administration) "Bedrails in Assisted Living, Residential Health Care and Home Plus Facilities" recommended the following: Complete an assessment of the resident to confirm that the device is not a restraint. Complete an assessment of the resident to determine the purpose of the device and the resident's ability to safely use the device and document the findings in the resident's record. Complete an assessment of the device using the recommendations in the FDA guidance to ensure the device is securely attached to the bed or bedframe and poses no risk for entrapment and document the findings in the resident record. If the purpose of the device is to assist the resident with transfers, the FCS should document the resident's functional capacity based on the use of the device and should be listed in the comments section. Include a description of the device, its purpose and special instructions on use and monitoring in the resident's NSA.	S3171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE ASSISTED LIVING	440 N 4TH STREET CLEARWATER, KS 67026

(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
S3171	Continued From page 16 Document periodic reassessments of the resident's use of the device and their ability to use it safely and reassessment of the safety of the device in the resident's record. The Operator failed to perform an assessment for R3 and R4 to confirm the bed assist devices were not a restraint, R3 and R4's ability to safely use the bed assist devices, an assessment to ensure the devices posed no risk for entrapment, and an assessment to ensure the devices were securely attached to the bedframe. The operator continued to fail to document the assessments for R3 and R4 in their medical record, and the Operator further failed to ensure the "Negotiated Service Agreements" (NSA)'s for R3 and R4 included a description of the bed assist devices, the purpose of the bed assist devices, and special instructions on use and monitoring of the bed assist devices.	S3171		
S3175 SS=E	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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE ASSISTED LIVING	440 N 4TH STREET CLEARWATER, KS 67026

(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
S3175	Continued From page 17	S3175		

This REQUIREMENT is not met as evidenced by:
K.A.R. 26-41-205 (a) (1)

The facility reported a census of 32 residents. The sample included 3 "Residents'" (R)'s, 4, 5, 6, and 3 focused reviews R's 1, 2, and 3. Based on observation, record review and interview, the operator failed to ensure the "Licensed Nurse" (LN) performed an assessment and determined that R's 4 and 6 could safely and accurately without staff assistance self-administer their own medications before R4 and R6 initially began self -administering their own medications.

Findings Included:

- Record review for R4 revealed an admission date of 07/11/25 with diagnoses of emphysema, chronic obstructive pulmonary disease, pleural plaque with the presence of asbestos, hypertension, and anemia.

Review of R4's "Functional Capacity Screen" (FCS) dated 08/27/25 revealed R4 was independent with bathing, dressing, toileting, and eating. R4 required supervision with transferring, and walking/mobility. R4 lacked the ability to manage his own medications and medical treatments. R4 was continent and his cognition was intact. R4 was able to make himself

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE ASSISTED LIVING	440 N 4TH STREET CLEARWATER, KS 67026

(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
S3175	Continued From page 18	S3175		

understood and he understood others. R4 was a fall risk and used no mobility device.

Review of R4's combined unsigned "Negotiated Service Agreement" (NSA)/"Health Service Plan" (HSP) dated 08/27/25 instructed facility staff to provide assistance for bathing. The section titled "Medication Management and Medical Treatment Management" lacked documentation of health services to be provided to R4 for the management of his medications and medical treatments.

The combined NSA/HSP lacked documentation of the outside provider of hospice services.

Review of R4's electronic "Medication Administration Record" e(MAR) revealed the following medications R4 was documented as self-administering;

Beet Root Oral Capsule
Prostate Oral Capsule
Hyoscyamine Sulfate Oral Tablet 0.125 milligrams

R4's electronic "Medical Record" lacked documentation of an assessment that determined R4 could safely and accurately without staff assistance self-administer some of his own medications before he initially began self -administering some of his own medications.

- Record review for R6 revealed an admission date of 09/09/25 with diagnoses of atrial fibrillation, dementia, and hypertension.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE ASSISTED LIVING	440 N 4TH STREET CLEARWATER, KS 67026

(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
S3175	Continued From page 19	S3175		

Review of R6's FCS dated 09/05/25 revealed she was independent with bathing, dressing, toileting, transferring, walking/mobility, and eating. She lacked the ability to manage her own medications and medical treatments. R6 was continent, cognitively intact and was able to make herself understood and she understood others. R6 used no mobility device.

Review of R6's combined NSA/HSP dated 09/09/25 instructed facility staff to physically assist R6 in dressing. The section titled "Cognition/Communication" identified R6 had "some cognitive impairment" and instructed facility staff to provide cues and reminder's through out the day. The section titled "Medication Management and Medical Treatment Management" instructed facility staff that R6 was "totally independent with ordering and self -administering " her own medications.

Review of R6's electronic "Medical Record" under the "Clinical Physician Orders" tab revealed the following orders;

Obtain a daily blood pressure
Obtain vital signs weekly

Review of R6's electronic "Medical Record" under the "Progress Notes" tab revealed the following entry:

On 10/02/25 at 08:38 PM signed by "Advanced Practice Registered Nurse" (APRN) P revealed R6 was taking Xarelto 20 milligrams by mouth daily, Metoprolol Succinate 50 milligrams by mouth daily, Memantine 10 milligrams twice daily, and Bupropion 150 milligrams daily. APRN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE ASSISTED LIVING	440 N 4TH STREET CLEARWATER, KS 67026

(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
S3175	Continued From page 20	S3175		

P documented that R6's family member was present at the appointment to help with resident history as patient has fairly significant dementia", and that the history and physical information was obtained from nursing "and patient is able, limited information available from patient due to cognitive deficit". APRN P continued to document that R6's family "manages" R6's medications, fills the pillboxes for her" and reported that R6 had been good at remembering to take them routinely.

Observation on 11/19/25 at approximately 11:00 AM of R6's bathroom cabinets revealed the following over the counter medications:

1 bottle of Tums
1 tube of Hydrocortisone Cream
1 bottle of Allergy relief nasal spray

R6's medical record lacked documentation of an assessment that determined R6 could safely and accurately without staff assistance self-administer some of her own medications before she initially began self -administering some of her own medications.

Interview on 11/19/25 at approximately 01:00 PM with Operator A confirmed the medical records for R4 and R6 lacked documentation of an assessment that determined they could safely and accurately without staff assistance self-administer some of their own medications before they initially began self -administering some of their own medications.

Review of the facility provided undated policy titled "Medications Brought from Home Including

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE ASSISTED LIVING	440 N 4TH STREET CLEARWATER, KS 67026

(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
S3175	Continued From page 21 Sample Medications" revealed the following; "Self-administration my be permitted based on the resident's cognitive and physical abilities, as assessed by the healthcare team after obtaining a physician order or self-administration". The operator failed to ensure the LN performed an assessment and determined that R's 4 and 6 could safely and accurately without staff assistance self-administer their own medications before R4 and R6 initially began self -administering their own medications.	S3175		
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 32 residents. Based on observation and interview the Operator	S3211		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE ASSISTED LIVING	440 N 4TH STREET CLEARWATER, KS 67026

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3211	Continued From page 22	S3211		

failed to ensure the "Licensed Nurse" (LN) or the Licensed Pharmacist placed the full name of the resident on the bottles of "Over the Counter" (OTC) medications.

Findings included:

- Observation on of the facility medication cart 11/17/25 at approximately 01:45 PM located in the front common area on the east wall. "Certified Medication Aide" (CMA) I unlocked the cart and revealed the following unlabeled OTC medications:

1 tube of Clotrimazole 1%
1 box of Claritin
1 bottle of Nervive
1 bottle of Papaya Digestive support

Interview on 11/17/25 at approximately 01:45 PM with CMA I confirmed the full resident name was not on the tube of Clotrimazole, the box of Claritin, the bottle of Nervive, and the bottle of Papaya Digestive Support.

Review of the facility provided undated policy titled "Assisted Living Medication and Treatment Labeling Policy" revealed the following:

On page two of the policy "A licensed nurse or medication aide may accept the over-the-counter medication in its original, unbroken, manufacturer's package. A Licensed Pharmacist or Licensed Nurse will place the full name of the resident on the package."

The Operator failed to ensure the "Licensed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE ASSISTED LIVING	440 N 4TH STREET CLEARWATER, KS 67026

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3211	Continued From page 23 Nurse" (LN) or the Licensed Pharmacist placed the full name of the resident on the bottles of "Over the Counter" (OTC) medications.	S3211		
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: K.A.R. 26-41-104 (d) (3) The facility reported a census of 32 residents. Based on interview, the Operator failed to ensure a quarterly review of the facility's Emergency Management Plan with staff and residents. Findings included:	S3280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE ASSISTED LIVING	440 N 4TH STREET CLEARWATER, KS 67026

(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 24 - On 11/17/25 at approximately 09:30 AM the request for documentation of the quarterly reviews for staff and residents was made to Regional "Registered Nurse" B. Interview on 11/19/25 at approximately 01:00 PM with Operator A and Regional Licensed Nursing Home Administrator C confirmed they were unable to find documentation of the required quarterly reviews for staff and residents. Regional Licensed Nursing Home Administrator C confirmed in the facilities electronic maintence log he was able to see an annual review of the facilities emergency management plan with staff. Review of the facility provided document titled "Emergency Management Plan" dated 07/07/25, revealed the following: "18. The Emergency Management Plan is reviwed and updated at a minimum anually to ensure its accuracy." The facility policy lacked documentation that the Emergency Management Plan is to be reviewed at the time of hire for new employees, at the time of admission for new residents, and at least quarterly with staff and residents. The Operator failed to ensure a quarterly review of the facility's Emergency Management Plan with staff and residents.	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	S3298		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE ASSISTED LIVING	440 N 4TH STREET CLEARWATER, KS 67026

(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
S3298	Continued From page 25 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: K.A.R. 26-41-206 (d) The facility reported a census of 32 residents. Based on interview and record review, the operator failed to ensure the facility dietary staff served the residents food at the proper temperatures. Findings included: - Record review of the facility provided document titled "Production Sheet" dated 11/17/25 revealed the morning meal with the food temperatures obtained. Record review of the facilty provided binder titled "Resident Council" reveald the following:	S3298		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE ASSISTED LIVING	440 N 4TH STREET CLEARWATER, KS 67026

(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
S3298	Continued From page 26 On 01/20/25 residents voiced concerns of "Meals have not been warm". On 04/17/25 residents voiced concerns that "Tuna and Pea salads should be cold". On 05/08/25 residents voiced concerns of "Food not coming out hot". On 06/12/25 residents voiced concers of "Food not hot". On 07/10/14 residents voiced conerns of "Food needs to be a little warmer". On 08/14/25 residents voiced they wanted "warm food". Interview on 11/17/25 at approximately 09:30 AM with Dietary Staff D revealed that she did not start obtaining food temperatures until 11/17/25. Interview on 11/19/25 at approximately 01:30 PM with Operator A confirmed when she started employment with the facility approximately "three weeks ago", and she noticed food temperatures were not being done and implemented the process for food temperatures to be obtained, and the dietary staff had started obtaining food temperatures on 11/17/25. The operator failed to ensure the facility dietary staff served the residents food at the proper temperatures.	S3298		
S3299 SS=F	26-41-206 (e) (1) Facility Food Storage (e) Food storage. Facility staff shall store all food under safe and sanitary conditions. (1) Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving.	S3299		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE ASSISTED LIVING	440 N 4TH STREET CLEARWATER, KS 67026

(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
S3299	Continued From page 27	S3299		

This REQUIREMENT is not met as evidenced by:
K.A.R. 26-41-206 (e)

The facility reported a census of 32 residents. Based on observation and interview, the Operator failed to ensure the facility dietary staff stored all food under safe and sanitary conditions.

Findings included:

- Observation on 11/17/25 at approximately 09:30 AM of the combination refrigerator and top freezer combination revealed in the freezer section the following undated when opened food items:

2 bowels of rainbow sherbet that were uncovered.
1 bag of chicken breast that was not sealed and stored with the opened part of the bag folded down.
1 bag of frozen burritos in a zip lock bag that was in the freezer door.

In the refrigerator section of the combination refrigerator freezer were the following food items that lacked a date of when the food item was opened:

½ of an onion wrapped in clear plastic. The onion was turning brown in the middle and was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE ASSISTED LIVING	440 N 4TH STREET CLEARWATER, KS 67026

(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
S3299	Continued From page 28 soft. The following food containers were beyond their use date: 1 bottle of Ranch dressing with a beyond use date of 06/19/25. 1 container of Miracle Whip with a beyond use date of 05/6/25. 1 container of Garlic in water with a beyond use date of 10/13/25. On the shelves in the combination refrigerator and freezer were the following items: On the top shelf on the right-side sat a round melon that was soft to the touch and had black and white spots growing out of the skin of the melon. 1 package of roast beef lunch meat lacked a date when it was opened. 1 package of ham lunch meat lacked a date when it was opened. 1 white plastic bag with handles contained lettuce and the bag lacked a date of when it was placed in the refrigerator. 1 small container of pudding lacked a covering and a date when it was opened. 2 packages of cooked hot dogs wrapped in clear plastic wrap and lacked a date of when cooked. 1 red bell pepper in the bottom drawer of the refrigerator was soft to the touch. In the two-door refrigerator that sat on the east wall of the kitchen was the following: Behind the door on the west side of the two-door refrigerator was a carton of scrambled egg mix	S3299		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE ASSISTED LIVING	440 N 4TH STREET CLEARWATER, KS 67026

(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
S3299	Continued From page 29 that lacked a date of when it had been opened. Behind the door on the east side of the two-door refrigerator on the second shelf down sat the following 5- pound cottage cheese containers that were dated beyond their use date: 2 containers had a beyond use date of 11/05/25. 1 container had a beyond use date of 10/06/25. 1 container lacked a beyond use date. In the dry food storage area located on the south side of the kitchen, on a wire rack located on the south wall, on the bottom shelf of the west end, sat an opened bag of flour. There was flour on the floor in front of the rack and a small cardboard box sat on top of the flour on the floor, with flour in the cardboard box. Review of the facility provided policy titled "Food Receiving and Storage" dated 10/21 revealed the following: "1. Food services, or other designated staff, will maintain clean food storage areas at all times". "6. Food in designated dry storage areas shall be kept off of the floor ...". "8. All foods stored in the refrigerator or freezer will be covered, labeled and dated ("use by" date)". "14 ...e. Other opened containers must be dated and sealed or covered during storage". The Operator failed to ensure the facility dietary staff stored all food under safe and sanitary conditions.	S3299		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE ASSISTED LIVING	440 N 4TH STREET CLEARWATER, KS 67026

(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
S3305 SS=F	26-41-207 (a) (b) Infection Control (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the provision of a safe, sanitary, and comfortable environment for residents. (b) Each administrator or operator shall ensure the development of policies and implementation of procedures to prevent the spread of infections. These policies and procedures shall include the following requirements: (1) Using universal precautions to prevent the spread of blood-borne pathogens; (2) techniques to ensure that hand hygiene meets professional health care standards; (3) techniques to ensure that the laundering and handling of soiled and clean linens meet professional health care standards; (4) providing sanitary conditions for food service; (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 (7) transferring a resident with an infectious disease to an appropriate health care facility if the administrator or operator is unable to provide the isolation precautions necessary to protect the health of other residents.	S3305		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE ASSISTED LIVING	440 N 4TH STREET CLEARWATER, KS 67026

(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
S3305	Continued From page 31 This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-207 (b) (4) The facility reported a census of 32 residents. Based on observation and interview, the Operator failed to ensure the facility dietary staff provided sanitary conditions for the food service. Findings included: - Observation on 11/17/25 at approximately 09:30 AM of the facility dishwasher in the dietary area revealed a white 5-gallon bucket on the floor under the dishwasher with a hose running from the bucket to the dishwasher. There were three containers of "Parts Per Million" (PPM) test strips setting on top of the facility dishwasher. Interview with Dietary Staff D revealed she was not aware that she should be doing a PPM test and continued that she was not trained to do the PPM test strips, and confirmed she had no documentation of the PPM test strips being done to confirm the dishes were being sanitized. Dietary Staff D further confirmed she did not know if the dish machine was a high temperature sanitation or a low temperature with chemical sanitation. Review of the facility provided policy titled "Sanitization" dated 10/21 revealed the following: "4. Sanitizing of utensils and removable parts of equipment should be accomplished in one of the following ways ...c. contact with QAC	S3305		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE ASSISTED LIVING	440 N 4TH STREET CLEARWATER, KS 67026

(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
S3305	Continued From page 32 (Quaternary Ammonium) at approved concentration per manufacturers instructions ...d. Immersion for thirty seconds in hot (at least 171 degree Fahrenheit) water. Review of the Department of Agriculture "Focus on Food Safety" revised 08/2017 on page 23 stated for chemical sanitation the chemicals mut be auto dispensed into the final rinse water; and checked daily. The Operator failed to ensure the facility dietary staff provided sanitary conditions for the food service.	S3305		
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 by: K.A.R. 26-41-207 (c)	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE ASSISTED LIVING	440 N 4TH STREET CLEARWATER, KS 67026

(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
S3310	Continued From page 33 The facility reported a census of 32 residents. The sample included 3 "Residents'" (R)'s, three focused reviews, and 5 newly hired employees. Based on record review and interview the Operator failed to ensure the facility's compliance with the department's "Tuberculosis" (TB) guidelines for adult care homes adopted by reference in K.A.R.39-932 for R's 4, 5, 6, newly hired "Certified Medication Aides'" (CMA)'s I, N, O, and Operator/"Licensed Nurse" (LN) A. Findings included: - Record review for newly employed CMA I revealed she began her employment on 04/04/25. The record contained a completed document titled "Tuberculosis Symptom Screening Questionnaire" and was dated 03/27/25. The record contained a document titled "Tuberculin Skin Test Consent and Report Form" that lacked documentation of the required two step TB skin test being administered. CMA I's personnel record lacked documentation of the required two step TB skin test being performed with seven days of employment. Interview on 11/17/25 at approximately 01:00 PM with CMA I confirmed she did not receive the required two step TB skin test at the time of employment. - Record review for newly employed CMA N revealed she began her employment on 01/06/25. The record contained a completed document titled "Tuberculosis Symptom	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE ASSISTED LIVING	440 N 4TH STREET CLEARWATER, KS 67026

(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
S3310	Continued From page 34 Screening Questionnaire" and was dated 12/30/24. CMA N's personnel record lacked documentation of the required two step TB skin test being performed with seven days of employment. - Record review for newly hired CMA O revealed she began her employment on 01/05/25. The record contained a completed document titled "Tuberculosis Symptom Screening Questionnaire" and was dated 01/03/25. CMA O's personnel record lacked documentation of the required two step TB skin test being performed with seven days of employment. - Record review for newly hired Operator/LN A revealed she began her employment on 05/30/24. The record lacked documentation of the required TB symptom screen withing seven days of employment, and the record further lacked documentation of the required two step TB skin test being performed within seven days of employment. - Record review for R4 revealed an admission date of 07/11/25 with diagnoses of emphysema, chronic obstructive pulmonary disease, pleural plaque with the presence of asbestos, hypertension, and anemia. R4's Record lacked documentation of the required TB symptom screening being performed within seven days of admission to the facility, the record further lacked documentation of the required two step TB skin test being performed	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE ASSISTED LIVING	440 N 4TH STREET CLEARWATER, KS 67026

(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
S3310	Continued From page 35 withing seven days of admission to the facility. - Record review for R5 revealed an admission date of 04/11/22 with diagnoses of unspecified sequelae of unspecified cerebrovascular disease, hypertension, restlessness, agitation, and Alzheimer's disease. Review of R5's electronic "Medical Record" under the "Immunization" tab revealed a "Tuberculosis Symptoms Screen Questionnaire" dated 04/23/25. R5's medical record lacked the required annual TB symptom screening questionnaire. - Record review for R6 revealed an admission date of 09/09/25 with diagnoses of atrial fibrillation, dementia, and hypertension. R6's record lacked documentation of the required TB symptom screening being performed within seven days of admission to the facility, the record further lacked documentation of the required two step TB skin test being performed withing seven days of admission to the facility. Interview on 11/19/25 at approximately 01:30 PM with Operator/LN A the personnel records for CMA's I, N, and O lacked the required documentation of the required two step TB skin test being performed with seven days of employment. Operator/LN A further confirmed the resident records for R4 and R6 lacked the required documentation of the required TB screening and two step TB skin test being	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE ASSISTED LIVING	440 N 4TH STREET CLEARWATER, KS 67026

(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
S3310	Continued From page 36 performed within seven days of admission to the facility, and she further confirmed R5's medical record lacked the required annual TB symptom screening questionnaire being performed. The Operator failed to ensure the facility's compliance with the department's TB guidelines for adult care homes adopted by reference in K.A.R.39-932 for R's 4, 5, 6, newly hired CMA's I, N, O, and Operator/LN A.	S3310		
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: (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.	S3320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE ASSISTED LIVING	440 N 4TH STREET CLEARWATER, KS 67026

(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 37 This REQUIREMENT is not met as evidenced by: K.A.R. 28-39-254 (a) The facility reported a census of 32 residents. Based on observation, record review, and interview the Operator failed to ensure the facility was equipped and maintained to protect the health and safety of the residents, personnel, and the public. Findings included: - Observation on 11/17/25 at approximately 09:30 AM during the facility tour, in the front entry area on the northeast wall sat a desk. On the corner of the desks was a clear plastic box with small apple pastries. The area surrounding the desk had 2 empty medium sized boxes, and 2 smaller opened boxes that contained only one item. There was a table behind the desk that sat in the northeast corner that held a small refrigerator. On top of the refrigerator there was a stack approximately 6 inches high of resident bath sheets. Under the table was 1 empty cloth bag, and one bag that had small plastic bags spilling out of it. The cabinets under the serving area of the kitchen that faced the northwest side, had a black, sticky residue on the front of the drawers located under the counter. The floor under the sink of the dishwasher room located on the northeast side of the dietary area, had a thick black sticky residue around the drain. The cabinets and drawers located on the southwest wall next to the stove had 2 missing cabinet doors, and 2 missing drawers. There were	S3320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE ASSISTED LIVING	440 N 4TH STREET CLEARWATER, KS 67026

(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 38	S3320		

drawers and doors that lacked the hardware to open them. The front of the cabinets and drawers had brown drip stains down the front of them. The dietary area floor was sticky when walked on. In the dry storage area on the in the southeast corner of the room sat an unplugged freezer and when opened had a slight odor. The carpets in R1 and R4's rooms were heavily stained, and the bathroom floor in front of the toilet in room R2's room was heavily stained.

Review of the facility provided document titled "Work Order" revealed the "Resident" (R) 7 had a work order created by prior operator E on Thursday 10/02/25 at 11:56 AM that revealed the toilet needed to be replaced. Under the "Notes" section it was entered by Maintence staff F that the toilet would be at the facility on Wednesday for installation. An entry on 11/10/25 at 01:48 PM entered by Maintence staff G revealed an "Updated Status" was set to in progress. On 11/18/25 at 08:29 an "Updated Priority" entered by Maintence staff G revealed the work order as a low priority.

Interview on 11/19/25 at 02:15 PM with Operator /"Licensed Nurse" (LN) A confirmed that the toilet had been installed.

Review of the facility provided document titled "Work Order" revealed R8 had a work order created by prior operator E on Thursday 10/02/25 at 11:33 AM that revealed the toilet needed to be replaced. An entry on 11/07/25 at 02:59 PM by Maintence staff G revealed an "Updated Status" was set to in progress. On 11/10/25 the following Status Updates were entered by Maintence staff G:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE ASSISTED LIVING	440 N 4TH STREET CLEARWATER, KS 67026

(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 39 At 10:46 AM the status was open. At 01:47 PM the status was set to be completed. At 01:47 PM the status was set to open At 01:47 PM the status was set to in progress. On 11/18/25 at 08:29 AM the status was set to low. Interview on 11/19/25 at approximately 11:00 AM with R8 confirmed her toilet still needed to be replaced. She stated she had a stray and a box of tissue at the side of the toilet to assist in pushing the toilet paper down when she flushed the toilet. Record review of the facility provided document titled "Work Order" revealed R2 had a work order created by prior Operator H on 01/17/25 at 11:57 AM, and in the section titled "Notes" it was typed "Toilet remains leaking, Resident unable to use." In the box titled "Priority" it was typed "Critical". Prior Operator H made the following entries in the "Timeline": On 01/17/25 at 11:59 the priority was set to "High" On 01/17/25 at 11:59 the "Updated Status" was set to "complete". On 01/17/25 at 11:59 the "Updated Status" was set to "Open". On 02/14/25 at 04:08 PM the "Updated Priority" was set to "Critical". On 02/14/24 at 04:08 PM the "Updated Status" was set to "Completed". Record review of the facility provided binder titled "Resident Council" revealed the following: On 01/30/25 a toilet needed to be installed "ASAP" (As Soon As Possible) for R2, and "Toilet needs to be done" for R8 and the sink in the	S3320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE ASSISTED LIVING	440 N 4TH STREET CLEARWATER, KS 67026

(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 40 bathroom was leaking and a light needed to be fixed. R3 was concerned that her room had not been cleaned and her laundry had not been done. On 04/17/25 R9 reported that her kitchen sink was "Clogged". On 05/08/25 R9 reported that her kitchen sink contined to be clogged. Next to the topice titled "Housekeeping" it was written "Not making imporvements", "still not cleaning showers, or sweeping or dusting". On 06/12/25 Residents voiced concerns that their showers were still not being cleaned and the floors were not being swept. On 07/10/25 Residents voiced concerns tthat the showers were still not being cleaned. On 08/14/25 Residents voiced concerns of a dirty shower shelf, and a shower handle was to have been replaced and was not, "added screws". On 09/11/25 Residents voiced concers that the dusting was not being done and sinks are not being cleaned. One resident voiced that the wood pieces on her floor are coming apart. Another resident complained that the window was still broken. Another resident voiced concern of not having a clip for their shower head. Record review of the facility provided document titled "Purchase History" revealed on 11/10/25 an order for three toilets was made.	S3320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE ASSISTED LIVING	440 N 4TH STREET CLEARWATER, KS 67026

(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 41 Interview on 11/29/25 at approximately 02:15 PM with Operator A and Regional Licensed Nursing Home Administrator C confirmed the work order dates for R7 and R8 were put into the facility work order system on 10/02/25 and purchase of the replacement toilets was on 11/10/25. Operator A and Regional Licensed Nursing Home Administrator C continued to confirm that R8's toilet was still not replaced, and they further confirmed that R2's toilet took 29 days to fix. Operator A and Regional Licensed Nursing Home Administrator C confirmed the facility maintence staff are from the Skilled Nursing facility owned by the same company that owns the Assisted living facility and that the staff are scheduled to be at the Assisted Living facility ten hours a week. They continued to confirm the facility did not have any designated housekeeping staff the housekeeping duties are assigned to the "Certified Nurse Aide" (CNA) and "Certified Medication Aide" (CMA) and they further confirmed current facility staffing model for 32 residents is one CMA and one CNA for first and second shift with one CMA or CNA for the night shift. Review of the facility policy titled "Sanitization" dated 10/21 revealed the following: "2. All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks, chipped areas that may affect their use or proper cleaning. Seals, hinges and fasteners will be kept in good repair". "10. ...Damaged or broken equipment that cannot	S3320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE ASSISTED LIVING	440 N 4TH STREET CLEARWATER, KS 67026

(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 42 be repaired shall be discarded." "14. ..Kitchen and dining room surfaces not in contact with food shall be cleaned on a regular schedule and frequently enough to prevent accumulation of grime". The Operator failed to ensure the facility was equipped and maintained to protect the health and safety of the residents, personnel, and the public.	S3320		
S3395 SS=F	28-39-255 LAUNDRY (c) Laundry facility. (1) The facility shall store soiled laundry in a manner which prevents odors and spread of disease. (2) If laundry is processed in the facility, the facility shall provide washing and drying machines. The facility shall arrange the work area to provide a "one-way flow" of laundry from a soiled area to a clean area. (3) The facility shall provide a work counter and a locked cabinet for storage of chemicals and supplies. (4) The facility shall provide a handwashing lavatory with a non-reusable method of hand-drying within or accessible to the laundry facility. This REQUIREMENT is not met as evidenced by:	S3395		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE ASSISTED LIVING	440 N 4TH STREET CLEARWATER, KS 67026

(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
S3395	Continued From page 43 K.A.R. 28-39-255 (c) (2) (3) The facility reported a census of 32 residents. Based on observation and interview the Operator failed to ensure the facility laundry room was maintained to provide a "One Way Workflow" from the soiled area to the clean area. The Operator further failed to ensure to maintain the work counter in the facility laundry room. Findings included: - Observation on 11/17/25 at approximately 09:15 AM of the secured facility laundry room revealed on the southwest wall of the room were 2 washers sitting side by side, and on the southeast wall were 2 dryers sitting side by side, with a single walkway between the appliances. There was an empty basket in the walkway. On the northeast wall of the room was a counter with a sink. The countertop was stacked with boxes, some material items, and bottles of cleaner. The countertop lacked an empty space to fold laundry. On the floor in front of the counter located on the northeast side of the room were opened boxes. One box contained a dirty toilet seat riser. Interview with Regional Licensed "Registered Nurse" (RN) B confirmed the laundry area appeared to be used for storage. The Operator failed to ensure the facility laundry room was maintained to provide a "One Way Workflow" from the soiled area to the clean area.	S3395		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087053	A. BUILDING: _____ B. WING _____	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER VILLAGE ASSISTED LIVING	440 N 4TH STREET CLEARWATER, KS 67026

(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
S3395	Continued From page 44 The Operator further failed to ensure to maintain the work counter in the facility laundry room.	S3395		