STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N057007	A. BUILDING: _____ B. WING _____	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION ASSISTED LIVING LLC	200 N EISENHOWER DR MARION, KS 66861

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of a Re-Licensure survey with complaint investigations 188983, 195027, and 195158 for the above named Assisted Living facility conducted on 05/22/25 and 05/27/25.	S 000		
S3080 SS=D	26-41-201 (a) (b) Functional Capacity Screen on Admission a) On or before each individual ' s admission to an assisted living facility or residential health care facility, a licensed nurse, a licensed social worker, or the administrator or operator shall conduct a screening to determine the individual ' s functional capacity and shall record all findings on a screening form specified by the department. The administrator or operator may integrate the department ' s screening form into a form developed by the facility, which shall include each element and definition specified by the department. (b) A licensed nurse shall assess any resident whose functional capacity screening indicates the need for health care services. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(a) The facility reported a census of 14 residents(R). The sample included three residents and two focused record reviews. Based on interview and record review the executive director failed to ensure one (R5) of three sampled residents had a "Functional Capacity Screen" completed by designated staff on or before admission to the	S3080		

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
	N057007	A. BUILDING: _____ B. WING _____	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION ASSISTED LIVING LLC	200 N EISENHOWER DR MARION, KS 66861

(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
S3080	Continued From page 1 assisted living facility to determine the resident's functional capacity. Findings included: - Review of R5's medical record revealed she moved into the facility on 04/03/25 with a diagnosis of Parkinson's disease. R5's "Electronic Medical Record" included an admission "Functional Capacity Screen" (FCS) staff opened on 04/03/25 but the licensed nurse did not complete it until 04/08/25, five days after moving into the facility Interview on 05/27/25 at 02:07 PM Administrative Nurse B questioned if the FCS needed to be done in the first 24 hours following admission. The Executive Director failed to ensure designated staff completed an admission Functional Capacity Screen for R5, on or before admission to the facility.	S3080		
S3085 SS=E	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information:	S3085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N057007	A. BUILDING: _____ B. WING _____	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION ASSISTED LIVING LLC	200 N EISENHOWER DR MARION, KS 66861

(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
S3085	Continued From page 2 (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(a)(1) The facility reported a census of 14 residents (R). The sample included three residents and two focused record reviews. Based on interview and record review the executive director failed to ensure the "Negotiated Service Agreements" (NSA) for three (R3, R4, R5) of three sampled residents described the services they received based on their "Functional Capacity Screen". Findings included: - R3's "Electronic Medical Record" (EMR) revealed she moved into the facility on 04/05/21 with diagnosis of Alzheimer's disease. R3's "Functional Capacity Screen" (FCS) dated 12/12/24 identified R4 had impaired cognition and impaired decision-making ability. R3s "Negotiated Service Agreement" (NSA) dated 12/12/24 failed to include a description of services related to impaired cognition and impaired decision-making ability. Interview on 05/27/25 at 10:59 AM Administrative	S3085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N057007	A. BUILDING: _____ B. WING _____	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION ASSISTED LIVING LLC	200 N EISENHOWER DR MARION, KS 66861

(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
S3085	Continued From page 3 Nurse B looked in the electronic record and confirmed the R3's NSA did not include a description of services related to cognition and decision-making to ensure her needs are met. The executive director failed to ensure designated staff completed R3's NSA based on service needs identified on her FCS. - R4's electronic record revealed she moved into the facility on 01/01/14 with diagnosis of rheumatoid arthritis and macular degeneration. R4's "Functional capacity screen dated 01/08/25 identified she had impaired vision. Interview on 05/2725 at 09:40 AM R4 reported she had Macular Degeneration (progressive deterioration of the retina) and could not see out of her right eye but still had a little vision out of the side of her left eye. She showed surveyor how she used a magnifying reader to be able to read the menu and her prescription medication bottles. Interview on 05/27/25 at 12:47 PM Administrative Nurse B looked and confirmed she had not include a description of services related to impaired vision and R4's assistive devices she used related to her poor vision. The executive director failed to ensure designated staff completed R4's NSA based on service needs identified on her FCS. - R5's electronic record revealed she moved into the facility on 04/03/25 with diagnosis of Parkinson's disease.	S3085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N057007	A. BUILDING: _____ B. WING _____	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION ASSISTED LIVING LLC	200 N EISENHOWER DR MARION, KS 66861

(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
S3085	Continued From page 4 R5's "Functional Capacity Screen" (FCS) dated 04/08/25 identified she had impaired vision and hearing. R5's "Negotiated Service Agreement" (NSA) dated 04/08/25 failed to include a description of services related to impaired vision and impaired hearing. Interview on 05/27/25 at 2:15 PM Administrative Nurse B looked at R5's NSA and confirmed it did not include a description of services related to impaired vision and hearing. Review of the facilities "Negotiated Service Agreement" Personal Care Policy reviewed on 12/28/23 revealed the NSA will be based on the results of the FCS and outline the services to be provided. The Executive director failed to ensure designated staff completed R5's NSA based upon service needs identified on her FCS.	S3085		
S3090 SS=D	26-41-202 (c) Admission Negotiated Service Agreement (c) Each administrator or operator shall ensure the development of an initial negotiated service agreement at admission. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(c)	S3090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N057007	A. BUILDING: _____ B. WING _____	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION ASSISTED LIVING LLC	200 N EISENHOWER DR MARION, KS 66861

(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
S3090	Continued From page 5 The facility reported a census of 14 residents(R). The sample included three residents and two focused record reviews. Based on interview and record review the executive director failed to ensure one (R5) of three sampled residents had an initial "Negotiated Service Agreement" completed at admission. Findings included: - Review of R5's medical record revealed she moved into the facility on 04/03/25 with a diagnosis of Parkinson's disease. R5's "Electronic Medical Record" included an admission Negotiated Service Agreement signed as completed on 04/08/25, five days after she moved into the facility. Interview on 05/27/25 at 02:07 PM Administrative Nurse B questioned if the NSA needed to be done in the first 24 hours following admission and confirmed she had not done so. Review of the "Negotiated Service Agreement" policy dated 01/02/23 identified an initial "Negotiated Service Plan" shall be developed at admission to the fiacili and reviewed within the first 30 days. The Executive Director failed to ensure designated staff completed an admission Negotiated Service Agreement for R5, at the time of admission	S3090		
S3101 SS=D	26-41-202 (h) NSA Signatures	S3101		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N057007	A. BUILDING: _____ B. WING _____	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION ASSISTED LIVING LLC	200 N EISENHOWER DR MARION, KS 66861

(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
S3101	Continued From page 6 (h) Each individual involved in the development of the negotiated service agreement shall sign the agreement. The administrator or operator shall ensure that a copy of the initial agreement and any subsequent revisions are provided to the resident or the resident's legal representative. This REQUIREMENT is not met as evidenced by: KAR 26-41-202 (h) The facility reported a census of 14 residents (R). The sample included three residents and two focused record reviews. Based on interview and record review for one (R5) of three sampled residents, the executive director failed to ensure that everyone involved in the development of the Negotiated Service Agreement signed the agreement. Findings included: - Review of R5's medical record revealed she moved into the facility on 04/03/25 with a diagnosis of Parkinson's disease. R5's "Electronic Medical Record" included an admission "Functional Capacity Screen" (FCS) completed on 04/08/25 that identified she needed physical assistance with management of medications and medical treatments, had risk for falls and unsteadiness, and had impaired vision and hearing. R5's "Negotiated Service Agreement" (NSA)	S3101		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N057007	A. BUILDING: _____ B. WING _____	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION ASSISTED LIVING LLC	200 N EISENHOWER DR MARION, KS 66861

(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
S3101	Continued From page 7 dated completed on 04/08/25 identified qualified staff would manage most of her medications and treatments, and she had a bed assistive device. Interview on 05/27/25 at 01:14 PM Administrative Licensed Nurse reported she had discussed the NSA with R5's son and daughter but confirmed she did not print it to get their signatures or R5's signature. The executive director failed to ensure all who participated in the development of R5's "Negotiated Service Agreement" signed it.	S3101		
S3105 SS=D	26-41-202 (j) Negotiated Service Agreement Outside Resource (j) If a resident's negotiated service agreement includes the use of outside resources, the designated facility staff shall perform the following: (1) Provide the resident, the resident's legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family, with a list of providers available to provide needed services; (2) assist the resident, if requested, in contacting outside resources for services; and (3) monitor the services provided by outside resources and act as an advocate for the resident if services do not meet professional standards of practice This REQUIREMENT is not met as evidenced by: KAR 26-41-202(j)(3)	S3105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N057007	A. BUILDING: _____ B. WING _____	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION ASSISTED LIVING LLC	200 N EISENHOWER DR MARION, KS 66861

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3105	Continued From page 8 The facility reported a census of 14 residents (R). The sample included three residents and two focused record reviews. Based on interview and record review, the operator failed to ensure one (R4) of three sampled residents who received services from an outside resource had staff monitor services and acted as an advocate for the resident to ensure services met professional standards of practice. Findings included: - R4 moved into the facility on 01/01/14 with diagnoses of rheumatoid arthritis and macular degeneration. R4's "Functional Capacity Screen" dated 01/08/25 identified R4 needed supervision with bathing and had impaired vision and risk for falls/unsteadiness. R4's "Negotiated Service Agreement" dated 02/06/25 revealed staff would implement interventions as needed for safety and to see additional fall interventions in her care plan. R4's "Service Plan" included she used a walker to assist with balance and mobility. Review of R4's Nursing progress notes included the following documentation post fall with hip fracture: 01/08/25 - Returned to facility with daughter and new orders for Home Health skilled nurse to evaluate and then therapy services to start when able. Instructions included to keep incision open to air and staples are not to be removed until	S3105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N057007	A. BUILDING: _____ B. WING _____	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION ASSISTED LIVING LLC	200 N EISENHOWER DR MARION, KS 66861

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3105	Continued From page 9 next appointment with surgeon. Review of R4's paper and electronic record lacked any documentation of skilled nursing or therapy services provided by Home Health. Interview on 05/27/25 at 12:45 PM Administrative Licensed Nurse B confirmed that R4 did receive skilled nursing and therapy services when she first came back from the hospital. Administrative Licensed Nurse B reported the Home Health nurse and therapy did their own thing and did not provide any notes of what they were doing and how R4 was responding. Administrative Nurse B reported they just let us know if there is something was going on. Review of "Assisted Living Coordination of Services with Outside Agences" policy dated 01/01/24 revealed outside providers will supply documentation of servcies delivered for resident records and a verbal report from the outside agency to the Resident Care Coordinator at least weekly. The administrator failed to ensure designated staff monitored Home Health to ensure they were managing R4's surgical incision and physical therapy according to standards of practice.	S3105		
S3175 SS=D	26-41-205 (a) (1) Self Administration of Medication (a) Self-administration of medication. Any resident may self-administer and manage medications independently or by using a medication container or syringe prefilled by a licensed nurse or pharmacist or by a family	S3175		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N057007	A. BUILDING: _____ B. WING _____	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION ASSISTED LIVING LLC	200 N EISENHOWER DR MARION, KS 66861

(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 10	S3175		

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.

This REQUIREMENT is not met as evidenced by:
KAR 26-41-205(a)(1)

The facility reported a census of 14 residents. The sample included three residents and two focused record reviews. . Based on interview and record review the Executive Director failed to ensure designated staff completed a self-administration assessment annually for one (R7) of two focused record reviews for a resident who self-injected his insulin after the qualified staff prepared the insulin pen.

Findings included:

- R7's medical record revealed he moved into the facility on 04/14/21 with a diagnosis of diabetes mellitus type II.

R7's "Functional Capacity Screen" dated 12/21/24 revealed he needed physical assistance with management of medications and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N057007	A. BUILDING: _____ B. WING _____	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION ASSISTED LIVING LLC	200 N EISENHOWER DR MARION, KS 66861

(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 11 supervision with medical treatments. R7's "Negotiated Service Agreement" dated 12/21/24 identified qualified staff would dial and prepare his insulin pen for him to self-inject. Review of R7's last self-medication administration assessment dated 12/21/23 identified he could safely and accurate demonstrate proper administration of injection and would self-inject his insulin after qualified staff prepared it. The record lacked an assessment to self-inject his insulin since 12/21/23. Interview on 05/27/25 at 02:40 PM Administrative Nurse B confirmed she had not completed an assessment to ensure R7 could safely and accurately self-inject his insulin after qualified staff prepared it. The executive director failed to ensure designated staff completed a self-administration medication assessment for R7annually to assess his ability to self-inject his insulin.	S3175		
S3186 SS=D	26-41-205 (b) Administration of Selected Medications (b) Administration of select medications. Any resident who self-administers medication may select some medications to be administered by a licensed nurse or medication aide. The negotiated service agreement shall reflect this service and identify who is responsible for the administration and management of selected medications.	S3186		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N057007	A. BUILDING: _____ B. WING _____	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION ASSISTED LIVING LLC	200 N EISENHOWER DR MARION, KS 66861

(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
S3186	Continued From page 12	S3186		

This REQUIREMENT is not met as evidenced by:
KAR 26-41-205 (b)

The facility reported a census of 14 residents(R). The sample included three residents and two focused record reviews. Based on observation, interview, and record review the executive director failed to ensure one (R5) of three sampled residents Negotiated Service Agreement included the selected medications the resident chose to administer.

Findings included:

- R5's medical record revealed she moved into the facility on 04/03/25 with a diagnosis of Parkinson's disease.

R5's "Functional Capacity Screen" dated 04/08/25 identified she needed physical assistance with management of medications and medical treatments.

R5's "Negotiated Service Agreement" (NSA) dated 04/08/25 identified qualified nursing staff will manage most of R5's medications and medical treatments. The NSA failed to identify what medications the resident chose to self-administer.

Interview/Observation on 05/27/25 at 01:47 PM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N057007	A. BUILDING: _____ B. WING _____	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION ASSISTED LIVING LLC	200 N EISENHOWER DR MARION, KS 66861

(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
S3186	Continued From page 13 R5 reported the staff gave her some of her medications but she also kept some in her room to do herself. Observations included the following oral medications and topical treatments: Tylenol, Advil, Centrum Multivitamin, Docusate Sodium (stool softener), Cortisone Cream (anti-itch), Vicks Vapor Rub, and Neosporin. Interview on 05/27/25 at 02:17 PM Administrative Nurse B confirmed the NSA did not state what medications R5 self-administered and reported she did not realize it needed to specify what medications the resident chose to self-administer. The executive director failed to ensure designated staff identified what select medications R5 chose to self-administer in her NSA.	S3186		
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.	S3211		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N057007	A. BUILDING: _____ B. WING _____	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION ASSISTED LIVING LLC	200 N EISENHOWER DR MARION, KS 66861

(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 14 This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (g)(3) The facility reported a census of 14 residents(R). Based on observation, interview, and record review the executive director failed to ensure a licensed nurse or pharmacist included the residents full name on all over-the-counter medications, including the original manufacturer's medication package and the medication container/tube. Findings included: - Observations on 05/22/25 at 09:30 AM Certified Medication Aide (CMA) C unlocked the medication room and the med cart for inspection. The medication cart contained the following medications: Two foil packets of Ondansetron (antiemetic) and a bottle of Gently Laxative tablets with no name on either packet or bottle. The drawers also included the following over-the-counter medications that either had no name or resident's first name and last initial: Woman's daily vitamin, vitamin B 12, three bottles of Tylenol 500 mg, Mucinex foil pack, aspirin 81 mg, ibuprofen 200 mg. Interview on 05/22/25 at 09:31 AM CMA C reported the Ondansetron and Laxative were "stock medications" meaning that any resident in the facility could use them if they had an order for it and did not have their own supply.	S3211		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N057007	A. BUILDING: _____ B. WING _____	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION ASSISTED LIVING LLC	200 N EISENHOWER DR MARION, KS 66861

(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 15 Interview on 05/22/25 at 02:19 PM Executive Director A and Regional Nurse D acknowledged the over-the-counter medications should have had a resident's full name on each container and they could not have stock medications for multiple resident use. Review of the undated "Medication Assistance and/or Administration" policy included a section for Labeling medications. It identified non-prescription medications shall be labeled with the resident's full name and apartment number and must be labeled by licensed nursing staff. The executive director failed to ensure a licensed nurse or pharmacist wrote the residents full name on all over-the-counter medications, including the medication package and container.	S3211		
S3215 SS=E	26-41-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility in separately locked compartments within a locked medication room, cabinet, or medication cart.	S3215		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N057007	A. BUILDING: _____ B. WING _____	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION ASSISTED LIVING LLC	200 N EISENHOWER DR MARION, KS 66861

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3215	Continued From page 16 Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the facility. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(h)(1)(4) The facility reported a census of 14 residents. Based on observation and interview, the executive director failed to ensure staff stored insulin pens and Tubersol solution according to manufacturer's recommendations to ensure staff did not administer the medication beyond the manufacturer's recommended date of expiration. Findings included: - Observation on 05/22/25 at 09:30 AM Certified Medication Aide C unlocked the medication room and reported staff kept the insulin pens in the small refrigerator which contained the following:	S3215		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N057007	A. BUILDING: _____ B. WING _____	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION ASSISTED LIVING LLC	200 N EISENHOWER DR MARION, KS 66861

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3215	Continued From page 17 Insulin Basaglar (Lantus)with 36 units remaining without an open date on the pen. Novolog insulin pen with 100 units remaining without an open date on the pen. Lantus insulin pen with 120 units remaining without an open date on the pen. TB solution vial approximately half full, with an open date of 04/07/25. Interview on 05/22/25 at 09:35 AM CMA C confirmed staff were supposed to have written the date on the pens when staff took them out and first used them. She stated she knew she had put the date on the Novolog pen with a marker, but it must have rubbed off. Interview on 05/22/25 at 09:55 AM Administrative Nurse B the TB solution is good for 30 days once it is opened and should have been discarded. Review of the Lantus manufacturer recommendations revealed to store at room temperature and discard after 28 days. Review of the Novolog manufacturer recommendations revealed to store at room temperature and discard after 28 days. Review of Tubersol manufacture directions revealed a vial of Tubersol which has been entered and in use for 30 days should be discarded. The executive director failed to ensure designated staff discarded TB solution after 30 days in use, and Lantus and Novolog insulin after 28 days to ensure staff did not use it past the manufacturers recommended date of expiration.	S3215		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N057007	A. BUILDING: _____ B. WING _____	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION ASSISTED LIVING LLC	200 N EISENHOWER DR MARION, KS 66861

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3261 SS=D	26-41-105 (f) (11) Resident Record Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action This REQUIREMENT is not met as evidenced by: KAR 26-41-105(f)(11) The facility reported a census of 14 residents (R). The sample included three residents and two focused record reviews. Based on interview and record review the operator failed to ensure one (R4) of three sampled residents records contained documentation of all incidents, symptoms, and other indications of illness or injury, what was done, and the results of action taken. Findings included: - R4 moved into the facility on 01/01/14 with diagnoses of rheumatoid arthritis and macular degeneration. R4's "Functional Capacity Screen" dated 01/08/25 identified R4 needed supervision with bathing and had impaired vision and risk for falls/unsteadiness. R4's "Negotiated Service Agreement" dated 02/06/25 revealed staff would implement interventions as needed for safety and to see	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N057007	A. BUILDING: _____ B. WING _____	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION ASSISTED LIVING LLC	200 N EISENHOWER DR MARION, KS 66861

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3261	Continued From page 19	S3261		

additional fall interventions in her care plan.

R4's "Service Plan" included she used a walker to assist with balance and mobility.

Review of R4's Nursing progress notes included the following documentation:
12/19/24 - found on floor in front of apt around 08:25 AM. R4 said she let go of her cane to get into the apartment and as she was getting her keys out of her pocket she lost her lost balance. EMS transported R4 to hospital due to not able to move left leg without pain.
12/19/24 - Facility notified R4 had a left hip fracture and went to a hospital in Wichita.
01/08/25 - Returned to facility with daughter and new orders for Home Health skilled nurse to evaluate and then therapy services to start when able. Instructions included to keep incision open to air and staples are not to be removed until next appointment with surgeon.

The record lacked further documentation related to incision, signs of infection and /or healing.

Interview on 05/27/25 at 12:45 PM Administrative Licensed Nurse B reviewed R4's nursing documentation and reported when she first returned, she was in a weakened condition and spent most of her time in her room because she did not want people to see her weak. Administrative Nurse B confirmed her documentation did not include anything about her incision when she returned and the healing process.

The executive director failed to ensure designated staff documented all symptoms of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N057007	A. BUILDING: _____ B. WING _____	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION ASSISTED LIVING LLC	200 N EISENHOWER DR MARION, KS 66861

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3261	Continued From page 20 illness, incidents, what action was taken and effectiveness of that action.	S3261		
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) The facility reported a census of 14 residents (R). The sample for infection control included three residents and five newly hired staff. Based on interview and record review for three of five newly hired staff the executive director failed to ensure the facility remained in compliance with the department's TB guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. Findings included:	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N057007	A. BUILDING: _____ B. WING _____	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION ASSISTED LIVING LLC	200 N EISENHOWER DR MARION, KS 66861

(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 21 - Review of five newly hired staff revealed the following: Administrative Nurse B hired on 09/03/24 did not have her TB symptom screen or two-step skin testing initiated until 09/23/24, more than seven days after hire date. Certified Medication Aide F hired on 07/02/24 and had an initial TB skin test completed on 05/30/24 but did not have a symptom screen completed until 08/01/24 and did not receive a second TB skin test. Licensed Nurse G hired on 02/20/25 had evidence of a prior two-step skin testing done on 04/18/24 and 05/02/24, more than six months prior to hire date. The facility did not complete two-step skin testing for Licensed Nurse G. Interview on 05/27/25 at 03:23 PM Administrative Nurse B reported she did not realize the time frames for completing employee TB symptom screens and skin testing. Review of the "Tuberculosis (TB) Guidelines for Adult Care Homes" June 2013 revealed each new employee shall have an initial TB symptom scree that includes the components of the Tuberculosis Symptom Screen Questionnaire within seven day of hire. They shall also receive a two-step TB skin test with seven days of employment unless specific conditions are met. Review of the "Employee TB Testing policy approved on 07/18/22 revealed all new employees will receive a two-step TB skin test	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N057007	A. BUILDING: _____ B. WING _____	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION ASSISTED LIVING LLC	200 N EISENHOWER DR MARION, KS 66861

(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 22 within the first seven days of employment. Employees with a TB completed within the past six months may provide proof of the test with results as their second step TB test. The executive director failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 by the failure to complete TB symptom screens and TB skin testing for newly hired staff in accordance with TB guidelines.	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	S3320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N057007	A. BUILDING: _____ B. WING _____	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION ASSISTED LIVING LLC	200 N EISENHOWER DR MARION, KS 66861

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3320	Continued From page 23 no. FDA 78-2081, as in effect on July 1, 1981. This REQUIREMENT is not met as evidenced by: KAR 28-39-254 (a) The facility reported a census of 14 residents(R). The Resident roster provided by Executive Director A identified nine residents with impaired cognition. Based on observation and interview the operator failed to ensure staff secured all chemicals for the safety of all residents, personnel and visitors. Findings included: - During initial tour on 05/22/25 at 09:59 AM revealed the following: Hall closet around the corner from the laundry room was unlocked and contained 9 plastic containers of ProSpray wipes, Gallon Jug of Barnacle Buster Lime Solvent, Companion disinfectant wipes, and a spray can of Terro Spider Killer, all of which included multiple warnings related to hazardous to humans, pets, cause severe burns and to keep out of reach of children. Interview on 05/22/25 at 10:00 AM Housekeeping Staff E reported the closet door was supposed to be kept locked and then stated the housekeeping closet was open if I needed to go in and check it out. Housekeeping Staff E proceeded to go to the other end of the hall and clean resident room, leaving the housekeeping closet unattended.	S3320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N057007	A. BUILDING: _____ B. WING _____	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION ASSISTED LIVING LLC	200 N EISENHOWER DR MARION, KS 66861

(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 24 Observation on 05/22/25 at 10:05 AM The housekeeping closet remained opened with a trash bag holding the door open. On the shelving unit just inside the door contained Drano Max gel, spray bottle of Quaternary , Jug of Pinalen Concentrated Multipurpose cleaner, Spray cans of Scrubbing Bubbles, 2 jugs of carpet cleaner, and three different types of disinfecting/sanitizing wipes. All f the chemical containers included warning labels on them related to burns, eyes, and keeping out of reach of children. Interview on 05/22/25 at 10:42 PM Executive Director A confirmed the housekeeping closet, and all chemicals were to be kept secured behind locked doors.	S3320		