STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175567	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Logan County Senior Living Inc	615 Price Ave Oakley, KS 67748

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. The facility had a census of 25 residents. The sample included 12 residents, with five reviewed for hospitalization. Based on interview, and record review, the facility failed to notify the Office of the Long-Term Care Ombudsman (LTCO- a public official who works to resolve resident issues in nursing facilities) for four residents, (R) 1, R6, R7, R12, and R13, and failed to provide two residents, R6 and R12, with written information regarding the facility's bed hold policy when they were transferred to the hospital.Findings included- The Nurse's Note, dated 11/01/25 at 03:21 AM, documented R1 admitted to the hospital for possible pulmonary embolism (occurs when a clump of material, most often a blood clot, gets stuck in an artery in the lungs, and blocks the flow of blood). R1's clinical record lacked evidence of the ombudsman notification for the 11/01/26 hospital transfer. The Nurse's Note dated 12/10/25 at 01:54 AM, documented R6 admitted to the hospital for pneumonia. R6's clinical record lacked evidence that the family received the bed hold notification or that the Ombudsman was notified of the hospital transfer. The Nurse's Note, dated 09/11/25 at 05:11 PM, documented R7 admitted to the hospital for pulmonary edema. The Nurse's Note, dated 01/03/26 at 09:58 PM, documented R7 admitted to the hospital for acute pulmonary edema. R7's clinical record lacked evidence of the ombudsman notification for R7's 09/11/25 and 01/03/26 hospital transfer. R12's Nurse's Note dated 12/19/25 at 09:02 AM documented R12 had chills, was not feeling well, lung sounds were diminished and had slurred speech. Staff received an order to send R12 to the emergency room and R12 left the facility with staff in the facility van. The Nurse's Notes dated 12/19/25 at 01:30 PM, documented R12 admitted to the hospital acute care with diagnosis of bilateral pneumonia (type of bacterial infection) and low blood pressure. R12's clinical record lacked a bed hold policy and a resident or resident representative signature. R12's clinical record lacked documentation staff notified the Long-Term Care Ombudsman (LTCO) of R12's discharge from the facility to the hospital. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R13's Nurse's Note date 09/19/25 at 11:35 PM documented R13 had severe abdominal pain on her right side, elevated blood pressure and rectal bleeding. An order was received to send R13 to the emergency room, R13 left the facility with staff and transported in the facility van. The Nurse's Notes dated 09/20/25 at 04:30 AM, documented R13 admitted to the hospital acute care with diagnosis of urinary tract infection (UTI-an infection in any part of the urinary system,) colitis (inflammation of the large intestine, characterized by severe diarrhea and ulceration of the large intestine) and elevated lactate (substance produced in the body when oxygen levels ae low or during intense physical activity) levels. R13's clinical record lacked documentation staff notified the Long-Term Care Ombudsman (LTCO) of R13's discharge from the facility to the hospital. On 02/10/26 at 11:11 AM, Social Service X stated she had not notified the ombudsman of the hospital transfers. On 02/11/26 at 11:35 AM, Administrative Staff A stated the ombudsman should be notified when a resident was discharged from the facility and was unaware that it had not been done. The facility's Transfer or Discharge Noise, policy, dated March 2025, documented residents (or residents' representatives) are notified of an impending transfer or discharge and the reasons for the move in writing and in a language they understand. A copy of the notice must be sent to the Office of the State-Long Term Care Ombudsman at the same time the notice of transfer or discharge is provided to the resident and representative.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 25 residents. The sample included 12 residents. Based on observation, interview, and record review, the facility failed to ensure a sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections when the facility failed to ensure Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistance organism which employ targeted gown and glove use during high contact care) were used for two residents with urinary catheters (a tube inserted into the bladder to drain the urine into a collection bag), Resident (R)3 and R6 Findings included: - The Electronic Medical Record (EMR) for R3 documented a diagnosis of neuromuscular dysfunctions of the bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying).The Annual Minimum Data Set (MDS), dated [DATE], documented R3 had a Brief Interview for Mental Status (BIMS) score of 7, which indicated severely impaired cognition. R3 was dependent upon staff assistance for toileting hygiene, transfers, and mobility. The MDS documented R3 had a urinary catheter.The Quarterly MDS, dated 11/18/25, documented R3 had had a BIMS of 7. R3 was dependent upon staff assistance for toileting hygiene and transfers. The MDS further documented R3 had a urinary catheter.The Care Plan, dated 11/14/25, initiated on 12/11/24, documented R3 was at risk of multiple drug-resistant organisms (MDRO-common bacteria that have developed resistance to multiple types of antibiotics) transmission through direct contact related to the indwelling medical device. The care plan directed staff to utilize gloves and gowns before performing any high contact care activities. This would include bathing, transferring residents from one position to another, while providing hygiene, changing briefs or assisting with toileting. The care plan further directed staff to use gowns and gloves when caring for an indwelling medical device, like a urinary catheter, and wound care. The care plan further directed staff to communication tools to explain the necessity and procedures of EBP effectively.On 02/10/26 at 08:55 AM, observation revealed a small red paper by R3's door that stated she was on EBP precautions and directed staff when to wear gowns and gloves. Certified Nurse Aide (CNA) M and CNA O donned clean gloves but did not put on a gown. CNA removed R3's incontinence brief and used foam cleanser to perform incontinence care. CNA O took R3's catheter bag and hooked it onto her pocket of her shirt while R3 rolled onto her right side so that CNA M could finish personal cares. The total mechanical lift sling was placed under R3, and they attached it to the lift to transfer her into her wheelchair. When questioned, CNA M stated she did not realize she needed to wear a gown unless she was emptying the catheter bag.On 02/10/26 at 09:49 AM, Administrative Nurse D stated they should have worn a gown while providing care and she had recently provided reeducation to staff regarding EBP.The facility's Enhanced Barrier Precautions policy, dated 12/24, directed staff to wear gloves and gown during high contact resident care activities. The policy further documented, staff are trained prior to caring for residents on EBP's and signs are placed on the door or wall outside the resident's room which communicate the type of precautions and personal protective equipment (PPE-gowns, face shields and/or eyeglasses/goggles, and gloves).- The Electronic Medical Record (EMR) for R6 documented a diagnosis of neuromuscular dysfunctions of the bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying.The admission Minimum Data Set (MDS), dated [DATE], documented R6 had a BIMS (Brief Interview for Mental Status Score of 11, which indicated moderately impaired decision-making skills. R6 was dependent upon staff assistance for toileting hygiene, showers, lower body dressing, transfers, and mobility. The MDS further documented R6 had a urinary catheter (a tube inserted into the bladder to drain the urine into a collection bag).The Quarterly MDS, dated 01/27/26, documented R6 had a BIMS score of 11, which indicated moderately impaired decision-making skills. R6 was dependent upon staff assistance for dressing, showers, toileting, and hygiene. The MDS further documented R6 had a urinary catheter and a urinary tract (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	infection (UTI-an infection in any part of the urinary system).The Care Plan, dated 02/04/26, initiated on 07/29/25, documented R6 was at risk of multiple drug-resistant organisms (MDRO-common bacteria that have developed resistance to multiple types of antibiotics) transmission through direct contact related to the urinary catheter. The care plan directed staff to utilize gloves and gowns before performing any high contact care activities. This would include bathing, transferring residents from one position to another, while providing hygiene, changing briefs or assisting with toileting. The care plan further directed staff to use gowns and gloves when caring for an indwelling medical device, like a urinary catheter, and wound care. The care plan further directed staff to communication tools to explain the necessity and procedures of EBP effectively. Change gowns and gloves before caring for another resident to prevent cross contamination. The care plan directed staff to ensure signage explaining EBP's is clear and visible throughout the facility. Implement enhanced cleaning protocols for rooms and equipment of residents requiring EBPs and informing residents and families about EBPs through welcome packets, meetings and educational materials. The care plan directed staff to monitor as needed and documentation of residents' conditions, focusing on infection signs and PPE effectiveness.On 02/10/26 at 08:45 AM, observation revealed R6's door did not have signage stating he was on EBP but had a three-drawer storage cart with gowns and gloves. Certified Nurse Aide (CNA) N, CNA P, and Licensed Nurse (LN) G went into R6's room and donned clean gloves but did not put gowns on. CNA P removed R6's attend, performed catheter care, had him roll to the left and used foam cleanser to provide personal cares. CNA P changed her gloves and applied ointment to his buttocks. CNA P placed a clean attend incontinence brief on him. LN G removed a small dressing from his left below the knee amputation, changed gloves, then went to get a small dressing. When questioned, she stated she did not put a gown on because she did not work with his catheter, she was just changing the small bandage to a scabbed area to the amputation site.On 02/10/26 at 09:49 AM, Administrative Nurse D stated the CNAs, and the Nurse should have worn a gown since they were providing high contact care. Administrative Nurse D further stated, she had recently provided education to staff about EBP and that she would talk to them again.On 02/10/26 at 11:42 AM, CNA N and CNA P went into R6's room, put gloves on but did not put on a gown. R6 stated, he was ready to get up and wanted in his electric wheelchair. CNA N stated, she was confused about when she should wear EBP and wanted clarification. This surveyor directed her to talk to the Director of Nursing, who is also the Infection Preventionist about any concerns they have and when they should wear PPE. Further observation revealed CNA P took the catheter bag from the side of the bed and laid it on his bed so that they could transfer him. CNA N had R6 roll to his left side and placed the full mechanical lift sling under him, and attached the sling to the lift, and transferred him into his electric chair.On 02/10/26 at 11:55 AM, Administrative Nurse D asked if they had been providing catheter care and this surveyor reminded her that the care plan directed staff to wear PPE while transferring the resident from his bed to the chair. Administrative Nurse D stated, staff should have worn gowns as well as gloves.The facility's Enhanced Barrier Precautions policy, dated 12/24, directed staff to wear gloves and gown during high contact resident care activities. The policy further documented, staff are trained prior to caring for residents on EBP's and signs are placed on the door or wall outside the resident's room which communicate the type of precautions and personal protective equipment (PPE-gowns, face shields and/or eyeglasses/goggles, and gloves).

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 25 residents. The sample included 12 residents, with five residents reviewed for immunizations, Resident (R) 2, R15, R16, and R27, to include pneumococcal (a disease that refers to a range of illnesses that affect various parts of the body and are caused by infection) vaccinations. Based on record review and interviews, the facility failed to offer and/or obtain an informed declination or a physician documented contraindication for the pneumococcal PCV20 vaccination per the latest guidance from the Centers for Disease Control and Prevention (CDC). Findings Included: - Review of the clinical medical records lacked evidence the facility or the resident representative received or signed a consent to receive or informed declination for the pneumococcal vaccine PCV20 for the following residents. Review of R2's Electronic Medical Record (EMR) revealed the resident admitted to the facility on [DATE]. R2 had not been offered or received a pneumococcal PCV20 vaccine since admission. Review of R15's EMR revealed the resident admitted to the facility on [DATE]. R15 had not been offered or received a pneumococcal PCV20 vaccine since admission. Review of R16's EMR revealed the resident admitted to the facility on [DATE]. R16 had not been offered or received a pneumococcal PVC20 vaccine since admission. Review of R27's EMR revealed the resident admitted to the facility on [DATE]. R27 had not been offered or received a pneumococcal PCV20vaccine since admission. On 02/11/26 at 09:30AM, Administrative Nurse D stated residents were offered pneumonia vaccines on admission and as indicated. Administrative Nurse D said the resident or resident representative would sign a consent or declination for receiving the vaccine. Administrative Nurse D verified that every resident in the building was not reviewed to determine if they were eligible to receive the PVC20 vaccine. Administrative Nurse D verified they did not have a definitive system in place to determine who was eligible, if they were eligible, if they had been offered or declined the vaccinations, and verified this was something they had recently been working on. The facility's Pneumococcal Vaccine policy, dated 10/2019, documented all residents would be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. Prior to or upon admission, all residents would be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, would be offered the vaccine series within 30 days of admission to the facility unless medically contraindicated or the resident has already been vaccinated. Assessment of pneumococcal vaccination status would be conducted within five working days of the resident's admission if not conducted prior to admission. Before receiving the pneumococcal vaccine, the resident or legal representative would receive information and education regarding the benefits and potential side effects of the pneumococcal vaccine. Information would be provided in the current vaccine information statement (VIN). Provision of the education would be documented in the resident's medical record. Pneumococcal vaccines would be administered to residents per the facility's physician-approved pneumococcal vaccination protocol. Residents/Representatives have the right to refuse vaccinations. If refused, appropriate entries would be documented in each resident's medical record indicating the date of the refusal or the pneumococcal vaccination. For residents who receive the vaccine, the date of vaccination, lot number, expiration date, person administering, and the site of the vaccination would be documented in the resident's medical record. Administration of the pneumococcal vaccines or vaccinations would be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination.