STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B026002	A. BUILDING: _____ B. WING _____	09/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WILLOW HOUSE	2900 WILLOW STREET HAYS, KS 67601

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S 000	INITIAL COMMENTS The following citations represents the findings of an abbreviated survey for complaint #182936 at the above named home plus facility conducted on 09/20/23, 09/21/23 and 09/25/23.	S 000		
S5026 SS=J	26-42-101 (f) (1) Staff Treatment of residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-42-101 (f) (1) (B) The facility reported a census of 5 residents. The sample included 1 focused record review resident. Based on record review, observation, and interview for 1 Resident (R)1, Operator/Licensed Nurse (LN) A failed to ensure no resident was subjected to neglect when Operator/LN A failed to provide or coordinate services reasonably necessary to ensure R1's safety and well-being and to avoid harm when R1 suffered from multiple untreated wounds to lower extremities. This failure placed the resident in immediate jeopardy for harm, injury or death.	S5026		

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

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S5026	Continued From page 1 Findings included: - Review of R1's medical record revealed she admitted to the facility on 11/23/16 with diagnosis of dementia, edema, depression and atrial fibrillation. R1's "Functional Capacity Screen" (FCS) dated 05/10/23 recorded the resident required physical assistance with bathing, dressing, toileting, mobility and eating, and was unable to perform transfer and management of medications and treatments. The FCS recorded the resident had short and long-term memory impairment, memory/recall impairment, impaired decision making and was sometimes understandable/ sometimes understood for communication. The FCS further recorded the resident was incontinent of urine, was at risk for falls/unsteadiness, had impaired vision, and was at risk for wandering. The FCS identified a wheelchair and mechanical lift used for mobility. The "Negotiated Service Agreement and Care Plan" dated 05/12/23 recorded the resident received physical assistance with bathing and toileting, one-person physical assistance with dressing, one person assistance or lift used for transfers, 1 person assistance when needed for mobility but could reposition self/move in wheelchair and as needed assistance with eating but could feed self and licensed staff to perform the management of medications and treatments for R1. The "Negotiated Service Agreement and Care Plan" further recorded R1 was incontinent of bowel and bladder and full assistance was provided, was at high risk for falls, unable to stand and needed encouragement to reposition.	S5026		

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S5026	Continued From page 2 Wheelchair, sit to stand lift and full lift identified as mobility devices used for R1. The "Negotiated Service Agreement and Care Plan" failed to identify specific directions for repositioning including frequency. The "Negotiated Service Agreement and Care Plan" failed to identify use of an air mattress. The "Negotiated Service Agreement and Care Plan" lacked signatures of the individuals involved at the time of development of the agreement including R1 and any legal representatives or family members . R1 admitted to hospital on 08/23/23 for scheduled right ischial debridement procedure to stage IV pressure ulcer wound located on the right ischium (right posterior upper thigh region). R1 discharged back to the facility on 08/29/23. Review of R1's "Nurse's Notes" revealed no documentation of wounds or skin upon return to facility on 08/29/23. Record revealed one documented "Nurse's Notes" entry from 08/21/23 to 09/20/23, which was dated 09/13/23 by LN B related to lab values. Last documented "Nurse's Notes" related to R1's wounds/skin was dated 05/02/23 by Operator/LN B, which recorded, "[R1's] sore on her bottom is at 1.3 cm [centimeters], looks good, healing, no signs/symptoms of infection. Sent to doctor today." "Physician's Orders" dated 08/31/23 and signed by Operator/LN A recorded, "1. [R1] returned from hospital with 2 sores on left calf from the air boot. They go around most of her leg. 2. New pressure ulcer on top of left foot. 5 cm [centimeters] x 5 cm. It's on top of left ankle/ foot. Currently still covered by skin but probably dead	S5026		

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S5026	Continued From page 3	S5026		

under skin. Also covered by air boot. 3. Left foot/ heel bruised, 2 blood hematomas likely pressure ulcers on left lower outside foot, one 3 cm wide and one 4 cm wide. Also caused by air boot at hospital. 4. [R1] rolled out of bed on 08/30/23 at 1409, found some discoloration on forehead ..." R1's primary care provider responded on 08/31/23 with no new orders regarding wounds.

Review of "Nurse Note for Fall" document dated 08/30/23 revealed R1 rolled out of bed onto floor on 08/30/23. Document signed by Operator/LN A.

Physician signed "Progress Note" dated 09/13/23 recorded, "positive for multiple pressure wounds bilateral lower extremities."

Signed "Physician Orders" dated 09/13/23 recorded, "Prevalon boots- bilaterally. Pillow between legs ." Order signed by wound care clinic physician.

Observation on 09/20/23 at 02:40 PM with Operator/LN A revealed R1 in bed, lying on her right side. Wound vac observed to right posterior upper thigh region, foley catheter bag observed and PICC (peripherally inserted central catheter) line observed to right upper arm. Prevalon boot observed on right foot but no boot on left foot. Air mattress observed in use to bed. Observation of R1's skin revealed the following wounds:

#1- left upper calf: open wound bed measuring approximately 2.5 cm x 1 cm
#2- left upper calf: eschar noted to wound measuring approximately 4 cm x 1 cm
#3- left ankle: red/ purple bruise measuring

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S5026	Continued From page 4	S5026		

approximately 2.8 cm x 1.5 cm
#4- left heel: eschar present, area measuring approximately 4.2 cm x 3.5 cm, red/ purple bruising surrounding area
#5- left lateral foot: eschar noted, area measuring approximately 11.7 cm x 4 cm, blackened area to bottom of foot and red/ purple bruising surrounding area,
#6- top of left knee: eschar noted, area measuring approximately 2.2 cm x 3 cm
#7- top of left knee: eschar noted, area measuring 1.5 cm x 2 cm
#8- left anterior calf: eschar noted, area measuring 8 cm x 5 cm, closed deep tissue injury noted below area, erythema surrounding area.
#9- top of left foot: eschar and opened/ pink area noted measuring 3.5 cm x 1 cm, purple bruising noted above wound, erythema surrounding area,
#10- top of left foot above big toe: eschar noted with erythema surrounding area, measuring 2 cm x 1 cm.

Observation on 09/21/23 at 03:10 PM revealed R1 in bed, lying on her back and slightly propped up on her left side with a pillow.

Observation on 09/21/23 at 05:15 PM revealed R1 in the same position in bed as 09/21/23 03:10 PM observation.

Interview on 09/21/23 at 02:00 PM with Outside Provider Licensed Staff AA, BB and CC stated R1 was admitted to their care on 09/01/23 for wound vac dressing changes for a coccyx pressure ulcer and IV (intravenous) antibiotic medication administration through the PICC line and discharged on 09/18/23 with visits occurring on 09/01/23, 09/04/23. 09/08/23, 09/11/23,

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S5026	Continued From page 5 09/15/23 and 09/18/23 by licensed staff. Interview on 09/21/23 at 02:00 PM with Outside Provider Licensed Staff CC stated she observed R1 during her on site visits on 09/01/23 and no wounds noted during on site visit other than the wound vac they were performing dressing changes on at each visit. Outside Provider Licensed Staff CC stated when she returned on 09/18/23 she completed a full head to toe assessment and identified wounds located on the left lateral foot, left heel and left anterior calf. Photo images obtained electronically on 09/22/23 from Outside Provider Licensed Staff AA, which revealed the following photo images: One wound to the left anterior calf, photo dated 09/11/23, Two wounds to the top of left knee, photo dated 09/11/23, One wound to the left ankle, 1 wound to the left heel and 1 wound to the left lateral foot, photo dated 09/18/23, One wound to the top of left foot and 1 wound to the top of left foot above big toe, photo dated 09/18/23. Interview on 09/21/23 at 03:37 PM with Operator/LN A confirmed R1's current "Negotiated Service Agreement and Care Plan" dated 05/12/23 failed to identify frequency R1 was to be repositioned by staff. Signed witness statement obtained on 09/20/23 from Operator/LN A recorded, "I do not have any documentation from the wound clinic on 09/13/23. Family has reported to me the visit. waiting for clinic to return call for request visit	S5026		

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S5026	Continued From page 6 report ... Upon [R1's] return to [facility] on 08/29/23, I [Operator/LN A] did an assessment on [R1] for skin but did not record on a written record. We do not have any measured documentation on [R1's] wounds, [Home Health Agency name] reported measuring the wound vac wound but did not leave any documentation. I have no measurements on any wounds yet at this time. [Home Health Agency name] has not given us or provided any documentation on size of any wounds including wound vac wound. No visit notes, no nurse's notes or our notes ... Other than the wound vac orders, we have no other orders for wounds. Before 09/18/23, on 08/29/23 vital signs were obtained by [Home Health Agency licensed nurse] and I, when [Home Health Agency name] admitted her. No other records are written down between 08/29/23 and 09/18/23 that I have record of. [Home Health Agency name] may have some but did not leave any record on visits." Abatement plan obtained on 09/20/23 at 06:50 PM recorded, "I left a message with the wound care clinic today for a report of last visit on 09/13/23. The did not return a call today, so I will contact them tomorrow for the report and ask if they wanted any other care on any of [R1's] other wounds. We will also follow up with the pharmacy to check on the foot/leg protectors if the doctor did order at the wound clinic as reported by the family. Will do a full skin assessment today with measurements of the wounds and description of each wound, document it and send results to primary care provider and the wound care clinic on the morning of 09/21/23 with a communication note so she is up to date on [R1's] leg wounds. Will	S5026		

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S5026	Continued From page 7 do daily vital signs and document while on the IV antibiotics to help monitor for any change in condition. For records at the house, we will communicate with [Home Health Agency name] and see if they can provide any nurse's notes." Signed and dated by Operator/LN A on 09/20/23. The jeopardy was removed on 09/20/23 at 06:50 PM when abatement plan obtained and signed by Operator/ LN A. Operator/Licensed Nurse (LN) A failed to ensure no resident was subjected to neglect when Operator/LN A failed to provide or coordinate services reasonably necessary to ensure R1's safety and well-being and to avoid harm when R1 suffered from multiple untreated wounds to lower extremities. This failure placed the resident in immediate jeopardy for harm, injury or death.	S5026		
S5105 SS=D	26-42-202 (a) Negotiated Service Agreement a) The administrator or operator of each home plus 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: (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	S5105		

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S5105	Continued From page 8 payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-42-202 (a) (1) (2) (3) The facility reported a census of 5 residents. The sample included 1 focused record review resident. Based on record review and interview for 1 sampled Resident (R)1, Operator/Licensed Nurse (LN) A failed to ensure the Negotiated Service Agreement (NSA) completed for residents who required health care services identified a description of the services the resident received, identified the provider of each service and identified each party responsible for payment if outside resources provided a service. Findings included: - Review of R1's medical record revealed she admitted to the facility on 11/23/16 with diagnosis of dementia, edema, depression and atrial fibrillation. R1's "Functional Capacity Screen" (FCS) dated 05/10/23recorded the resident required physical assistance with bathing, dressing, toileting, mobility and eating, and was unable to perform transfer and management of medications and treatments. The FCS recorded the resident had short and long-term memory impairment, memory/recall impairment, impaired decision making and was sometimes understandable/ sometimes understood communication. The FCS further recorded the resident was incontinent of urine, was at risk for falls/unsteadiness, had	S5105		

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S5105	Continued From page 9	S5105		

impaired vision, and was at risk for wandering. The FCS identified a wheelchair and mechanical lift used for mobility.

The "Negotiated Service Agreement and Care Plan" dated 05/12/23 recorded the resident received physical assistance with bathing and toileting, one-person physical assistance with dressing, one person assistance or lift used for transfers, 1 person assistance when needed for mobility but could reposition self/move in wheelchair and as needed assistance with eating but could feed self and licensed staff to perform the management of medications and treatments for R1. The "Negotiated Service Agreement and Care Plan" further recorded R1 was incontinent of bowel and bladder and full assistance was provided, was at high risk for falls, unable to stand and needed encouragement to reposition. Wheelchair, sit to stand lift and full lift identified as mobility devices used for R1.

The "Negotiated Service Agreement and Care Plan" lacked signatures of the individuals involved at the time of development of the agreement including R1 and any legal representatives or family members.

The "Negotiated Service Agreement and Care Plan" lacked a description of the services the resident received, identified the provider of each service and identified each party responsible for payment if outside resources provided a service.

Signed physician's order dated 08/28/23 recorded home health ordered for administration of IV (intravenous) antibiotics, management of wound vac and PICC (peripherally inserted

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S5105	Continued From page 10 central catheter) line. Interview on 09/21/23 at 03:37 PM with Operator/ LN A confirmed R1 received home health services from 09/01/23 to 09/18/23 and further confirmed no addendum or updated NSA was completed upon start or stop of home health services to include a description of services provided by home health, the provider of the service and party responsible for payment of the service. Operator/LN A failed to ensure the NSA completed for residents who required health care services identified a description of the services the resident received, identified the provider of each service and identified each party responsible for payment if outside resources provided a service.	S5105		
S5126 SS=D	26-42-202 (h) NSA Signatures (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 26-42-202 (h) The census equaled 5 residents. The sample included 1 focused record review resident. Based on record review and interview for 1	S5126		

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S5126	Continued From page 11	S5126		

sampled Resident (R)1, Operator/Licensed Nurse (LN) A failed to ensure each individual involved in the development of the negotiated service agreement (NSA) signed the agreement.

Findings included:

- Review of R1's medical record revealed she admitted to the facility on 11/23/16 with diagnosis of dementia, edema, depression and atrial fibrillation.

R1's "Functional Capacity Screen" (FCS) dated 05/10/23 recorded the resident required physical assistance with bathing, dressing, toileting, mobility and eating, and was unable to perform transfer and management of medications and treatments. The FCS recorded the resident had short and long-term memory impairment, memory/recall impairment, impaired decision making and was sometimes understandable/ sometimes understood communication. The FCS further recorded the resident was incontinent of urine, was at risk for falls/unsteadiness, had impaired vision, and was at risk for wandering. The FCS identified a wheelchair and mechanical lift used for mobility.

The "Negotiated Service Agreement and Care Plan" dated 05/12/23 recorded the resident received physical assistance with bathing and toileting, one-person physical assistance with dressing, one person assistance or lift used for transfers, 1 person assistance when needed for mobility but could reposition self/move in wheelchair and as needed assistance with eating but could feed self and licensed staff to perform the management of medications and treatments

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S5126	Continued From page 12 for R1. The "Negotiated Service Agreement and Care Plan" further recorded R1 was incontinent of bowel and bladder and full assistance was provided, was at high risk for falls, unable to stand and needed encouragement to reposition. Wheelchair, sit to stand lift and full lift identified as mobility devices used for R1. NSA lacked signatures of the individuals involved in the development of the agreement including R1 and any legal representatives or family members. Interview on 09/21/23 at 03:37 PM with Operator/LN A confirmed R1's current NSA dated 05/12/23 lacked signatures including R1 and any legal representatives or family members. Operator/LN A failed to ensure each individual involved in the development of the NSA signed the agreement.	S5126		
S5251 SS=D	26-42-105 (f) (11) Resident Records 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 26-42-105 (f) (11) The census totaled 5 residents. The sample included 1 focused record review resident.	S5251		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S5251	Continued From page 13 Based on record review and interview for 1 focused record review resident (R)1, Operator/Licensed Nurse (LN) A failed to ensure documentation of all incidents, and indications of illness or injury including date, time of occurrence, action taken and results of the action. Findings included: - Review of R1's medical record revealed she admitted to the facility on 11/23/16 with diagnosis of dementia, edema, depression and atrial fibrillation. R1's "Functional Capacity Screen" (FCS) dated 05/10/23recorded the resident required physical assistance with bathing, dressing, toileting, mobility and eating, and was unable to perform transfer and management of medications and treatments. The FCS recorded the resident had short and long-term memory impairment, memory/recall impairment, impaired decision making and was sometimes understandable/ sometimes understood communication. The FCS further recorded the resident was incontinent of urine, was at risk for falls/unsteadiness, had impaired vision, and was at risk for wandering. The FCS identified a wheelchair and mechanical lift used for mobility. The "Negotiated Service Agreement and Care Plan" dated 05/12/23 recorded the resident received physical assistance with bathing and toileting, one-person physical assistance with dressing, one person assistance or lift used for transfers, 1 person assistance when needed for mobility but could reposition self/move in	S5251		

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	B026002	A. BUILDING: _____ B. WING _____	09/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WILLOW HOUSE	2900 WILLOW STREET HAYS, KS 67601

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S5251	Continued From page 14	S5251		

wheelchair and as needed assistance with eating but could feed self and licensed staff to perform the management of medications and treatments for R1. The "Negotiated Service Agreement and Care Plan" further recorded R1 was incontinent of bowel and bladder and full assistance was provided, was at high risk for falls, unable to stand and needed encouragement to reposition. The "Negotiated Service Agreement and Care Plan" failed to identify specific directions for repositioning including frequency. Wheelchair, sit to stand lift and full lift identified as mobility devices used for R1.

R1 admitted to hospital on 08/23/23 for scheduled right ischial debridement procedure to stage IV pressure ulcer wound located on the right ischium (right posterior upper thigh region). R1 discharged back to the facility on 08/29/23.

Review of R1's "Nurse's Notes" revealed no documentation of wounds or skin upon return to facility on 08/29/23. Record revealed one documented "Nurse's Notes" entry from 08/21/23 to 09/20/23, which was dated 09/13/23 by LN B related to lab values. Last documented "Nurse's Notes" related to R1's wounds/skin was dated 05/02/23 by Operator/LN B, which recorded, "[R1's] sore on her bottom is at 1.3 cm [centimeters], looks good, healing, no signs/symptoms of infection. Sent to doctor today."

"Physician's Orders" dated 08/31/23 and signed by Operator/LN A recorded, "1. [R1] returned from hospital with 2 sores on left calf from the air boot. They go around most of her leg. 2. New pressure ulcer on top of left foot. 5 cm

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S5251	Continued From page 15 [centimeters] x 5 cm. It's on top of left ankle/ foot. Currently still covered by skin but probably dead under skin. Also covered by air boot. 3. Left foot/ heel bruised, 2 blood hematomas likely pressure ulcers on left lower outside foot, one 3 cm wide and one 4 cm wide. Also caused by air boot at hospital. 4. [R1] rolled out of bed on 08/30/23 at 1409, found some discoloration on forehead ..." R1's primary care provider responded on 08/31/23 with no new orders regarding wounds. Physician signed "Progress Note" dated 09/13/23 recorded, "positive for multiple pressure wounds bilateral lower extremities." Observation on 09/20/23 at 02:40 PM with Operator/LN A revealed R1 in bed, lying on her right side. Wound vac observed to right posterior upper thigh region, foley catheter bag observed and PICC (peripherally inserted central catheter) line observed to right upper arm. Prevalon boot observed on right foot but no boot on left foot. Air mattress observed in use to bed. Observation of R1's skin revealed the following wounds: #1- left upper calf: open wound bed measuring approximately 2.5 cm x 1 cm #2- left upper calf: eschar noted to wound measuring approximately 4 cm x 1 cm #3- left ankle: red/ purple bruise measuring approximately 2.8 cm x 1.5 cm #4- left heel: eschar present, area measuring approximately 4.2 cm x 3.5 cm, red/ purple bruising surrounding area #5- left lateral foot: eschar noted, area measuring approximately 11.7 cm x 4 cm, blackened area to bottom of foot and red/ purple bruising surrounding area,	S5251		

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S5251	Continued From page 16 #6- top of left knee: eschar noted, area measuring approximately 2.2 cm x 3 cm #7- top of left knee: eschar noted, area measuring 1.5 cm x 2 cm #8- left anterior calf: eschar noted, area measuring 8 cm x 5 cm, closed deep tissue injury noted below area, erythema surrounding area. #9- top of left foot: eschar and opened/ pink area noted measuring 3.5 cm x 1 cm, purple bruising noted above wound, erythema surrounding area, #10- top of left foot above big toe: eschar noted with erythema surrounding area, measuring 2 cm x 1 cm. Signed witness statement obtained on 09/20/23 from Operator/LN A recorded, " ...Upon [R1's] return to [facility] on 08/29/23, I [Operator/LN A] did an assessment on [R1] for skin but did not record on a written record. We do not have any measured documentation on [R1's] wounds." Operator/LN A failed to ensure designated staff documented all incidents, symptoms, and other indications of illness including the date and time of occurrence, action taken, and results of the action.	S5251		
S5335 SS=F	28-39-437 Construction (a) Each home-plus 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,	S5335		

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S5335	Continued From page 17 county, and state jurisdictions, including the state fire marshal. This REQUIREMENT is not met as evidenced by: KAR 26-39-437 (a) The census equaled 5 residents. The sampled included 1 focused record review resident. Based on observation and interview, the facility failed to ensure it was maintained to protect the health and safety of residents, personnel, and the public. Findings included: - On 09/20/23, Operator/ Licensed Nurse (LN) A provided a "Resident Roster", which included 5 residents and three residents were identified as having impaired cognition. Observation on 09/20/23 at 12:05 PM of the facility kitchen revealed an unlocked cabinet under the kitchen sink. The cabinet contained the following chemicals: One bottle of Clorox Bleach Foam cleaner, one container of disinfecting wipes and one bottle of Sparkle Glass Cleaner. The listed containers included a warning label on each of them. Observation on 09/20/23 at 12:10 PM of the media room revealed a pile of plant dirt on the floor by the window next to a recliner. Observation on 09/20/23 at 12:30 PM of the kitchen revealed an opened stick of butter on the counter next to the oven, which had food particles in it. Observation of the kitchen	S5335		

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S5335	Continued From page 18 appliances revealed a buildup of food particles and grime on the inside and outside of the following kitchen appliances: microwave, oven, stove, refrigerator, freezer and toaster. Observation on 09/20/23 at 04:02 PM of the public restroom revealed a mop and mop bucket turned upside down inside the tub shower. Operator/ LN A confirmed the shower was used by residents in the facility. The facility failed to ensure it was maintained to protect the health and safety of residents, personnel, and the public.	S5335		