STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087001	A. BUILDING: _____ B. WING _____	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

(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 investigation 184448 for the above named Assisted Living Facility conducted on 06/25/24 and 06/26/24.	S 000		
S3081 SS=E	26-41-201 (c) Functional Capacity Screen Reassessment (c) Designated facility staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: KAR 26-41-201 (c)(1) The facility reported a census of 100 residents(R), 65 in the main assisted living and 35 in the memory care neighborhoods. The sample included three residents and three focused reviews. Based on interview and record review the operator failed to ensure staff completed a "Functional Capacity Screen" for two (R3 and R5) of three sampled residents at least every 365 days. Findings Included: - R3's "Electronic Medical Record" (EMR) revealed she moved into the facility on 01/08/22 with diagnoses of muscle weakness and atrial	S3081		

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

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S3081	Continued From page 1	S3081		

fibrillation.

R3's current "Functional Capacity Screen"(FCS) in her EMR is dated 09/27/23.

On 06/25/24 at 10:00 AM Administrative Nurse B reported she would have to look in the prior EMR for any previous FCS.

On 06/26/24 11:04 AM Administrative Nurse B reported she could not find a previously completed FCS for R3. Administrative Nurse B reported since starting in January of 2024, she has had to do a lot of audits and found that some of the residents did not have FCS completed at least every 365 days.

On 06/26/24 at 11:22 AM Administrative Staff A acknowledged he had looked in the prior EMR for R3's FCS and could not find one.

The administrator failed to ensure designated staff completed R3's FCS at least every 365 days.

- R5's "Electronic Medical Record" (EMR) revealed she moved into the facility on 11/04/22 with a diagnosis of vascular dementia.

R5's current "Functional Capacity Screen" (FCS) in her EMR is dated 10/24/23.

On 06/25/24 at 10:00 AM Administrative Nurse B reported she would have to look in the prior EMR for any previous FCS.

On 06/26/24 at 11:22 AM Administrative Staff A acknowledged he had identified concerns with prior Administrative not completing FCS in a timely manner and acknowledged they audited

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S3081	Continued From page 2 charts and are working on getting residents records up to date. On 06/26/24 at 11:47 AM Administrative Nurse B reported she was unable to locate R5's previous FCS in the prior EMR. The administrator failed to ensure designated staff completed R5's FCS at least every 365 days.	S3081		
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: (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)(2) The facility reported a census of 100	S3085		

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S3085	Continued From page 3	S3085		

residents(R), 65 in the main assisted living and 35 in the memory care neighborhoods. The sample included three residents and three focused reviews. Based on interview and record review the administrator failed to ensure designated staff completed three (R3, R4, R5) of three sampled residents "Negotiated Service Agreement" to include a description of services the resident received based upon their "Functional Capacity Screen, service needs, and identify who provided each service including services that required specialized education or training.

Findings included:

- R3's "Electronic Medical Record" (EMR) revealed she moved into the facility on 01/08/22 with diagnoses of muscle weakness and atrial fibrillation.

R3's "Functional Capacity Screen"(FCS) dated 09/27/23 revealed she needed physical assistance with management of medications and medical treatments, had impaired cognition and decision making, and had a risk or problem with falls/unsteadiness.

R3's "Negotiated Service Agreement" (NSA) dated 04/14/24 failed to identify services related to impaired cognition and decision-making ability and falls/unsteadiness. It also identified "nursing staff" would administer medications and medical treatments but failed to identify which nursing staff would administer the medications as not all nursing staff are qualified to administer medications.

On 06/26/24 at 11:06 AM Administrative Nurse B reviewed R3's NSA and acknowledged it did not

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S3085	Continued From page 4	S3085		

address services for cognition, falls, or decision-making, and it did not identify qualified staff, (certified medication aide or licensed nurse) would administer medications and medical treatments.

The operator failed to ensure designated staff completed R3's NSA to address service needs based on the FCS and identify who provided each service.

- R4's "Electronic Medical Record" EMR revealed she moved into the facility on 02/06/24 with a diagnosis of dementia.

R4's "Functional Capacity Screen" dated 03/11/24 identified she was unable to participate in the management of her medications and medical treatments, had impaired cognition and decision-making, and had risk or problem with falls/unsteadiness.

R4's "Negotiated Service Agreement" (NSA) dated 03/22/24 failed to address services related to R4's impaired cognition or decision-making and did not address her risk or problems with falls/unsteadiness. It identified [facility name] would administer medications and medical treatments but failed to identify who of the facility staff administered the medications and medical treatments.

On 06/26/24 at 01:32 PM Administrative Nurse B reviewed R4's NSA and acknowledged it did not address all the service needs as identified on the FCS and it did not specify who provided the services related to medications and treatments.

The operator failed to ensure designated staff completed R4's NSA to address service needs

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S3085	Continued From page 5 based on R4's FCS and identify who provided each service. - R5's "Electronic Medical Record" (EMR) revealed she moved into the facility on 11/04/22 with a diagnosis of vascular dementia. R5's "Functional Capacity Screen" (FCS) in her EMR is dated 10/24/23 identified R5 was unable to participate in the management of her medications and medical treatments, had impaired cognition and decision making, had impaired communication, and had risk or problem with falls/unsteadiness. R5's "Negotiated Service Agreement" dated 10/25/23 failed to address related to R5's impaired cognition, decision-making ability and her impaired communication. It also failed to address services for risk for or problems related to falls/unsteadiness. R5's NSA identified [facility name} staff would give resident all medications and medical treatments. On 06/26/24 at 03:20 PM Administrative Nurse B reviewed R5's NSA and acknowledged it did not address service needs as identified in the FCS or identify who of the facility staff provided medication administration or administration of medical treatments. The administrator failed to ensure designated staff completed R5's NSA to address service needs based on R5's FCS and identify who provided each service.	S3085		
S3092 SS=D	26-41-202 (d) Negotiated Service Agreement Revisions	S3092		

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S3092	Continued From page 6 (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements:(1) At least once every 365 days; (2) following any significant change in condition, as defined in K.A.R. 26-39-100; (3) at least quarterly, if the resident receives assistance with eating from a paid nutrition assistant; and (4) if requested by the resident or the resident ' s legal representative, facility staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. This REQUIREMENT is not met as evidenced by: KAR 26-41-202 (d)(1) The facility reported a census of 100 residents(R), 65 in the main assisted living and 35 in the memory care neighborhoods. The sample included three residents and three focused records. Based on observation, interview, and record review the operator failed to ensure designated staff reviewed and revised the "Negotiated Service Agreement" for one(R3) of three sampled residents at least once every 365 days. Findings included: - R3's "Electronic Medical Record" (EMR) revealed she moved into the facility on 01/08/22 with diagnoses of muscle weakness and atrial fibrillation. R3's current "Negotiated Service Agreement"	S3092		

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S3092	Continued From page 7 (NSA) in her EMR is dated 04/14/24. She did not have any additional NSA's in the current EMR system. On 06/25/24 at 10:00 AM Administrative Nurse B reported she would have to look in the prior EMR for any previous NSA's. On 06/25/24 at 11:04 AM Administrative Nurse B acknowledged when she started in January of 2024 she did audits and found that some of the residents did not have NSA's reviewed or revised as they were supposed to. On 06/26/24 at 11:47 AM Administrative Nurse B reported R3's previous NSA was completed on 04/2021, more than 365 days prior to completion of the current NSA. The administrator failed to ensure designated staff reviewed and revised R3's NSA every 365 days.	S3092		
S3155 SS=D	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced	S3155		

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S3155	Continued From page 8 by: KAR 26-41-204 (a) The facility reported a census of 100 residents(R), 65 in the main assisted living and 35 in the memory care neighborhoods. The sample included three residents and three focused reviews. Based on observation, interview and record review the administrator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to meet the needs of one (R3) of three sampled residents who experienced falls. Findings included: - R3's "Electronic Medical Record" (EMR) revealed she moved into the facility on 01/08/22 with diagnoses of muscle weakness and atrial fibrillation. R3's "Functional Capacity Screen"(FCS) dated 09/27/23 revealed had impaired cognition and a current risk for or problem with falls/unsteadiness. R3's "Negotiated Service Agreement" (NSA) dated 04/14/24 failed identify services related to R3's risk for falls. R3's "Health Care Service Plan" (HCSP) initiated on 10/25/23 included a problem with falls initiated on 09/13/23 with generalized interventions to be specified "clutter free, support/assistive devices are available and in good repair, the bed in low position at night, personal items and call device within reach., non-glare soft lighting, etc." It also included encourage to call for assistance when needed. Review of R3's EMR progress notes included the following fall information:	S3155		

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S3155	Continued From page 9 04/14/23 - fall in activity room when she got up from chair and reached into walker and fell backwards, no injuries. Intervention: educations to lock wheelchair first. 05/16/23 - fall in her room and said she lost her balance while getting something out of the freezer, no injuries. No specific intervention mentioned. 05/21/23 - fall in her room lost balance when coming back from restroom which resulted in a skin tear on left arm. No specific intervention mentioned. 07/01/23 - fall in her room while trying to organize her closet, no injuries Intervention: Educated resident on safety of bending down and to do so with staff to help her. 12/03/23 - fall in her restroom when she turned toward her walker and fell. Resident complained of shoulder pain and went to hospital for evaluation. Resident was kept overnight due to fluid in her lungs, treated for a UTI, and had two fractured ribs and laceration on right arm. Intervention: toilet was leaking may have contributed to her fall, she also had a throw rug in restroom which was removed and hung on the towel rack due to trip hazard and to only be used when resident takes a shower, which requires staff assistance. 05/29/2024 -fall in her room and she reported she was getting up from a nap and started to sit up and was too close to the edge and slid off the bed, no injuries Intervention: resident to wear gripper socks when not wearing shoes. Observation/interview on 06/26/24 at 09:54 AM resident sat on the couch visiting with family. She is alert and oriented and admitted she was prone to falling. She had a four wheeled walker beside her and stated it has been a life saver. R3 stated she does not need anyone to help her walk but	S3155		

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S3155	Continued From page 10 sometimes she just looses her balance and will fall. She stated the staff help her with bathing, but she can do everything else herself. Interview on 06/26/24 at 09:45 AM Certified Nurse Aide (CNA) I reported R3 walks with a walker, dresses herself, and transfers herself. CNA I remembered one particular fall when R3 was sick and went to the hospital. CNA I also reported R3 is better at calling for help if she needs it now. Interview on 06/26/24 at 11:24 PM Administrative Nurse B reviewed R3's NSA and HCSP and acknowledged the specific interventions had not been added to R3's care plan when they were initiated. The administrator failed to ensure a licensed nurse provided and coordinated health care services related to falls for R3.	S3155		
S3165 SS=F	26-41-204 (d) Health Care Services (d) The negotiated service agreement shall contain a description of the health care services to be provided and the name of the licensed nurse responsible for the implementation and supervision of the plan. This REQUIREMENT is not met as evidenced by: KAR 26-41-204 (d) The facility reported a census of 100 residents(R), 65 in the main assisted living and 35 in the memory care neighborhoods. The	S3165		

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S3165	Continued From page 11	S3165		

sample included three residents and three focused record reviews. Based on record review and interview for all residents in the facility, the executive director failed to ensure three (R3, R4, R5) of three sampled resident's "Negotiated Service Agreement" included the name of the licensed nurse responsible for the implementation and supervision of the service plan.

Findings included:

- On 06/26/24 at 04:11 PM Administrative Nurse B reported all residents in the assisted living had the same format for their "Negotiated Service Agreements" in the "Electronic Medical Record".

- R3's EMR revealed she moved into the facility on 01/08/22 with diagnoses of muscle weakness and atrial fibrillation.

R3's "Functional Capacity Screen"(FCS) dated 09/27/23 revealed she needed physical assistance with bathing, management of medications and medical treatments, had impaired cognition and decision making, and had a risk or problem with falls/unsteadiness.

R3's "Negotiated Service Agreement" (NSA) dated 04/14/24 failed to identify the name of the licensed nurse responsible for the implementation and supervision of R3's "Health Care Service Plan.

On 06/26/24 at 11:15 AM Administrative Licensed Nurse B reviewed R3's NSA and acknowledged it identified three different nurses who provided nursing services but failed to identify the nurse responsible for the implementation and supervision of the health care service plan.

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S3165	Continued From page 12 The operator failed to ensure designated staff included the name of the licensed nurse responsible for the implementation and supervision of R3's service plan. - R4's "Electronic Medical Record" EMR revealed she moved into the facility on 02/06/24 with a diagnosis of dementia. R4's "Functional Capacity Screen" dated 03/11/24 identified she needed physical assistance with all activities of daily living except for eating. R4 was unable to participate in the management of her medications and medical treatments, had impaired cognition and decision-making, and had risk or problem with falls/unsteadiness. R4's "Negotiated Service Agreement" (NSA) dated 03/22/24 failed to identify the name of the licensed nurse responsible for the implementation and supervision of R4's "Health Care Service Plan. On 06/26/24 at 11:15 AM Administrative Licensed Nurse B reviewed R4's NSA and acknowledged it identified Licensed Nurse H as providing nursing services but failed to identify the nurse responsible for the implementation and supervision of the health care service plan. The administrator failed to ensure designated staff included the name of the licensed nurse responsible for the implementation and supervision of R4's service plan. - R5's "Electronic Medical Record" (EMR) revealed she moved into the facility on 11/04/22 with a diagnosis of vascular dementia. R5's "Functional Capacity Screen" (FCS) in her	S3165		

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S3165	Continued From page 13 EMR is dated 10/24/23 identified R5 she needed physical assistance with all ADL's, was unable to manage medications or medical treatments, had impaired cognition and decision-making ability and had impaired communication. It also identified she had a risk or problem for falls/unsteadiness. R5's "Negotiated Service Agreement" dated 10/25/23 failed to identify the name of the licensed nurse responsible for the implementation and supervision of her "Health Care Service Plan. On 06/26/24 at 03:24 PM Administrative Licensed Nurse B reviewed R5's NSA and acknowledged it identified four different nurses as providing nursing services but failed to identify the nurse responsible for the implementation and supervision of the health care service plan. For all residents, including R3, R4, and R5, the administrator failed to ensure designated staff included the name of the licensed nurse responsible for the implementation and supervision of the health care service plan.	S3165		
S3201 SS=E	26-41-205 (d) (3) Facility Administration of Medication (3) A licensed nurse or medication aide shall perform the following: (A) Administer only the medication that the licensed nurse or medication aide has personally prepared; (B) identify the resident before medication is administered; (C) remain with the resident until the medication is ingested or applied; and (D) document the administration of each	S3201		

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S3201	Continued From page 14	S3201		

resident ' s medication in the resident ' s medication administration record immediately before or following completion of the task. If the medication administration record identifies only time intervals or events for the administration of medication, the licensed nurse or medication aide shall document the actual clock time the medication is administered.

This REQUIREMENT is not met as evidenced by:
KAR 26-41-205 (d)(3)(A)

The facility reported a census of 100 residents(R), 65 in the main assisted living and 35 in the memory care neighborhoods. The sample included three residents with three residents focused resident reviews. . Based on observation and interview, the administrator failed to ensure facility staff followed professional standards of practice related to the administration of medications for three (R6, R7, R8) of three focused residents by the failure of Certified Medication Aide (CMA) to administer only medications that they had personally prepared.

Findings included:

- During initial tour on 06/25/24 and observations of medication carts revealed weekly pill containers were filled and prepared by the licensed nurse for the CMA to administer.

Observation on 06/25/24 at 12:48 PM while inspecting the medication cart for Garden Hall CMA D reported some of R6's medications were kept by the nurse because she had a lot of supplements. The CMA gets them from the

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	N087001	A. BUILDING: _____ B. WING _____	06/26/2024

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S3201	Continued From page 15 nurse for that day. Observation on 06/25/24 at 01:43 PM CMA G unlocked the medication cart for inspection which revealed two weekly pill containers with medications, no list of what medications were in the containers, and the container was labeled with R7 and R8's first name and last initial. At 01:44 PM CMA G reported the nurses fill the containers and the CMA administers the medications in the containers. Interview on 6/24/25 02:31 PM Administrative Nurse B acknowledged for R6, R7, and R8 the licensed nurses set up the weekly pill containers with extra supplements and vitamins that there is not room for in the medication carts. Interview on 06/25/24 at 02:40 PM Administrative Nurse F reported the nurse should not be setting up medications for the CMA to administer. She acknowledged the CMA would have no idea as to what was in the pill container. On 06/25/24 at 04:45 PM, CMA G unlocked the Garden Hall medication cart and in the top drawer were two filled pill containers without a resident's name on them. CMA G reported the nurse had two large pill containers they fill and the CMA picks out the day they need and keep the daily container in the med cart. CMA G acknowledged she had no way to know exactly what medications were in the pill containers but just trusted the nurse filled them correctly. CMA G then went to the nurse's office and in the metal filing cabinet were two large weekly pill containers that had R6's medications in them. labeled with her first name and #1 and #2. CMA G said the CMA's take the day section out of each planner for administration on that day.	S3201		

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S3201	Continued From page 16 The administrator failed to ensure only the person who personally prepared the medication also administered it.	S3201		
S3211 SS=E	26-41-205 (g) (3) OVER THE COUNTER DRUGS (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and the medication container. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (g)(3) The facility reported a census of 100 residents(R), 65 in the main assisted living and 35 in the memory care neighborhoods. Based on observation and interview, the administrator failed to ensure all over-the-counter medications were labeled with the resident's full name. This includes the need for the resident's full name to be on the original manufacturer's medication package and the medication container/tube. Findings included:	S3211		

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S3211	Continued From page 17 - During initial tour of the facility the following concerns related to over-the-counter medications was identified: On 06/25/24 at 12:45 PM Certified Medication Aide (CMA) D unlocked the Garden Memory Care medication cart for inspection which revealed the following over the counter medications that did not include the resident's full name on the bottle: Thrive probiotic, Pregnenolone, Ester C 500 milligrams (mg), bottle of Extra virgin olive oil , Homocysteine Plus, Gaba 750 mg, Melatonin 10 mg, Magnesium Glycinate, Niacinamide 500 mg, and a bottle of Tee Tree oil. The above over-the-counter medications had either a room number on them and/or resident initials. On 06/25/24 at 12:57 PM CMA E unlocked the Farmland medication cart for inspection which revealed a bottle of Power C , Calcium 500 mg, and a bottle of Melatonin 5 mg with a resident's last name only on the bottles. On 06/25/24 at 02:41 PM Administrative Nurse F reported each resident in assisted living has their own medication and each bottle needed to be labeled with their full name on it. The administrator failed to ensure all over-the-counter medications included the full name of the resident they belonged to which included their name on the original manufacturer's medication package and the medication container.	S3211		
S3261 SS=D	26-41-105 (f) (11) Resident Record Documentation of Incidents	S3261		

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S3261	Continued From page 18 (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 100 residents(R), 65 in the main assisted living and 35 in the memory care neighborhoods.). The sample included three residents and three focused reviews. Based on interview and record review the operator failed to ensure one (R5) 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 related to fall sand medication changes. Findings included: - R5's "Electronic Medical Record" (EMR) revealed she moved into the facility on 11/04/22 with a diagnosis of vascular dementia. R5's "Functional Capacity Screen" (FCS) in her EMR is dated 10/24/23 identified R5 she needed physical assistance with all ADL's, was unable to manage medications or medical treatments, had impaired cognition and decision-making ability and had impaired communication. It also identified she had a risk or problem for falls/unsteadiness. R5's "Negotiated Service Agreement" dated	S3261		

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S3261	Continued From page 19 10/25/23 identified she would need assistance of staff with all activities of daily living and facility staff would administer medications and complete medical treatments. Review of R5's nursing progress ntoes included the following documentation: 05/12/23 - resident's left leg with scratches and weeping with noticable edema present. The record lacked follow-up as to status of residents edema or physician response to notification. 05/15/23 - uranalysis report received and antibiotic started. The record lacked prior documentation of R5 having urinary symptoms or obtaining a urinalysis. 05/19/23 - chest x-ray obtained due to coughing and to take an additional Furosemide (diuretic) at noon for three days. The record lacked follow-up as to the resident's cough and results of administering extra Furosemide for three days. 06/13/23 - new orders for Trazadone (antidepressant) to be discontinued, discontinue Lasix (diuretic) 40 mg twice a day to once a day and discontinue Melatonin. The record lacked follow-up of the results of Trazadone and Melatonin discontinuation and decrease in Lasix. The administrator failed to ensure designated staff documented all symptoms of illness, incidents, action taken, and effectiveness of the action taken for R5.	S3261		

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S3320	Continued From page 20	S3320		
S3320 SS=E	28-39-254 CONSTRUCTION (a) The assisted living facility or residential health care facility shall be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel and the public. (b) All new construction, renovation, remodeling and changes in building use in existing buildings shall comply with building and fire codes, ordinances and regulations enforced by city, county, and state jurisdictions, including the state fire marshal. (c) New construction, modifications and equipment shall conform to the following codes and standards: (1) Title III of the Americans with disabilities act, 42 U.S.C. 12181, effective as of January 26, 1992; and (2) "Food Service Sanitation Manual," health, education, and welfare (HEW) publication no. FDA 78-2081, as in effect on July 1, 1981. This REQUIREMENT is not met as evidenced by: KAR 28-39-254 (a) The facility reported a census of 100 residents(R), 65 in the main assisted living and 35 in the memory care neighborhoods. Fourteen out of 65 residents in the main assisted living unit, were identified on the roster as having impaired cognition. .Based on observation and interview the administrator failed to ensure staff secured all chemicals to maintain the safety of all residents,	S3320		

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S3320	Continued From page 21 personnel, and the public. Findings included: - On 06/25/24 during initial tour the following chemicals were observed in areas of the facility that were used and accessible to residents and were accessible to the public. The door to the laundry room on the first floor, north side was open. In the cabinets above the sink one side of the double cabinet was locked but not the other. The unlocked cabinet contained three spray bottles of Shout and four plastic containers of Clorox wipes. A gallon bottle of bleach behind the part of the cabinet that was locked was accessible. The door to the north laundry room on the second floor, north side was open and contained the following chemicals in the unlocked cabinet: a spray bottle of stain remover and deodorizer, plastic containers of Clorox disinfecting wipes, two spray bottles of Shout. The door to the south laundry room on second floor was open and had unlocked cabinets above the sink that included the following chemicals: three spray bottles of Shout, two gallons of bleach, gallon of Tide laundry soap, and a bottle of floor finish. Each of the above chemicals included warning labels on them. On 06/25/24 at 02:08 PM while surveyor was in the south upstairs laundry room Maintenance staff C came into the laundry room and locked the cabinets and acknowledged they were to be kept locked.	S3320		

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S3320	Continued From page 22 On 06/25/24 at 05:08 PM Administrative staff A acknowledged the cabinets in the laundry rooms that contained chemicals needed to be kept locked. Review of the undated policy for "Storage Areas, Chemicals" revealed all chemicals in the laundry rooms must be secured behind locked doors when associate(s) are not present. The administrator failed to ensure chemicals were secured for the safety of all residents, personnel, and visitors.	S3320		