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	B023024	A. BUILDING: _____ B. WING _____	02/27/2025

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HOPE SENIOR LIVING LLC	2303 OXFORD ROAD LAWRENCE, KS 66049

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S 000	INITIAL COMMENTS The following represent the findings of an initial survey for the above named home plus facility conducted on 02/27/25.	S 000		
S5029 SS=F	26-42-101 (g) Availability of policies and procedures (g) Availability of policies and procedures. Each administrator or operator shall ensure that policies and procedures related to resident services are available to staff at all times and are available to each resident, legal representatives of residents, case managers, and families during normal business hours. A notice of availability shall be posted in a place readily accessible to residents. This REQUIREMENT is not met as evidenced by: KAR 26-42-101(g) The facility reported a census of one resident. Based on observation and interview the operator failed to ensure a notice of the availability of the facility's policies and procedures was posted in a place accessible to all residents. Findings included: - Observation on 02/27/25 at approximately 09:58 AM during the initial tour revealed the facility lacked a notice that the facility's policies and procedures were available. On 02/27/25 at 09:58 AM Administrative Staff A confirmed a notice of the facility's policies and procedures available was not posted.	S5029		

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

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S5029	Continued From page 1 On 02/27/25 at 03:03 PM policies were requested which the facility failed to provide. The operator failed to ensure a notice of the availability of the facility's policies and procedures was posted in a place accessible to all residents.	S5029		
S5040 SS=F	26-42-101 (j) Emergency Telephone (j) Emergency telephone. Each administrator or operator shall ensure that the residents and employees have access to a telephone for emergency use at no cost. Each administrator or operator shall ensure that the names and telephone numbers of persons or places commonly required in emergencies are posted adjacent to this telephone. This REQUIREMENT is not met as evidenced by: KAR 26-42-101(j) The facility reported a census of one resident. Based on observation and interview the operator failed to ensure the names and telephone numbers of commonly required persons for emergencies were posted adjacent to the emergency telephone. Findings included: - Observation on 02/27/25 at approximately 09:34 AM during the initial tour revealed the no list of commonly required telephone numbers for emergencies.	S5040		

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S5040	Continued From page 2 On 02/27/25 at 09:44 AM Administrative Staff A stated he did not have emergency numbers near emergency telephone. The operator failed to ensure the names and telephone numbers of commonly required persons for emergencies were posted adjacent to the emergency telephone.	S5040		
S5080 SS=D	26-42-201 (a) (b) Functional Capacity Screen on Admission (a) On or before each individual ' s admission to a home plus, 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 home, 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 26-42-201(a) The facility reported a census of one resident.	S5080		

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S5080	Continued From page 3 Based on interview and record review the operator failed to ensure all elements were addressed including cognition on the Functional Capacity Screen (FCS) for Resident (R) 1. Findings included: - Record review for R1 revealed an admission date of 10/26/24 with a diagnosis of dementia. The 10/22/24 FCS failed to identify R1's capacity for cognition. The cognition section was left blank. On 02/27/25 at 01:37 PM Administrative Staff A confirmed R1's cognition section on his FCS was blank. On 02/27/25 at 03:03 PM an FCS policy was requested which the facility failed to provide. The operator failed to ensure facility staff addressed all elements, specifically cognition on the FCS for R1.	S5080		
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:	S5105		

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S5105	Continued From page 4 (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 26-42-202(a)(1) The facility reported a census of one resident with one included in the sample. Based on interview, observation, and record review the operator failed to ensure the Negotiated Service Agreement (NSA) for Residents (R)1 described the services he received based on his Functional Capacity Screen (FCS). Findings included: - Review of R1's record revealed an admission date of 10/26/24 with the following diagnoses: macular degeneration, dementia, hypertension, chronic kidney disease, and chronic obstructive pulmonary disease. The 10/22/24 FCS identified R1 required supervision with dressing and mobility; required physical assistance with transfers and bathing; was unable to perform management of medications and treatments; was usually continent of bladder; was usually able to understand and be understood when communicating; was at risk for falls and wandering; and had impaired vision, socially inappropriate behavior, and impaired decision	S5105		

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S5105	Continued From page 5 making. The 10/26/24 "Negotiated Services Agreement and Care Plan" is the facility's combined NSA and Healthcare Service Plan (HSP) for R1 which identified staff assisted with bathing, administered medications, supervised walking, reminded R1 to wear appropriate clothes, and assisted with glasses for vision. The NSA failed to identify services or the provider of service for transfers, cognition difficulties, prevention of falls, impaired decision making, wandering, and socially inappropriate behavior. Observation on 02/27/25 at 09:51 AM Administrative Staff A gave choices, redirected, and reoriented R1 when he showed signs of confusion, wandering, and to difficulty making decisions. On 02/27/25 at 01:45 PM Administrative Staff A stated R1's room was kept tidy without trip hazards to prevent falls. He confirmed that R1's NSA/HSP lacked services and provider of service for transfers, cognition difficulties, prevention of falls, impaired decision making, wandering, and socially inappropriate behavior. On 02/27/25 at 03:03 PM an NSA policy was requested which the facility failed to provide. The operator failed to ensure the NSA for R1 described the services provided based on his FCS.	S5105		
S5171 SS=D	26-42-204 (i) Health Care Services Standards of Practice	S5171		

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S5171	Continued From page 6 (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: KAR 26-42-204(i) The facility reported a census of one resident with one included in the sample. Based on observation, interview, and record review the operator failed to ensure a licensed nurse completed an assessment for the ability to use bed rails safely without risk of entrapment and to confirm the bed rails were not a restraint for Residents (R) 1. Findings included: - Review of R1's record revealed an admission date of 10/26/24 with the following diagnoses: macular degeneration, dementia, hypertension, chronic kidney disease, and chronic obstructive pulmonary disease. The 10/22/24 Functional Capacity Screen (FCS) identified R1 required physical assistance with transfers. The 10/26/24 Negotiated Service Agreement (NSA) for R1 failed to identify services or the provider of service for transfers. Review of R1's record lacked documentation of a bed assistive device assessment. Observation on 02/27/25 at 11:01 AM revealed bilateral bed rails were attached to R1's bed.	S5171		

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S5171	Continued From page 7 On 02/27/25 at approximately 01:44 PM Administrative Staff A confirmed there was no bed rail assessment in R1's record. On 02/27/25 at 03:03 PM a policy regarding bed assistive devices was requested which the facility failed to provide. The operator failed to ensure a licensed nurse completed an assessment for the purpose to use bed rails, ability to use bed rails safely without risk of entrapment, and to confirm the bed rails were not a restraint for R1.	S5171		
S5192 SS=F	26-42-206 (e) Food Preparation (e) Food shall be prepared using safe methods that conserve the nutritive value, flavor, and appearance and shall be served at the proper temperature. (1) Food used by facility staff to serve to the residents, including donated food, shall meet all applicable federal, state, and local laws and regulations.(2) Food in cans that have significant defects, including swelling, leakage, punctures, holes, fractures, pitted rust, or denting severe enough to prevent normal stacking or opening with a manual, wheel-type can opener, shall not be used. (3) Food provided by a resident ' s family or friends for individual residents shall not be required to meet federal, state, and local laws and regulations. This REQUIREMENT is not met as evidenced by:	S5192		

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S5192	Continued From page 8 KAR 26-42-206(e) The facility reported a census of one resident. Based on record review, observation, and interview the operator failed to ensure food was served at the proper temperature. Findings included: -On 02/27/25 at 12:10 PM food temperature logs were requested which the facility failed to provide. Observation on 02/27/25 at 11:17 PM Administrative Staff A prepared food for R1. Temperature of food was not taken prior to serving. On 02/27/25 at approximately 11:09 AM Administrative Staff A confirmed there was no food temperature log. The Kansas Department of Agriculture's 2024 "Focus on Food Safety" booklet page 16 documented "minimum hot holding temperature is 135 degrees Fahrenheit (F)" and "maximum cold holding temperature is 41 degrees F." On 02/27/25 at 03:03 PM a policy regarding taking food temperatures was requested which the facility failed to provide. The operator failed to ensure food was served at the proper temperature.	S5192		
S5195 SS=F	26-42-206 (f) (g) Facility Food Storage (f) Staff shall store all food under safe and	S5195		

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S5195	Continued From page 9	S5195		

sanitary conditions. Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving.

(g) Each home shall maintain at least a three-day supply of food to meet the requirements of the planned menus.

This REQUIREMENT is not met as evidenced by:
KAR 26-42-206(f)

The facility reported a census of one resident. The facility had a main kitchen where food was stored, prepared, and served. Based on observation and interview the operator failed to ensure foods were stored under safe conditions.

Findings included:

- Observation on 02/27/25 at 10:02 AM revealed a refrigerator and freezer was in the facility's main kitchen which contained food items for the residents. Thermometer inside read 50 degrees Fahrenheit (F). A temperature log was requested which the facility failed to provide. The following items were located inside and undated for when opened or prepared:

One container of commercially prepared cherry pie
Two cans of opened progresso soup
One bag of sliced yellow cheese
One ½ gallon container vitamin D milk
One container 64 fluid ounce coconut milk
Five containers of unidentified foods prepared in facility

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S5195	Continued From page 10 One container labeled "dressing" The following foods were located in the freezer unsealed: One bag sausage links One bag sausage patties One bag beef patties One bag pillsbury biscuits On 02/27/25 at approximately 10:25 AM Administrative Staff A confirmed foods in refrigerator and freezer were not dated when opened or prepared. He confirmed the temperature log was not available and temperature of refrigerator was greater than 41 degrees F. The 2024 Kansas Department of Agriculture's "Focus on Food Safety" booklet pages 16, 19 and 20 and documented maximum cold holding temperature for foods was 41 degrees Fahrenheit (F) or below. The temperature DANGER ZONE is from 41F to 135F, the range in which rapid growth occurs. Potentially hazardous foods, foods requiring time and temperature control for safety, should not be exposed to the danger zone for more than four hours total, including time spent in preparation, cooling and reheating. Page 21 explains that commercially prepared foods must be date marked after the original container was opened and held under refrigeration. Foods prepared on site must be labeled and date marked for consumption or discarded within 24 hours. On 02/27/25 at 03:03 PM a policy regarding food storage was requested which the facility failed to	S5195		

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S5195	Continued From page 11 provide. The operator failed to ensure foods were stored under safe conditions.	S5195		
S5215 SS=F	26-42-104 (d) Disaster and Emergency Preparedness Education (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the home ' s emergency management plan; (2) education of each resident upon admission to the home regarding emergency procedures; (3) quarterly review of the home ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-42-104(d)(3) The facility reported a census of one resident. Based on interview and record review the operator failed to provide quarterly reviews of the facility's emergency management plan with all staff and residents. Findings included:	S5215		

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S5215	Continued From page 12 - On 02/27/25 at 10:00 AM the dates of the quarterly reviews of the facility's emergency management plan with residents and staff since the previous survey was requested which the facility failed to provide. On 02/27/25 at 10:00 AM Administrative Staff A stated he just talked with the resident about emergencies but had nothing signed or documented. On 02/27/25 at 10:00 AM Administrative Staff A confirmed reviews of the facility's emergency management plan with staff and residents was not conducted quarterly. On 02/27/25 at 03:03 PM a policy regarding emergency management plan reviews was requested which the facility failed to provide. The operator failed to provide quarterly reviews of the facility's emergency management plan with all staff and residents.	S5215		
S5230 SS=F	26-42-207 (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; (c) Each administrator or operator shall ensure the home ' s compliance with the department ' s	S5230		

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S5230	Continued From page 13 tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. This REQUIREMENT is not met as evidenced by: KAR 26-42-207(c) The facility reported a census of one resident with one resident included in the sample and five hired staff. Based on interview and record review the operator failed to ensure the facility remained in compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in KAR 26-39-105 for Resident (R) 1 and five of five hired staff. Findings included: - Record review for R1 revealed an admission date of 10/26/24. His record lacked evidence of documentation of TB testing. Record review for Administrative Staff A, Administrative Staff B, Certified Medication Aide (CMA) C, CMA D, and Certified Nurse Aide E revealed all staff were hired prior to R1's admission in October of 2024. All records lacked evidence of documentation of TB testing and symptom screening completed upon employment. On 02/27/25 at approximately 01:46 PM Administrative Staff A confirmed R1's record and all staff records lacked documentation of TB skin testing completed upon admission or hire and all staff records lacked TB symptom screening.	S5230		

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S5230	Continued From page 14 The department's June 2013 "Tuberculosis (TB) Guideline for Adult Care Homes" documented each new resident and employee shall have an initial TB symptom screen that includes the components of the Tuberculosis Symptom Screen Questionnaire and shall receive a two-step TB skin test within seven days of employment or admission. On 02/27/25 at 03:03 PM a policy regarding TB screening and testing was requested which the facility failed to provide. The operator failed to ensure the facility remained in compliance with the State Agency's tuberculosis guidelines for adult care homes adopted by reference in KAR 26-39-105.	S5230		
S5301 SS=D	26-42-205 (d) (3) Facility Administration of Medications (d) (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 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	S5301		

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S5301	Continued From page 15 medication is administered. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(d)(3)(A)(D) The facility reported a census of one resident with one resident included in the sample. Based on observation and interview the operator failed to ensure licensed nurses or certified medication aides administer only medications personally prepared and documented administration immediately before or following completion of the task. Findings included: - Record review of R1's Medication Administration Record (MAR) revealed Administrative Staff A as only staff to administer medications. The MAR lacked documentation administration of four different medications on four different days. Observation on 02/27/25 at 10:55 AM revealed a weekly medication container containing multiple medications in all days of the week, without labels identifying what medications were in the slot, in two different rows. Pharmacy prepared medication cassettes for each medication were located beside the weekly container. On 02/27/25 at 10:55 AM Administrative Staff A stated he removed the medications from the pharmacy prepared and labeled cassettes and placed them in the weekly container. If he was not around, the family or a Certified Medication	S5301		

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	B023024	A. BUILDING: _____ B. WING _____	02/27/2025

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S5301	Continued From page 16 Aide (CMA) could administer the medications without confusion. He confirmed that someone else may administer the medications he prepared. On 02/27/25 at 02:22 PM Administrative Staff A stated the CMAs did not have access to the medication administration documentation system. He confirmed they have no way to document upon completion of the task. On 02/27/25 at 03:03 PM a policy regarding medication administration was requested which the facility failed to provide. The operator failed to ensure licensed nurses or certified medication aides administer only medications personally prepared and documented administration immediately before or following completion of the task.	S5301		
S5312 SS=D	26-42-205 (g) (2) Medication Labeling (g) (2) Each prescription medication container shall have a label that was provided by a dispensing pharmacist or affixed to the container by a dispensing pharmacist in accordance with K.A.R. 68-7-14. This REQUIREMENT is not met as evidenced by: KAR 26-42-205 (g)(2) The facility reported a census of one resident. Based on observation and interview the operator failed to ensure each prescription medication container had a label provided by a dispensing	S5312		

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S5312	Continued From page 17 pharmacist affixed to the container. Findings included: - Observation on 02/27/24 at 10:57 AM revealed the facility's medication cart contained one bottle tamsulosin 0.4mg, 30 capsules prescription medication which had a labeled with a blacked out name. On 02/27/24 at approximately 10:58 AM Administrative Staff A confirmed the medication bottle was not labeled with a resident's full name. On 02/27/25 at 03:03 PM a policy regarding medication labeling was requested which the facility failed to provide. The operator failed to ensure each prescription medication container had a label provided by a dispensing pharmacist affixed to the container.	S5312		
S5316 SS=D	26-42-205 (i) Disposition of Medication (i) Accountability and disposition of medications. Licensed nurses and medication aides shall maintain records of the receipt and disposition of all medications managed by the home in sufficient detail for an accurate reconciliation. (1) Records shall be maintained documenting the destruction of any deteriorated, outdated, or discontinued controlled medications and biologicals according to acceptable standards of practice by one of the following combinations: (A) Two licensed nurses; or (B) a licensed nurse and a licensed pharmacist. (2) Records shall be maintained documenting the destruction of any deteriorated, outdated, or	S5316		

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S5316	Continued From page 18 discontinued non-controlled medications and biologicals according to acceptable standards of practice by any of the following combinations: (A) Two licensed nurses; (B) a licensed nurse and a medication aide; (C) a licensed nurse and a licensed pharmacist; or (D) a medication aide and a licensed pharmacist. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(i) The facility reported a census of one resident. Based on interview, record review and observation the operator failed to ensure licensed nurses and medication aides maintained records of medications managed by the home for an accurate reconciliation when one controlled medication had more than the amount in the box than was documented on the medication count log. Findings included: - Observation and record review of facility's controlled medication count sheets on 02/27/25 at approximately 10:58 AM revealed three Fentanyl patches in box and a corresponding "Controlled Substance Log" which documented two patches remaining.	S5316		

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S5316	Continued From page 19 Observation of R1 on 02/27/24 at 11:01 AM revealed a Fentanyl patch on his mid-back without date it was applied. On 02/27/25 at 10:58 AM Administrative Staff A confirmed the Fentanyl box contained more than what was documented in the reconciliation book. On 02/27/25 at 03:03 PM a medications policy was requested which the facility failed to provide. The operator failed to ensure licensed nurses and medication aides maintained records of medications managed by the home for an accurate reconciliation when one controlled medication had more than the amount in the box than was documented on the medication count log.	S5316		
S5325 SS=D	26-42-205 (l) Medication Regimen Review Frequency (l) Medication regimen review. A licensed pharmacist or licensed nurse shall conduct a medication regimen review at least quarterly for each resident whose medication is managed by the home and each time the resident experiences any significant change in condition. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(l) The facility reported a census of one resident	S5325		

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S5325	Continued From page 20 with one resident included in the sample. Based on interview and record review the operator failed to ensure quarterly medication regimen reviews were conducted for Resident (R) 1. Findings included: - Review of R1's record revealed an admission date of 10/26/24 with the following diagnoses: macular degeneration, dementia, hypertension, chronic kidney disease, and chronic obstructive pulmonary disease. The 10/22/24 Functional Capacity Screen (FCS) identified R1 was unable to perform management of medications. The 10/26/24 Negotiated Service Agreement (NSA) for R1 identified facility staff would administer medications. R1's record lacked evidence of documentation of a medication regimen review. On 02/27/25 at 12:10 PM Administrative Staff A confirmed a medication regimen review had not been completed for R1. On 02/27/25 at 03:03 PM a policy regarding medication regiment reviews was requested which the facility failed to provide. The operator failed to ensure a quarterly medication regimen review was conducted for R1 since his admission.	S5325		
S5335 SS=F	28-39-437 Construction (a) Each home-plus facility shall be designed,	S5335		

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S5335	Continued From page 21 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. This REQUIREMENT is not met as evidenced by: KAR 28-39-437(a) The facility reported a census of one resident. Based on observation and interview the operator failed to ensure the building was maintained to protect the health and safety of the residents by ensuring all chemicals were stored within locked areas. Findings included: - Observation on 02/27/25 at approximately 10:15 AM revealed a cabinet below the kitchen sink was unlockable. The following chemicals were inside with labels that read "Keep out of reach of children:" One container 75 wipes disinfecting wipes One 32 fluid ounce spray bottle of all-purpose cleaner One 24 fluid ounce bottle Gonzo disinfectant/cleaner One container of 62 "dishwasher pacs" - Observation on 02/27/25 at approximately 10:18 AM revealed a pantry cabinet was	S5335		

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S5335	Continued From page 22 unlockable and contained one 8.8 fluid ounce spray bottle of febreeze inside with label that read, "Keep out of reach of children:" - Observation on 02/27/25 at approximately 10:18 AM revealed one 28 fluid ounce spray bottle of ever spring disinfecting spray hanging above the kitchen sink. - Observation on 02/27/25 at 10:40 AM revealed a cabinet below east private bathroom sink was unlockable and contained one container 75 wipes disinfecting wipes and one 8.8 fluid ounce spray bottle of febreeze with labels that read, "Keep out of reach of children:" - Observation on 02/27/25 at 10:41 AM revealed a cabinet below southwest public bathroom sink was unlockable and contained two 24 fluid ounce bottles Clorox toilet bowl cleaner with labels that read, "Keep out of reach of children:" On top of the sink counter was one aerosol 19 fluid ounce can of Lysol disinfecting spray. - Observation on 02/27/25 at 10:45 AM revealed a cabinet below southeast public bathroom sink was unlockable and contained one container 75 wipes disinfecting wipes and one 8.8 fluid ounce spray bottle of febreeze with labels that read, "Keep out of reach of children:" On 02/27/25 at approximately 10:47 AM Administrative Staff A confirmed chemicals were not in locked areas. On 02/27/25 at 03:03 PM a policy regarding chemical storage was requested which the facility failed to provide.	S5335		

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S5335	Continued From page 23 The operator failed to ensure the building was maintained to protect the health and safety of the residents by ensuring all chemicals were stored within locked areas.	S5335		
S5380 SS=F	28-39-437 Plumbing and Piping Systems (i) Plumbing and piping systems. (1) Backflow prevention devices or vacuum breakers shall be installed on fixtures to which hoses or tubing can be attached. (2) Water distribution systems shall be arranged to provide hot water at hot water outlets at all times. The temperature of hot water shall range between 98° F and 120° F at showers, tubs, and lavatories accessible to residents. This REQUIREMENT is not met as evidenced by: KAR 28-39-437(i)(2) The facility reported a census of one resident. Based on observation and interview the operator failed to ensure water temperatures were maintained within a safe range between 98 degrees Fahrenheit (F) and 120 degrees F. The facility had three public bathrooms and access to the kitchen sink which all residents could use. Findings included: - Observation on 02/27/25 at 10:02 AM revealed the water temperature in kitchen sink was 131.4 degrees F. Observation on 02/27/25 at 10:36 AM revealed	S5380		

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S5380	Continued From page 24 the water temperature in east public shower was 132.3 degrees F. Observation on 02/27/25 at 10:01 AM revealed the water temperature in east public bathroom sink was 134.4 degrees F. Observation on 02/27/25 at 10:01 AM revealed the water temperature in northwest bathroom sink was 139.4 degrees F. On 02/27/25 at 02:51 PM the kitchen sink water temperature was 132.3 with department thermometer and 188 according to facility thermometer. On 02/27/25 at 02:54 PM the east public bathroom sink water temperature was 134.8 with department thermometer and 113 according to facility thermometer. On 02/27/25 at 12:10 PM water temperature logs were requested which the facility failed to provide. On 02/27/25 at 02:55 PM Administrative Staff A confirmed he did not think the facility thermometer was accurate. He stated he took temperatures but could not find the water temperature log to verify water temperatures. On 02/27/25 at 03:03 PM a policy regarding water temperatures was requested which the facility failed to provide. The operator failed to ensure water temperatures were maintained within a safe range between 98 degrees Fahrenheit (F) and 120 degrees F.	S5380		

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