STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087083	A. BUILDING: _____ B. WING _____	09/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREDO MEMORY CARE OF WICHITA	6887 E ROCKHILL STREET WICHITA, KS 67206

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S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey with complaints 192168, 194788, 195217, 195528, 195817, and 196583 at the above named Assisted Living, Home Plus conducted on 09/16/25, 09/17/25 and 09/22/25.	S 000		
S3026 SS=J	26-41-101 (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 26-41-101(f)(1)(B) The facility reported a census of 21 residents with three residents included in the sample and six focused reviews. Based on observation, interview, and record review the operator failed to protect Resident (R) 106 from neglect by the failure to ensure designated staff secured all exit doors during a fire alarm activation. Cognitively impaired R106 exited the facility through the main front door without staff knowledge and police found her found her approximately 1.6 miles away from the facility. This placed R106 in Immediate Jeopardy.	S3026		

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

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S3026	Continued From page 1 Findings included: - Record review for R106 revealed an admission date of 09/13/24 with a diagnosis of mild neurocognitive disorder. The 03/03/25 "Functional Capacity Screen" (FCS) identified R106 had short-term and long-term memory, memory/recall, and decision-making cognitive difficulties and was at risk for wandering. The 10/31/24 (most recent) combined "Negotiated Service Agreement/Healthcare Service Plan" (NSA/HSP) identified facility staff provided R106 reminders, redirection, and reorientation as needed for cognitive difficulties. Staff provided safety checks every two to three hours and observed R106's location within the community for wandering behavior. The 09/13/24 admission "Elopement Risk Screening" documented R106 was at risk for elopement. The 03/03/25 nursing "Incident Note" documented the following: At approximately 11:46 AM Certified Medication Aide (CMA) C saw R106 walking in the dining area. A smoking food item in the kitchen triggered the fire alarm. At 11:54 AM facility staff discovered R106 was not in the dining area and began looking for her. At 12:15 PM staff notified R106's family she was	S3026		

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missing.

At 12:45 PM Administrative Staff A notified police R106 could not be found in the nearby neighborhood. Police informed Administrative Staff A they found R106 approximately 1.2 miles away from the facility walking on the sidewalk. Administrative Nurse B and Administrative Staff A went to the site where police found R106. A nursing assessment revealed R106 had no injuries, and her vital signs were normal. Facility staff transported R106 back to the facility and provided visual checks every 30 minutes for the first 72 hours following the incident.

The 03/04/25 facility's "Investigation" reported, review of the facility's video surveillance footage revealed the front door automatically unlocked due to the fire alarm activation. R106 opened the door and walked out. Administrative Staff provided direct-care staff education regarding elopement risk and the procedure when an elopement occurred. Notarized witness statements included in the investigation documented direct-care staff present at the time of the incident last saw R106 in the dining area at approximately 11:46 AM. They reported to Administrative Staff A as soon as they noticed R106 was not in the dining area and began looking for her.

Review of the 03/03/25 "Resident Census" provided by the facility on 09/17/25 revealed 14 residents lived at the facility with three at risk for wandering.

Observation on 09/16/25 at 01:30 PM revealed the main front door to the facility was keypad

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locked to enter and exit. Facility staff answered the doorbell and used a code to unlock the door to allow visitors to enter and exit the building.

Observations of R106 on 09/17/25 revealed the following:

At 02:45 PM R106 walked through the dining room to the common area near the front door. She passed the piano to a window and looked out. She turned around, walked back through the dining area towards the hallway. There were no staff nearby.

At 02:52 PM R106 walked through the dining room to common area. She stated she was "walking around looking for something to do." There were no staff nearby.

At 02:56 PM R106 walked through the dining room for a third time during the last 11 minutes. She did not go all the way to the window. She stopped at the edge of the carpet, picked something off the floor, turned around and walked back toward the hallway.

Observation on 09/17/25 at approximately 04:00 PM revealed a probable route R106 walked when she exited the facility on 03/03/25. From the dining area where staff last saw R106 to the front door was approximately 25 steps. From the front door to the side street in front of the facility was approximately 800 feet. The street had no sidewalks or posted speed limit. From the front door to a heavily traveled street was approximately 1722.0 feet. The street had 4 lanes with sidewalks on both sides with a speed limit of 45 miles per hour (mph). There was a

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large flat open field of tall grass, north of the facility with a pond 425 feet from the front door. A wooded area with large trees was on the east side of the facility and a church with a large parking lot was west past a stand of tall trees.

The weather on 03/03/25 at 11:53 AM per Wunderground.com was a temperature of 64 degrees Fahrenheit (F), wind speed of 16 mph, and sunny with no precipitation.

On 09/17/25 at 12:32 PM Administrative Staff A stated all doors to enter and exit the facility were keypad locked. The code was known to staff only and not shared with families or visitors. The exit doors opened during a drill or fire alarm. If it was a drill, a staff member supervised all exit doors to ensure no residents went out. The incident on 03/03/25 was not a drill so no one watched the doors. There was smoke in the kitchen that triggered the alarm. A visitor entered the facility during that time, did not ensure the door locked behind him, and R106 was able to get out.

On 09/17/25 at 01:46 PM R106 stated she liked to walk inside the building. She did not go outside because "they don't let you do that." If the fire alarm went off she would go to a place to get out.

The facility's revised 2022 "Fire Prevention and Procedures" policy did not address staff response to a fire alarm due to smoke that was not a fire.

The facility's revised 2022 "Resident Guide to Fire Procedures" documented designated staff conducted periodic fire drills to ensure all staff

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and residents were aware of the procedures. "If you smell smoke from outside your room or hear a fire alarm. . . if the door is cool, slowly open the door and check for presence of smoke in the hallway. . . If the hallway is free of smoke, you may leave your room and proceed to the nearest exit or to a point of refuge."
The facility's revised 2022 "Elopement Prevention" policy documented residents identified at risk for elopement were to be accounted for every 30 minutes until reassessment and transferred to a more appropriate setting if necessary.

The Immediate Jeopardy was removed prior to the surveyor entering the building on 09/16/25, when the following actions were taken by the facility. The removal plan showed the immediacy was removed on 03/27/25.

On 03/03/25, a sign was posted which read "STOP. Be resident aware. Do not open doors for any residents and ensure the light on code pad is red before walking away from the door."

On 03/03/25 staff provided R106 visual checks every 30 minutes for 72 hours.

On 03/03/25 Administrative Staff sent a group text to all staff to greet all guests at the front door. Staff were to discontinue using the "side pads" to open the front door. Staff received elopement risk and process education during all shifts.

On 03/03/25 maintenance staff received education to supervise the front door when conducting a fire drill.

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S3026	Continued From page 6 On 03/03/25 designated staff updated R106's "FCS" and "NSA/HSP" for increased elopement risk. On 03/07/25 Administrative Staff informed all staff by group text regarding a new communication sheet which included elopement risk. Each staff filled out a form and returned to Administrative Nurse B to acknowledge understanding by the end of their shift. On 03/27/25 a mandatory all-staff meeting included education regarding elopement prevention and the policy and procedure if a resident went missing. The 03/28/25 "Disaster and Emergency Preparation Education" provided to the residents included missing resident. The 04/01/25 "2nd Quarter Staff Meeting" included elopement prevention and missing persons policy and procedure. The 05/09/25 staff meeting included fire prevention and safety. The 05/27/25 mandatory all staff meeting included missing resident and elopement prevention. On 07/09/25 designated staff conducted an elopement drill.	S3026		
S3085 SS=E	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each	S3085		

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S3085	Continued From page 7 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) The facility reported a census of 21 residents with three residents included in the sample and six focused record reviews. Based on observation, interview, and record review the operator failed to ensure the "Negotiated Service Agreement/Health Care Plan" (NSA/HCP) was fully developed based on the resident's "Functional Capacity Screen" (FCS), service needs, and preferences for Resident (R)102, R103, and R106. Findings included:	S3085		

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S3085	Continued From page 8 - R102's medical record revealed she moved into the facility on 03/04/25 with a diagnosis of dementia. The 03/03/25 FCS identified R102 sometimes understood others and others sometimes understood her when she communicated. The 06/30/25 NSA/HCP failed to identify what services facility staff provided in order to ensure good communication with R102. On 09/22/25 at approximately 02:26 PM Administrative Nurse B confirmed R102's NSA/HCP failed to address services provided by staff concerning communication. The operator failed to ensure R102's NSA/HCP was fully developed to include all items that triggered on the FCS, his service needs, and preferences. - R103's medical record revealed he moved into the facility on 03/28/25 with a diagnosis of Alzheimer's Disease. The 03/27/25 FCS documented R103 required physical assistance with management of treatments, triggered for communication, falls and improper behaviors. The 03/28/25 NSA/HCP failed to identify what services facility staff provided concerning management of R103's treatments, communication, falls or improper behaviors. On 09/22/25 at 01:57 PM Administrative Nurse B confirmed not everything that triggered on	S3085		

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S3085	Continued From page 9 R103's FCS was addressed on his NSA/HCP. The operator failed to ensure R103's NSA/HCP was fully developed to include all items that triggered on the FCS, his service needs, and preferences. - R106's medical record revealed she moved into the facility on 10/11/24 with a diagnosis of mild neurocognitive disorder. The 09/11/24 FCS documented R106 required physical assistance with management of treatments. The 10/31/24 NSA/HCP failed to identify what services facility staff provided concerning management of R106's treatments. On 09/22/25 at 03:22 PM Administrative Nurse B acknowledged R106's NSA/HCP did not address services staff provided for management of treatments. The operator failed to ensure R106's NSA/HCP was fully developed to include all items that triggered on the FCS, her service needs, and preferences.	S3085		
S3090 SS=E	26-41-202 (c) Admission Negotiated Service Agreement (c) Each administrator or operator shall ensure the development of an initial negotiated service agreement at admission.	S3090		

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S3090	Continued From page 10 This REQUIREMENT is not met as evidenced by: KAR 26-41-202(c) The facility reported a census of 21 residents. Three residents were reviewed and there were six abbreviated record reviews completed. Based on interview, and record review the operator failed to ensure the development of an initial "Negotiated Service Agreement/Health Care Plan" (NSA/HCP) was completed at admission for Resident (R)104, R106, R107, R108 and R109. Findings included: - R104's medical record revealed he moved into the facility on 12/09/24 with a diagnosis of Alzheimer's Disease. The 12/09/24 FCS identified R104 required physical assistance with bathing, dressing, management of medications and treatments, had severely impaired cognition and communication and wandered. Review of R104's medical record there was no evidence an NSA/HCP corresponding to the 12/09/24 FCS was completed upon R104's readmission to the facility. On 09/22/25 at 01:47 PM Administrative Nurse B acknowledged that she did not complete a new NSA/HCP to correspond with the 12/09/24 FCS upon R104's readmission to the facility.	S3090		

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S3090	Continued From page 11 The operator failed to ensure R104's NSA/HCP was developed at admission. - R106's medical record revealed she moved into the facility on 09/13/24 with a diagnosis of mild neurocognitive disorder. The most recent NSA/HCP completed on admission was dated 10/31/24 which was 48 days after R106 admitted to the facility. On 09/22/25 at 03:22 PM Administrative Nurse B acknowledged R106's NSA/HCP was not completed upon admission to the facility. The operator failed to ensure R106's NSA/HCP was developed at admission. - R107's medical record revealed she moved into the facility on 05/01/25 with a diagnosis of senile degeneration of the brain. The most recent NSA/HCP completed on admission was dated 06/03/25 which was 33 days after R107 admitted to the facility. On 09/22/25 at 03:27 PM Administrative Nurse B acknowledged R107's NSA/HCP was not signed until 06/03/24. The operator failed to ensure R107's NSA/HCP was developed at admission. - R108's medical record revealed she admitted to the facility on 10/11/24 with a diagnosis of diabetes mellitus. The most recent NSA/HCP completed on	S3090		

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S3090	Continued From page 12 admission was dated 10/21/24 which was 10 days after R108 admitted to the facility. On 09/22/25 at approximately 02:54 PM Administrative Nurse B confirmed R108's NSA/HCP was not signed until 10/21/24. The operator failed to ensure R108's NSA/HCP was developed at admission. - R109's medical record revealed he admitted to the facility on 10/11/24 with a diagnosis of Alzheimer's Disease. The most recent NSA/HCP completed on admission was dated 10/18/24 which was seven days late. On 09/22/25 at 02:07 PM Administrative Nurse B stated the NSA/HCP was initiated on 10/11/24 but was not completed until 10/18/24. The operator failed to ensure R108's NSA/HCP was developed at admission.	S3090		
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	S3211		

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S3211	Continued From page 13 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 21 residents. Based on observation and interview the operator failed to ensure a licensed pharmacist or licensed nurse placed the full name of the resident on the original package of "over-the-counter" (OTC) medications for a total of six containers of medications that were not labeled. Findings included: - An observation on 09/16/25 at 02:16 PM of the Medication Room #1 cart revealed the following OTC medications not labeled with the full name of a resident on the medication container: One 240 count bottle of Melatonin 5 milligrams (mg.) One 30 count container of Mucous relief DM On 09/16/25 at approximately 02:16 PM Administrative Nurse B confirmed the bottles of OTC medications were not labelled with the full name of a resident. An observation on 09/16/25 at 02:22 PM of the Medication Room #2 cart revealed the following OTC medications not labeled with the full name	S3211		

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S3211	Continued From page 14 of a resident on the medication container: One 200 count bottle of Bayer ASA 325 mg. One 100 count bottle of Tylenol Extra Strength Two bottles of nasal moisturizing spray One 90 count bottle of Vitamin D2, 2000 International Units (IU). On 09/16/25 at approximately 02:22 PM Administrative Nurse B confirmed the bottles of OTC medications were not labelled with the full name of a resident. The "Medication Management" policy dated 2022 documented, "..A pharmacist or licensed nurse shall place the full name of the resident on the package if over-the-counter drugs are removed from the original manufacturer's package..." The operator failed to ensure all over-the-counter medications were labeled with the resident's full name.	S3211		
S3215 SS=F	26-41-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility in separately locked compartments within a locked	S3215		

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CREDO MEMORY CARE OF WICHITA	6887 E ROCKHILL STREET WICHITA, KS 67206

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S3215	Continued From page 15 medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the facility. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(h) The facility reported a census of 21 residents. Based on observation and interview, the operator failed to ensure resident medications were stored in accordance with each manufacturer's recommendations. Findings included: - Observation on 09/16/25 at approximately 02:16 PM medication room #1 had a refrigerator that contained two opened boxes of TUBERSOL with unsealed vials that were not marked with the	S3215		

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S3215	Continued From page 16 opened date. The box, product insert and the vial of TUBERSOL itself contained instructions that a vial of TUBERSOL which has been entered and in use for 30 days should be discarded. On 09/16/25 at approximately 02:16 PM after showing Administrative Nurse B the instructions for storage of the vial of TUBERSOL, Administrative Nurse B acknowledged these medications should have been dated when they were opened and discarded the two vials. The 2022 "Medication Management" policy documented, "All medications must be stored...in accordance with the manufacturers...storage instructions." The operator failed to ensure medications were stored in accordance with each manufacturer's recommendations.	S3215		
S3261 SS=E	26-41-105 (f) (11) Resident Record Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action This REQUIREMENT is not met as evidenced by: KAR 26-41-105(f)(11)	S3261		

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The facility reported a census of 21 residents. The sample included three residents and six focused record reviews. Based on observation, interview and record review the operator failed to ensure six of nine sampled resident records contained documentation of all incidents, symptoms, and other indications of illness or injury for Resident (R)102, R103, R104, R106, R108 and R109.

Findings included:

- R102's medical record revealed she moved into the facility on 03/04/25 with a diagnosis dementia.

The 03/03/25 FCS documented R102 required physical assistance from staff for bathing, dressing, toileting, transfers, walking/mobility, management of medications and treatments. R102 had severe cognitive impairment, and triggered for falls, impaired vision, impaired hearing, and impaired decision-making.

Review of R102's medical records revealed documentation for 05/13/25 which indicated she had a yeast infection in her groin. There was no follow-up documentation for condition, and no interventions for treatment of this infection.

On 09/22/25 at approximately 02:26 PM Administrative Nurse B stated the R102's skin issues in her groin area healed up but there was no documentation to show this.

The operator failed to ensure designated staff included documentation of all incidents,

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symptoms and other indications of illness of injury including the date, time of occurrence, action taken, and results of the action.

- R103's medical record revealed he moved into the facility on 03/28/25 with a diagnosis of Alzheimer's Disease.

The 03/28/25 FCS documented R103 required physical assistance from staff for bathing, dressing, toileting, transfers, walking/mobility, management of medications and treatments. R103 had severe cognitive impairment and triggered for falls, impaired vision, impaired hearing, wandering, inappropriate behavior and impaired decision-making.

Review of R103's medical record revealed lack of nurse documentation from 04/17/25 to 05/17/25 and lacked documentation of his discharge from the facility.

On 09/22/25 at 01:57 PM Administrative Nurse A stated R103 was discharged due to financial reasons and had to move to a different facility. Administrative Nurse B confirmed there was no documentation concerning R103's discharge in his medical record.

- R104's medical record revealed he moved into the facility on 12/09/24 with a diagnosis of Alzheimer's Disease.

The 12/09/24 FCS documented R104 required physical assistance with bathing and dressing. Staff managed his medications and treatments. He was severely cognitively impaired, had impaired communication and wandered.

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S3261	Continued From page 19 Review of R104's medical records revealed a lack of nurse documentation between 05/18/25 to 06/17/25 and 07/19/25 to 08/18/25. On 09/22/25 at 01:47 PM Administrative Nurse B stated she was told by the regional nurse that she had to document on residents at least once a month or more if there was a change in condition, or if there was an incident such as a fall. Administrative Nurse B acknowledged there were periods of time where R104's medical records lacked documentation in the nursing notes. The operator failed to ensure designated staff included documentation of all incidents, symptoms and other indications of illness of injury including the date, time of occurrence, action taken, and results of the action. - R106's medical record revealed she moved into the facility on 09/13/24 with a diagnosis of mild neurocognitive disorder. The 09/11/24 FCS indicated R106 required staff to manage her medications and treatments and that she wandered and had impaired decision-making. Review of R104's medical records revealed a lack of nurse documentation between: 10/13/24 to 11/12/24 12/14/24 to 01/13/25 04/17/24 to 05/17/25 05/18/25 to 06/17/25 07/19/25 to 08/18/25 08/19/25 to 09/18/25	S3261		

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S3261	Continued From page 20 On 09/22/25 at 03:22 PM Administrative Nurse B acknowledged there were periods of time where R106's medical records lacked documentation in the nursing notes. The operator failed to ensure designated staff included documentation of all incidents, symptoms and other indications of illness of injury including the date, time of occurrence, action taken, and results of the action. - R108's medical record revealed she admitted to the facility on 10/11/24 with a diagnosis of diabetes mellitus. The 02/27/25 FCS documented R108 required staff to manage her medications and treatments. Review of R108's medical records revealed that upon admission she had an order for Nystatin/Calmoseptine for treatment of a yeast infection on her skin included on the "Electronic Medication Administration Record" (EMAR) but the nursing progress notes lacked documentation for follow-up for this skin condition. On 09/22/25 at approximately 02:54 PM Administrative Nurse B confirmed R108 had a yeast infection on her bottom and stated she assessed R108's skin on a weekly basis and that she had an appointment to see dermatology about this. Administrative Nurse B confirmed there was no follow-up documentation concerning R108's yeast infection. The operator failed to ensure designated staff	S3261		

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S3261	Continued From page 21 included documentation of all incidents, symptoms and other indications of illness of injury including the date, time of occurrence, action taken, and results of the action. - R109's medical record revealed he admitted to the facility on 10/11/24 with a diagnosis of Alzheimer's Disease. The 10/09/24 FCS documented R109 required physical assistance with bathing, dressing, management of medications and treatments, had severely impaired cognition, and wandered. Review of R109's medical records revealed a lack of documentation for the following time periods: 05/18/25 to 06/17/25 07/19/25 to 08/18/25 On 09/22/25 at 02:07 PM Administrative Nurse B confirmed there were periods of time within the nursing progress notes that did not have any documentation. Administrative Nurse B stated they spent a lot of with the residents but did not necessarily take credit for this by documenting this in the nursing progress notes. The operator failed to ensure designated staff included documentation of all incidents, symptoms and other indications of illness of injury including the date, time of occurrence, action taken, and results of the action.	S3261		
S3299 SS=F	26-41-206 (e) (1) Facility Food Storage (e) Food storage. Facility staff shall store all food under safe and sanitary conditions.	S3299		

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S3299	Continued From page 22 (1) Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving. This REQUIREMENT is not met as evidenced by: KAR 26-41-206 (e) The facility had a census of 21 residents. All 21 residents ate food prepared in the same kitchen. The operator failed to ensure food items were stored under safe and sanitary conditions by the failure to ensure food was dated and kept at 41 degrees Fahrenheit (F) or lower according to Food Safety Guidelines while stored in the refrigerator. Findings included: - An observation of the kitchen on 09/16/25 at 02:33 PM revealed refrigerator #1 had contained the following food items opened but not dated: Two gallons jugs of milk One 64-ounce (oz.) container of grape juice One 1-gallon container of Sunny D orange juice drink One package of sliced turkey breast One package of sausages Review of temperature logs revealed no refrigerator or freezer temperatures were documented since 06/29/25. On 09/16/25 at approximately 02:33 PM Dietary	S3299		

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S3299	Continued From page 23 Staff E confirmed the opened food items found in the refrigerator were not dated. Review of the 2022 "Food Services" policy documented, "All perishable food stored in the refrigerator ...is to be marked with the date the item was opened or served. The kitchen staff will be responsible for maintaining the kitchen logs..." The operator failed to ensure food items were stored under safe and sanitary conditions.	S3299		