STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B026002	A. BUILDING: _____ B. WING _____	12/16/2025

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

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S 000	INITIAL COMMENTS The following represent the findings of a resurvey for the above named Home Plus facility conducted on 12/15/25 and 12/16/25.	S 000		
S5085 SS=D	26-42-201 (c) Functional Capacity Screen Reassessment (c) Designated 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 26-42-201(c)(1) The facility reported a census of six residents. The sample included three residents. Based on interview, and record review the operator failed to ensure designated staff completed a "Functional Capacity Screen" (FCS) for Resident (R)103 at least once every 365 days. Findings included: - R103's medical record revealed he moved into the facility on 04/24/24 with a diagnosis of hypertension. The most current FCS available in R103's	S5085		

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

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S5085	Continued From page 1 medical records was dated 04/24/24 with no documentation to show a FCS was completed since this date. On 12/16/25 at 01:39 PM Administrative Staff A stated he did not complete an annual FCS for R103. The operator failed to ensure a FCS for R103 was completed at least once every 365 days.	S5085		
S5095 SS=D	26-42-201 (d) Functional Capacity Screen Accurate (d) Designated staff shall ensure that each resident ' s functional capacity at the time of screening is accurately reflected on that resident ' s screening form. This REQUIREMENT is not met as evidenced by: KAR 26-42-201(d) The facility reported a census of six residents with three included in the sample. Based on interview, and record review the operator failed to ensure a resident's "Functional Capacity Screen" (FCS) accurately reflected the resident's use of a wheelchair for mobility. Findings included: - Resident (R)101's medical record revealed she moved into the facility on 09/14/25.	S5095		

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S5095	Continued From page 2 The 09/14/25 Admission FCS identified R101 used a mechanical lift but failed to identify that she used a wheelchair for mobility. On 12/16/25 at 01:14 PM Administrative Staff A stated R101 used a wheelchair but the FCS did not indicate this. The operator failed to ensure R101's FCS accurately reflected her status by the failure to identify the use of a wheelchair for mobility.	S5095		
S5105 SS=E	26-42-202 (a) Negotiated Service Agreement a) The administrator or operator of each home plus shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-42-202(a)(1)	S5105		

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S5105	Continued From page 3 The facility reported a census of six residents with three residents included in the sample. Based on interview, and record review the operator failed to ensure the "Negotiated Service Agreement" (NSA) was fully developed based on the resident's "Functional Capacity Screen" (FCS), service needs, and preferences for Resident (R)101, R102 and R103. Findings included: - R101's medical record revealed she moved into the facility on 09/14/25 with a diagnosis of dementia. The 09/14/25 FCS identified R101 had severely impaired cognition. The 09/14/25 NSA did not address what services staff provided concerning R101's cognition. On 12/16/25 at 01:14 PM Administrative Staff A confirmed R101's NSA did not address all items that triggered on the FCS. The operator failed to ensure R101's NSA was fully developed to include all items that triggered in the FCS. - R102's medical record revealed he moved into the facility on 06/01/25 with diagnoses of dementia and diabetes mellitus. The 06/01/25 FCS identified R102 required physical assistance with management of medications, had impaired vision, impaired hearing and wandered.	S5105		

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S5105	Continued From page 4 The 06/01/25 NSA did not address R102's self-injection of insulin, impaired vision, impaired hearing and wandering. On 12/16/25 at 01:23 PM Administrative Staff A confirmed R102's NSA did not address that R102 self-injected his insulin, did not address his visual impairment, hearing impairment or wandering. The operator failed to ensure R102's NSA was fully developed to include all items that triggered in the FCS. - R103's medical record revealed he moved into the facility on 04/24/24 with a diagnosis of hypertension. The 04/24/24 FCS identified R103 required triggered cognition due to short-term memory impairment and was identified for wandering. The 04/24/24 NSA did not address what services staff provided to address R103's impaired cognition or his wandering. On 12/16/25 at 01:39 PM Administrative Staff A stated R103's NSA did not address his short-term memory impairment, and wandering. The operator failed to ensure R103's NSA was fully developed to include all items that triggered in the FCS.	S5105		
S5116 SS=D	26-42-202 (d) NSA revisions (d) Each administrator or operator shall ensure	S5116		

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S5116	Continued From page 5 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, 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 26-42-202(d)(1) The facility reported a census of six residents with three residents included in the sample. Based on interview, and record review the operator failed to ensure a "Negotiated Service Agreement" (NSA) was developed for Resident (R)103 at least every 365 days. Findings included: - R103 admitted to the facility on 04/24/24 with diagnosis of hypertension. The 04/24/24 Functional Capacity Screen revealed R103 required physical assistance with bathing, dressing, toileting, transfers, and mobility. R103 also required assistance with management of medications and triggered for	S5116		

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S5116	Continued From page 6 falls and wandering. The most current NSA available in R103's medical records was dated 04/24/24 with no documentation to show a NSA was completed since this date. On 12/16/25 at 01:39 PM Administrative Staff A stated he did not complete an annual NSA for R103. The operator failed to ensure a NSA for R103 was completed at least once every 365 days.	S5116		
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: KAR 26-42-206 (e)	S5192		

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S5192	Continued From page 7 The facility had a census of six residents. All six residents ate food prepared in the same kitchen. The operator failed to ensure food items were served at the proper temperature. Findings included: - On 12/15/25 at approximately 04:17 PM an observation of the kitchen revealed the following: Review of the October (2025) "Temp food log" revealed staff documented food temperatures on 10/19 but there was no documentation for all the other days. A food temperature log for the month of November 2025 was not found. Review of the December 2025 "Temp food log" revealed staff documented food temperatures on 12/01/25 but there was no documentation from 12/02 through 12/15. On 12/15/25 at 04:36 PM with Administrative Staff A stated it was his expectation that staff documented food temperatures each meal. The 2005 "Dietary Guideline for Americans" documented bacteria grow most rapidly in the range of 40 degrees Fahrenheit (F) and 140 F. To keep food out of this danger zone, keep cold food cold (below 40 F) and hot food hot (above 140 F). The operator failed to ensure food items were served at the proper temperature.	S5192		

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S5195 SS=F	26-42-206 (f) (g) Facility Food Storage (f) Staff shall store all food under safe and 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 had a census of six residents. All six 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 foods stored in the refrigerators were kept at 41 degrees Fahrenheit (F) or lower, and foods were dated and labeled according to Food Safety Guidelines. Findings included: - On 12/15/25 at approximately 04:07 PM an observation of the kitchen revealed the refrigerator contained a bread loaf pan with what appeared to be corn bread not dated or labeled. There was a small covered rectangular container of what appeared to be chili-mac, and a covered small square glass container with some kind of sauce not dated or labeled. In a pullout drawer of the refrigerator there was a plastic storage bag of pancakes not dated or labeled. The freezer pullout drawer contained a plastic storage bag	S5195		

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S5195	Continued From page 9 food not identified or dated. Review of the October 2025 Fridge Temperature Log revealed only 10 of 31 days had temperatures recorded. Review of the October 2025 Outdoor Upright Freezer temperature log revealed only six of 31 days had temperatures recorded. Review of the October 2025 Inside Freezer temperature log revealed only four of 31 days had temperatures recorded. No documentation of refrigerator/freezer temperatures were provided for the months of November and December of 2025. On 12/15/25 at 04:36 PM with Administrative Staff A stated it was his expectation that staff documented refrigerator/freezer temperatures daily. Review of the undated "Food Handling and Storage" policy documented opened containers must be dated and sealed during storage...after the original container is opened and held under refrigeration, if potentially hazardous, is ready-to-eat, or held for more than 24 hours. Foods that are cooked or chilled to recommended temperature will be recorded in a temperature log." The operator failed to ensure food items were stored under safe and sanitary conditions by failing to document refrigerator/freezer temperatures and ensure foods were appropriately dated and labeled.	S5195		

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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 six residents. Based on record review and interview for all residents and all facility employees, the operator failed to ensure disaster and emergency preparedness by ensuring performance of quarterly review of the facility's emergency management plan with employees and residents. Findings included: - On 12/15/25 documentation of quarterly reviews of the emergency management plan was requested from Administrative Staff A. The	S5215		

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S5215	Continued From page 11 facility lacked documentation of quarterly reviews completed for 2024 and 2025. On 12/16/26 at 11:55 AM Administrative Staff A stated that he did not complete quarterly reviews of the emergency management plan with staff and residents. The operator failed to ensure the performance of quarterly reviews of the emergency management plan with employees and staff.	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 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 six residents. Based on interview and record review for three residents and four new employee records, the	S5230		

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S5230	Continued From page 12 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. Findings included: - Review of four newly hired staff records revealed the following: Certified Nurse Aide (CNA) B's employee record revealed a hire date of 10/21/25. The operator failed to ensure a two-step TB skin test (TST) was completed upon hire. Certified Medication Aide (CMA) C's employee record revealed a hire date of 09/08/25. The operator failed to ensure TB symptom screen questionnaire, and a two-step TST was completed. CNA D's employee record revealed a hire date of 06/24/25. The operator failed to ensure a two-step TST was completed upon hire. CNA E's employee record revealed a hire date of 12/16/24. The operator failed to ensure staff provided x-ray results in lieu of having a two-step TST completed upon hire. On 12/16/25 at 12:00 PM Administrative Staff A confirmed the required TB screenings and TSTs were completed for staff upon hire. The June 2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented, "Each ... new employee shall have an initial TB symptom screen that includes the components of the TB	S5230		

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S5230	Continued From page 13 symptom questionnaire within seven days of ...employment ...Each new ...employee shall receive a two-step TST ...within 7 days of ...employment." The operator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in KAR 26-39-105 regarding newly hired employees. - Resident (R)101 moved into the facility on 09/14/25 with a diagnosis of dementia. R101's medical record revealed a two-step TST was not completed upon admission to the facility. On 12/16/25 at 01:14 PM Administrative Staff A stated a two-step TST was not completed for R101 upon admission to the facility. The June 2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented, "Each resident ...shall receive a two-step ...within 7 days of residency ..." The operator failed to ensure compliance with the department's TB guidelines for adult care homes adopted by reference to K.A.R. 26-29-105. - R102 moved into the facility on 06/01/25 with a diagnosis of dementia. R102's medical record revealed a two-step TST was not completed upon admission to the facility. On 12/16/25 at 01:23 PM Administrative Staff A	S5230		

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S5230	Continued From page 14 stated a two-step TST was not completed for R102 upon admission to the facility. The June 2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented, "Each resident ...shall receive a two-step ...within 7 days of residency ..." The operator failed to ensure compliance with the department's TB guidelines for adult care homes adopted by reference to K.A.R. 26-29-105. - R 103 moved into the facility on 04/24/24 with a diagnosis of hypertension. R103's medical record an annual TB symptom screen questionnaire was not completed annually during 2025. On 12/16/25 at 01:39 PM Administrative Staff A stated an annual TB screen was not completed for R103. The June 2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented, "Each resident ...shall have an annual TB symptom screen ..." The operator failed to ensure compliance with the department's TB guidelines for adult care homes adopted by reference to K.A.R. 26-29-105.	S5230		
S5258 SS=F	26-42-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff records shall contain the following information:	S5258		

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S5258	Continued From page 15 (1) Evidence of licensure, registration, certification, or a certificate of successful completion of a training course for each employee performing a function that requires specialized education or training; (2) supporting documentation for criminal background checks of facility staff and contract staff, excluding any staff licensed or registered by a state agency, pursuant to K.S.A. 39-970 and amendments thereto; (3) supporting documentation from the Kansas nurse aide registry that the individual does not have a finding of having abused, neglected, or exploited a resident in an adult carehome; and (4) supporting documentation that the individual does not have a finding of having abused, neglected, or exploited any resident in an adult care home, from the nurse aide registry in each state in which the individual has been known to work as a certified nurse aide. This REQUIREMENT is not met as evidenced by: KAR 26-42-102(d)(1) The facility reported a census of six residents. Based on interview and record review, the operator failed to ensure three of four newly hired employees records included evidence of verification with the nurse aide registry was completed prior to staff employment. Findings included: - Review of employee files conducted on	S5258		

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	B026002	A. BUILDING: _____ B. WING _____	12/16/2025

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S5258	Continued From page 16 12/16/25 revealed the following: Certified Nurse Aide (CNA) B was hired on 10/21/25. Review of personnel records lacked documentation of a verification with the nurse aide registry completed prior to CMA B being hired. Certified Medication Aide (CMA) C was hired on 09/08/25. Review of personnel records lacked documentation of a verification with the nurse aide registry completed prior to CMA C being hired. CNA D was hired on 06/24/25. CNA D was issued her certification on 09/09/25 but review of personnel records lacked documentation of a verification with the nurse aide registry being completed. The operator failed to ensure verification with the nurse aide registry were completed.	S5258		
S5286 SS=D	26-42-205 (b) Administration of Selected Medications (b) Administration of select medications. Any resident who self-administers medication may select some medications to be administered by a licensed nurse or medication aide. The negotiated service agreement shall reflect this service and identify who is responsible for the administration and management of selected medications. This REQUIREMENT is not met as evidenced by:	S5286		

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S5286	Continued From page 17 KAR 26-42-205(b) The facility reported a census of six residents. Based on interview, and record review the operator failed to ensure the "Negotiated Service Agreement" (NSA) for Resident (R)102 identified the responsible person for administration and management of selected medications. Findings included: -R102's medical record revealed he moved into the facility on 06/01/25 with a diagnosis of diabetes mellitus. The 06/01/25 "Functional Capacity Screen" (FCS) documented R102 required physical assistance with medication administration. The 06/01/25 NSA failed to identify qualified staff prepared R102an insulin pen and R102 self-injected his own insulin. On 12/16/25 at 01:02 PM Certified Medication Aide G stated staff administered all of R102's oral medications but the resident self-administered his insulin. CMA G stated staff prepared the insulin pen and then handed the pen to the R102 to self-inject. On 12/16/25 at 01:23 PM Administrative Staff A stated R102's NSA did not identify staff prepared the insulin pen and then handed it to R102 to self-inject. The operator failed to ensure the NSA identified the responsible person for administration and	S5286		

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S5286	Continued From page 18 management of R102's insulin.	S5286		
S5302 SS=D	26-42-205 (d) (4) Delegation of Medication Administration (4) Any licensed nurse may delegate nursing procedures not included in the medication aide curriculum to medication aides under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(d)(4) The facility reported a census of six residents. Based on interview and record review the operator failed to ensure the sampled Certified Medication Aide (CMA) was trained and completed a competency for delegated insulin pen preparation for residents to self-administer insulin. Findings included: - Review of the personnel record for CMA C revealed a competency for preparing insulin for a resident to self-administer was not completed. On 12/16/25 at 12:00 PM Administrative Staff A stated CMA C did not complete a competency for insulin pen preparation for residents to self-administer. The operator failed to ensure designated staff	S5302		

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S5302	Continued From page 19 completed competencies for preparing an insulin pen for one resident who received insulin to self-administer.	S5302		
S5313 SS=E	26-42-205 (g) (3) Over the counter medication (g) (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 26-42-205(g)(3) The facility reported a census of six residents. Based on observation, record review 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 medications (OTC). Findings included: - Observation on 12/15/25 at 03:00 PM of the medication cabinet revealed the following OTC	S5313		

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S5313	Continued From page 20 medications that were not labelled with the resident's full name: Two bottles of Nature Made Iron One bottle of Spring Valley Super Vitamin B-Complex One bottle of Health A2Z Mucus Relief One bottle of Equate All Day Allergy Relief One bottle of Nature Made D3 One bottle of Equate Ibuprofen PM One tube of Cortizone 10 One bottle of NyQuil Honey Cold and Flu One bottle of DayQuil Honey Cold & Flu The undated "Medication Storage" policy documented, "All over the counter medications or any medication bottles/containers not marked by pharmacy labels will be marked by permanent ink/marker with patients first and last name." The operator failed to ensure all over-the-counter medications were labeled with the resident's full name.	S5313		
S5335 SS=F	28-39-437 Construction (a) Each home-plus facility shall be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public. (b) All new construction, renovation, remodeling, and changes in building use in existing buildings shall comply with building and fire codes, ordinances, and regulations enforced by city, county, and state jurisdictions, including the state fire marshal. This REQUIREMENT is not met as evidenced by:	S5335		

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S5335	Continued From page 21 KAR 28-39-437(a) The facility reported a census of six residents. Based on observation, and interview the operator failed to ensure staff secured all chemicals to maintain the safety of all residents. Findings included: - An observation on 12/15/25 at 04:03 PM of the southwest resident bathroom revealed there was a one-gallon container of Dymon Liquid Alive Odor Control with a KEEP OUT OF REACH OF CHILDREN warning label found under the sink in an unlocked cabinet. At 03:18 PM revealed an aerosol spray can of Clorox Disinfectant Spray located in the restroom by the front entrance which had a "Keep Out of Reach of Children Warning." An observation on 12/15/25 at 04:07 PM of the kitchen revealed a cabinet located under the sink that was lockable but was not locked that contained chemicals with KEEP OUT OF REACH OF CHILDREN warning labels. There were at least two residents wandering about the home to include one that was observed rummaging through a large plastic shopping bag located in the front foyer. This same resident was observed walking through the kitchen looking at and touched items. On 12/15/25 at 04:47 PM Administrative Staff A stated he expected the kitchen cabinet containing chemicals to be locked when staff were not using it.	S5335		

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S5335	Continued From page 22 The operator failed to ensure staff kept chemicals locked for resident safety.	S5335		
S9999	Final Observations 9999 KAR 26-42-103(c) If the home plus admits residents with dementia, the administrator or operator shall ensure the provision of staff education, at orientation and at least annually thereafter, on the treatment and appropriate response to persons who exhibit behaviors associated with dementia. This requirement is not met as evidenced by: The facility reported a census of six residents. Two of three residents sampled had a diagnosis of dementia or were identified as cognitively impaired. Based on interview and record review the operator failed to provide dementia training to direct care staff upon hire for four out of four sampled staff. s/s of E Findings included: - Record review for Certified Nurse Aide (CNA) B revealed a hire date of 10/21/25. The record lacked evidence of documentation dementia training was completed upon hire. Record review for Certified Medication Aide (CMA) B revealed a hire date of 09/08/25. The record lacked evidence of documentation dementia training was completed upon hire.	S9999		

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S9999	Continued From page 23 Record review for CNA C revealed a hire date of 06/24/25. The record lacked evidence of documentation dementia training was completed upon hire. Record review for CNA D revealed a hire date of 12/16/24. The record lacked evidence of documentation dementia training was completed upon hire. On 12/16/25 at 01:52 PM Administrative Staff A confirmed dementia training for staff had not been completed upon hire. The operator failed to provide dementia training to direct care staff upon hire for four out of four sampled staff.	S9999		