STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B022002	A. BUILDING: _____ B. WING _____	12/23/2025

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THE WILLOW	2125 HIGHWAY 36 WATHENA, KS 66090

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S 000	INITIAL COMMENTS The following represents the findings of a resurvey with attached incident 193961 at the above named home plus facility conducted on 12/22/25-12/23/25.	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 12 residents with three included in the sample and one closed record review. Based on interview and record review the operator failed to complete a Functional Capacity Screen (FCS) for Resident (R) 3 every 365 days. Finding included: - Record review for R3 revealed an admission date of 11/20/24 with a diagnosis of dementia. The 11/20/24 admission FCS identified R3 required physical assistance with bathing,	S5085		

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

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S5085	Continued From page 1 dressing, transfers, toileting, walking/mobility and eating; was unable to perform management of medications and treatments; was occasionally incontinent; had short-term memory, long-term memory, memory/recall, and decision-making difficulties; was at risk of falls; and had impaired vision. The 11/20/24 Negotiated Service Agreement (NSA) identified facility staff would provide R3 maximum assistance with bathing, dressing, transfers, toileting, and walking/mobility. The facility managed medications and provided cues and reminders for cognition difficulties. R3's record lacked evidence of documentation of an FCS or NSA since admission which was 30 days late. On 12/23/25 at 10:21 AM Administrative Staff A confirmed R3's record lacked evidence of documentation of an FCS since admission. The operator failed to ensure an FCS was completed for R3 every 365 days.	S5085		
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	S5105		

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S5105	Continued From page 2 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) The facility reported a census of 12 residents with three included in the sample and one closed record review. Based on interview and record review the operator failed to ensure the Negotiated Service Agreement (NSA) for Residents (R)2 and R3 described the services they received, and the provider of the service based on their Functional Capacity Screens (FCS). Findings included: - Record review for R2 revealed an admission date of 09/29/25 with a diagnosis of neuropathy. The 09/27/25 FCS identified R2 required physical assistance with bathing and toileting; supervision with dressing, transfers, walking/mobility, and management of medications; had no cognitive or communication impairments; and was at risk of falls. The 09/27/25 NSA identified R2 would be provided three showers each week, minimal assistance with hygiene, and supervision with	S5105		

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S5105	Continued From page 3	S5105		

walker for transfers and mobility without identifying the provider of the services. The facility managed medications. The NSA failed to address prevention of falls.

The 09/27/25 Health Service Plan (HSP) instructed staff to provide R2 with minimal assistance for bathing and administration of medications. The HSP failed to instruct staff how to prevent R2 from falling.

- Record review for R3 revealed an admission date of 11/20/24 with a diagnosis of dementia.

The 11/19/24 FCS identified R3 required physical assistance with bathing, dressing, transfers, toileting, walking/mobility and eating; was unable to perform management of medications and treatments; was occasionally incontinent; had short-term memory, long-term memory, memory/recall, and decision-making difficulties; was usually understandable and understood during communication, at risk of falls, and had impaired vision.

The 11/20/24 NSA identified R3 would be provided maximum assistance with bathing, dressing, transfers, toileting, and walking/mobility without identifying the provider of the service. The facility managed medications and provided cues and reminders for cognition difficulties. The NSA failed to address transfer, eating, communication, fall prevention, and vision services.

The 11/20/24 HSP instructed staff to assist with feeding, bathing one time a week with hospice completing one time per week, dressing, mobility,

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S5105	Continued From page 4 and frequent checks for toileting. The HSP failed to instruct staff how to transfer, communicate, prevent falls, and assist R3 with her vision. On 12/23/25 at 12:07 PM Licensed Nurse C confirmed R2 and R3's NSAs failed to describe the services provided based on their FCS. The operator failed to ensure the NSA for R2 and R3 described the services they received, and the provider of the service based on their FCS.	S5105		
S5190 SS=F	26-42-206 (d) Dietary Services (d)(1) Menu plans shall be available to each resident on at least a weekly basis. This REQUIREMENT is not met as evidenced by: KAR 26-42-206(d)(1) The facility reported a census of 12 residents. Based on observation and interview the operator failed to ensure the menu was available to all residents on at least a weekly basis. Findings included: - Observation on 12/22/25 at 11:57 AM revealed a weekly menu was not posted for residents to access. On 12/22/25 at approximately 11:58 AM Administrative Staff A confirmed a weekly menu was not posted for the residents.	S5190		

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S5190	Continued From page 5 The operator failed to ensure a weekly menu was available to all residents.	S5190		
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 reported a census of 12 residents. The facility had a main kitchen where food was stored, prepared, and served to all residents. Based on observation and interview the operator failed to ensure foods were stored under safe conditions. Findings included: - Observation on 12/22/25 at 11:25 AM revealed a refrigerator in the facility's main kitchen which contained the following food items for the residents without opened dates. One 64 fluid ounce container of almond milk with label that read "fresh 7-10 days after opening." One seven-ounce package of colby and Monterey jack cheese	S5195		

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S5195	Continued From page 6 Observation on 12/22/25 at 11:57 AM revealed a refrigerator in the facility's food storage room which contained the following food items for the residents. One container peppermint mocha coffee creamer without date opened One can whipped topping with date opened of 11/12 On 12/22/25 at 11:58 AM Administrative Staff A confirmed her expectation is to use opened foods within three days or discard and the foods found were not dated or used within the expected time frame. The operator failed to ensure foods were stored under safe conditions.	S5195		
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.	S5230		

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S5230	Continued From page 7 This REQUIREMENT is not met as evidenced by: KAR 26-42-207(c) The facility reported a census of 12 residents with three residents included in the sample. 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 two of five newly hired staff and for Residents (R)1, R2, and R3. Findings included: - Record review for Certified Nurse Aide (CNA) G revealed a hire date of 10/15/24. A first step of the TB two-step test (TST) was administered 07/23/24 and read 08/26/24, which was prior to hire. A second step was documented as administered 08/13/25 and read 08/15/25. The second step failed to be administered within one to three weeks after the first. Record review for CNA H revealed a hire date of 01/28/25. The screening questionnaire was dated 06/06/25. The record failed to include a questionnaire from start of employment. Record review for CNA J revealed a hire date of 08/01/25. A first step of the TB two-step test (TST) was administered 08/13/25 and read 08/15/25. The record failed to include a second step. Review of R1's record revealed an admission date of 06/08/20 and with most recent TB	S5230		

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S5230	Continued From page 8 screening questionnaire completed 05/16/24. The record failed to include a current annual screening questionnaire. Review of R2's record revealed an admission date of 09/29/25. The record failed to include a screening questionnaire from admission. Review of R3's record revealed an admission date of 11/20/24 with the most recent TB screening questionnaire was completed on admission. The record failed to include a current annual screening questionnaire. On 12/22/25 at approximately 01:25 PM Administrative Staff A confirmed she did not have proof of completed TST for CNA G or CNA J or CNA H's screen on hire. On 12/23/25 at 10:21 AM Administrative Staff A confirmed R1, R2, and R3's records lacked required screening questionnaires. The department's June 2013 "Tuberculosis (TB) Guideline for Adult Care Homes" documented each new employee shall receive a two-step TST or Interferon Gamma Release Assay within seven days of employment unless completed TST documentation is provided from within six months prior to hire. Each resident and employee should have a TB symptom screen completed on hire, admission, and annually. 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, which had the potential to affect all residents.	S5230		

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S5251 SS=D	26-42-105 (f) (11) Resident Records Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action. This REQUIREMENT is not met as evidenced by: KAR 26-42-105(f)(11) The facility reported a census of 12 residents with three residents included in the sample and one closed record review. Based on interview and record review the operator failed to ensure staff provided adequate documentation of symptoms which indicated illness or injury including dates, times, action taken, and results of the actions when Resident (R) 1 received new orders for treating illnesses and was hospitalized. Findings included: - Record review for R1 revealed an admission date of 06/08/20 with a diagnosis of neuropathy. The 03/07/25 Functional Capacity Screen (FCS) identified R1 required physical assistance with bathing, dressing, toileting, transfers, and walking/mobility; was unable to perform management of medications; was usually continent of bladder, had no cognitive or communication impairments; and had impaired hearing.	S5251		

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S5251	Continued From page 10 The 03/07/25 Negotiated Service Agreement (NSA) identified facility would provide R1 two-person assistance with toileting, transfers, and walking/mobility; a nurse would provide management of medications; and R1 would be provided assistance getting dressed without who provided the service. The NSA listed a nurse responsible for monitoring vital signs, weight, and reviewing/reporting changes in function or condition. The 03/07/25 Health Service Plan (HSP) instructed staff to provide R1 with physical assistance of one person for bathing and dressing, two-person assistance with mobility, physical assist to bathroom and change brief for toileting, and administration of medications. The 11/18/24 entry for "Nurses Notes" documented R1 returned from hospital. The 11/07/24 entry for "Nurses Notes" was most recent prior and documented R1 received a shot in her deltoid. R1's record lacked documentation of symptoms of illness or injury requiring hospitalization. The 03/17/25 and 04/11/25 "Nurses Notes" documented new orders were received for R1 to start Nystatin swish and swallow without listing symptoms of illness. The notes following failed to include result of the actions. The 04/28/25 "Nurses Notes" documented new orders for increased Lasix (diuretic) dose and to start Keflex (antibiotic) without describing symptoms of illness or result of the action.	S5251		

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S5251	Continued From page 11 The 05/06/25 "Nurses Notes" documented a new order for doxycycline without indication of illness. The 05/27/25 "Nurses Notes" documented a urinalysis was sent for culture and sensitivity with new order for an antibiotic without listing R1's symptoms. On 12/23/25 at approximately 12:11 PM Licensed Nurse C stated R1 has intermittent edema, urinary tract infections, and thrush and confirmed lack of documentation in R1's record regarding symptoms of illnesses and results of the actions. The operator failed to ensure staff provided adequate documentation of symptoms which indicated illness or injury including dates, times, action taken, and results of the actions for R1.	S5251		
S5313 SS=F	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	S5313		

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S5313	Continued From page 12 by: KAR 26-42-205(g)(3) The facility reported a census of 12 residents. Based on observation and interview the operator failed to ensure a licensed pharmacist or licensed nurse placed the full names of the residents on the original packages of nine over-the-counter (OTC) medications. Findings included: - Observation on 12/22/25 at 11:25 AM revealed Certified Medication Aide D unlocked and opened the medication cabinet where the medications for the residents were stored. The following over-the-counter medications were not labeled with residents' full names: One bottle 100 softgels magnesium 400 milligram (mg) One bottle 510 grams polyethlene glycol 3350 One bottle 84 capsules probiotic supplement One bottle 300 tablets melatonin 10 mg One bottle 150 tablets fexofenadine hydrochloride 180 mg One bottle 400 softgels vitamin d supplement One card guaifenesin 600mg One bottle 120 tablets docusate sodium 100mg and sennosides 8.6mg One bottle 100 tablets vitamin c 1000mg On 12/22/25 at approximately 11:50 AM Administrative Staff A confirmed the OTC medications were not labeled with residents' full names. The operator failed to ensure all OTC	S5313		

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S5313	Continued From page 13 medications were labeled with the residents' full names.	S5313		
S5315 SS=F	26-42-205 (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 home in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the home in separately locked compartments within a locked 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 home. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration.	S5315		

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S5315	Continued From page 14 This REQUIREMENT is not met as evidenced by: KAR 26-42-205(h) The facility reported a census of 12 residents. Based on observation and interview the operator failed to ensure that all medications and biologicals are stored in accordance with manufacturer and pharmacy recommendations or federal and state laws and regulations. Further, the operator failed to ensure non-controlled medications were in a locked medication room, cabinet, or cart. Findings included: - Observation on 12/22/25 at 11:01 AM revealed an unlockable cabinet in the public bathroom to the right of the sink containing one 30-gram bottle of nystatin powder and one three ounce bottle of miconazole nitrate 2%. On 12/22/25 at approximately 11:09 AM Administrative Staff A confirmed the medications were not in a locked cabinet. - Observation on 12/22/25 at 11:03 AM revealed an unlockable cabinet in the kitchen containing a latch tote with the following medications: One box of four caplets loperamide 2 milligram (mg) One bottle 0.3 fluid ounce GenTeal Tears One zippered bag labeled "stock" with 18 bisacodyl suppositories 10mg One tablet diphenhydramine 50 mg	S5315		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5315	Continued From page 15 One card severe cold and flu daytime 12 tablets Two tablets of ondansetron 4 mg One envelope with two unidentified white tablets inside One bottle 365 tablets aspirin 81 mg On 12/22/25 at approximately 11:09 AM Administrative Staff A confirmed the medications were not in a locked cabinet. - Observation on 12/22/25 at 11:25 AM revealed a locked cabinet in the medication room containing all resident medications. The following medications were found: One bottle 100 gelcaps acetaminophen 500 mg exp 05/25 One bottle 150 tablets iron 65 mg expired 12/25 One bottle "Stimulant lax plus 50/8.6" expired 8/30/25 One bottle eight fluid ounces Nyquil cold and flu expired 09/25 One bottle of four tablets Ondansetron 4 mg expired 2/25 On 12/22/25 at approximately 11:54 AM Administrative Staff A confirmed the medications were expired. The operator failed to ensure that all medications and biologicals are stored in accordance with manufacturer and pharmacy recommendations or federal and state laws and regulations.	S5315		
S5325 SS=F	26-42-205 (l) Medication Regimen Review Frequency (l) Medication regimen review. A licensed	S5325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B022002	A. BUILDING: _____ B. WING _____	12/23/2025

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S5325	Continued From page 16 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 12 residents with three included in the sample and one closed record review. Based on interview and record review the operator failed to ensure quarterly medication regimen reviews were conducted for all residents. Findings included: - Review of R1, R2, and R3's records revealed lack of documentation of quarterly medication reviews since last survey. On 12/22/25 at 02:55 PM Administrative Staff A stated her expectation was for Administrative Nurse B to have completed medication reviews quarterly and complete follow up as necessary and confirmed they had not been completed. The operator failed to ensure quarterly medication regimen reviews were conducted for all residents.	S5325		

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S5335	Continued From page 17	S5335		
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: KAR 28-39-437(a) The facility reported a census of 12 residents. 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 a locked area. Findings included: - Observation on 12/22/25 at 10:52 AM revealed a table outside resident rooms in the southwest corner of facility with an 85-wipe container of disinfectant wipes and a 160 towelette container of CaviWipes with labels that read "Keep out of reach of children:" On 12/22/25 at approximately 11:23 AM Administrative Staff A confirmed chemicals were not in a locked area. - Observation on 12/22/25 at 10:58 AM of R3's	S5335		

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S5335	Continued From page 18	S5335		

room revealed a 185-milliliter spray bottle of air mist labeled "Keep out of reach of children" was located on her dresser.

- Observation on 12/22/25 at 11:01 AM of the public bathroom revealed two 32 fluid ounce bottles of hydrogen peroxide in an unlocked cabinet next to the sink and two 85-wipe containers of disinfectant wipes on the wire rack above the toilet which had labels that read "Keep out of reach of children:"

- Observation on 12/22/25 at 11:10 AM of the laundry room revealed the door was open. Inside were unsecured cabinets which contained the following chemicals with labels that read "Keep out of reach of children".

The cabinet below the sink was unlockable and contained:

One 32 fluid ounce bottle hydrogen peroxide
One gallon container professional floor cleaner
One bottle 180 fluid ounce Clorox multi-surface cleaner with bleach

The cabinet directly to the right had a broken safety lock and contained:

One container 120 pacs of laundry detergent
One spray bottle 33 fluid ounce of wrinkle releaser
One 22-ounce aerosol can of foaming carpet cleaner
One 20-ounce aerosol can of spray starch
One 240 wipe disinfectant/cleaner wipes
One 5 tablet box of washing machine cleaner
One 32-ounce spray bottle of simple green

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S5335	Continued From page 19 solution The lower cabinet to the right of the salon sink contained: One 32 fluid ounce volume crème developer One 33.8 fluid ounce pro-oxide cream developer One 16 fluid ounce volume clear developer On 12/22/25 at approximately 11:23 AM Administrative Staff A confirmed chemicals were not in a locked area. 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 a locked area.	S5335		