STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089034	A. BUILDING: _____ B. WING _____	02/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEGGY KELLY HOUSE II	1800 FAIRMONT ROAD TOPEKA, KS 66604

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey with a complaint (#163466) at the above named residential healthcare facility conducted on 02/14/23.	S 000		
S3081 SS=D	26-41-201 (c) Functional Capacity Screen Reassessment (c) Designated facility staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: KAR 26-41-201 (c) (1) (2) The census equaled 8 residents. The sample included 3 residents. Based on observation, record review and interview for 1 of 3 sampled resident (R)2, Operator/Certified Medication Aide (CMA) A failed to ensure designated facility staff conducted a screening following any significant change in condition as defined in K.A.R. 26-39-100. Findings included: - Review of R2's "Medical Record" revealed she admitted to the facility on 11/16/22 with	S3081		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089034	A. BUILDING: _____ B. WING _____	02/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEGGY KELLY HOUSE II	1800 FAIRMONT ROAD TOPEKA, KS 66604

(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
S3081	Continued From page 1	S3081		

diagnoses of Alzheimer's Disease, hypertension, insomnia, hallucinations, aphasia, depression, Pick's Disease, anxiety disorder and Tourette's Disease.

R2's "Functional Capacity Screen (FCS)/ Negotiated Service Agreement (NSA)" dated 11/16/22 recorded resident as independent with dressing, toileting, transfer, walk/mobility and eating, supervision required for bathing and physical assistance required for management of medications and treatments. The FCS/NSA recorded R2 was continent, had difficulty with long-term memory and memory/recall and was understandable/understood. R2 had impaired vision, was socially inappropriate and had impaired decision-making skills.

R2's "Care Plan" dated 11/16/22 recorded the following: staff to wash, rinse and dry the areas R2 unable to reach, staff to report any changes/ concerns with dressing to the nurse, independent with toileting, bed cane used for mobility and safety, diet as ordered and reminders for meals, staff to order, prepare, reorder and give medications, staff to allow time for resident to respond when communicating and remove resident from situations when increased agitation is noted.

Signed physician orders dated 11/28/22 recorded Hospice to evaluate.

R2's FCS lacked a screening upon significant change in status.

Observation on 02/14/23 at 12:13 PM in living room of facility revealed R2 sitting on a recliner.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089034	A. BUILDING: _____ B. WING _____	02/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEGGY KELLY HOUSE II	1800 FAIRMONT ROAD TOPEKA, KS 66604

(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
S3081	Continued From page 2 Certified Nurse Aide (CNA) C pivot transferred R2 from recliner to wheelchair for lunch. Interview on 02/14/23 at 11:20 AM with CNA C stated R2 required physical assistance with bathing, dressing and pivot transfer. CNA C stated R2 no longer ambulated, used a wheelchair for mobility and was incontinent of bowel and bladder. R2 was unable to converse with others and had impaired cognition. Interview on 02/14/23 at 12:22 PM with Licensed Nurse (LN) B confirmed R2's current FCS completed upon admission did not reflect her current status for bathing, dressing, toileting, transfer, walk/mobility and eating and further confirmed the FCS should have been updated. LN B confirmed R2 required increased cares after admission to facility, which is reason Hospice was added. Operator/CMA A failed to ensure designated facility staff conduct a screening following any significant change in condition as defined in K.A.R. 26-39-100.	S3081		
S3092 SS=D	26-41-202 (d) Negotiated Service Agreement Revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements:(1) At least once every 365 days; (2) following any significant change in condition, as defined in K.A.R. 26-39-100; (3) at least quarterly, if the resident receives assistance with eating from a paid nutrition	S3092		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089034	A. BUILDING: _____ B. WING _____	02/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEGGY KELLY HOUSE II	1800 FAIRMONT ROAD TOPEKA, KS 66604

(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
S3092	Continued From page 3	S3092		

assistant; and
(4) if requested by the resident or the resident ' s legal representative, facility staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family.

This REQUIREMENT is not met as evidenced by:
KAR 26-41-202 (d) (2)

The census equaled 8 residents. The sample included 3 residents. Based on record review and interview for 1 of 1 sampled resident (R)2, Operator/Certified Medication Aide (CMA) A failed to ensure the review, and if necessary, revision of the negotiated service agreement following any significant change in condition, as defined in K.A.R. 26-39-100.

Findings included:

- Review of R2's "Medical Record" revealed she admitted to the facility on 11/16/22 with diagnoses of Alzheimer's Disease, hypertension, insomnia, hallucinations, aphasia, depression, Pick's Disease, anxiety disorder and Tourette's Disease.

R2's "Functional Capacity Screen (FCS)/ Negotiated Service Agreement (NSA)" dated 11/16/22 recorded resident as independent with dressing, toileting, transfer, walk/mobility and eating, supervision required for bathing and physical assistance required for management of medications and treatments. The FCS/NSA recorded R2 was continent, had difficulty with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089034	A. BUILDING: _____ B. WING _____	02/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEGGY KELLY HOUSE II	1800 FAIRMONT ROAD TOPEKA, KS 66604

(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
S3092	Continued From page 4	S3092		

long-term memory and memory/recall and was understandable/understood. R2 had impaired vision, was socially inappropriate and had impaired decision-making skills.

R2's "Care Plan" dated 11/16/22 recorded the following: staff to wash, rinse and dry the areas R2 unable to reach, staff to report any changes/ concerns with dressing to the nurse, independent with toileting, bed cane used for mobility and safety, diet as ordered and reminders for meals, staff to order, prepare, reorder and give medications, staff to allow time for resident to respond when communicating and remove resident from situations when increased agitation is noted.

Signed physician orders dated 11/28/22 recorded Hospice to evaluate.

R2's FCS lacked a screening upon significant change in status.

Observation on 02/14/23 at 12:13 PM in living room of facility revealed R2 sitting on a recliner. Certified Nurse Aide (CNA) C pivot transferred R2 from recliner to wheelchair for lunch.

Interview on 02/14/23 at 11:20 AM with CNA C stated R2 required physical assistance with bathing, dressing and pivot transfer. CNA C stated R2 no longer ambulated, used a wheelchair for mobility and was incontinent of bowel and bladder. R2 was unable to converse with others and had impaired cognition.

Interview on 02/14/23 at 12:22 PM with Licensed Nurse (LN) B confirmed R2's current FCS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089034	A. BUILDING: _____ B. WING _____	02/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEGGY KELLY HOUSE II	1800 FAIRMONT ROAD TOPEKA, KS 66604

(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
S3092	Continued From page 5 completed upon admission did not reflect her current status for bathing, dressing, toileting, transfer, walk/mobility and eating and further confirmed the FCS should have been updated. LN B confirmed R2 required increased cares after admission to facility, which is reason Hospice was added. Operator/CMA A failed to ensure the review, and if necessary, revision of the negotiated service agreement following any significant change in condition, as defined in K.A.R. 26-39-100.	S3092		