STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089030	A. BUILDING: _____ B. WING _____	04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CELEBRATION VILLA OF HEARTHSTONE WEST	3515 SW 6TH AVENUE TOPEKA, KS 66606

(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 Re-Licensure Survey with Complaint Investigations 177269, 177842, 185878, and 186025 for the above named Assisted Living Facility conducted on 04/15/24 and 04/16/24.	S 000		
S3026 SS=D	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)(A) The facility reported a census of 36 residents (R). The sample include three residents and one focused record review. Based on observation, interview, and record review, the administrator failed to ensure one (R6) of one focused resident review was not subjected to abuse when an active employee, "Certified Nurse Aide" (CNA) G, put R6's call pendent on the dresser, out of reach and told her to get up and get a drink herself. Findings included:	S3026		

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

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S3026	Continued From page 1 - Review of R6's medical record revealed she moved into the facility on 08/13/22 with diagnoses of anxiety, major depressive disorder, and insomnia. R6's "Functional Capacity Screen" dated 01/11/24 revealed she needed physical assistance with bathing and was independent with other activities of daily living except for needing physical assistance with management of medications and medical treatments. It also identified she was at risk for falls. Cognition was coded a 1 for issues with memory recall. R6's "Negotiated Service Agreement" dated 01/11/24directed caregivers to provide set up assistance with bathing, and that she was independent in other activities of daily living including transfers and mobility. R6's Brief Interview for Mental Status dated 01/11/24 had a score of 14 indicating the resident was cognitively intact. Review of Certified Medication Aide (CMA) F's notarized witness statement dated 02/20/24 revealed CNA G told her she had gotten into it with R6 because the resident asked for some juice. CNA G told CMA F that she took R6's call light away from her and put it on her dresser. CMA F's statement included R6 telling her that CNA G took her watch pendent and she did not know where it was. CMA F noted it was on F6's dresser when she gave her medications. Review of CNA H's notarized statement dated 02/20/24 revealed she had seen CMA G be verbally abusive to residents and knew she	S3026		

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S3026	Continued From page 2	S3026		

refused to help them if they could walk or usually get things themselves. CMA G documented she had heard CMA G tell residents "I am not your servant" and to get it yourself or tell them it was not her job to do it.

Review of CMA I's notarized statement dated 02/20/24 revealed R6 wanted cranberry juice and CMA G told her she was not her servant and to get out of bed and go get it herself.

On 04/16/24 at 03:45 PM surveyor spoke with R6 and she said she felt safe in the facility now and thought she had problems with staff in the past. R6 was unable to provide any specifics about a time when she had a problem with staff being mean to her.

Review of the facility report revealed on 02/20/24 Administrative Staff A interviewed R6 and she said "The one with the long hair at night" had treated her disrespectfully. R6 then proceeded to explain that she had asked CMA G to get her a drink and CMA G told her she could get up and get it herself since she does it during the day. R6 said CMA G is just "mean and hateful". Administrative Staff A asked R6 if anyone had ever taken her call pendant away and R6 confirmed that CMA G had. R6 also told Administrative Staff A that she did not feel safe when CMA G was working. The report concluded that CMA G was disrespectful when she told R6 to get her own glass of juice and concluded that CMA G also put R6's call pendent on her dresser.

Surveyor requested a policy for Abuse, Neglect, and Exploitation on 04/17/24 at 11:59 AM and as

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S3026	Continued From page 3 of 11/17/24 at 09:36 PM had not received the requested policy. The Executive Director failed to ensure R6 was not subjected to abuse when CMA G told R6 she was not her servant and told her to get up out of bed and get her own drink and then put her call pendent out of reach so she could not call for assistance if needed.	S3026		
S3028 SS=F	26-41-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the facility as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or	S3028		

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S3028	Continued From page 4 exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(3) The facility reported a census of 38 residents(R). The sample included three residents, and one focused record review. Based on interview, and record review of notarized employee statement, the facility staff failed to report allegations of abuse and neglect to the administrator of the facility as soon as staff were aware of the allegation. This failure had the potential to affect all residents who were to receive services provided by Certified Medication Aide G. Findings included: - Review of self-reported complaint 186025 revealed on 02/20/24 R6 reported to staff that CMA G was disrespectful to her and would not get her a drink, told her to get it herself, and then took her call pendent and put it on her dresser, out of R6's reach. Review of R6's medical record revealed she moved into the facility on 08/13/22 with diagnoses of anxiety, major depressive disorder, and insomnia. Review of Certified Medication Aide (CMA) F's notarized witness statement dated 02/20/24 revealed CNA G told her she had gotten into it	S3028		

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S3028	Continued From page 5	S3028		

with R6 because the resident asked for some juice. CNA G told CMA F that she took R6's call light away from her and put it on her dresser. CMA F's statement included R6 telling her that CNA G took her watch pendent, and she did not know where it was. CMA F noted it was on R6's dresser when she gave her medications. CMA F then informed Administrative Staff A what R6 had reported.

Review of CNA H's notarized statement dated 02/20/24 revealed she had seen CMA G be verbally abusive to residents and knew she refused to help them if they could walk or usually get things themselves. CNA H noted she had also heard CMA G tell residents "I am not your servant" and to get it yourself or tell them it was not her job to do it. Based on CNA H's notarized statement, she had observed and heard CMA G be verbally abusive/rude to other residents in the facility prior to 02/20/24.

Review of CMA I's notarized statement dated 02/20/24 revealed R6 wanted cranberry juice and CMA G told her she was not her servant and to get out of bed and go get it herself. CMA I also documented "I have heard her verbally abuse residents", indicating she had heard CMA G verbally abuse residents prior to 02/20/24.

Review of CMA J's notarized statement dated 02//20/24 revealed she had heard CMA G talk really bad to residents and tells them their family's do not want them in their homes. Based on CMA J's statement she had concerns about how CMA G treated and spoke to residents prior to 02/20/24.

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S3028	Continued From page 6 Based on three of the four facility staff notarized statements, all dated 02/20/24 revealed they had heard CMA G or observed CMA G talked inappropriately and/or treat residents inappropriately and failed to report their concerns to the administrator as soon as they were aware of it. Surveyor requested a policy for Abuse, Neglect, and Exploitation on 04/17/24 at 11:59 AM and as of 11/17/24 at 09:36 PM had not received the requested policy. The Executive Director failed to ensure facility employees understood possible signs of abuse and neglect and understood they are mandatory reporters and need to follow the guidelines of reporting concerns to the administrator as soon as they are aware of it.	S3028		
S3082 SS=E	26-41-201 (d) Functional Capacity Screen Accurate d) Designated facility 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: K.A.R 26-41-201 (d) The facility reported a census of 38 residents(R). The sample included three residents and one focused record review. Based on interview and record review, the executive director failed to ensure designated staff completed two (R3 and	S3082		

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S3082	Continued From page 7 R5) of three sampled residents "Functional Capacity Screen" accurately to reflect their functional ability and need for health care services. Findings included: - R3's medical record revealed he moved into the facility on 06/28/21 with diagnosis of Parkinson's disease. R3's "Functional Capacity Screen" (FCS)Dated 12/11/23 identified the resident as unable to participate in walking/mobility and did not identify the resident at risk for falls. R3's "Negotiated Service Plan" (NSA) dated 12/11/23 directed staff to escort the resident to and from activities and the dining room. Staff to provide two-person assistance with most all transfers using the gait belt and two person assist with bed mobility. It also identified the resident as at risk for falls related to needed two-person assistance with all transfers. The NSA noted the resident had further decline in activities and mobility. Review of R3's nursing progress notes revealed the following: 05/19/23 - R3 had an unwitnessed fall and was found by staff on the bathroom floor. 10/16/23 - R3 had an unwitnessed fall and was found by staff on the floor in her bathroom. Observation on 04/15/24 at 04:10 PM Certified Nurse Aide (CNA) C and CNA D went into R3's room , raised her recliner, put her slippers on, put gait belt around R3 and then put her	S3082		

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S3082	Continued From page 8	S3082		

4-wheeled walker in front of her. Staff held onto the gait belt from each side and assisted R3 to stand up. R3 was very stiff and leaned backwards while she stood. Staff cued R3 to take some steps and not to sit down yet but as she took a couple little steps and staff tried to turn her R3 started to sit and staff then positioned the wheelchair under her. CNA C and CNA D pushed R3 into the bathroom and R3 held onto the grab bar, pulled herself up, and staff then proceeded to help her with toileting.

Interview on 04/15/24 at 03:30 PM CNA D reported R3 used a wheelchair for going to and from meals and activities. R3 also has a walker and only uses it when transferring to help with balance. She needs a lot of help to stand up, so two people transfer her using a gait belt because she will lean backwards and could fall.

On 04/16/24 at 02:05 PM Administrative Licensed Nurse B reported she misunderstood the coding for mobility and since she no longer walked, she coded it a "3". Administrative Licensed Nurse B also acknowledged R3 was at risk for falls, and it should have been coded accordingly.

The executive director failed to ensure designated staff coded R3's FCS correctly to identify her risk for falls and need for physical assistance with mobility.

- R5's medical record revealed she moved into the facility on 03/26/21 with diagnoses of osteoporosis, anxiety disorder and insomnia.

R5's "Functional Capacity Screen" dated

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S3082	Continued From page 9 03/30/24 coded R5 a "3" for walk/mobility which indicates R3 is unable to participate in walking/mobility. R5's "Negotiated Service Agreement" dated 03/30/24 indicated the resident was at risk for falls and used a walker, two staff assistance for all transfers and a wheelchair for mobility. Observation on 04/15/23 at 04:23 PM CNA C and CNA D went into R5's room and she sat in her recliner. CNA's C and D set her walker in front of her and the wheelchair beside her and with one on each side of her assisted her to stand up holding onto her arms. Staff then cued R5 to move her feet and turn to sit in her wheelchair. Staff then pushed R5 in her wheelchair down to the dining room. On 04/16/24 at 10:00 AM Certified Medication Aide E reported R5 is a two person assist with transfers and is on Hospice services. She has a walker she uses for transfers and a wheelchair she uses for going to meals and activities. On 04/16/24 at 02:05 PM Administrative Licensed Nurse B reported she misunderstood the coding for mobility and since she no longer "walked" she coded it a "3". The executive director failed to ensure designated staff completed R5's FCS accurately related to mobility.	S3082		
S3092 SS=E	26-41-202 (d) Negotiated Service Agreement Revisions (d) Each administrator or operator shall ensure	S3092		

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S3092	Continued From page 10 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, 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 facility reported a census of 38 residents (R). The sample included three residents and one focused record review. Based on interview and record review the administrator failed to ensure designated staff reviewed and revised the "Negotiated Service Agreement" if necessary, for two (R3 and R5) of three sampled residents when the resident experienced a significant change in status related to the starting and stopping of services provided by outside resources. Findings included: - R3's medical record revealed she moved into the facility on 06/28/21 with diagnosis of Parkinson's disease.	S3092		

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S3092	Continued From page 11 R3's "Functional Capacity Screen" (FCS)Dated 12/11/23 identified the resident needed physical assistance with bathing, dressing, toileting, transfers and did not participate in walking/mobility. R3's "Negotiated Service Plan" (NSA) dated 12/11/23 directed staff and hospice to provide moderate assistance with bathing and dressing, needs full assistance with toileting and two staff to provide assistance with transfers. Staff also needed to escort the resident to and from activities and the dining room. R3's record included one amended NSA dated 09/14/23 for the discontinuations of therapy services. An interview on 04/16/23 at 01:18 PM with local Home Health (HH) agency staff reported R3 received physical therapy from 06.23 to 08/16/23, occupational therapy from 06/23 to 09/12/23, and skilled nursing services from 08/23 to 09/12/23. Review of R3's medical record lacked revisions of her NSA to identify the start and stopping of skilled nursing, and therapy services she received from an outside resource. On 04/16/24 at 01:48 PM Administrative Licensed Nurse B reported an addendum needed to be completed when a resident started and stopped therapy services and acknowledged a revision to the NSA for the changes in therapy services had not been completed. The executive director failed to ensure	S3092		

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S3092	Continued From page 12	S3092		

designated staff reviewed and revised R3's NSA when she had changes in the services provided by outside resources.

- R5's medical record revealed she moved into the facility on 03/26/21 with diagnoses of osteoporosis, anxiety disorder and insomnia.

R5's "Functional Capacity Screen" dated 03/30/24 revealed R5 needed physical assistance with bathing, dressing, toileting, transfers, and was not able to participate in walking/mobility. It a lso identified she had impaired cognition.

R5's "Negotiated Service Agreement" (NSA) dated 03/30/24revealed R5 directed staff to provide moderate assist with dressing, toileting, transfers and bathing with Hospice providing bathing 1x per week. It also directed staff to use two staff with transfers and a wheelchair for mobility.

Review of R5's paper and electronic medical record lacked review and revision of R5's NSA when she started and stopped physical, occupation, and speech therapy services with an outside resource.

An interview on 04/16/24 at 01:25 PM with local Home Health agency staff revealed R5 received occupational services from 09/25/23 to 03/13/24, physical therapy services from 09/25/23 to 01/08/24, and speech therapy services from 02/19/24 to 03/26/24.

On 04/16/23 at 02:16 PM Administrative Nurse B reported an addendum was to be completed

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S3092	Continued From page 13 when a resident started and stopped therapy services. She looked in R5's record and confirmed there was not an addendum completed to revise the NSA for when R5 started physical, occupational, and speech therapy services or when she discontinued the services. The executive director failed to ensure designated staff reviewed and revised R5's NSA to indicate changes in services provided by outside resources.	S3092		
S3175 SS=D	26-41-205 (a) (1) Self Administration of Medication (a) Self-administration of medication. Any resident may self-administer and manage medications independently or by using a medication container or syringe prefilled by a licensed nurse or pharmacist or by a family member or friend providing this service gratuitously, if a licensed nurse has performed an assessment and determined that the resident can perform this function safely and accurately without staff assistance. (1) An assessment shall be completed before the resident initially begins self-administration of medication, if the resident experiences a significant change of condition, and annually. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(a)(1)	S3175		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089030	A. BUILDING: _____ B. WING _____	04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CELEBRATION VILLA OF HEARTHSTONE WEST	3515 SW 6TH AVENUE TOPEKA, KS 66606

(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
S3175	Continued From page 14 The facility reported a census of 38 residents (R). The sample included three residents and one focused record review. Based on interview and record review the executive director failed to ensure a licensed nurse completed an assessment for self-administrations of medications for one (R4) of one sampled residents prior to her administering her own medications. Findings included: -- Review of R4's "Electronic Medical Record" (EMR) revealed she moved into the facility on 03/01/23 with diagnoses of pain in rigt knee and congestive heart failure. R4's "Functional Capacity Screen" dated 03/01/23 and 12/19/23 revealed the resident needed physical assistance with management of her medications. R4's "Negotiated Service Agreement" (NSA) dated 03/01/23 identified she was independent with management of her medications. Her NSA dated 12/19/23 identified the resident was independent with family support to set up a pill box for the residents to take medications from. R4's EMR include "Self-Administration of Medications" assessments completed on 05/15/23, 09/25/23, 12/19/23 and 03/18/24. The EMR and the paper chart lacked evidence that staff completed a "Self-Administration of Medication assessment prior to 03/01/23 when she initially started administering her own medications.	S3175		

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S3175	Continued From page 15 On 04/16/24 at 11:13 PM Administrative Licensed Nurse B reported a self-medication assessment needed to be completed on admission, with changes in condition, and annually. She checked R4's record and confirmed staff had not completed an initial self-administration of medication assessment for R4 prior to her administering her own medications. The executive director failed to ensure a licensed nurse completed a self-administration assessment for R4 prior to self-administering her medications.	S3175		
S3280 SS=F	26-41-104 (d) Disaster and Emergency Preparedness (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 facility ' s emergency management plan; (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' 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.	S3280		

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S3280	Continued From page 16 This REQUIREMENT is not met as evidenced by: KAR 26-41-104(d)(3) The facility reported a census of thirty-eight residents. Based on record review and interview for all residents and all employees, the executive director failed to ensure disaster and emergency preparedness by ensuring performance of quarterly reviews of the facility's emergency management plan with all residents and employees. Findings included: - On 04/15/24 at 09:50 AM Maintenance Staff C provided information or reviewing the emergency management plan with residents and facility employees. He acknowledged that there were some missing records, and he would continue to look for them and provide when found. Review of the records provided revealed the emergency management plan was reviewed with facility employees on 01/06/23, 04/07/23, 02/02/24, and 04/05/24. The records lacked evidence of reviewing the emergency management plan with employees the third and fourth quarters of 2023. Review of the records for reviewing the emergency management plan only included a review conducted on 09/28/23. On 04/15/24 at 10:00 AM Maintenance Staff C reported they review the eight potential emergency's when they do their fire drills, but he did not have anything in writing to show it had	S3280		

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S3280	Continued From page 17 been reviewed. As of 04/17/24 at 12:08 PM the facility had not provided any additional reviews of the emergency management plan for review. The executive director failed to ensure the facility's emergency management plan which included all eight required possible emergencies was reviewed with all residents and employees quarterly.	S3280		
S9999	Final Observations Kansas Statute 39-981. Authorized electronic monitoring; reasonable accommodations; notice; consent; use as evidence; prohibitions. (d) A resident, or such resident's guardian or legal representative, who wishes to conduct authorized electronic monitoring shall notify the adult care home on a form prescribed by the secretary for aging and disability services. (i) Each adult care home shall post a conspicuous notice at the entrance to the adult care home and each resident's room stating that the rooms of some residents may be monitored electronically by or on behalf of the room's resident or residents. This Requirement is not met as evidenced by: Scope and Severity of D. The facility reported a census of thirty-eight residents(R). The sample included three residents and one focused record review. Based	S9999		

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S9999	Continued From page 18 on record review, and interview, the executive director failed to ensure R3'slegal representative completed the required paperwork as prescribed by the secretary for aging and disability services for Authorized Electronic Monitoring R3's room. Findings included: - During initial tour on 04/15/24 from 08:45 AM to 09:45 AM observations revealed postings on each resident room and the front entrance door that some residents rooms may be electronically monitored on behalf of the resident. During the initial entrance conference with Administrative Staff A she reported there was one resident who had authorized electronic monitoring in her room, R3. Observation on 05/15/24 at 02:06 PM R3 sat in her recliner. On the dresser across from her recliner is an electronic monitoring device on top of the dresser. On 04/16/24 at 10:19 AM Administrative Staff A reported she did not have any signed documentation for R3 to have the AEM in her room and acknowledged there were two different forms that her legal representative needed to sign. The Executive Director failed to ensure all the required forms related to Authorized Electronic Monitoring were completed and in the resident's record.	S9999		