STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089069	A. BUILDING: _____ B. WING _____	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARHURST OF TOPEKA	6732 SW 17TH STREET TOPEKA, KS 66615

(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 188631, 191173, 193433, 193760 for the above named Assisted Living Facility conducted on 06/16/25, 06/17/25, 06/18/25, and 06/23/25.	S 000		
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 80 residents(R). The sample included six residents and three closed record reviews. Based on observation, record review and interview the executive director failed to ensure designated facility staff completed two (R6, R7) of six sampled residents "Functional Capacity Screen" accurately to reflect their functional ability and need for assistance. Findings included: - R6's medical record revealed she moved into the facility on 04/03/23 with diagnoses of Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces,	S3082		

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

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S3082	Continued From page 1	S3082		

shuffling gait, muscle rigidity and weakness) and Spinal Stenosis (degenerative condition of the spine that could cause weakness and loss of use of extremities).

R6's "Functional Capacity Screen" (FCS) dated 05/05/25 identified R6 was unable to participate in ability to transfer or walking/mobility. It also failed to identify she had a current problem/risk for falls/unsteadiness.

R6's "Negotiated Service Agreement" 05/05/25 directed staff to bring R6's walker to her to use during transfers. It also included assistive devices of a walker and wheelchair. It identified R6 was a high risk for falls and staff should not leave her alone while on the toilet as she had a history of falls. She needed stand-by assistance for fall prevention while on the toilet and hands-on assistance with transfers. R6 may require assistance of one or sometimes two staff and is able to verbalize how much assistance she will need.

Interview on 06/17/25 at 04:02 PM R6 reported staff will take her to the bathroom and sometimes on person can do it and other times it takes two people. R6 said she did not go to the dining room for meals very often because she did not like to be around that many people.

Interview on 06/17/25 at 04:39 PM Certified Medication Aide (CMA) E reported R6 transfers from her recliner to wheelchair to toilet with assistance of 1-2 staff, depending on the day.

Interview on 06/23/25 at 12:25 PM Administrative Nurse B reported R6 could walk with a walker at

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times, pivot transfers when getting out of recliner, or wheelchair. Administrative Nurse B reviewed R6's FCS and confirmed transfers, walking/mobility should have been coded a "2" and should have marked "fall/unsteadiness" because she is at risk for falls.

The executive director failed to ensure designated staff completed R6's FCS accurately related to her functional ability with transfers, walking/mobility and her risk for falls.

- R7's medical record revealed he moved into the facility on 02/10/25 with diagnoses of Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness) and Alzheimer's diseases (progressive mental deterioration characterized by confusion and memory failure).

R7's "Functional Capacity Screen" dated 03/12/25 identified he was independent with management of his medications and medical treatments.

R7's "Negotiated Service Agreement" dated 03/12/25 identified R6's wife would be managing and administering his medications and medical treatments.

Interview on 06/17/25 at 04:31 PM Certified Medication Aide E reported R6's wife helps him with all his medications.

Interview on 06/18/25 at 07:49 AM Administrative Nurse B confirmed R6's wife administered his

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S3082	Continued From page 3 medications and treatments so staff should have coded the FCS a "2" for needing physical assistance with management of medications and medical treatments. Review of the undated "Resident Functional Capacity Screening and Negotiated Service Agreement Policy and Procedures" revealed facility staff sahll ensure that each resident's Functional Capacity Screen is accurate at the time completed. The Executive director failed to ensure designated staff completed R6's FCS accurately related to management of his medications and medical treatments.	S3082		
S3085 SS=E	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service.	S3085		

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S3085	Continued From page 4 This REQUIREMENT is not met as evidenced by: KAR 26-41-202 (a)(1)(2)(3) The facility reported a census of 80 residents (R). The sample included six sampled residents and three closed record reviews. Based on observation, record review, and interview the executive director failed to ensure designated staff completed the "Negotiated Service Agreement" for five (R3, R4, R5, R6, R7) of six sampled residents based on the resident's "Functional Capacity Screen" and service needs, which included a description of the services the resident received, the provider of each service, and payment source if the service was provided by an outside resource. Findings included: - Review of R3's medical record revealed she moved into the facility on 11/02/23 with a diagnosis of dementia ((progressive mental disorder characterized by failing memory, confusion). R3's "Functional Capacity Screen" dated 12/23/24 identified she needed physical assistance with activities of daily living and had a risk for falls. R3's "Negotiated Service Agreement" (NSA) dated 12/23/24, identified a description of services the facility staff provided but failed to include that she received podiatry services from a outside company.	S3085		

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S3085	Continued From page 5 Review of R3's medical record included notes from a local company that provided in house podiatry services. Interview on 06/18/25 at 02:10 PM Administrative Nurse B reviewed R3's NSA and confirmed it did not include the appropriate information related to podiatry services. The executive director failed to ensure R3's NSA included a description of services related to podiatry, who provided the service and who was responsible for payment of the service. - Review of R4's medical record revealed she moved into the facility on 03/31/25 with diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure). R4's "Functional Capacity Screen" (FCS) dated 03/31/25 identified she had impaired cognition, wandering and socially inappropriate/disruptive behaviors. R4's "Negotiated Service Agreement" (NSA) dated 03/31/25 failed to include a description of services needed related to her wandering and socially inappropriate behaviors. R4's "Observation Notes" included the following: 04/01/25 - resident wondering and agitated this evening going into other rooms and banging on doors and cussing. 04/08/25 - R6 attempted to hit another resident. Staff intervened and separated residents. 04/17/25 - R6 exit seeking this evening shaking	S3085		

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the doors stating she needed to go home.
04/23/25 - Medical provider notified resident had been experiencing increased irritability and agitation the past few days hitting door frames and physical altercations with others.

Interview on 06/23/25 at 10:58 AM Administrative Nurse B reported most of her behaviors are all on how she is approached . We did change some medications because of her behaviors and staff are to encourage her to be in activities. Administrative Nurse B reviewed R6's NSA and confirmed it should have identified her behaviors and wandering and what staff needed to do for her.

The executive director failed to ensure R4's NSA included a description of services related to her behaviors and wandering.

- R5's medical record revealed he moved into the facility on 11/15/24 with diagnosis dementia (progressive mental disorder characterized by failing memory, confusion).

R5's "Functional Capacity Screen" dated 03/17/25 identified he needed physical assistance with bathing and management of his medications. He also had impaired cognition and was at risk for falls.

R5's "Negotiated Service Agreement" (NSA) dated 03/17/25 identified a description of services the facility staff provided but failed to include that he received podiatry services from a outside company.

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S3085	Continued From page 7 Review of R5's medical record included notes from a local company that provided in house podiatry services. Interview on 06/18/25 at 02:10 PM Administrative Nurse B reviewed R5's NSA and confirmed it did not include the appropriate information related to podiatry services. The executive director failed to ensure R5's NSA included a description of services related to podiatry, who provided the service and who was responsible for payment of the service. - R6's medical record revealed she moved into the facility on 04/03/23 with diagnoses of Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness) and Spinal Stenosis (degenerative condition of the spine that could cause weakness and loss of use of extremities).. R6's "Functional Capacity Screen" dated 05/05/25 identified R6 needed physical assistance with activities of daily living. R6's "Negotiated Service Agreement" failed to identify she received services from a local Home Health company for Physical and Occupational therapy and Speech therapy. Interview with Home Health Staff reported R6 started Physical therapy on 01/22/25,Occupational therapy on 01/20/25, and Speech therapy on 04/07/25. She reported as of 06/23/25, R6 continued with all three services.	S3085		

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S3085	Continued From page 8 Interview on 06/23/25 at 12:07 PM Administrative Nurse confirmed the NSA did not include information regarding R6 receiving Home Health services. The executive director failed to ensure R6's NSA included a description of services related to physical, occupational and speech therapy, who provided the service and who was responsible for payment of the service. - R7's medical record revealed he moved into the facility on 02/10/25 with diagnoses of Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness) and Alzheimer's diseases (progressive mental deterioration characterized by confusion and memory failure). R7's "Functional Capacity Screen" dated 03/12/25 identified he needed physical assistance with all activities of daily living. R7's "Negotiated Service Agreement" (NSA) dated 03/12/25 identified a description of services the facility staff provided but failed to include that he received podiatry services from a outside company. Review of R7's medical record included documentation a local company provided podiatry services. Interview on 06/18/25 at 02:10 PM Administrative Nurse B and confirmed R7's NSA did not include	S3085		

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S3085	Continued From page 9 the appropriate information related to podiatry services. Review of the undated "Resident Functional Capacity Screening and Negotiated Service Agreement Policy and Procedures" revealed the Negotiated Service Agreement shall provide a description of services the resident receives, who provides each service and each party responsible for payment if outside resourced provide the service. The executive director failed to ensure R7's NSA included a description of services related to podiatry, who provided the service and who was responsible for payment of the service.	S3085		
S3092 SS=E	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 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	S3092		

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S3092	Continued From page 10 by: KAR 26-41-202 (d)(2) The facility reported a census of 80 residents(R). The sample included six residents and three closed record reviews. Based on interview, and record review the executive director failed to ensure designated staff reviewed and revised the "Negotiated Service Agreement" for two (R5 & R6) of six sampled residents when the resident had a significant change in service needs related to Home Health and Therapy services. Findings included: - R5's medical record revealed he moved into the facility on 11/15/24 with diagnosis dementia (progressive mental disorder characterized by failing memory, confusion). R5's "Functional Capacity Screen" dated 03/17/25 identified he needed physical assistance with bathing and management of his medications. He also had impaired cognition and was at risk for falls. R5's Record included a "Negotiated Service Agreement Addendum" dated 02/21/25 for home Health with a local company for Speech, Physical therapy and Skilled Nursing. The record failed to include a "Negotiated Service Agreement Addendum" when R5 started services with a local wound company. Review of R5's "Observation Notes" included on 04/08/25 wound company Medical Provider in facility for initial assessment of wound on right	S3092		

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S3092	Continued From page 11 forearm - orders received. Interview on 06/18/25 at 10:38 AM Administrative Nurse B confirmed they did not do an addendum to the Negotiated Service Agreement when R5 started services with wound company. The executive director failed to designated staff reviewed and revised R5's Negotiated Service agreement when he started services with a local wound company. - R6's medical record revealed she moved into the facility on 04/03/23 with diagnoses of Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness) and Spinal Stenosis (degenerative condition of the spine that could cause weakness and loss of use of extremities)... R6's "Functional Capacity Screen" dated 05/05/25 identified R6 needed physical assistance with activities of daily living. R6's record included a "Negotiated Service Agreement Addendum" for when she had a swallow study done but did not include an addendum for when she started therapy services with a contracted local company in the facility. Interview with Home Health Staff reported R6 started Physical therapy on 01/22/25,Occupational therapy on 01/20/25, and Speech therapy on 04/07/25. She reported as of 06/23/25, R6 continued with all three services.	S3092		

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S3092	Continued From page 12 Interview on 06/23/25 at 12:07 PM Administrative Nurse confirmed staff had not completed an addendum for therapy services through the in-house company. Review of the undated "Resident Functional Capacity Screening and Negotiated Service Agreement Policy and Procedures" revealed staff shall review and revise if necessary each Negotiated Service Agreement following any significant change in condition. The executive director failed to ensure designated staff reviewed/revised R6's Negotiated Service Agreement when she started therapy services.	S3092		
S3105 SS=E	26-41-202 (j) Negotiated Service Agreement Outside Resource (j) If a resident's negotiated service agreement includes the use of outside resources, the designated facility staff shall perform the following: (1) Provide the resident, 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, with a list of providers available to provide needed services; (2) assist the resident, if requested, in contacting outside resources for services; and (3) monitor the services provided by outside resources and act as an advocate for the resident if services do not meet professional standards of practice	S3105		

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S3105	Continued From page 13 This REQUIREMENT is not met as evidenced by: KAR 26-41-202(j)(3) The facility reported a census of 80 residents (R). The sample included six residents and three focused record reviews. Based on interview and record review, the operator failed to ensure one (R6) of six sampled residents who received services from an outside resource had staff monitor services and acted as an advocate for the resident to ensure services met professional standards of practice. Findings included: - R6's medical record revealed she moved into the facility on 04/03/23 with diagnoses of Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness) and Spinal Stenosis (degenerative condition of the spine that could cause weakness and loss of use of extremities). R6's "Functional Capacity Screen" dated 05/05/25 identified R6 needed physical assistance with activities of daily living. R6's record included a "Negotiated Service Agreement Addendum" for when she had a swallow study done but did not include an addendum for when she started therapy services with a contracted local company in the facility. Interview with Home Health Staff reported R6	S3105		

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S3105	Continued From page 14 started Physical therapy on 01/22/25,Occupational therapy on 01/20/25, and Speech therapy on 04/07/25. She reported as of 06/23/25, R6 continued with all three services. Review of R6's record lacked any progress notes or other documentation of Therapy services for facility staff to be able to monitor and be an advocate for R6. . Interview on 06/23/25 at 12:07 PM Administrative Nurse B reported the company that provides services for R6 do not leave notes or meet with the Nurse to let them know how things are going. She reported the company used to send her a case load but have not been doing that anymore. Administrative Nurse B acknowledged she did not have a way to monitor this particular company for standards of practice. The administrator failed to ensure designated staff monitored Home Health to ensure they were managing R6's therapy according to standards of practice.	S3105		
S3171 SS=F	26-41-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-204 (i)	S3171		

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S3171	Continued From page 15 The facility reported a census of 80, with 58 on the Assisted Living side and 22 residents in Memory Care. The sample included six residents and three closed chart reviews. Based on interview and record review the executive director failed to ensure qualified staff provided healthcare services in accordance with acceptable standards of practice when staff failed to respond to call lights in a timely manner. Findings included: - Review of the Resident Roster provided by Executive Director A on 06/18/25 revealed 39 residents in Assisted Living and 21 residents on Memory Care required some type of physical assistance with their activities of daily living. This included four residents who required assistance of two staff for cares. - Review of the call light report provided by Administrative Staff A revealed the following: June 2024 : 81 times a resident had to wait longer than 28 minutes with three of those greater than 50 minutes. September 2024: 280 times a resident had to wait longer than 28 minutes with 14 of those times greater than 50 minutes. October 2024: 393 times a resident had to wait longer than 28 minutes with 61 of those times greater than 50 minutes. February 2025 :126 times a resident had to wait longer than 28 minutes with 35 minutes being the longest wait time. March 2025: 70 times a resident had to wait longer than 28 minutes with 38 minutes being the longest wait time. April 2025 : 57 times a resident had to wait	S3171		

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longer than 28 minutes with 38 minutes the longest wait time.
May 2025: 91 times a resident had to wait longer than 28 minutes with 45 minutes the longest wait time.

Confidential resident interviews on 06/16/25 and 06/17 25 revealed 15 out of 16 residents interviewed reported they use their call pendants when they need help. Ten of those residents reported they had to wait for varied lengths of time before staff came to help them. Comments included the following:
-I wish I could give my own medication because it was after 11:00 this morning before I got my breakfast medications.
-When they have enough staff, I can use the toilet but they are usually short staffed so I end up being incontinent before I can get to the toilet.
-The worst part is waiting for someone to help me with my pants when I use the bathroom.
-I do not have to wait as long as some of the residents in wheelchairs do for someone to take them to their rooms after a meal.

Interview on 06/16/25 at 12:51 PM Administrative Nurse B reported she came in November and the facility has had some staffing issues. Administrative Nurse B reported the facility used Agency staff now to help fill in to meet staffing goals.

Interview on 06/17/25 at 06:05 AM CMA E had worked at the facility for 6 months and reported on the nights she has worked, there are three staff for the whole facility.

Interview on 06/17/25 at 06:28 AM Certified

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Nurse Aide (CNA) J reported she had worked here for about a month and there are only three staff on night shift with only one person on the Memory Care unit. She reported the first day she worked there were only two staff for the whole facility.

Interview on 06/17/25 at 06:53 AM CNA K reported she has worked here for a couple of months and there are two CMAs and two CNAs in Assisted living and one CMA in Memory Care. She reported one of the CNAs will float between Assisted living and Memory Care.

Interview on 06/17/25 at 10:01 AM with CNA J reported she had worked here a little over a year and night shift is a problem. People will call in and they try to get someone to cover but it doesn't always happen. CNA J reported when she first started working it was just her and the CMA working.

Interview on 06/17/25 at 03:30 PM CMA L reported working at the facility for over a year. CMA L reported on nights there is one staff in Assisted Living and one in Memory Care with occasionally having someone to float. CMA L reported it is better now than it used to be.

Electronic interview on 06/25/25 at 04:11 PM Administrative Staff A reported the facility's goal is to get call lights answered within five minutes. If the call light goes longer than five minutes the concierge will call over the walkie to ensure someone is answering the call light.

Review of the "Use of Pagers and Walkie Talkies" policy dated 05/08/24 direct staff if they

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S3171	Continued From page 18 are unable to immediately respond to a page, staff should use a Walkie Talkie to ask for assistance. If assistance is not available, the employee should leave the resident they are currently assisting in a safe environment to respond to the other page. The executive director failed to ensure facility staff responded to call lights to ensure health care services were provided in a timely manner. This failure put all residents who required assistance at risk for delay in assistance, increased risk for incontinence, and increased risk for falls.	S3171		
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.	S3175		

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S3175	Continued From page 19 This REQUIREMENT is not met as evidenced by: KAR 26-41-205(a)(1) The facility reported a census of 80 residents (R). The sample included six residents and three focused record reviews. Based on interview and record review the executive director failed to ensure a licensed nurse completed an assessment for self-administration of medications one (R8) of six sampled residents prior to the resident self-injecting her insulin. Findings included: - R8's record revealed she moved into the facility on 11/06/23 with a diagnosis of Diabetes insipidus. R8's "Functional Capacity Screen dated 04/09/25 identified she was unable to manage her medications or medical treatments. R8's "Negotiated Service Agreement" (NSA) revealed she needed someone to assist her with all aspects of medication management. The NSA failed to identify R8 self-injected her insulin. Review of R8's medical record on 06/18/25 lacked evidence a nurse conducted an assessment to ensure R8 could safely and accurately self-inject her insulin after staff prepared the pen. Interview on 06/18/25 at 11:32 AM Administrative Nurse B reviewed R8's records and confirmed a nursing assessment to identify if R8 could safely	S3175		

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S3175	Continued From page 20 and accurately self-inject her insulin was not conducted. The executive director failed to ensure a licensed nurse completed a self-administration assessment for R8 to ensure she could safely and accurately self-inject her insulin.	S3175		
S3186 SS=D	26-41-205 (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: KAR 26-41-205 (b) The facility reported a census of 80 residents(R). The sample included six residents and three focused record reviews. Based on observation, interview, and record review the executive director failed to ensure one (R8) of six sampled residents "Negotiated Service Agreement" included the selected medications the resident chose to administer.	S3186		

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S3186	Continued From page 21 Findings included: - R8's record revealed she moved into the facility on 11/06/23 with a diagnosis of Diabetes insipidus. R8's "Functional Capacity Screen dated 04/09/25 identified she was unable to manage her medications or medical treatments. R8's "Negotiated Service Agreement" (NSA) revealed she needed someone to assist her with all aspects of medication management. The NSA failed to identify qualified staff prepared her insulin pen, dialed it to the ordered dosage, and then R8 self-injected the insulin. Interview on 06/17/25 at 04:36 PM Certified Medication Aide (CMA) E reported the resident was pretty independent with daily cares, but staff administered her medications. CMA E reported the staff prepare her insulin pen and dial it to the ordered dosage and then we hand it to her for her to self inject. Interview on 06/18/25 at 11:35 AM Administrative Nurse B reviewed R8's NSA and confirmed it did not identify that R8 self-injected her insulin after staff prepared the insulin pen. The executive director failed to ensure designated staff identified what select medications R8 chose to self-administer in her NSA.	S3186		
S3211 SS=E	26-41-205 (g) (3) OVER THE COUNTER DRUGS	S3211		

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S3211	Continued From page 22 (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 26-41-205 (g)(3) The facility reported a census of 80 residents(R). Based on observation, interview, and record review the executive director failed to ensure a licensed nurse or pharmacist included the residents full name on all over-the-counter medications, including the original manufacturer's medication package and the medication container/tube. Findings included: - Observation on 06/16/25 at 02:11 PM Certified Medication Aide (CMA) C unlocked the "Memory Care" medication cart for inspection which revealed the following over-the-counter medications without resident's full name: Vitamin D3, Tums, Voltaren Gel, Restful Legs, Gas relief, Advil, Antidiarrheal, and Hemorrhoid ointment.	S3211		

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S3211	Continued From page 23 The bottles, boxes, and tubes included a room number but failed to include the resident's full name. Observation on 06/16/25 at 04:35 PM CMA D unlocked medication cart "2" which revealed the following over-the-counter medications without a resident's full name: Bayer Aspirin, Zyrtec, Omega 3, Turmeric, Mega Vitamins, Biotin, Calcium-Magnesium-Zinc, Vitamin D3, CoQ 10, and Acetaminophen. The bottles, boxes, and tubes included a room number but failed to include the resident's full name. Observation on 06/16/25 at 04:40 PM CMA D unlocked medication cart "1" which revealed the following over-the-counter medications without a resident's full name on the bottle: Aspirin, Vitamin B12, Vitamin D3, Aspirin, Tylenol, Areds 2, Tylenol ES, Areds 2, One-a-Day Vitamin, and Calcium. The bottles, boxes, and tubes included a room number but failed to include the resident's full name. Interview on 06/16/25 at 04:51 PM Administrative Nurse B confirmed each over-the-counter medication needed to include the residents full name on the medication bottle. The executive director failed to ensure a licensed nurse or pharmacist wrote the resident's full name on all over-the-counter medications, including the medication package and container.	S3211		
S3261 SS=E	26-41-105 (f) (11) Resident Record Documentation of Incidents (f) (11) documentation of all incidents, symptoms,	S3261		

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S3261	Continued From page 24 and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action This REQUIREMENT is not met as evidenced by: KAR 26-41-105(f)(11) The facility reported a census of 80 residents (R). The sample included six residents and three focused record reviews. Based on interview and record review the operator failed to ensure five (R3, R4, R5, R6, R7) of six sampled residents records contained documentation of all incidents, symptoms, and other indications of illness or injury, actions taken, and the results of action taken. Findings included: - Review of R3's medical record revealed she moved into the facility on 11/02/23 with a diagnosis of dementia ((progressive mental disorder characterized by failing memory, confusion). R3's "Functional Capacity Screen" dated 12/23/24 identified she needed physical assistance with activities of daily living and had a risk for falls. R3's "Negotiated Service Agreement" (NSA) dated 12/23/24, identified a description of services the facility staff provided but failed to include that she received podiatry services from	S3261		

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S3261	Continued From page 25 a outside company. Review of R3's "Observation Notes" included documentation of seven falls since 11/17/24. However, the notes also included information that staff completed an incident report related to 52 falls since 11/12/24. The facility nurse failed to document residents' status when she fell, what was done and follow up post falls. R3's record also included the following documentation: 12/11/24- resident very lethargic, not able to respond to verbal communication daughter does not wish to send to emergency room currently. The record lacked follow up as to monitoring resident and her status related to lethargy. 01/17/25 - new order to start Diphenhydramine (antihistamine) at hour of sleep as needed for sleep. The record lacked follow up as to results of use of medication. 03/12/25 - resident complaining of urinary frequency/urgency and pain during urination. 03/13/25 - new order for Macrobid (antibiotic) for seven days related to urine analysis. 03/17/25 - resident complaining of pain in her right knee and having confusion. The record failed to follow up on her right knee pain. 03/18/25 - resident continued to complain of urinary tract infection symptoms, new order for different antibiotic. The record lacked follow up if the change in antibiotics helped to resolve her symptoms. 03/22/25 - resident had a fall with injury and returned to facility with laceration on her forehead reapproximated with skin glue and	S3261		

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abrasion to bridge of nose.
The record lacked nurse follow up as to residents' status post fall.
04/02/25 - resident said she fell and hit her left side of her cheek, specifically her left eye and felt pressure behind her eye. Residents' family wanted to try Tylenol to see if it helped and to call the family back later.
The record lacked follow up residents' status post fall or calling the family back
04/24/25 - New order to increase Zoloft (antidepressant).
04/25/25 - New order to start Depakote (anticonvulsant) daily
04/27/25 - new order to increase Depakote.
The record lacked documentation as to symptoms for starting new medications and increasing Zoloft and results of starting the medications.

Interview on 06/18/25 at 02:48 PM Administrative Nurse B confirmed designated staff should have documented falls and follow up in the chart as well as following up on antibiotics and medication changes.

The executive director failed to ensure designated staff documented incidents, symptoms, what was done and results of what was done in R3's medical record.

- Review of R4's medical record revealed she moved into the facility on 03/31/25 with diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure).

R4's "Functional Capacity Screen" (FCS) dated

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S3261	Continued From page 27 03/31/25 identified she needed physical assistance with activities of daily living and had impaired cognition. R4's "Negotiated Service Agreement" (NSA) dated 03/31/25 included staff to provide assistance with activities of daily living and provide reminders and redirection for activities. R4's "Observation Notes" included the following documentation: 04/24/25 - new order for Seroquel (antipsychotic) in am along with current dose at bedtime related to agitation and irritability. The record lacked follow up as to effects of increasing medication. 04/2/25 - resident with a bad wet cough that has been going on for the past couple of weeks, she does not have any as needed cough medication ordered. The record lacked documentation as to what was done related to her cough and results of what they did. Interview on 06/23/25 at 11:02 AM Administrative Nurse B confirmed staff should have followed up when medication changes occurred as well as documented on her cough and what was done. The Executive Director failed to ensure designated staff documented all incidents/symptoms, what was done, and results of action taken. - R5's medical record revealed he moved into the facility on 11/15/24 with diagnosis dementia (progressive mental disorder characterized by	S3261		

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S3261	Continued From page 28 failing memory, confusion). R5's "Functional Capacity Screen" dated 03/17/25 identified he needed physical assistance with bathing and management of his medications. He also had impaired cognition and was at risk for falls. R5's "Negotiated Service Agreement" (NSA) dated 03/17/25 identified a description of services the facility staff provided to meet his needs. R5's "Observation Notes" included the following documentation: 11/20/24 - resident feeling good about moving into the facility. The record lacked documentation that he moved into the facility and nurse assessment upon moving in. 03/31/25 - New order for skilled nursing for wound care with Home Health. The record lacked documentation of R5's wound initially, where it was including a description of the wound. Interview on 06/18/25 at 10:40 AM Administrative Nurse B reported the nurse was supposed to document in the record when a resident moves in with a head-to-toe assessment and confirmed staff should have documented on his wound when it was first identified. The executive director failed to ensure designated staff documented in R5's record when he moved into the facility and a description of his wound.	S3261		

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	N089069	A. BUILDING: _____ B. WING _____	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARHURST OF TOPEKA	6732 SW 17TH STREET TOPEKA, KS 66615

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- R6's medical record revealed she moved into the facility on 04/03/23 with diagnoses of Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness) and Spinal Stenosis (degenerative condition of the spine that could cause weakness and loss of use of extremities)..

R6's "Functional Capacity Screen" dated 05/05/25 identified R6 needed physical assistance with activities of daily living.

R6's "Negotiated Service Agreement" identified facility staff would help R6 with her activities of daily living.

Review of R6's "Observation Notes" included the following documentation:
01/10/25-resident is not feeling good today her temperature was 100.5, having cold shakes and is very pale and clammy nurse notified.
The record lacked follow up as to what was done and results.
01/27/25 - Dental office to come to facility on 1/28/25 for tooth extraction
The record lacked documentation if of dental company coming and extracting R6's tooth.
03/14/25 - New order for Metamucil (fiber) for constipation and Erythromycin (antibiotic) for conjunctivitis.
The record lacked follow up on the results of starting new medications.

Interview on 06/23/25 at 12:28 PM Administrative Nurse B confirmed the record lacked documentation as to what staff did and results of

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S3261	Continued From page 30	S3261		

what was done.

The executive director failed to ensure R6's record included documentation of incidents, symptoms, what was done, and results of action taken.

- R7's medical record revealed he moved into the facility on 02/10/25 with diagnoses of Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness) and Alzheimer's diseases (progressive mental deterioration characterized by confusion and memory failure).

R7's "Functional Capacity Screen" dated 03/12/25 identified he needed physical assistance with all activities of daily living.

R7's "Negotiated Service Agreement" (NSA) dated 03/12/25 identified a description of services the facility staff provided to assist with activities of daily living.

Review of R7's "Observation Notes" included the following documentation:
The record lacked documentation of resident moving into the facility.
03/02/25 - unwitnessed fall and went to emergency department for evaluation and was admitted to hospital.
03/21/25 new order for Nystatin oral suspension for Candidiasis (infection) of mouth.
The record lacked documentation of results of treatment.
04/04/25 - open wound to buttock, refer to wound

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S3261	Continued From page 31 care and Home Health to evaluate and treat. The record lacked facility nurse assessment of wound including description, measurements, treatment and results of treatment. 05/02/25 - New order for Hydrocortisone cream to dermatitis on face. The record lacked documentation on results of treatment. Interview on 06/18/25 at 07:51 AM Administrative Nurse reviewed R7's documentation and reported she would expect staff to document a nursing assessment when he moved into the facility and follow up on new medications. The executive director failed to ensure designated staff documented when R7 moved into the facility and results of actions taken to resolve medical conditions.	S3261		
S3310 SS=F	26-41-207 (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; and (c) Each administrator or operator shall ensure the facility ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105	S3310		

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S3310	Continued From page 32 This REQUIREMENT is not met as evidenced by: KAR 26-41-207(c) The facility reported a census of 80 residents (R). The sample included six residents and review of five newly hired employees' record. Based on interview and record review the executive director 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 five of five newly hired employees. Findings included: - Review of all five newly hired staff TB symptom screens included the same TB screening form. The TB screening form lacked all of the components of the TB symptom Screen Review questionnaire in the "Tuberculosis (TB) Guidelines for Adult Care Homes" June 2013. The Tuberculosis (TB) Guidelines for Adult Care Homes" June, 2013, included the following screening questions that were not a part of the facility's questionnaire: 1. Have you ever been told you have active TB? 2. Have you ever had contact with anyone with active TB? 3. Have you ever traveled or lived outside the country for 3 months or greater? Interview on 06/23/25 at 08:24 AM Administrative Nurse B reported the TB symptom screens had been revised for the residents but not for	S3310		

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S3310	Continued From page 33 employees and confirmed the employee TB screens did not include all the components of the questionnaire in the TB guidelines. The executive director 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.	S3310		