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 _____	08/25/2025

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 represents the findings of a resurvey with attached complaint 187638, 188778, 188876, 189258, 190169, 192119, 193461, 194007, 196278, 194725, 195684, and 196432 at the above named assisted living facility conducted 08/18, 8/20, 8/21 and 08/25/25.	S 000		
S 135 SS=D	26-39-103 (h) Resident Right Notification of Changes (h) Notification of changes. (1) The administrator or operator shall ensure that designated facility staff inform the resident, consult with the resident's physician, and notify the resident's legal representative or designated family member, if known, upon occurrence of any of the following: (A) An accident involving the resident that results in injury and has the potential for requiring a physician's intervention; (B) a significant change in the resident's physical, mental, or psychosocial status; (C) a need to alter treatment significantly; or (D) a decision to transfer or discharge the resident from the adult care home. (2) The administrator or operator shall ensure that a designated staff member informs the resident, the resident's legal representative, or authorized family members whenever the designated staff member learns that the resident will have a change in room or roommate assignment.	S 135		

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

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S 135	Continued From page 1 This STANDARD is not met as evidenced by: KAR 26-39-103(h)(1)(C) The facility reported a census of 34 residents. Based on interview and record review the administrator failed to ensure designated facility staff notified the legal representative or designated family member of a change in medications for Resident (R)6. Findings included: - Review of R6's medical record revealed she was admitted to the facility on 12/01/22 with a diagnosis of Alzheimer's Disease. The 06/21/24 "Functional Capacity Screen" (FCS) documented R6 was unable to self-manage her medications. The 06/21/24 "Negotiated Service Agreement" (NSA) documented family helped with administering R6's medications. 12/18/24 "Pharmacy Note" by Administrative Nurse D documented with family approval, facility staff would take over administering R6's medications. Review of R6's medical records revealed a physician's order dated 01/21/25 Trazadone 50 milligrams (mg.), give half a tablet (25 mg.) by mouth at bedtime for insomnia. On 08/25/25 at 02:29 PM Administrative Nurse D stated she was unable to locate any documentation in the nursing note that indicated R6's family was notified when she was started on	S 135		

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S 135	Continued From page 2 Trazadone. Administrative Nurse D admitted that it was her that wrote the note and stated the family should have been notified but it was not documented. The administrator failed to ensure staff notified R6's legal representative or designated family member was notified when R6 was started on a new medication.	S 135		
S3026 SS=J	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)(B) The facility reported a census of 34 residents with three residents included in the sample, three focused record reviews, and six closed record reviews. Based on observation, interview, and record review the administrator failed to protect one resident from neglect by the failure to ensure residents unknowingly did not leave the facility unsupervised. This failure placed Resident (R)2 in Immediate Jeapordy when she exited the facility by way of a staff member opening the	S3026		

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door and letting her out without supervision and R7 in Immediate Jeopardy when he exited the facility on two different dates, 06/28/25 and 07/06/25, through unlocked, unsecured exits and was outside the facility for unknown amounts of time resulting in a fall each time.

Findings included:

- Record review for R2 revealed an admission date of 08/31/23 with diagnoses of dementia and Parkinsonism.

The 02/12/24 Functional Capacity Screen (FCS) identified R2 required supervision with bathing and physical assistance with management of medications and treatments. R2 had long-term memory, memory/recall, and decision-making difficulties and was independent with dressing, toileting, transferring, walking, and eating. She had impaired vision. The FCS failed to identify R2 at risk of wandering.

The 02/12/24 NSA identified R2 received set up assistance and cueing for bathing; facility medication technicians administered medication; had door alarm in place; and staff was to monitor each time she left her room. R2 is independent with transferring and walking.

The 02/14/24 "Service Plan Report" is the facility's Healthcare Service Plan (HSP) which instructed staff to engage R2 in meaningful and purposeful activities during confusion, distract from wandering, and document wandering behavior.

Review of "Alert Note" dated 05/04/24 at 12:27

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S3026	Continued From page 4 PM revealed R2 eloped and was found off campus. A sign was posted on the Southeast exit door after the incident for all residents and family to use main entrance at all times. Review of facility investigation completed on 05/10/24 revealed R2 had a door alarm on her apartment for elopement risk intervention. The investigation documented R2 asked CMA Q to let her go outside for a walk on 05/04/24 at approximately 10:55 AM. CMA Q let R2 outside, watched her walk across the parking lot and then told CNA R what she had done which triggered the missing resident procedure. Unlicensed Staff S found R2 and returned her to the facility at approximately 11:30 AM after she walked approximately 0.3 miles down the street. A "Teachable Moment" form was completed for CMA Q to educate her on use of the south doorways. The investigation submitted failed to include elopement drills or trainings provided to staff prior to or following the incident. Review of CMA Q's notarized "Witness Statement" on 05/04/24 revealed she let R2 out of the facility. Review of "Wandering Risk Assessment" dated 02/12/24 revealed a score of four which is "Low Risk." The assessment failed to identify R2's known wandering or history of wandering. Review of "Wandering Risk Assessment" dated 05/06/24 revealed a score of nine which is "Moderate Risk." The only change from the 02/12/24 assessment was identifying R2 as a known wanderer.	S3026		

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S3026	Continued From page 5 On 08/20/25 at 10:00 AM elopement drills and training prior to the 05/04/24 incident, and after the incident, were requested; which the facility failed to provide. Observation on 08/20/25 at 11:20 AM of possible route taken by R2 on 05/04/24 revealed approximately 100 paces from south door to the busy, four-lane, 40 miles per hour street, and then 0.3 miles East to location found. On 08/20/25 at 11:20 AM Unlicensed Staff P stated she had a list of six residents at the desk who are at risk for wandering currently. She confirmed R2 was on the list. On 08/20/25 at 04:10 PM Administrative Staff A confirmed only the staff working the shift at the time of the incident were provided any training after the incident. The facility's "Missing Resident/Elopement Policy and Procedure" dated 06/29/18 instructed staff to develop and revise the resident service plan when a resident is determined to be at risk for elopement. Residents' HSP should address individual risk factors and include appropriate interventions to prevent elopement. Removal plan requested 08/20/25 at 04:10 PM. The following was submitted: 1. Staff training provided 05/06/24 2. One-on-one care provided to R2 until discharged to memory care 3. Scheduled a care plan meeting with R2's family to discuss safety and discharge plan 4. Care conferences conducted for all residents identified at moderate or high risk of wandering	S3026		

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with developed individualized plan
5. Weekly elopement drill for four weeks including all shifts
6. Mandatory meeting for all staff regarding elopement procedures to be held 08/21/25

- Record review for R7 revealed an admission date of 08/31/23 with diagnoses of dementia and Parkinsonism.

The 01/06/25 Functional Capacity Screen (FCS) identified R7 required physical assistance with management of medications and treatments. R7 had short-term memory, memory/recall, and decision-making difficulties and was independent with bathing, dressing, toileting, transferring, walking, and eating. He was at risk of falls and had impaired vision and impaired hearing. The FCS failed to identify R7 at risk for wandering.

The 05/15/25 Negotiated Service Agreement (NSA) identified R7 received reminders for grooming, dressing, toileting, and wearing hearing aids. Facility medication technicians administered medications to R7 and was supported to make decisions about care and environment due to memory loss. The NSA failed to identify interventions for R7's risk of wandering.

The "Service Plan Report" initiated 12/06/24 was the facility's Healthcare Service Plan (HSP) which documented R7 had "mild/moderate/severe memory loss" without specifying which level or instructing staff what to do about it. The HSP failed to instruct staff what do to when R7 wandered.

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S3026	Continued From page 7 Review of 12/09/24 "Move-In note" revealed R7 wandered in halls and did not want to stay in his room. Review of "progress notes" revealed on 12/10/24 at 12:57 PM R7 had confusion when away from his room or familiar surroundings. Review of "Progress Notes" dated 05/01/25 at 10:33 AM revealed R7 had increased confusion and the hospice staff thought he needed a higher level of care. Review of "Progress Notes" dated 05/07/25 at 12:59 PM revealed R7 hallucinated. The note did not describe the hallucination or what R7 said regarding the hallucination. Review of "Wandering Risk Assessment" dated 06/04/25 revealed a score of ten which is "Moderate." The assessment failed to identify R7's behavior of not understanding surroundings. Review of "Behavior Note" dated 06/17/25 at 06:20 AM revealed R7 was exit seeking and hallucinated. He had told staff he did not live at the facility, and he was going to walk out the doors and leave. Review of "Incident Note" dated 06/28/25 at 09:43 PM revealed R7 eloped prior to 06:50 PM and was found later, on the ground at a nearby intersection. The police brought R7 back to the facility. Staff noticed he was "soaked" and had two short-sleeved as well as a long-sleeved shirt on. It was unknown how long R7 was out of the building.	S3026		

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S3026	Continued From page 8 Review of "Incident Note" dated 06/29/25 at 03:33 AM revealed R7 returned to the facility from a local hospital with no new orders. Review of "Incident Note" dated 06/29/25 at 11:41 AM revealed staff were to start 15-30 minute checks on R7. Review of the facility investigation (for the 06/28/25 incident), completed on 07/07/25, revealed R7 was a moderate risk for wandering. On 06/28/25, R7 possibly left the facility out the unsecured main entrance doors. Certified Medication Aid (CMA) K last saw R7 walking down the hallway to the dining room. He was found approximately 0.25 miles from the facility on the sidewalk after sustaining a fall. R7 was disoriented to person, time, and surroundings. Certified Nurse Aid (CNA) J and CMA K notified Licensed Nurse L. Unlicensed staff M who was assigned duties to watch for wander risk residents did not see R7 leave the dining area or walk out the door. Review of CMA K's notarized "Witness Statement" on 06/28/25 revealed she last saw R7 going to the dining room without giving a time. Review of 30-minute check log (post incident) revealed R7 continued to frequent the atrium on 06/29/25 at 02:00 PM and 06/30/25 at 06:00 PM. Review of "Incident Note" dated 07/06/25 at 07:00 AM revealed R7 was missing at approximately 06:00 AM during scheduled checks. R7 was last seen at 05:25 AM. He was	S3026		

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found near the back patio. R7 was unable to recall event.

Review of the facility investigation (for the 07/06/25 incident) completed on 07/14/25 revealed R1 was receiving safety checks every 15-30 minutes. He was last seen by CMA O at 05:25 AM wandering in the hallway. CNA N notified Administrative Staff A at 05:45 AM R7 was missing. At 06:10 AM CMA O found R7 outside on the west side of building by the landscaping rocks. Staff reported the alarmed doors were not sending alerts to staff pagers.

Review of CMA O's notarized "Witness Statement" on 07/06/25 revealed she last saw R7 at 05:25 AM.

Review of elopement drill provided on 07/11/25 revealed six staff members in attendance including CMA G, CNA H, CMA K, and CNA J.

Review of facility in-service 07/11/25 included elopement and wandering behavior, proper completion of safety checks, and responding to emergency door alerts. It listed 10 of 21 staff members in attendance

Observation on 08/20/25 at 11:20 AM revealed the atrium area was north of a set of double doors. The atrium space had a set of doors facing West out the "back" of the facility and a set on the East or "front" of building. Both sets of doors were unlocked and unalarmed. No staff within visible site of door when opened. An approximately six-foot-wide row of four-to-eight-inch rocks ran along a ditch on the west side of the building.

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S3026	Continued From page 10 On 08/20/25 at 10:29 AM the Southwest door was opened to trigger exit alarm. At 10:43 AM a CNA enters the hall but does not respond to the door. Staff failed to respond to door alarm and verify the door was latched with all residents accounted for. Observation on 08/20/25 at 11:20 AM of possible route taken by R7 on 06/28/25 revealed approximately eight steps from dining room to the front door. R7 then could have walked approximately 200 feet on a sidewalk to the busy 4 lane street in front of the facility and then 0.3 miles to the intersection west of the facility. Possible route taken on 07/06/25 revealed R7 could have walked from his room to atrium door approximately 225 feet and then approximately 110 feet to location found. On 08/20/25 at 10:40 AM Administrative Staff A stated the care staff are to respond to an exit alarm immediately. On 08/20/25 at 10:55 AM CMA F stated they are to check the door when an exit alarm came across pagers, make sure it is latched, and check the wander risk residents. CMA F stated he does not have a pager to know if the door alarm triggered as the facility only had two pagers and the CNA and other CMA had them. On 08/20/25 at 11:20 AM Unlicensed Staff P stated she had a list of six residents at the front desk who are at risk for wandering. She confirmed R7 was on the list while he was in the facility. She stated the patio door does not have an alarm to alert her it had opened and she could not directly see door without leaning around.	S3026		

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S3026	Continued From page 11 On 08/20/25 at 11:43 AM Administrative Staff A stated the concierge can see the east and west door and "mainly just watch for the at-risk people." She confirmed the facility only has two working pagers. On 08/20/25 at 11:05 AM CMA G stated R7 spent lots of time in the atrium. She was told R7 went out the atrium door on 07/06/25. The facility's "Missing Resident/Elopement Policy and Procedure" dated 06/29/18 instructed staff to develop and revise the resident service plan when a resident is determined to be at risk for elopement. The HSP was to be reviewed with a change in condition for effectiveness of prevention strategies. Residents' HSP should address individual risk factors and include appropriate interventions to prevent elopement. Removal plan requested 08/20/25 at 04:10 PM. The following was submitted: 1. Staff educated on elopement, wandering behavior, and missing resident procedures on 06/28/25 2. R7 was transported to the emergency room 06/28/25 and 07/06/25 3. The director of nursing completed change of condition documentation including wandering risk assessment 4. Care plan conducted 06/30/25 with resident's family to discuss discharge to memory care 5. R7 placed on safety checks every 15-30 minutes 06/28/25 6. Re-education on elopement and wandering behavior completed 07/11/25 7. Managing elopement training assigned to all	S3026		

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S3026	Continued From page 12 staff 07/14/25 8. Staff education on proper completion of safety checks 07/11/25 9. R7 discharged to memory care unit 10. Staff training per shift on responding to emergency door alerts from 07/14/25 to 08/21/25 11. Care conferences conducted for all residents identified at moderate or high risk of wandering with developed individualized plan 12. Weekly elopement drill for four weeks including all shifts 13. Mandatory meeting for all staff regarding elopement procedures to be held 08/21/25	S3026		
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. This REQUIREMENT is not met as evidenced	S3085		

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S3085	Continued From page 13 by: KAR 26-41-202(a)(1)(3) The facility census equaled 34 residents with three residents sampled and nine abbreviated record reviews. Based on record review and interview for three Residents (R)1, R3 and R6 the administrator failed to ensure the "Negotiated Service Agreement" (NSA) was fully developed based on the resident's "Functional Capacity Screen" (FCS), service needs, preferences and identified each party responsible for payment if outside resources provide a service. Findings included: - Review of R1's medical record revealed she was admitted to the facility on 03/01/23 with a diagnosis of muscle weakness. The 06/16/25 FCS identified R1 was marked as having impaired vision. The 06/16/25 NSA did not address what services staff provided concerning R1's impaired vision. The service plan revised on 04/04/24 indicated R1 had vision loss in her right eye and wore an eye patch. On 08/21/25 at 02:48 PM Administrative Nurse D stated staff made sure R1 wore her eye patch but confirmed the NSA did not address this. The administrator failed to ensure R1's NSA was fully developed to include all items that triggered on the FCS, her service needs, and preferences.	S3085		

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	N089030	A. BUILDING: _____ B. WING _____	08/25/2025

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S3085	Continued From page 14 - Review of R3's medical record revealed she was admitted to the facility on 12/26/22 with a diagnosis of Parkinson's Disease. The 05/19/25 FCS identified R3 required physical assistance with transfers and triggered for falls. The 05/19/25 NSA documented staff physically assisted R3 with transfers but did not indicate that she used a bed assist device. The NSA documented R3 received services from a local home health agency but did not identify the party responsible for payment of these services. On 08/25/25 at 12:56 PM Administrative Nurse D confirmed R3's NSA did not address the use of a bed assist device. On 08/25/25 at 02:52 PM Administrative Nurse D confirmed an addendum to the NSA identifying who the payer of home health services provided for R3 had been started but not completed. The administrator failed to ensure R3's NSA was fully developed to include all items that triggered on the FCS, her service needs, preferences, and failed to identify the party responsible for payment of services provided by an outside provider. - Review of R6's medical record revealed she was admitted to the facility on 12/01/22 with diagnoses of Alzheimer's Disease and insomnia. The 06/21/24 FCS identified R6 was independent with transfers and mobility and was at risk for falls.	S3085		

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S3085	Continued From page 15 The 06/21/24 NSA failed to address what services staff provided R6 to prevent falls. On 08/25/25 at 02:47 PM Administrative Nurse confirmed R6's NSA did not include interventions to prevent falls. The administrator failed to ensure R6's NSA was fully developed to include all items that triggered on the FCS, her service needs, and preferences.	S3085		
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 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)(4) The facility reported a census of 34 residents. The sample included three residents and nine	S3092		

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S3092	Continued From page 16 abbreviated record reviews. Based on record review the administrator failed to ensure designated staff revised a "Negotiated Service Agreement" (NSA) when facility staff assumed management of R6's medications. Findings included: - Review of R6's medical record revealed she was admitted to the facility on 12/01/22 with a diagnosis of Alzheimer's Disease. The 06/21/24 "Functional Capacity Screen" (FCS) documented R6 was unable to self-manage her medications. The 06/21/24 NSA documented family helped with administering R6's medications. The NSA was not revised when facility staff took over management of R6's medications in December 2024. 12/18/24 "Pharmacy Note" by Administrative Nurse D documented with family approval, facility staff would take over administering R6's medications. The administrator failed to ensure designated staff revised the NSA when facility staff assumed management of R6's medications.	S3092		
S3110 SS=E	26-41-203 (a) Range of Services (a) Range of services. The administrator or operator of each assisted living facility or residential health care facility shall ensure the provision or coordination of the range of services specified in each resident ' s negotiated service	S3110		

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S3110	Continued From page 17 agreement. The range of services may include the following: (1) Daily meal service based on each resident's needs; (2) health care services based on an assessment by a licensed nurse and in accordance with K.A.R. 26-41-204; (3) housekeeping services essential for the health, comfort, and safety of each resident; (4) medical, dental, and social transportation; (5) planned group and individual activities that meet the needs and interests of each resident; and (6) other services necessary to support the health and safety of each resident. This REQUIREMENT is not met as evidenced by: KAR 26-41-203(a)(3) The facility reported a census of 34 residents with three residents included in the sample and nine abbreviated record reviews. Based on observation, interview, and record review the administrator failed to provide or coordinate services as specified in Resident (R)1, R3, R5, R6, and R12's Negotiated Service Agreements (NSA). Findings included: - Review of R1's medical record revealed she was admitted to the facility on 03/01/23 with a diagnosis of muscle weakness.	S3110		

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S3110	Continued From page 18 The 06/16/25 FCS identified R1 required physical assistance with bathing. The 06/16/25 NSA listed housekeeping would be provided on scheduled days. On 08/20/25 at 01:42 PM Administrative Nurse D confirmed R1's biggest complaint was housekeeping, and she was not receiving services consistently per her NSA. The administrator failed to ensure R1 received services as specified in her NSA. - Review of R3's medical record revealed she was admitted to the facility on 12/26/22 with a diagnosis of Parkinson's Disease. The 05/19/25 FCS identified R3 required physical assistance with bathing, dressing, toileting, transfers, and management of medications and treatments. She had no communication or cognition difficulties. The 05/19/25 NSA documented staff physically assisted R3 with bathing, dressing, toileting, incontinence, and transfers. The NSA listed housekeeping would be provided on scheduled days. On 08/20/25 at 12:38 PM R3 stated her scheduled housekeeping day was Tuesday. She confirmed no one came the day prior which was Tuesday. R1 stated her apartment had not been cleaned for two weeks. R3 stated she has her own toilet brush and cleans when staff have not completed her regular cleaning.	S3110		

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S3110	Continued From page 19 The administrator failed to ensure R3 received services as specified in her NSA. - Review of R5's medical record revealed she was admitted to the facility on 04/30/24 with a diagnosis of need for assistance with personal care. The 05/15/25 FCS identified R5 required supervision with bathing and physical assistance with management of medications and treatments. R5 was at risk of falls, had impaired vision, and had occasional bladder incontinence. The 05/15/25 NSA identified staff would assist R5 with safe entry and exit from shower as well as a safe water temperature. She liked her showers on Sundays and Wednesdays and would complete a sponge bath independently if she needed. The NSA listed housekeeping would be provided on scheduled days and R5 required assistance with bed making per schedule. The NSA failed to be revised when the showers days were changed. Observation 08/21/25 at 02:15 PM revealed a posted paper in R5's room with shower and laundry day of Thursday and housekeeping day of Friday. On 08/21/25 at 02:03 PM R5 stated the staff refused to change her bed linens if she did not shower. She was taking a sponge bath per her preferences and NSA. She stated staff did not vacuum her room from January until August. The toilet had not been cleaned for three weeks one time when she had a bout of diarrhea.	S3110		

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S3110	Continued From page 20 The administrator failed to ensure R5 received services as specified in her NSA. - Review of R6's medical record revealed she was admitted to the facility on 12/01/22 with diagnoses of Alzheimer's Disease and insomnia. The 06/21/24 FCS identified R6 required physical assistance with bathing and supervision with dressing. R6 was unable to perform management of medications and treatments; was occasionally incontinent of bladder; had short-term memory, long-term memory, and memory/recall difficulties; was usually understandable and usually understood others when communicating; was at risk of falls; and had impaired decision-making. The 06/21/24 NSA listed housekeeping would be provided on scheduled days. On 08/25/25 at 10:05 AM R6's daughter stated her family had to complete cleaning including vacuuming, dusting and toilet scrubbing weekly as staff was not doing it. The administrator failed to ensure R6 received services as specified in her NSA - Review of R12's medical record revealed she was admitted to the facility on 08/20/23 with a diagnosis of congestive heart failure. The 06/16/25 FCS identified R12 required physical assistance with bathing, dressing, and management of medications and treatments. The 11/27/24 NSA listed housekeeping would	S3110		

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S3110	Continued From page 21 empty garbage on Wednesdays and bed linen changes on Fridays. On 08/21/25 at 12:12 PM R12 stated she had to complain about her toilet and sink in order to get it cleaned. This past Friday she had to take out her trash herself. The administrator failed to ensure R12 received services as specified in her NSA. On 08/21/25 at 04:49 PM Unlicensed Staff T stated there are only two housekeepers and that is why "you will see this place is such a mess." She stated no housekeeping was completed in the assisted living today and confirmed it was Thursday. On 08/25/25 at 01:21 PM Administrative Staff A confirmed housekeeping was not keeping up on tasks. She expected housekeeping to clean once a week.	S3110		
S3171 SS=E	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: KAR 26-41-204(i) The facility reported a census of 34 residents with three residents included in the sample and	S3171		

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S3171	Continued From page 22 nine abbreviated record reviews. Based on observation, interview, and record review the administrator failed to ensure designated staff completed an assessment for Resident (R)1 and R3 to confirm their bed assist devices were not a restraint, to determine the purposes of the bed assist devices, to assess the residents' ability to use the bed assist devices safely, that the bed assist devices were securely attached to the bed or bedframe, and they posed no risk for entrapment. Findings included: - Review of R1's medical record revealed she was admitted to the facility on 03/01/23 with diagnoses of muscle weakness and difficulty walking. The 06/16/25 "Functional Capacity Screen" (FCS) documented R1 was independent with transfers and mobility. The 06/16/25 "Negotiated Service Agreement" NSA documented R1 was independent with transfers and mobility and did not indicate that she used a bed assist device. R1's medical record lacked evidence of a completed bed assist device assessment. Observation on 08/21/25 at 12:45 PM revealed a bed rail attached to left side of R1's bed. On 08/25/25 at 12:56 PM Administrative Nurse D confirmed there was no bed rail assessment or other documentation completed for R1's use of a bed assist devices.	S3171		

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S3171	Continued From page 23 The undated "Beside Mobility Devices" policy documented, "The resident's support plan must reflect the specific need for the device, the intended use and any risks associated with the use of the device, the resident's education and ability to use the device safely as intended, identification of the specific device and whether a cover is required to meet FDA guidelines. This information must be reviewed with the resident and their designated person/POA." The administrator failed to ensure designated staff completed an assessment for R1. - Review of R3's medical record revealed she was admitted to the facility on 12/26/22 with a diagnosis of Parkinson's Disease. The 05/19/25 FCS documented R3 required physical assistance with transfers and was independent with mobility. The 05/19/25 NSA documented staff physically assisted R3 with transfers but did not mention the use of a bed assist device. R3's medical record lacked evidence of a completed bed assist device assessment. An observation on 08/19/25 at approximately 01:15 PM revealed a bed cane attached to the right side of R3's bed with zone a of entrapment greater than 4.75 inches. On 08/19/25 at approximately 01:15 PM R3 stated that she used the bed cane to pull herself up from the bed.	S3171		

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S3171	Continued From page 24 On 08/25/25 at 12:56 PM Administrative Nurse D confirmed there was no bed rail assessment or other documentation completed for R3's use of a bed assist devices. The undated "Beside Mobility Devices" policy documented, "The resident's support plan must reflect the specific need for the device, the intended use and any risks associated with the use of the device, the resident's education and ability to use the device safely as intended, identification of the specific device and whether a cover is required to meet FDA guidelines. This information must be reviewed with the resident and their designated person/POA." The administrator failed to ensure designated staff completed an assessment for R3.	S3171		
S3200 SS=D	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route.	S3200		

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S3200	Continued From page 25	S3200		

This REQUIREMENT is not met as evidenced by:
KAR 26-41-205(d)

The facility reported a census of 34 residents with three included in the sample, three focused record reviews, and six closed record reviews. Based on interview and record review the administrator failed to ensure facility staff administered medications to Resident (R) 3 in accordance with her provider's orders.

Findings included:

- Record review for R3 revealed an admission date of 12/26/22 with a diagnosis of Parkinson's disease.

The 05/19/25 Functional Capacity Screen (FCS) identified R3 required physical assistance with management of medications.

The 05/19/25 Negotiated Service Agreement for R3 identified facility medication technicians would administer medications.

The 12/03/24 medical provider's order for diclofenac gel 1% had instructions to apply four grams four times a day for right shoulder pain.

The August 2025 Medication Administration Record (MAR) documented R3 was administered diclofenac gel four times a day. CMA F

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S3200	Continued From page 26 documented application of the gel 26 times. On 08/20/25 at approximately 01:10 PM R3 stated CMA F had not applied her pain relief gel to her shoulder yet today. She confirmed he is very inconsistent and does not do it very often. She stated she has pain it in so often and it is worse the days it is not applied as ordered. The facility's undated "Medication Policy" documented medicine is to be taken regularly as prescribed by residents' physicians and residents were to be assisted by the staff if necessary. The administrator failed to ensure facility staff administered all medications to R3 in accordance with her medical care provider's order.	S3200		
S3211 SS=E	26-41-205 (g) (3) OVER THE COUNTER DRUGS (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	S3211		

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S3211	Continued From page 27 by: KAR 26-41-205 (g)(3) The facility reported a census of 34 residents. Based on observation and record review the administrator failed to ensure a licensed pharmacist or licensed nurse placed the full name of the resident on the original package of over the counter (OTC) medications. Findings included: - Observation on 08/18/25 at 12:07 PM of the medication cart revealed the following OTC medications not labeled with the full name of a resident: One 180 count bottle of omega-3 fish oil, 1000 micrograms (mcg) soft gels One 200 count bottle of fish oil, 1200 mcg soft gels One 8.3-ounce (oz.) bottle of polyethylene glycol One 30 count box of 4.0% lidocaine pain relieving patches Two boxes of earwax removal aid On 08/18/25 at approximately 12:07 PM Certified Medication Aide (CMA) F identified the two boxes of earwax removal aid belonged to Resident (R)5 and should have been labeled with her full name. Observation of the overflow medication cart revealed the following OTC medications not labeled with the full name of a resident: One box containing three bottles of Aspirin 81 milligrams (mg) One 90 count bottle of Omega-3 soft gels Three 30 count bottles of Protandim Synergizer caplets	S3211		

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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
S3211	Continued From page 28 One 30 count bottle Probio Immune Health capsules One 60 count bottle of Benfotiamine 300 mg capsules One 24 count bottle of Acetaminophen 500 mg caplets One 72 count box of simethicone 125 mg soft gels Review of the undated "Medication Policy" documented, OTC medications are required to have a Physician's Order with the same information as prescription medications (resident name.) The administrator failed to ensure all OTC medications were labeled by a pharmacist or licensed nurse with the resident's full name.	S3211		
S3227 SS=E	26-41-205 (l) (2) Medication Regimen Review Variance Report (l) (2) The licensed pharmacist or licensed nurse shall notify the medical care provider upon discovery of any variance identified in the medication regimen review that requires immediate action by the medical care provider. The licensed pharmacist shall notify a licensed nurse within 48 hours of any variance identified in the resident ' s regimen review that does not require immediate action by the medical care provider and specify a time within which the licensed nurse must notify the resident ' s medical care provider. The licensed nurse shall seek a response from the medical care provider within five working days of the medical care provider ' s notification of a variance.	S3227		

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S3227	Continued From page 29 This REQUIREMENT is not met as evidenced by: KAR 26-41-205(l)(2) The facility reported a census of 34 residents with three included in the sample and nine focused reviews. Based on interview, and record review the operator failed to ensure staff followed up on pharmacist review recommendations for Resident (R)1, R2 and R3. Findings included: - Review of R1's medical record revealed she was admitted to the facility on 03/01/23 with a diagnosis of muscle weakness. The 06/16/25 "Functional Capacity Screen" (FCS) identified R1 was independent with management of her medications. The 06/16/25 "Negotiated Service Agreement" (NSA) documented R1 needed assistance with self-administration of medications. R1's daughter assisted her with set up of her pill box. The 03/29/25 "Pharmacy Consultant" note documented the medication regimen review was completed and to see report for recommendations. The 04/02/25 "Pharmacy Consultant" note documented, "Recommendation: Please evaluate therapy with prednisolone ophthalmic suspension OU BID since December for efficacy and duration. Consider discontinuation if	S3227		

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S3227	Continued From page 30	S3227		

clinically appropriate. Will fax recommendation to PCP."

On 08/20/25 at 01:57 PM Administrative Nurse D confirmed she has not followed up on any pharmacist recommendations since the facility switched pharmacies back in December 2024.

The administrator failed to ensure pharmacy recommendations were followed up and responded to by R1's provider.

- Review of R2's medical record revealed she was admitted to the facility on 08/28/23 with a diagnosis of Alzheimer's Disease.

The 05/15/25 FCS identified R2 required physical assistance with the management of her medications.

The 05/15/25 NSA documented staff managed all of R2's medications.

The 06/27/25 "Pharmacy Consultant" note documented the medication regimen review was completed and to see report for recommendations.

On 08/20/25 at 01:57 PM Administrative Nurse D confirmed she has not followed up on any pharmacist recommendations since the facility switched pharmacies back in December 2024.

The administrator failed to ensure pharmacy recommendations were followed up and responded to by R2's provider.

- Review of R3's medical record revealed she

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S3227	Continued From page 31 was admitted to the facility on 12/26/22 with a diagnosis of Parkinson's Disease. The 05/19/25 FCS identified R3 required physical assistance with the management of her medications. The 05/19/25 NSA documented staff managed all of R3's medications. The 06/27/25 "Pharmacy Consultant" note documented the medication regimen review was completed and to see report for recommendations. On 08/20/25 at 01:57 PM Administrative Nurse D confirmed she has not followed up on any pharmacist recommendations since the facility switched pharmacies back in December 2024. The administrator failed to ensure pharmacy recommendations were followed up and responded to by R3's provider.	S3227		
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;	S3280		

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S3280	Continued From page 32 and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-41-104(d)(3) The facility reported a census of 34 residents. Based on record review and interview for all residents and all facility employees, the operator failed to ensure disaster and emergency preparedness by ensuring performance of quarterly review of the facility's emergency management plan with all employees and residents. Findings included: - Record review of quarterly emergency management plan reviews with residents and staff completed between 04/2024 and 06/2025 lacked evidence that all staff and residents took part in the reviews. On 08/20/25 at 04:35 PM Administrative Staff A confirmed that she did not have proof all staff and residents took part in the quarterly reviews of the emergency management plan. The administrator failed to ensure the completion of quarterly reviews of the emergency management plan with all employees and	S3280		

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S3280	Continued From page 33 residents.	S3280		
S3298 SS=F	26-41-206 (d) Food Preparation (d) Food preparation. Food shall be prepared using safe methods that conserve the nutritive value, flavor, and appearance and shall be served at the proper temperature. (1) Food used by facility staff to serve to the residents, including donated food, shall meet all applicable federal, state, and local laws and regulations. (2) Food in cans that have significant defects, including swelling, leakage, punctures, holes, fractures, pitted rust, or denting severe enough to prevent normal stacking or opening with a manual, wheel-type can opener, shall not be used. (3) Food provided by a resident ' s family or friends for individual residents shall not be required to meet federal, state, and local laws and regulations. This REQUIREMENT is not met as evidenced by: KAR 26-41-206(d) The facility had a census of 34 residents. All 34 residents ate food prepared in the same kitchen. The operator failed to ensure food items were served at the proper temperature. Findings included: - On 08/18/25 at approximately 01:04 PM review of the most recent 35-day food temperature	S3298		

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S3298	Continued From page 34 documentation cycle revealed breakfast food temperatures were not documented 15 of 35 days. On 08/18/25 at 03:06 PM Dietary Staff E confirmed the food temperature logs were not complete and lacked documentation for breakfast food temperature for multiple days. Dietary guidelines for Americans 2005 recommends using a clean thermometer that measures the internal temperature of cooked food to make sure food is cooked to and held at proper temperatures and to keep food out of the "danger zone" (40 degrees Fahrenheit to 140 degrees Fahrenheit) where bacteria can multiply rapidly. The administrator failed to ensure food items were served at the proper temperature.	S3298		
S3299 SS=F	26-41-206 (e) (1) Facility Food Storage (e) Food storage. Facility staff shall store all food under safe and sanitary conditions. (1) Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving. This REQUIREMENT is not met as evidenced by: KAR 26-41-206(e) The facility had a census of 34 residents. All 34 residents ate food prepared in the same kitchen.	S3299		

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S3299	Continued From page 35 The administrator failed to ensure food items were stored under safe and sanitary conditions by ensuring food was dated according to food safety guidelines. Findings included: -Observation of the kitchen on 08/18/25 at 12:39 PM revealed the following: A three-door stainless steel refrigerator contained a 48 fluid ounce (fl. oz.) bottle of prune juice that had a label that read "Consume within 7-10 days" but lacked an open date. One undated squeezable container of whipped topping identifying a shelf life of two weeks. One undated and unsealed five-pound bag of cheddar/Monterey jack cheese. Eight undated bottles of salad dressing. A plastic tub containing individually packaged small containers of "Ranch" dressing with a preparation date of 07/06/25 and a shelf life date of 07/11/25. A plastic tub containing individually packaged small containers of "Honey Mustard" with a preparation date of 05/23/25 and a shelf life date of 06/23/25. A plastic tub containing individually packaged small containers of "1000 Island Dressing" with a preparation date of 05/10/25 and a shelf life date of 05/31/25. A plastic tub containing individually packaged small containers of "French Dip" with a shelf life date of 06/24/25. An observation of the dry storage goods revealed: One unsealed bag of Biscuit mix.	S3299		

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S3299	Continued From page 36 Review of the "July 2025 Ref/Freezer Temp. Logs" revealed no temperatures were documented between 07/23 and 07/31. On 08/18/25 at approximately 12:39 PM Dietary Staff E confirmed there were food items that were not dated and no August refrigerator temperature log for the three-door stainless steel refrigerator. Review of the undated "Storage of Refrigerated and Dry Foods" policy documented, "All containers must be labeled with the contents and date food item was placed in storage...Food items that remain sealed from the supplier may be held until the expiration date if unopened." The August 2017 "Focus on Food Safety" published by the Kansas Department of Agriculture documented food should be marked with the date by which food is to be consumed or discarded after the original container is opened. Food can be held for seven days in adequate refrigeration. The administrator failed to ensure food items were stored under safe and sanitary conditions.	S3299		
S3305 SS=F	26-41-207 (a) (b) Infection Control (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the provision of a safe, sanitary, and comfortable environment for residents. (b) Each administrator or operator shall ensure the development of policies and implementation of procedures to prevent the spread of infections. These policies and procedures shall include the	S3305		

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S3305	Continued From page 37 following requirements: (1) Using universal precautions to prevent the spread of blood-borne pathogens; (2) techniques to ensure that hand hygiene meets professional health care standards; (3) techniques to ensure that the laundering and handling of soiled and clean linens meet professional health care standards; (4) providing sanitary conditions for food service; (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 (7) transferring a resident with an infectious disease to an appropriate health care facility if the administrator or operator is unable to provide the isolation precautions necessary to protect the health of other residents. This REQUIREMENT is not met as evidenced by: KAR 26-41-207(a) The facility reported a census of 34 residents with three residents included in the sample, three focused record reviews, and six closed record reviews. Based on observation and interview the administrator failed to ensure the facility provided a safe, sanitary, and comfortable environment for	S3305		

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S3305	Continued From page 38 all residents. Findings included: - Observations on 08/18/25 at 11:55 AM during initial tour revealed carpet in common areas and hallways with stains of various sizes and ages. One larger dark colored stain and two stains lighter in color were in common area by the south sliding doors. Observation on 08/25/25 at 12:16 PM revealed the toilet in R13's bathroom had dried feces on the front and multiple incontinence briefs in the trash can. Observation on 08/25/25 at 12:24 PM revealed the same stains in the common area by the south sliding doors without any change in size or color. Observation on 08/25/25 at 12:40 PM in the hallway approximately 15 feet from R14's door revealed a strong odorous urinary smell. CMA G confirmed the smell was coming from R14's room and has always smelled this way. On 08/21/25 at 12:12 PM R12 stated she had to complain about her toilet and sink in order to get it cleaned. This past Friday she had to take out her trash herself. R12 stated it made her uncomfortable. On 08/21/25 at 12:45 PM R3 stated she has her own toilet brush and cleans when staff have not completed her regular cleaning. On 08/21/25 at 02:03 PM R5 stated she had to complain to staff about not cleaning her toilet for	S3305		

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S3305	Continued From page 39 three weeks. She stated her apartment was not vacuumed from January until August of this year. On 08/21/25 at 04:21 PM R15's son stated the room was cleaned by family. The room was not vacuumed regularly, and the bathroom smelled bad most of the time. On 08/21/25 at 04:49 PM Unlicensed Staff I stated there are only two housekeepers and that is why "you will see this place is such a mess." On 08/25/25 at 10:05 AM R6's daughter stated her family had to complete cleaning including vacuuming, dusting and toilet scrubbing weekly for a sanitary and comfortable environment. On 08/25/25 at 01:21 PM Administrative Staff A confirmed housekeeping was not keeping up on tasks. She expected the nursing assistants to clean visible things like stool on a toilet when seen and housekeeping to clean once a week. The administrator failed to ensure the facility provided a safe, sanitary, and comfortable environment for residents.	S3305		
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	S3310		

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S3310	Continued From page 40 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 This REQUIREMENT is not met as evidenced by: KAR 26-41-207(c) The facility reported a census of 34 residents. The sample included three residents and nine abbreviated record reviews. Based on interview and record review for three residents and five new employee records, the administrator failed to ensure the facility remained in compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. This failure effected all residents who lived in the assisted living facility. Findings included: - Resident (R)2 moved into the facility on 08/28/23 with a diagnosis of Alzheimer's Disease. Review of R2's medical record lacked evidence she had an annual TB Symptom Screen Questionnaire completed in 2024. On 08/21/25 at 02:55 PM Administrative Nurse D confirmed R2 did not have an annual TB Symptom Screen Questionnaire since May 2024. The 06/2013 "Tuberculosis (TB) Guidelines for	S3310		

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S3310	Continued From page 41 Adult Care Homes" documented, "Each resident ...shall have an annual TB symptom screen ..." The administrator failed to ensure compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. - Review of three newly hired employee files revealed the following: Review of facility personnel records revealed Certified Medication Aide F was hired on 07/17/24. A Tuberculosis Symptom Screen Questionnaire was not completed, and the two-step TB Skin Test was not started until 08/15/24 which was 12 days late. On 08/20/25 at 02:01 PM Administrative Staff A confirmed that a TB Symptom Screen Questionnaire and two-step TST were not started until 08/15/24. The 06/2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented, "Each new ...employee shall have an initial TB symptom screen that includes the components of the Tuberculosis Symptom Screen Questionnaire within 7 days of ...employment ...Each new ...employee shall receive a two-step TST or an IGRA for Mycobacterium tuberculosis within 7 days of ...employment ..." The administrator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105.	S3310		