STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089101	A. BUILDING: _____ B. WING _____	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE HOMES PLUS	1920 SW 32ND ST TOPEKA, KS 66611

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S 000	INITIAL COMMENTS The following represents the findings of a resurvey for the above named home plus facility conducted on 03/12/26.	S 000		
S5105 SS=E	26-42-202 (a) Negotiated Service Agreement a) The administrator or operator of each home plus shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-42-202(a)(1) The facility reported a census of eight residents with three included in the sample. Based on interview, observation, and record review, the operator failed to ensure the Negotiated Service Agreement (NSA) for Residents (R)1, R2, and R3 described the services they received based on their service needs and preferences.	S5105		

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

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S5105	Continued From page 1 Findings included: - Record review for R1 revealed an admission date of 12/23/24 with a diagnosis of dementia. The 12/23/25 FCS identified R1 required physical assistance with bathing, dressing, toileting, transfers, walking/mobility, and eating; was unable to perform management of medications and treatments; was incontinent of bladder; had short term memory, memory/recall, and decision-making difficulties; was usually understood or understandable with communication; was at risk for falls; and had impaired vision, impaired decision-making, and socially inappropriate behavior. The 12/23/25 Negotiated Service Agreement which also serves as the facility's Healthcare Service Plan (HSP) documented staff provided assistance of one person with bathing, dressing, toileting, transfers, and walking/mobility; involved R1 in activities and provided redirection for cognition; administered medications and treatments; and staff ensured adequate lighting to reduce falls. The NSA directed staff to update interventions on the NSA/Care Plan with any occurrence of a fall. Review of "Charting Notes" dated 02/16/25 at 03:45 PM revealed R1 slid out of recliner. The note failed to include any intervention for prevention of future fall. Review of "Charting Notes" dated 02/17/25 at 04:22 PM revealed R1 was found on his knees in front of his recliner at 02:30 PM. The note failed to include any intervention for prevention of	S5105		

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S5105	Continued From page 2	S5105		

future fall.

Review of "Charting Notes" dated 02/25/25 at 04:20 PM revealed R1 was witnessed standing up from his wheelchair and then fell. He was transported to a local emergency room. The note failed to include any intervention for prevention of future fall.

Review of "Charting Notes" dated 03/02/25 at 07:43 PM revealed the resident slid out of his wheelchair onto the floor after behaviors of throwing items. The note failed to include any intervention for prevention of future fall.

Review of "Charting Notes" dated 04/01/25 at 04:00 PM revealed R1 was found on his knees in front of his recliner after his wife had just walked away. The note failed to include any intervention for prevention of future fall.

Review of "Charting Notes" dated 08/17/25 at 08:13 PM revealed R1 slid off of shower chair and staff was instructed to make sure his feet were not down when transporting.

Review of "Charting Notes" dated 12/14/25 at 08:30 PM revealed R1 fell forward out of wheelchair and staff were informed to keep a close eye on him.

Observation on 03/12/26 at approximately 11:30 AM revealed staff moved R1 to keep in their sight at all times. He reached forward from wheelchair when no visitor or staff sat beside him.

On 03/12/26 at approximately 3:30 PM Administrative Staff A stated her expectation was

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S5105	Continued From page 3	S5105		

for an intervention to be in the nurse's note regarding a fall to prevent future occurrence.

- Record review for R2 revealed an admission date of 06/05/25 with diagnoses of dementia, hypothyroidism, hypertension, and Raynaud's syndrome.

The 06/05/25 FCS identified R2 required physical assistance with bathing, dressing, toileting, and transfers; supervision with walking/mobility and eating; was unable to perform management of medications and treatments; was incontinent; had difficulty with short term memory, long term memory, memory/recall, and decision making; was sometimes understood and sometimes could understand when communicating; and had problems including falls, impaired vision, impaired hearing, and impaired decision making.

The 06/05/25 NSA/HSP indicated staff assisted with bathing, dressing, toileting, transfers if needed, mobility, management of medications and treatments, and impaired vision. Staff was to remind R2 to slow down and call for assistance to prevent falls. The NSA/HSP failed to indicate services provided for cognition, impaired decision making, and communication.

Review of "Charting Notes" revealed on 07/14/25 at 01:40 PM R2 was found on her fall mat by her bed at 06:00 AM wrapped in her sheets, on 07/29/25 at 08:29 PM R2 slipped out of her bed onto fall mat and was moved to a recliner for staff to watch closer, on 09/30/25 at 01:17 PM R2 got up from toileting on her own and fell, and on 03/08/26 at 10:08 AM R2 was found on fall mat

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S5105	Continued From page 4 after sliding from bed. The notes involving falls from her bed failed to indicate how staff were to prevent future falls. Observation on 03/12/26 at 10:30 AM R2 sat in common living area in staff's sight. Observation on 03/12/26 at 12:40 PM Certified Medication Aide (CMA) B repeated self twice when talking to resident and spoke in Spanish at times. CMA B stated R2 will sometimes respond to English but often requires Spanish instructions. On 03/12/26 at approximately 12:45 PM CMA B stated staff looks for R2's non-verbal cues like fidgeting to know if she is hungry or needs to use the bathroom. - Record review for R3 revealed an admission date of 07/22/25 with diagnoses of parkinsonism, glaucoma, and failure to thrive. The 07/22/25 FCS identified R3 required physical assistance with dressing and toileting; was unable to perform management of medications and treatments; and was at risk of falls. The 07/22/25 NSA/HSP indicated R3 had a fall mat at bedside but failed to indicate any other services provided to prevent falls. Review of "Incident Report" dated 08/17/25 at 10:01 PM revealed R3 had rolled out of his bed without indicating an intervention to prevent future falls with the same cause.	S5105		

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S5105	Continued From page 5 "Incident Report" dated 09/19/25 at 02:44 AM documented R3 fell after his foot slipped out of his slipper. The note failed to indicate how staff would prevent a future fall of the same type. "Incident Report" dated 10/01/25 at 02:44 PM documented R3 had a witnessed fall at 06:15 AM without any further details including where, how, or why and any intervention to prevent future falls. On 03/13/26 at approximately 03:02 PM Administrative Staff A stated her expectation was for an intervention to be included in a nurse's note after a fall to prevent future recurrence. She confirmed R1, R2, and R3's NSAs failed to describe services provided based on their needs and preferences. The operator failed to ensure the NSA for R1, R2, and R3 described the services they received based on their service needs.	S5105		
S5171 SS=E	26-42-204 (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 26-42-204(i) The facility reported a census of eight residents with three included in the sample. Based on observation, interview, and record review, the operator failed to ensure a licensed nurse	S5171		

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S5171	Continued From page 6	S5171		

completed an assessment for the ability to use bed rails safely without risk of entrapment and to confirm the bed rails were not a restraint for Residents (R) 1 and R2.

Findings included:

- Record review for R1 revealed an admission date of 12/23/24 with a diagnosis of dementia.

The 12/23/25 FCS identified R1 required physical assistance with bathing, dressing, toileting, transfers, walking/mobility, and eating; was unable to perform management of medications and treatments; was incontinent of bladder; had short term memory, memory/recall, and decision-making difficulties; was usually understood or understandable with communication; was at risk for falls; and had impaired vision, impaired decision-making, and socially inappropriate behavior.

The 12/23/25 Negotiated Service Agreement which also serves as the facility's Healthcare Service Plan (HSP) documented staff provided assistance of one person with bathing, dressing, toileting, transfers, and walking/mobility; involved R1 in activities and provided redirection for cognition; administered medications and treatments; and staff ensured adequate lighting to reduce falls. The NSA indicated R1 used a bedrail for mobility.

R1's record failed to include an assessment of a bed assistive device.

- Record review for R2 revealed an admission date of 06/05/25 with diagnoses of dementia,

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hypothyroidism, hypertension, and Raynaud's syndrome.

The 06/05/25 FCS identified R2 required physical assistance with bathing, dressing, toileting, and transfers; supervision with walking/mobility and eating; was unable to perform management of medications and treatments; was incontinent; had difficulty with short term memory, long term memory, memory/recall, and decision making; was sometimes understood and sometimes could understand when communicating; and had problems including falls, impaired vision, impaired hearing, and impaired decision making.

The 06/05/25 NSA/HSP indicated staff assisted with bathing, dressing, toileting, transfers if needed, mobility, management of medications and treatments, and impaired vision. Staff was to remind R2 to slow down and call for assistance to prevent falls. The NSA/HSP failed to indicate services provided for cognition, impaired decision making, and communication. The NSA/HSP indicated R2 had a hospital bed with bed rails.

R2's record failed to include an assessment of a bed assistive device.

On 03/12/26 at approximately 03:04 PM Administrative Staff A confirmed there was no bed rail assessment in R1 or R2's records.

The operator failed to ensure a licensed nurse completed an assessment of bed assistive devices for R1 and R2.

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S5185	Continued From page 8	S5185		
S5185 SS=E	26-42-206 (a) (b) (c) Dietary Services (a) The administrator or operator of each home plus shall ensure the provision or coordination of dietary services to residents as identified in each resident ' s negotiated service agreement. (b) The supervisory responsibility for dietetic services shall be assigned to one employee. (c) If a resident ' s negotiated service agreement includes the provision of a therapeutic diet, mechanically altered diet, or thickened consistency of liquids, a medical care provider ' s order shall be on file in the resident ' s clinical record, and the diet or liquids, or both, shall be prepared according to instructions from a medical care provider or licensed dietitian. This REQUIREMENT is not met as evidenced by: KAR 26-42-206(c) The facility reported a census of eight residents. Based on observation and interview, the operator failed to ensure mechanically altered diets were prepared for R1 and R4 according to instructions from a medical care provider or licensed dietician. Findings included: - Review of "Resident Roster" provided during entrance on 03/12/26 revealed two residents, R1 and R4, had therapeutic diets. Record review for R1 revealed an admission	S5185		

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date of 12/23/24 with a diagnosis of dementia.

The 12/23/25 FCS identified R1 required physical assistance with bathing, dressing, toileting, transfers, walking/mobility, and eating; was unable to perform management of medications and treatments; was incontinent of bladder; had short term memory, memory/recall, and decision-making difficulties; was usually understood or understandable with communication; was at risk for falls; and had impaired vision, impaired decision-making, and socially inappropriate behavior.

The 12/23/25 Negotiated Service Agreement which also serves as the facility's Healthcare Service Plan (HSP) documented staff provided R1 with soft foods.

Review of "Care Notes" dated 01/06/26 at 12:51 PM revealed R1's nurse practitioner ordered a mechanical soft diet which was noted to be ordered upon R1's admission to facility.

Observation on 03/12/26 at 10:29 AM revealed multiple foods pureed in storage containers in the kitchen's refrigerator labeled with residents' names.

On 03/12/26 at approximately 10:29 AM instructions for preparing pureed foods was requested from CMA B, which the facility failed to provide.

On 03/12/26 at 02:56 PM Administrative Staff A confirmed she did not have instructions from a medical provider or licensed dietician on how to prepare mechanically soft or pureed foods. She

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S5185	Continued From page 10 stated she trained the staff how to prepare based on her previous knowledge and training. The operator failed to ensure mechanically altered diets were prepared according to instructions from a medical care provider or licensed dietician.	S5185		