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LEGEND AT CAPITAL RIDGE	1931 SW ARVONIA PLACE 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 represents the findings of a resurvey with attached complaint 193174, 194980, 195425, 195767, 196225, 196542, 196984, 197162, 197445, 198188, 198354, 198469, 198466, and 198465 at the above named assisted living and residential health care facility conducted on 04/28/26-05/05/26.	S 000		
S3026 SS=G	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 60 residents with three residents included in the sample, two focused record reviews, and seven closed record reviews. Based on observation, interview, and record review the administrator failed to protect one resident from neglect by the failure to ensure facility staff provided cares to Resident (R) 7 per facility service agreement and his Negotiated Service Agreement/Healthcare Service Plan (NSA/HSP) which caused alcohol withdrawal, dehydration, and subsequent hospitalization for	S3026		

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

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S3026	Continued From page 1 eight days. Findings included: - Record review for R7 revealed an admission date of 09/26/25 with diagnoses including dementia, alcohol dependence, hypertension, and atrial fibrillation. The 10/03/25 FCS identified R7 was independent with bathing, dressing, toileting, transfers, mobility, and eating; required physical assistance with management of medications and treatments; was continent of bladder; had memory recall and decision-making cognitive difficulties; had impaired decision making; and was at risk for falls. The 10/03/25 combined NSA/HSP identified facility staff would prompt R7 to shower, and his family managed his medications. R7 was independent with dressing, toileting, mobility, and eating. The NSA/HSP identified facility staff were to notify the healthcare director of any changes with nutrition, hygiene and grooming, social needs like going to and from meals independently, toileting, and R7's mentation. The NSA/HSP failed to identify services provided for cognition, fall prevention, or impaired decision making. Review of facility's "Admission Agreement" revealed the facility provided three meals a day and residents or their legal representative consented to residents drinking alcohol unless a provider's order was obtained or they were at risk of harm to themselves or others.	S3026		

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S3026	Continued From page 2	S3026		

The 10/03/25 at 05:30 PM "Observation" note documented R7's arrival to the facility. The resident's power of attorney was to contact his primary physician regarding a specific order for alcohol consumption.

The next "Observation" note was dated 10/17/25 indicating R7's primary care provider visited him to establish care and ordered some laboratory studies.

The next "Observation" note was dated 11/03/25 at 04:00 PM and indicated R7 was admitted to the hospital for encephalopathy.

Review of R7's record revealed lack of documentation of all symptoms and other indications of illness including the date and time of occurrence, action taken, and results of the action when R7 was in the facility for approximately 30 days and showed decline, refusal of cares, symptoms of alcohol withdrawal, weight loss, dehydration, and was hospitalized. The record further lacked documentation any symptoms were reported to R7's primary care provider before sent to emergency room on 11/03/25.

On 04/30/26 at 01:28 PM an order for resident to not receive alcohol was requested which the facility failed to provide.

Review of local hospital provider's "History and Physical" dated 11/03/25 revealed R7 had a decline in self-care abilities. He was incontinent, not bathing self, and not taking medications as ordered. The provider diagnosed R7 with dehydration, inadequate oral intake, and acute

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S3026	Continued From page 3 encephalopathy. Interview on 04/30/26 at 01:20 PM Administrative Nurse C stated R7 quit drinking alcohol "cold turkey", and she was aware he began refusing to go to meals, soiled himself, and refused cares. R7 ' s family had notified her they thought he drank about four cases of wine each week. She stated she was concerned about weight loss but did not report this to a provider. She confirmed R7 had withdrawal symptoms due to his family and provider choosing not to provide him with more alcohol. She confirmed she did not receive an order for R7 to not consume any alcohol, nor did she ask his power of attorney or primary care provider for an order. She further confirmed the lack of documentation of his symptoms. The administrator failed to protect one resident from neglect by the failure to ensure facility staff provided cares to R7 per facility service agreement and his NSA/HSP which caused alcohol withdrawal, dehydration, and subsequent hospitalization for eight days.	S3026		
S3080 SS=E	26-41-201 (a) (b) Functional Capacity Screen on Admission a) On or before each individual ' s admission to an assisted living facility or residential health care facility, a licensed nurse, a licensed social worker, or the administrator or operator shall conduct a screening to determine the individual ' s functional capacity and shall record all findings on a screening form specified by the department. The administrator or operator may integrate the department ' s screening form into a form developed by the facility, which shall include	S3080		

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S3080	Continued From page 4 each element and definition specified by the department. (b) A licensed nurse shall assess any resident whose functional capacity screening indicates the need for health care services. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(b) The facility reported a census of 60 residents with three residents included in the sample, two focused record reviews, and seven closed record reviews. Based on interview and record review the administrator failed to ensure a licensed nurse documented they assessed Residents (R) 1 and R2 when their Functional Capacity Screen (FCS) indicated health care services were required. Findings included: - Record review for R1 revealed an admission date of 08/05/22 with diagnoses including anemia and hypertension. The 03/31/26 FCS identified R1 required physical assistance with bathing, and was independent with dressing, toileting, transfers, walking/mobility, and eating. He was unable to perform management of medications and treatments, had short-term memory and memory recall cognitive difficulties, was understandable and understood others during communication, was incontinent of bladder, had impaired decision making, and was at risk of falls. The 03/31/26 FCS lacked a signature to confirm	S3080		

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S3080	Continued From page 5 assessment was completed by a licensed nurse. - Record review for R2 revealed an admission date of 12/01/25 with a diagnosis of hypothyroidism. The 12/29/25 FCS identified R2 needed physical assistance with bathing, dressing, toileting, and transferring; required assistance with management of medications and treatments; was at risk for falls due to unsteadiness; and had impaired decision-making. R2 had short-term memory, long-term memory, memory recall, and decision-making cognitive difficulties. R2 sometimes understood and sometimes understandable with communication. The 12/29/25 FCS lacked a signature to confirm assessment was completed by a licensed nurse. On 05/04/26 at 03:43 PM Administrative Staff B confirmed R1 and R2's FCS's lacked signatures to confirm assessments were completed by a licensed nurse. The administrator failed to ensure a licensed nurse documented they assessed R1 and R2 when their FCS indicated health care services were required.	S3080		
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	S3085		

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S3085	Continued From page 6 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 26-41-202(a)(1)(2) The facility reported a census of 60 residents with three residents included in the sample, two focused record reviews, and seven closed record reviews. Based on interview, observation, and record review the administrator failed to ensure the Negotiated Service Agreement (NSA) was fully developed based on the resident's Functional Capacity Screen (FCS), service needs, and preferences for resident (R)1, R2 and R3 including a description of the services the resident received and the provider of each service. Findings included: - Record review for R1 revealed an admission date of 08/05/22 with diagnoses including anemia and hypertension.	S3085		

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S3085	Continued From page 7 The unsigned 03/31/26 Functional Capacity Screen (FCS) identified R1 required physical assistance with bathing, and was independent with dressing, toileting, transfers, walking/mobility, and eating. He was unable to perform management of medications and treatments, had short-term memory and memory recall cognitive difficulties, was understandable and understood others during communication, was incontinent of bladder, had impaired decision making, and was at risk of falls. The 03/31/26 combined Negotiated Service Agreement and Healthcare Service Plan (NSA/HSP) acknowledged facility staff provided assistance with bathing twice a week. R1 could perform dressing, transfers, toileting, and eating by self. Facility staff administered medications. The NSA/HSP failed to describe services provided for prevention of falls and impaired decision making. Review of nurse's notes revealed a note dated 01/30/26 at 10:45 AM regarding low blood pressure. The next note was dated 03/03/26 at 10:30 AM documented R1's power of attorney was concerned about a recent fall. The notes failed to indicate any recent fall, action taken or result of action to prevent future recurrence. Review of nurse note dated 03/03/26 at 01:00 PM documented R1 sustained a fall by losing his balance while removing his pants. The note failed to indicate actions taken to prevent R1 from falling again from this type of situation or to help R1 with making safer decisions. Review of nurse note dated 03/04/26 at 10:30	S3085		

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S3085	Continued From page 8 AM revealed an order was obtained for a urinalysis due to R1's change in status, the next note dated 03/08/26 at 04:15 PM documented R1 had returned to the facility after being seen in the local emergency room after sustaining a fall. The notes failed to indicate the fall, any possible injury, symptoms, or actions taken to prevent future falls. On 05/05/26 at approximately 04:08 PM R1 stated he was visiting a friend's apartment about six weeks ago and slipped while trying to sit. He began physical therapy because of the incident. He was unaware of any precautions put into place to prevent falls. On 05/05/26 at 06:30 PM Administrative Staff A confirmed R1's NSA failed to describe the services provided for prevention of falls and impaired decision making. The administrator failed to ensure R1's NSA described the services he received, and the provider of the service based on his FCS. - Record review for R2 revealed an admission date of 12/01/25 with a diagnosis of hypothyroidism. The 12/29/25 FCS identified R2 needed physical assistance with bathing, dressing, toileting, and transferring; required assistance with management of medications and treatments; was at risk for falls due to unsteadiness; and had impaired decision-making. R2 had short-term memory, long-term memory, memory recall, and decision-making cognitive difficulties. R2 sometimes understood and sometimes	S3085		

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S3085	Continued From page 9	S3085		

understandable with communication.

The 12/29/25 combined NSA/HSP identified R2 required assistance of more than one staff member to transfer, bathe, and toilet. The NSA/HSP indicated she required periodic orientation to complete daily routine, and "resident/family" was to provide service. R2 was able to make needs known most times and receives assistance from husband as needed. R2's husband provided management of medications. The NSA/HSP failed to describe services provided for prevention of falls or cognition difficulties.

On 05/05/26 at 03:47 PM Certified Nurse Aide H stated R2's husband answers for her most of the time, staff gives choices for things like clothing, and standard fall precautions are taken to prevent her from falling.

On 05/05/26 at 06:30 PM Administrative Staff A confirmed R2's NSA failed to include services she received and the provider of the services.

The administrator failed to ensure R2's NSA described the services she received, and the provider of the services.

- Record review for R3 revealed an admission date of 02/27/25 with a diagnosis of Alzheimer's.

The 03/04/25 FCS (most recent provided by facility when requested) identified R3 required supervision with bathing and dressing; physical assistance with management of medications and treatments; was independent with toileting, transfers, walking/mobility, and eating; had no

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S3085	Continued From page 10	S3085		

communication difficulties; had short-term memory, long-term memory, memory recall, and decision-making cognitive difficulties. R3 was identified at risk of falls and had impaired decision making.

The 04/28/26 combined NSA/HSP identified R3 was provided assist with bathing by hospice twice a week and staff assistance to dress. Staff reminded R3 to toilet and provided peri care and administered medications. R3 transferred and ambulated by self. Facility staff and hospice staff asked simple questions for yes and no answers. The NSA/HSP failed to indicate services provided for fall prevention and impaired decision making.

On 05/05/26 at 02:55 PM R3's husband stated he expected staff to help R3 with decisions and keep her safe.

On 05/06/26 at approximately 09:31 AM Certified Medication Aide I stated R3's falls were mostly balance issues but she was unable to state what interventions were put into place to prevent balance issues causing falls.

On 05/04/26 at 02:54 PM Administrative Staff A stated she expected staff to document an intervention with an addendum to the NSA and then the next NSA/HSP would be updated with all addendums created since last NSA/HSP. She confirmed R3's NSA failed to describe the services provided for impaired decision making and prevention of falls.

The facility's 07/01/12 "Negotiated Service Agreement" policy instructed staff to include in

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S3085	Continued From page 11 each residents' NSA the services to be provided and providers of each service. The administrator failed to ensure R3's NSA described the services she received, and the provider of the service based on her FCS.	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 by: KAR 26-41-202(d)(2) The facility reported a census of 60 residents with three residents included in the sample, two focused record reviews, and seven closed record reviews. Based on interview and record review the administrator failed to ensure facility staff reviewed and revised the Negotiated Service Agreement (NSA) for Resident (R) 2, R4, R7,	S3092		

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and R9 upon significant change in condition as defined in K.A.R. 26-39-100.

Findings included:

- Record review for R2 revealed an admission date of 12/01/25 with a diagnosis of hypothyroidism.

The 12/29/25 FCS identified R2 needed physical assistance with bathing, dressing, toileting, and transferring; required assistance with management of medications and treatments; was at risk for falls due to unsteadiness; and had impaired decision-making. R2 had short-term memory, long-term memory, memory recall, and decision-making cognitive difficulties. R2 sometimes understood and sometimes understandable with communication.

The 12/29/25 combined NSA/HSP identified R2 required assistance of more than one staff member to transfer, bathe, and toilet. The NSA/HSP indicated she required periodic orientation to complete daily routine, and "resident/family" was to provide service. R2 was able to make needs known most times and receives assistance from husband as needed. R2's husband provided management of medications. The NSA/HSP failed to describe services provided for prevention of falls or cognition difficulties.

Review of nurse note dated 01/20/26 at 12:45 PM revealed the resident was seen by her primary care provider on 01/17/26 and ordered physical therapy and occupational therapy to evaluate and treat R2 for physical debility and

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S3092	Continued From page 13 generalized weakness. On 05/04/26 at 03:43 PM Administrative Staff B confirmed there was not an updated NSA/HSP or revised NSA for 01/27/26 when third party services started. On 05/05/26 at 12:46 PM Administrative Nurse C confirmed she had not revised the NSA for R2 when she started or stopped services with therapies. The administrator failed to ensure R2's NSA described the services she received, and the provider of the service. - Record review for R4 revealed an admission date of 10/31/25 with diagnoses including dementia, depression, and schwannoma of cranial nerve. The 01/05/26 (most recent) FCS identified R4 required supervision with bathing, dressing, and transfers; was unable to perform management of medications and treatments; was independent with toileting, mobility, and eating; was continent of bladder; had short-term memory, memory recall, and decision making cognitive difficulties; was rarely or never understood and sometimes understood others with communication; and was at risk for falls, wandering, impaired decision making, and socially inappropriate behavior. The 01/05/26 combined NSA/HSP identified facility staff would provide R4 assistance with bathing; management of medications and treatments; and redirection for cognition. The NSA indicated R4 worked with a local palliative	S3092		

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S3092	Continued From page 14 care team but failed to include home health, physical therapy, or occupational therapies. Review of 01/07/26 at 10:00 AM "Observation" revealed R4 was seen by a local home health agency for a routine visit. This note written by Administrative Nurse E was the first "Observation" note indicating the home health agency was caring for R4. Review of 01/26/26 "Third Party Coordination Form" revealed occupational therapy discharged R4 due to reaching maximum level of functioning. Review of 01/29/26 "Third Party Coordination Form" revealed physical therapy discharged R4. On 05/05/26 at 06:30 PM Administrative Staff A confirmed R4's NSA failed to include home health, physical therapy, or occupational therapies for when they started and when they discharged. - Record review for R7 revealed an admission date of 09/26/25 with diagnoses including dementia, alcohol dependence, hypertension, and atrial fibrillation. The 10/03/25 (most recent) FCS identified R7 was independent with bathing, dressing, toileting, transfers, mobility, and eating; required physical assistance with management of medications and treatments; was continent of bladder; had memory recall and decision-making cognitive difficulties; had impaired decision making; and was at risk for falls.	S3092		

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S3092	Continued From page 15 The 10/03/25 combined NSA/HSP identified facility staff would prompt R7 to shower, and his family managed his medications. R7 was independent with dressing, toileting, mobility, and eating. The NSA/HSP failed to identify services provided for cognition, fall prevention, or impaired decision making. Review of local hospital provider's "History and Physical" dated 11/03/25 revealed R7 had a decline in self care abilities. He was incontinent, not bathing self, and not taking medications as ordered. The provider diagnosed R7 with dehydration, inadequate oral intake, and acute encephalopathy. On 05/05/26 at 06:30 PM Administrative Staff A confirmed R7 did not receive an updated NSA/HSP when he experienced a significant change in condition. - Record review for R9 revealed an admission date of 10/18/24 with diagnoses including cerebral infarction, diabetes mellitus type two, chronic kidney disease, and nutritional anemia. The 03/18/25 (most recent) FCS identified R9 was independent with toileting, transfers, eating, and management of medications and treatments; required physical assistance with bathing and dressing; required supervision with mobility; was occasionally incontinent of bladder; had no cognitive difficulties; and had impaired vision. The 03/18/25 combined NSA/HSP identified facility staff would assist R9 to shower and dress. R9 was independent with toileting, mobility, and management of medications and had no special	S3092		

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S3092	Continued From page 16 needs with eating. Review of "Observation" note dated 06/23/25 at 11:00 AM revealed R9 was transported to the local hospital for treatment. Review of "Observation" note dated 08/07/25 at 07:00 PM revealed R9 was readmitted to the facility and had established care with hospice. On 05/05/26 at 06:30 PM Administrative Staff A confirmed R9's record failed to include an updated NSA/HSP when R9 was hospitalized and returned with hospice. The facility's 07/01/12 "Negotiated Service Agreement" policy instructed staff to update the plan upon significant change in condition and every 120 days. The administrator failed to ensure facility staff reviewed and revised the NSA for R2, R4, R7, and R9 upon change in condition.	S3092		
S3211 SS=F	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	S3211		

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S3211	Continued From page 17 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 60 residents. Based on observation and interview, the administrator failed to ensure a licensed pharmacist or licensed nurse placed the full names of residents on the original packages of eight over-the-counter (OTC) medications in the medication carts. Findings included: - Observation on 04/28/26 at 11:54 AM revealed the "200 and 300" hall medication cart unlocked by Certified Medication Aide F contained the following OTC medications were not labeled with residents' full names: Two bottles acetaminophen 500 milligram (mg), 250 gelcaps One bottle Plasmanex dietary supplement, 60 capsules One bottle Ostinol proteins, 30 capsules One bottle Prevagen supplement, 30 capsules One bottle Acid-A-Cal supplement, 100 capsules One bottle Brain Reset supplement, 60 capsules On 04/28/26 at approximately 11:58 AM Administrative Staff A confirmed the OTC medications were not labeled with residents' full names and she expected licensed nurses to	S3211		

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S3211	Continued From page 18 label upon receiving the medications. The administrator failed to ensure a licensed pharmacist or licensed nurse placed the full names of residents on the original packages of eight OTC medications.	S3211		
S3216 SS=F	26-41-205 (i) Disposition of Medication (i) Accountability and disposition of medications. Licensed nurses and medication aides shall maintain records of the receipt and disposition of all medications managed by the facility in sufficient detail for an accurate reconciliation. (1) Records shall be maintained documenting the destruction of any deteriorated, outdated, or discontinued controlled medications and biologicals according to acceptable standards of practice by one of the following combinations: (A) Two licensed nurses; or (B) a licensed nurse and a licensed pharmacist. (2) Records shall be maintained documenting the destruction of any deteriorated, outdated, or discontinued non-controlled medications and biologicals according to acceptable standards of practice by any of the following combinations: (A) Two licensed nurses; (B) a licensed nurse and a medication aide; (C) a licensed nurse and a licensed pharmacist; or (D) a medication aide and a licensed pharmacist. This REQUIREMENT is not met as evidenced by: KAR 26-41- 205(i)	S3216		

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S3216	Continued From page 19 The facility reported a census of 60 residents. Based on observation and interview the administrator failed to ensure licensed nurses maintained records of the disposition of all medications in sufficient detail for accurate reconciliation. Findings included: - Observation on 04/28/26 at approximately 12:15 PM revealed the 200 and 300 halls medication cart contained medications for the residents. The medication cart included a separate locked compartment which contained controlled medications and a binder on top including paper logs for each medication. Inside the locked compartment was a bottle of morphine sulfate 20 milligrams per milliliter with approximately 25 milliliters for R13 with no corresponding log in the logbook. On 04/28/26 at 12:43 PM the facility provided a "Controlled Drug Receipt Record/Disposition Form" for "morphine sul" with R13's name which documented 26 milliliters were destroyed by Administrative Nurse C and Administrative Nurse D on 04/27/26. On 05/05/26 at 06:00 PM the drug destruction log from 04/27/26 was requested and Administrative Nurse C pulled the logs from a file in her office. Review of the destruction log revealed morphine sulfate was not listed. On 05/05/26 at approximately 06:05 PM Administrative Nurse C confirmed the controlled medication had been documented as destroyed	S3216		

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S3216	Continued From page 20 but was still located in the medication cart. She also confirmed she did not document any liquids that were wasted 04/27/26 on the facility's destruction log and liquids included medications from residents other than R13. The facility's 07/01/2012 "Medication Disposal" policy instructed staff to record all disposed medications on the "Drug Destruction Log." The policy indicated the "Drug Destruction Log" was to be completed separately for each resident and placed in the resident's file. The administrator failed to ensure licensed nurses maintained records of the disposition of all medications in sufficient detail for accurate reconciliation.	S3216		
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 21 This REQUIREMENT is not met as evidenced by: KAR 26-41-205(l)(2) The facility reported a census of 60 residents with three residents sampled, two focused record reviews, and seven closed record reviews. Based on interview and record review the administrator failed to ensure a licensed nurse notified Resident (R)1 and R3's medical care providers of variances identified in the medication regimen reviews by the licensed pharmacist; and failed to ensure a licensed nurse sought a response within five working days. Findings included: - Review of R1's record revealed an admission date of 08/05/22 with the following diagnoses in the electronic record: diabetes mellitus type two, anemia, and hypertension. The 03/31/26 Functional Capacity Screen (FCS) identified R1 was unable to perform management of medications. The 03/31/26 combined Negotiated Service Agreement/Healthcare Service Plan (NSA/HSP) for R1 identified facility staff would administer medications. Review of R1's electronic medical record revealed a total of four diagnoses. Review of 05/08/25 "Problem List" revealed a total of 53 diagnoses including atrial fibrillation, urinary retention, benign prostatic hyperplasia,	S3227		

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S3227	Continued From page 22	S3227		

neuropathy, chronic kidney disease, coronary artery disease, hypertension, and transient ischemic attack.

On 05/05/26 at 12:20 PM pharmacy reviews were requested from Administrative Staff A who stated the reviews were in a separate binder in Administrative Nurse C's office.

On 05/05/26 at 04:22 PM Administrative Staff A provided a pharmacy review dated 06/23/25 with request to update the diagnosis list in the electronic medical record from the "problem list dated 5/8/25" from R1's primary care provider.

On 05/05/26 at approximately 04:25 PM Administrative Staff A confirmed R1's record lacked evidence a licensed nurse had completed any of the pharmacist's recommendations.

- Review of R3's record revealed an admission date of 02/27/25 with a diagnosis of Alzheimer's.

The 03/04/25 FCS identified R3 required physical assistance with management of medications.

The 04/28/26 NSA/HSP for R3 identified facility staff would administer medications.

Review of 03/04/25 "Recommendation Outcomes" revealed the licensed pharmacist recommended diagnoses to be added to the electronic medical record as none were listed.

Review of 09/30/25 "Recommendation Outcomes" revealed the licensed pharmacist recommended diagnoses to be added to the

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S3227	Continued From page 23 electronic medical record as none were listed. Review of 06/01/25 "Pharmacist's Report to Nursing" revealed the licensed pharmacist recommended to verify acetaminophen extended-release tablet could be taken whole. If not, to request R3's provider to change it to a crushable form of the medication. Review of R3's record revealed the lack of documentation acetaminophen extended-release tablets were able to be taken whole. R3's "Medication Administration Record" for April of 2026 listed acetaminophen 650 milligrams extended release was ordered to be given twice a day and acetaminophen 650 milligrams (not extended-release) could be given every four hours as needed for pain. On 05/05/26 at approximately 04:25 PM Administrative Staff A confirmed R3's record lacked evidence a licensed nurse had completed any of the pharmacist's recommendations. The administrator failed to ensure a licensed nurse notified R1 and R3's medical care providers of variances identified in the medication regimen reviews by the licensed pharmacist; and failed to ensure a licensed nurse sought a response within five working days.	S3227		
S3228 SS=F	26-41-205 (l) (3) Medication Regimen Review Record (l) (3) The administrator or operator, or the designee, shall ensure that the medication regimen review is kept in each resident ' s	S3228		

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S3228	Continued From page 24 clinical record. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(l)(3) Scope and Severity F The administrator or operator, or the designee, shall ensure that the medication regimen review is kept in each resident's clinical record. This requirement is not met as evidenced by: The facility reported a census of 60 residents with three residents sampled, two focused record reviews, and seven closed record reviews. Based on interview and record review the administrator failed to ensure medication regimen reviews were kept in all residents' clinical records. Findings included: - Review of R1's record revealed an admission date of 08/05/22 with the following diagnoses in the electronic record: diabetes mellitus type two, anemia, and hypertension. The 03/31/26 Functional Capacity Screen (FCS) identified R1 was unable to perform management of medications. The 03/31/26 combined Negotiated Service Agreement/Healthcare Service Plan (NSA/HSP) for R1 identified facility staff would administer	S3228		

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S3228	Continued From page 25 medications. R1's record lacked documentation of quarterly medication regimen reviews. On 05/05/26 at 12:20 PM pharmacy reviews were requested from Administrative Staff A who confirmed the reviews were in a separate binder in Administrative Nurse C's office. - Review of R2's record revealed an admission date of 12/01/25 with a diagnosis of hypothyroidism. The 11/12/25 FCS identified R2 was able to independently perform management of medications. The 12/29/25 NSA/HSP for R2 identified R2's husband would manage medications. R2's record lacked documentation quarterly medication regimen reviews were offered or completed. - Review of R3's record revealed an admission date of 02/27/25 with a diagnosis of Alzheimer's. The 03/04/25 FCS identified R3 required physical assistance with management of medications. The 04/28/26 NSA/HSP for R3 identified facility staff would administer medications. R3's record lacked documentation of quarterly medication regimen reviews.	S3228		

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S3228	Continued From page 26 On 05/05/26 at 12:20 PM Administrative Staff A stated pharmacy reviews were kept in a file in Administrative Nurse C's office. On 04/30/26 at approximately 03:45 PM Administrative Staff A and Administrative Nurse B confirmed quarterly medication regimen reviews were not in and part of the residents' records. The administrator failed to ensure quarterly medication regimen reviews were kept in all resident clinical records.	S3228		
S3260 SS=E	26-41-105 (f) (1 - 10) Resident Records Content (f) Each resident record shall contain at least the following: (1) The resident's name; (2) the dates of admission and discharge; (3) the admission agreement and any amendments; (4) the functional capacity screenings; (5) the health care service plan, if applicable; (6) the negotiated service agreement and any revisions; (7) the name, address, and telephone number of the physician and the dentist to be notified in an emergency; (8) the name, address, and telephone number of the legal representative or the individual of the resident's choice to be notified in the event of a significant change in condition; (9) the name, address, and telephone number of the case manager, if applicable; (10) records of medications, biologicals, and treatments administered and each medical care provider ' s order if the facility is managing the resident's medications and medical treatments;	S3260		

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S3260	Continued From page 27 and This REQUIREMENT is not met as evidenced by: KAR 26-41-105(f)(4) The facility reported a census of 60 residents with three residents included in the sample, two focused record reviews, and seven closed record reviews. Based on interview and record review the administrator failed to ensure R1, R2, and R3's records contained all completed functional capacity screens. Findings included: - On 04/28/26 at 10:05 AM during entrance interview Administrative Staff A stated the facility used an electronic system for Functional Capacity Screens (FCS) and Negotiated Service Agreements (NSA), a separate electronic system for medication and nurse documentation, and had paper charts. She stated the FCS and NSA were printed and placed in the paper records. On 05/04/26 at 12:27 PM R2 and R3's paper records were requested. - Record review for R1 revealed an admission date of 08/05/22 with diagnoses including anemia and hypertension. R1's record revealed an FCS dated 11/20/25 in	S3260		

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his paper record which was not signed.

On 05/04/26 at approximately 05:41 PM Administrative Staff A provided an FCS dated 03/31/26 which was not signed and she confirmed it was not in R1's paper record.

- Record review for R2 revealed an admission date of 12/01/25 with a diagnosis of hypothyroidism.

R2's record revealed the 11/12/25 (admission) FCS in her record was not signed by a licensed nurse.

R2's record included an NSA dated 04/07/26.

On 05/04/26 at 03:43 PM an FCS dated 04/07/26 was requested which the facility failed to provide.

On 05/04/26 at 06:41 PM Administrative Staff A sent an FCS dated 11/12/25 which was signed by Administrative Nurse C and stamped "File Copy" via email.

On 05/04/26 at approximately 03:43 PM Administrative Staff A confirmed R2's paper record failed to include her completed FCSs.

- Record review for R3 revealed an admission date of 02/27/25 with a diagnosis of Alzheimer's.

R3's paper record failed to include an FCS.

On 05/04/26 at approximately 03:00 PM Administrative Staff B confirmed R3's record failed to include an FCS.

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S3260	Continued From page 29 The administrator failed to ensure R1, R2, and R3's records contained all completed functional capacity screens.	S3260		
S3261 SS=E	26-41-105 (f) (11) Resident Record Documentation of Incidents (f) (11) documentation of all incidents, symptoms, 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 60 residents with three residents included in the sample, two focused record reviews, and seven closed record reviews. Based on interview and record review the administrator failed to ensure licensed staff documented all incidents, symptoms, and other indications of illness or injury including the date and time of occurrence, action taken, and results of the action when Resident (R) 3 sustained falls, R7 was hospitalized, and R8 became deceased. Findings included: - Record review for R3 revealed an admission date of 02/27/25 with a diagnosis of Alzheimer's. The 03/04/25 Functional Capacity Screen (FCS) identified R3 required supervision with bathing and dressing; physical assistance with management of medications and treatments; was	S3261		

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	N089045	A. BUILDING: _____ B. WING _____	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGEND AT CAPITAL RIDGE	1931 SW ARVONIA PLACE TOPEKA, KS 66615

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S3261	Continued From page 30	S3261		

independent with toileting, transfers, walking/mobility, and eating; had no communication difficulties; had short-term memory, long-term memory, memory recall, and decision-making cognitive difficulties. R3 was identified at risk of falls and had impaired decision making.

The 04/28/26 combined Negotiated Service Agreement/Health Care Plan (NSA/HSP) identified R3 was provided assist with bathing by hospice twice a week and staff assistance to dress. Staff reminded R3 to toilet and provided peri care and administered medications. R3 transferred and ambulated by self. Facility staff and hospice staff asked simple questions for yes and no answers. The NSA/HSP failed to indicate services provided for fall prevention and impaired decision making.

The 11/10/25 at 03:00 PM "Observation" note revealed R3 fell on 11/07/25 and 11/08/25. The note failed to include time of occurrence, action taken, and results of the action.

The 01/08/26 at 10:15 AM "Observation" note revealed R3 fell on 01/06/26 and received abrasions to nose and forehead. The note failed to include time of occurrence, action taken, and results of the action.

The 02/13/26 at 05:00 PM "Observation" note by Administrative Nurse C documented hospice had seen R3 for follow up from non-injury fall. Staff had reported to hospice that R3 was "found on the floor at 02:10". The note failed to indicate what day, action taken, or result of the action.

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S3261	Continued From page 31 The 02/19/26 at 04:00 PM "Observation" note documented hospice was in for a routine visit. The next "Observation" note dated 02/23/26 at 04:15 PM by Administrative Nurse C documented hospice nurse visited due to R3 having three falls in past two days without listing any details. Review of R3's record revealed lack of evidence of documentation of all incidents including the date and time of occurrence, action taken, and results of the action when she sustained at least seven falls. On 05/04/26 at 02:54 PM Administrative Staff A confirmed R3's record lacked evidence of documentation of incidents, symptoms, and other indications of illness or injury including the date and time of occurrence, action taken, and results of the action after at least seven falls. - Record review for R7 revealed an admission date of 09/26/25 with diagnoses including dementia, alcohol dependence, hypertension, and atrial fibrillation. The 10/03/25 (most recent) FCS identified R7 was independent with bathing, dressing, toileting, transfers, mobility, and eating; required physical assistance with management of medications and treatments; was continent of bladder; had memory recall and decision-making cognitive difficulties; had impaired decision making; and was at risk for falls. The 10/03/25 combined NSA/HSP identified facility staff would prompt R7 to shower, and his family managed his medications. R7 was	S3261		

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independent with dressing, toileting, mobility, and eating. The NSA/HSP failed to identify services provided for cognition, fall prevention, or impaired decision making.

Review of local hospital provider's "History and Physical" dated 11/03/25 revealed R7 had a decline in self-care abilities. He was incontinent, not bathing self, and not taking medications as ordered. The provider diagnosed R7 with dehydration, inadequate oral intake, and acute encephalopathy.

The 10/03/25 at 05:30 PM "Observation" note documented R7's arrival to the facility.

The next "Observation" note was dated 10/17/25 indicating R7's primary care provider seen him to establish care and ordered some laboratory studies.

The next "Observation" note was dated 11/03/25 at 04:00 PM and indicated R7 was admitted to the hospital for encephalopathy.

Review of R7's record revealed lack of evidence of documentation of all symptoms and other indications of illness including the date and time of occurrence, action taken, and results of the action when R7 was in the facility for approximately 30 days and showed decline, refusal of cares, symptoms of alcohol withdrawal, weight loss, dehydration, and was hospitalized.

Interview on 04/30/26 at 01:20 PM Administrative Nurse C stated R7 quit drinking alcohol "cold turkey" and began refusing to go to meals and refused cares. She stated she was concerned

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about weight loss. R7 had withdrawal symptoms and Administrative Nurse C confirmed it was not charted in his record.

- Record review for R8 revealed an admission date of 07/01/24 with a diagnosis of dementia.

The 11/19/24 FCS identified R8 required physical assistance with bathing, dressing, toileting, transfers, walking/mobility, eating, and management of medications and treatments; was frequently incontinent of bladder; had no cognitive or communication difficulties; and had impaired vision.

The 11/19/24 NSA/HSP identified facility staff would provide R8 assistance with bathing, dressing, toileting, transfers, walking/mobility and management of medications.

Review of R8's "Observations" which are the clinical notes had one entry dated 01/20/25 at 07:21 AM which indicated R8 was deceased on 01/19/25.

Review of R8's record revealed lack of evidence of documentation of all incidents, symptoms, and other indications of illness or injury including the date and time of occurrence, action taken, and results of the action when R8 became ill enough she passed away.

On 05/05/26 at 12:20 PM Administrative Staff A confirmed R8's record lacked evidence of documentation of incidents, symptoms, and other indications of illness or injury including the date and time of occurrence, action taken, and results of the action during R8's admission.

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S3261	Continued From page 34 The administrator failed to ensure licensed staff documented all incidents, symptoms, and other indications of illness or injury including the date and time of occurrence, action taken, and results of the action when R3 sustained falls, R7 was hospitalized, and R8 became deceased.	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 This REQUIREMENT is not met as evidenced by: KAR 26-41-207(c) The facility reported a census of 60 residents three sampled, two focused record reviews, and seven closed record reviews included in the sample. Based on interview and record review the administrator failed to ensure the facility remained in compliance with the department's	S3310		

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S3310	Continued From page 35 tuberculosis (TB) guidelines for adult care homes adopted by reference in KAR 26-39-105 for two residents and one staff which had the potential to affect all residents. Findings included: - Record review for Resident (R) 2 revealed an admission date of 12/01/25 with diagnosis of Hypothyroidism. R2's record lacked evidence of documentation an initial TB two-step skin test (TST) was administered within seven days of residency or documentation of a previous significant reaction. During interview on 05/05/26 at 12:41PM Administrative Staff A stated R2 refused Tuberculin and could not provide documentation of the refusal. - Record review for R3 revealed an admission date of 02/27/25 with diagnosis of Alzheimer's. R3's record lacked evidence of documentation an initial TB TST was administered within seven days of residency or documentation of a previous significant reaction. During interview on 05/05/26 at 12:41PM Administrative Staff A confirmed R3's record failed to include TB TST. - Review of Certified Medication Aide (CMA) G's employee record revealed a hire date of 11/10/25 and lacked evidence of documentation of TB testing.	S3310		

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S3310	Continued From page 36 During interview on 04/30/26 at approximately 09:50AM with Administrative Staff A, she confirmed the employee CMA G's record lacked TB TST. The June 2013 department's "Tuberculosis (TB) Guidelines for Adult Care Homes" documented each new employee, and each new resident shall receive a two-step TB skin test within seven days of employment or residency. The administrator 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		