STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089033	A. BUILDING: _____ B. WING _____	04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEGGY KELLY HOUSE I	2111 SW RANDOLPH AVENUE TOPEKA, KS 66614

(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 incident 198062 and complaint 197926, 197808, and 197529 at the above named residential healthcare facility conducted on 04/06/26-04/07/26.	S 000		
S3155 SS=E	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(a) The facility reported a census of seven residents with three included in the sample. Based on interview and record review the operator failed to ensure a licensed nurse provided and coordinated care according to Resident (R) 2 and R3's Negotiated Service Agreement (NSA). Findings included: - Record review for R2 revealed an admission date of 09/24/24 with a diagnosis of dementia.	S3155		

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

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S3155	Continued From page 1 The 11/19/25 FCS identified R2 required supervision with eating; was usually understood and was usually understandable during communication; and had short-term memory, long-term memory, memory recall, and decision-making difficulties. The 11/19/25 NSA identified facility staff assisted R2 with eating and allowed time to respond when communicating. The 11/19/25 "Service Plan Report" which is the facility's Healthcare Service Plan (HSP) instructed staff to assist R2 with eating. Observation on 04/07/26 at 01:23 PM of R2 eating lunch revealed she dropped approximately 20% of her food on the floor. At 01:36 PM Certified Medication Aide C fed R2 an individual sized amount of yogurt. At 01:45 PM Administrative Nurse B put one piece of Cheetos in R2's hand which R2 was unable to get into mouth. R2 was unable to pick up any pieces of the pizza or Cheetos on own. Staff failed to sit next to R2 and assist her with eating her meal. On 04/07/26 at 01:23 PM Administrative Nurse B stated R2 ate well with finger foods but with other foods she needed assistance. On 04/07/26 at 01:58 PM Administrative Staff A confirmed R2 was not receiving eating assistance per her NSA. She also stated she expected more details on the NSA regarding what assistance R2 required. - Record review for R3 revealed an admission date of 11/30/19 with a diagnosis of dementia.	S3155		

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S3155	Continued From page 2 The 02/18/26 FCS identified R3 was unable to perform bathing, toileting, transfers, and management of medications or treatments; required physical assistance with dressing, mobility, and eating; was incontinent of bladder; sometimes understood and was sometimes understandable during communication; had short-term memory, long-term memory, memory recall, and decision-making difficulties; and had impaired decision making. The 02/18/26 NSA identified facility staff assisted R3 with eating and had a mechanical soft diet. The 02/18/26 HSP "eating" section instructed staff to serve the diet as ordered, food textures needed to be altered in order to eat, and to provide physical assistance with meals. The HSP included a section titled "Eating/Dietary and Nutrition" which instructed staff to provide physical assistance or cueing with meals which was not the same as the "eating" section. Review of "Resident Roster" provided 04/06/26 upon entrance to facility revealed R3 had a therapeutic diet. Observation on 04/07/26 at 01:11 PM revealed all residents were served the same meal at regular diet consistency including an individual sized pizza, yogurt, and a bag of crunchy Cheetos. Observation on 04/07/26 at 01:48 PM revealed R3 had not received any assistance from staff to eat and still had approximately 75% of meal still on plate. She took one small bite of pizza crust	S3155		

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S3155	Continued From page 3 and was unable to chew and swallow within approximately 3 minutes. Interview of Administrative Staff A on 04/07/26 at 01:58 PM confirmed the meal served to R3 was not mechanical soft. The facility's policy binder failed to include a policy regarding healthcare services and the NSA. The operator failed to ensure a licensed nurse provided and coordinated care according to Resident (R) 2 and R3's NSAs.	S3155		
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 seven residents with three residents included in the sample. Based on interview and record review the operator 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) 1 and R2	S3261		

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S3261	Continued From page 4 sustained falls. Findings included: - Record review for R1 revealed an admission date of 09/26/23 with diagnoses of dementia and hemiplegia. The 11/19/25 Functional Capacity Screen (FCS) identified R1 was unable to perform bathing, dressing, toileting, and transfers; required physical assistance with mobility, eating, and management of medications; was incontinent of bladder; had short-term memory, long-term memory, memory recall, and decision-making difficulties; was sometimes understandable and understood others during communication; and had impaired vision, impaired hearing, and impaired decision-making. The 11/19/25 Negotiated Service Agreement (NSA) identified facility staff would provide complete assistance with bathing, dressing, toileting, mobility, and bladder incontinence; two-person assistance with transfers; physical assistance with eating; management of medications; and allow her time to respond when communicating. The NSA failed to indicate services provided to R1 for her impaired vision, impaired hearing, and impaired decision making. Review of "Nurses Note" dated 10/25/25 at 10:05 PM revealed R1 was found laying beside her bed. She was sent to the local emergency room. The notes failed to indicate result of the action and actions taken to prevent future falls of the same type. Review of "Nurses Note" dated 11/12/25 at 05:50	S3261		

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S3261	Continued From page 5 PM revealed R1 was found sitting in front of recliner and had no injuries. The note failed to indicate what actions were taken after the fall to prevent future falls. Review of R1's record revealed lack of documentation including the actions taken and results of the actions when she sustained falls. On 04/07/26 at 12:22 PM fall incident reports were requested. - Record review for R2 revealed an admission date of 09/24/24 with a diagnosis of dementia. The 11/19/25 FCS identified R2 required physical assistance with bathing, dressing, toileting, and mobility; supervision with transfers and eating; was unable to perform management of medications and treatments; was frequently incontinent; usually understood and was usually understandable during communication; had short-term memory, long-term memory, memory recall, and decision-making difficulties; and was at risk of falls, impaired decision making, and wandering. The 11/19/25 NSA identified facility staff assisted R2 with bathing, dressing, toileting, transfers, mobility, eating, management of medications and treatments, and bladder incontinence. Staff removed R2 from agitating situations for decision making, took outside for walks when wandering, and allowed time to respond when communicating. The 11/19/25 "Service Plan Report" which is the facility's Healthcare Service Plan (HSP)	S3261		

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S3261	Continued From page 6	S3261		

instructed staff, which started on 05/16/25, to anticipate R2's needs, assist her to seated position if wandering in an unsafe area, allow to sleep in living area, and familiarize with her routine to prevent falls. The HSP failed to include any more recent fall prevention interventions.

Review of "Nurses Note" dated 12/11/25 at 04:10 AM revealed R2 was found lying on the floor and had sustained a laceration. She was sent to the local emergency room and received radiology testing and laceration repair. The note failed to indicate actions taken to prevent future falls.

Review of "Nurses Note" dated 01/31/26 at 06:24 AM revealed R2 fell headfirst to floor from toilet. The note failed to indicate action taken and result of action to prevent future falls.

Review of "Nurses Note" dated 03/22/26 at 06:52 PM revealed R2 was lowered to the floor after leaning forward off stool. The note failed to indicate action taken and result of action to prevent fall recurrence.

On 04/07/26 at 01:13 PM Administrative Staff A stated she expected the nurse notes to indicate what interventions were put into place to prevent recurrence of falls. She confirmed the fall incident report forms and the nurse notes for R1 and R2's falls did not indicate actions taken and results of the actions after they sustained multiple falls.

The facility's policy binder failed to include a policy regarding documentation.

The operator failed to ensure licensed staff

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S3261	Continued From page 7 documented all incidents, symptoms, and other indications of illness or injury including the date and time of occurrence, action taken, and results of the actions when Resident (R) 1 and R2 sustained falls.	S3261		
S3320 SS=F	28-39-254 CONSTRUCTION (a) The assisted living facility or residential health care facility shall be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel and the public. (b) All new construction, renovation, remodeling and changes in building use in existing buildings shall comply with building and fire codes, ordinances and regulations enforced by city, county, and state jurisdictions, including the state fire marshal. (c) New construction, modifications and equipment shall conform to the following codes and standards: (1) Title III of the Americans with disabilities act, 42 U.S.C. 12181, effective as of January 26, 1992; and (2) "Food Service Sanitation Manual," health, education, and welfare (HEW) publication no. FDA 78-2081, as in effect on July 1, 1981. This REQUIREMENT is not met as evidenced by: KAR 28-39-254(a)	S3320		

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S3320	Continued From page 8 The facility reported a census of seven residents. Based on observation and interview, the operator failed to ensure the facility was maintained to protect the health and safety of the residents and visitors by ensuring all chemicals were stored within locked areas. Findings included: - Observation on 04/06/26 at 09:48 AM of the public bathroom revealed the door was open with a cabinet inside with a broken lock that contained the following chemicals with labels that said "Keep out of reach of children": One 32 fluid ounce spray bottle of glass cleaner One 12.5-ounce aerosol can of disinfectant spray One 24 fluid ounce container of toilet bowl cleaner One 32 fluid ounce spray bottle of disinfectant cleaner with bleach Sitting on top of the cabinet was a basket containing one 19 ounce aerosol can of disinfectant spray and one 8.1 ounce spray bottle of air mist with labels that read "Keep out of reach of children." On 04/06/26 at approximately 10:45 AM Administrative Staff A confirmed chemicals were not in a locked area. - Observation on 04/06/26 at 10:07 AM of the kitchen revealed two entry gates into area both open, no staff within area, and a cabinet below the sink with a broken lock that contained the following chemicals with labels that said "Keep out of reach of children":	S3320		

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S3320	Continued From page 9 One 32 fluid ounce spray bottle of all-purpose cleaner One 12.5-ounce aerosol can of disinfectant spray One 36 fluid ounce bottle of pot and pan detergent One 80-fluid ounce bottle of multi-surface cleaner Three boxes 140 count dishwasher packs On 04/06/26 at approximately 10:15 AM Certified Nurse Aide D confirmed chemicals were not in a locked area. On 04/07/26 at 10:46 AM Administrative Staff A stated her expectation was for the bathroom door and kitchen gates to be shut and locked when staff not around as well as the cabinets with working locks. She also expected the staff to notify her of any items needing reported to maintenance for repair. The facility's policy binder failed to include a policy regarding storage of chemicals. The operator failed to ensure the building was maintained to protect the health and safety of the residents and visitors by ensuring all chemicals were stored within locked areas.	S3320		