STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089040	A. BUILDING: _____ B. WING _____	11/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE TOPEKA	5800 SW DRURY LANE TOPEKA, KS 66604

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S 000	INITIAL COMMENTS The following represents the findings of a resurvey with attached complaint 192035, 189606, 188771, 188532, 188435, and 188458 at the above named assisted living facility conducted 10/29/25-11/03/25.	S 000		
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 by: KAR 26-41-202(a)(1)(2) The facility reported a census of 32 residents with three residents included in the sample and two closed record reviews. Based on interview, observation, and record review the administrator	S3085		

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

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S3085	Continued From page 1	S3085		

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)3 and R4 including a description of the services the resident received and the provider of each service.

Findings included:

- Record review for R3 revealed an admission date of 12/06/22 with a diagnosis of Alzheimer's.

The 09/02/25 FCS identified R3 required physical assistance with bathing, dressing, toileting, transferring, walking/mobility, and management of medications. He needed supervision with eating; had short-term memory, long-term memory, memory/recall, and decision-making cognitive difficulties; was usually understandable and sometimes understood others during communication; and was occasionally incontinent of bladder, at risk of falls, had impaired hearing and impaired decision-making.

The 09/02/25 combined NSA and Healthcare Service Plan (HSP) for R3 acknowledged facility staff provided assistance with bathing, dressing, toileting, transferring, walking/mobility, management of medications, and with cognitive difficulties. The NSA/HSP failed to describe services provided for hearing impairment and communication.

On 11/03/25 at 02:39 PM during interview R3 was difficult to understand with communication. Phrases, questions, and responses had to be

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S3085	Continued From page 2	S3085		

repeated for understanding when talking to and listening to R3. He leaned closer to speaker to hear. Talking in a louder voice close to his ear allowed R3 to understand during communication.

On 11/03/25 at 02:52 PM Administrative Nurse C stated the staff know they need to get close to his ear for R3 to hear.

On 11/03/25 at 02:55 PM Administrative Nurse C confirmed R3's NSA failed to describe the services provided for communication and hearing impairment.

The administrator failed to ensure R3's NSA described the services he received, and the provider of the service based on his FCS.

- Record review for R4 revealed an admission date of 10/20/23 with diagnoses of dementia and Parkinson's disease.

The 03/18/24 FCS identified R4 needed physical assistance with bathing, dressing, toileting, and transferring; required supervision with mobility and eating; was unable to perform management of medications and treatments; had short-term memory, long-term memory, memory/recall, and decision-making cognitive difficulties; was at risk for falls; had impaired vision, decision making, and inappropriate disruptive behavior.

The 08/31/24 combined NSA/HSP identified R4 needed assistance with toileting without who provided the service. R4 was independent with mobility. The NSA/HSP failed to describe services provided for transfers.

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S3085	Continued From page 3 Review of "Post-Fall Evaluation Initial" forms provided by the facility for July of 2024 revealed R4 sustained unwitnessed falls in the hallway on 07/01/24, 07/04/24, a fall in the common living area on 07/09/24 when trying to walk, a fall in the dining room on 07/21/24, a fall while standing from wheelchair on 07/23/24, and a fall with injury from his wheelchair on 07/27/24 in the hallway. On 11/03/25 at 03:25 PM Administrative Nurse C confirmed R4's NSA failed to describe the services provided for transfers and the provider of the service for transfers and toileting. The administrator failed to ensure R4's NSA described the services he received, and the provider of the service based on his FCS.	S3085		
S3171 SS=D	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 32 residents with three residents included in the sample and two closed record reviews. Based on observation, interview, and record review the administrator failed to ensure a low air loss mattress was properly used according to	S3171		

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S3171	Continued From page 4 manufacturer or provider recommendations for Resident (R) 3. Findings included: - Record review for R3 revealed an admission date of 12/06/22 with a diagnosis of Alzheimer's. The 09/02/25 FCS identified R3 required physical assistance with bathing, dressing, toileting, transferring, walking/mobility, and management of medications. He needed supervision with eating; had short-term memory, long-term memory, memory/recall, and decision-making cognitive difficulties; was usually understandable and sometimes understood others during communication; and was occasionally incontinent of bladder, at risk of falls, had impaired hearing and impaired decision-making. The 09/02/25 combined NSA and Healthcare Service Plan (HSP) for R3 acknowledged facility staff provided assistance with bathing, dressing, toileting, transferring, walking/mobility, management of medications, and with cognitive difficulties. The NSA/HSP listed an air loss mattress provided by hospice on 08/30/25. Observation on 11/03/25 at 02:21 PM revealed a low air loss mattress applied to R4's bed with the pump dial turned as high or firm as the pump allows. On 11/03/25 at 02:15 PM Certified Nurse Aide E stated she knows how to use R4's low air loss mattress but was unaware of what setting it should be set at.	S3171		

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S3171	Continued From page 5 On 11/03/25 at 02:28 PM Administrative Nurse C stated she does not have instructions or settings from the hospice provider or the manual for the mattress. On 11/03/25 at 02:30 PM a policy for the low air loss mattress was requested which the facility failed to provide. The administrator failed to ensure a low air loss mattress was properly utilized according to manufacturer or provider recommendations for R3.	S3171		
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 32 residents with three residents included in the sample and two 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	S3261		

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Resident (R) 1, R2, and R4 sustained falls, R2 sustained a skin tear during care, and R3 was transferred to the hospital after a fall.

Findings included:

- Record review for R1 revealed an admission date of 12/12/24 with diagnoses of mild cognitive impairment and cerebral infarction.

The 07/24/25 "Functional Capacity Screen" (FCS) identified R1 required physical assistance with bathing, dressing, toileting, transfers, and walking/mobility; was independent with eating; was unable to perform management of medications and treatments; was occasionally incontinent of bladder; had short-term memory, long-term memory, memory recall, and decision-making difficulties; was usually understandable and sometimes understood others during communication; was at risk for falls; and had impaired hearing.

The 07/24/25 combined Negotiated Service Agreement/Health Care Plan (NSA/HSP) for R1 identified facility staff would provide physical assist of two persons for transfers. R1 propelled self in wheelchair.

Review of "Post-Fall Evaluation Initial" forms revealed R1 sustained falls on 04/21/25, 05/22/25, 05/29/25, and 09/23/25.

Review of R1'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 he sustained falls on 04/21/25, 05/22/25, 05/29/25, and 09/23/25.

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S3261	Continued From page 7 - Record review for R2 revealed an admission date of 11/12/24 with a diagnosis of failure to thrive. The 04/07/25 FCS identified R2 required physical assistance with bathing, dressing, and toileting; required supervision with transfers; was independent with walking/mobility and eating; was unable to perform management of medications and treatments; was occasionally incontinent of bladder; had short-term memory, long-term memory, memory recall, and decision-making difficulties; was understandable and sometimes understood others during communication; and was at risk for falls, wandering, and impaired decision-making. The 04/07/25 NSA/HSP identified facility staff would provide R2 physical assistance with bathing, dressing, toileting, transfers, and administration of medications. Staff was to encourage R2 to participate in programs and activities to prevent falls. Review of "Post-Fall Evaluations" revealed R2 had "Follow-Up Analysis" completed on 11/27/24, 02/24/25, 05/26/25, 06/19/25, 07/18/25, and 09/05/25. Review of R2'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 had falls approximately 11/27/24, 02/24/25, 05/26/25, 06/19/25, 07/18/25, and 09/05/25. Review of 02/18/25 at 01:50 PM "Alert Charting	S3261		

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Note" revealed R2 was found to have a skin tear four inches in length. The record failed to indicate details of the incident including date and time it occurred.

On 11/03/25 at 01:29 PM Administrative Nurse C confirmed R2 received a skin tear during a care episode prior to finding the wound and it was not documented in her record. She also confirmed the details of the fall incidents were not in her record.

- Record review for R3 revealed an admission date of 12/06/22 with a diagnosis of Alzheimer's.

The 09/02/25 FCS identified R3 required physical assistance with bathing, dressing, toileting, transferring, walking/mobility, and management of medications. He needed supervision with eating; had short-term memory, long-term memory, memory/recall, and decision-making cognitive difficulties; was usually understandable and sometimes understood others during communication; and was occasionally incontinent of bladder, at risk of falls, had impaired hearing and impaired decision-making.

The 09/02/25 combined NSA and Healthcare Service Plan (HSP) for R3 acknowledged facility staff provided assistance with bathing, dressing, toileting, transferring, walking/mobility, management of medications, and with cognitive difficulties. The NSA/HSP failed to describe services provided for hearing impairment and communication.

Review of 08/05/24 at 01:04 PM "General

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Progress Note" revealed R3 was in the hospital and possibly returning to facility 08/06/24. The previous note was a pharmacy note on 07/03/24 and the following note was 08/26/24 at 02:39 PM requesting a follow up appointment from surgery. The record failed to indicate details of the fall R3 sustained as well as the actions taken.

On 11/03/25 at 02:55 PM Administrative Nurse C 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 following a fall and transfer to the hospital resulting in hip surgery.

- Record review for R4 revealed an admission date of 10/20/23 with diagnoses of dementia and Parkinson's disease.

The 03/18/24 FCS identified R4 needed physical assistance with bathing, dressing, toileting, and transferring; required supervision with mobility and eating; was unable to perform management of medications and treatments; had short-term memory, long-term memory, memory/recall, and decision-making cognitive difficulties; was at risk for falls; had impaired vision, decision making, and inappropriate disruptive behavior.

The 08/31/24 combined NSA/HSP identified R4 was provided assistance with toileting without who provided the service. R4 was independent with mobility. The NSA/HSP failed to describe services provided for transfers.

Review of "Post-Fall Evaluation Initial" forms provided by the facility for July of 2024 revealed

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S3261	Continued From page 10 R4 sustained unwitnessed falls in the hallway on 07/01/24, 07/04/24, a fall in the common living area on 07/09/24 when trying to walk, a fall in the dining room on 07/21/24, a fall while standing from wheelchair on 07/23/24, and a fall with injury from his wheelchair on 07/27/24 in the hallway. Review of R4'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 with all of his July 2024 falls. On 11/03/25 at 03:25 PM Administrative Nurse C 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 when he sustained multiple falls. 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 R1, R2, and R4 sustained falls, R2 sustained a skin tear during care, and R3 was transferred to the hospital after a fall.	S3261		