STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089047	A. BUILDING: _____ B. WING _____	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACES AT HERITAGE GROVE ESTATES	1608 SW 37TH STREET TOPEKA, KS 66611

(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 citations represent the findings of a Re-Licensure Survey with Complaint Investigations 192564, 192570, 192805, 1955904, 197323 for the above named Assisted Living Facility conducted on 02/24/26, 02/25/26, and 02/26/26.	S 000		
S3081 SS=E	26-41-201 (c) Functional Capacity Screen Reassessment (c) Designated facility staff shall conduct a screening to determine each resident ' s functional capacity 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; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: KAR 26-41-201 (c)(2) The facility reported a census of 53 residents (R). The sample included three residents, one focused record review, and two closed record reviews. Based on observation, interview, and record review the operator failed to ensure staff completed a "Functional Capacity Screen" for one (R5) of three sampled residents and one (R8) of one focused record review when they experienced a significant change in status. Findings Included:	S3081		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089047	A. BUILDING: _____ B. WING _____	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACES AT HERITAGE GROVE ESTATES	1608 SW 37TH STREET TOPEKA, KS 66611

(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
S3081	Continued From page 1 - R5 moved into the facility on 11/11/25 with diagnosis of dementia. R5's "Functional Capacity Screen" (FCS) dated 11/11/24 identified he was independent with dressing, toileting, and walking/mobility. Observation/interview on 02/24/26 at 02:18 PM R5 lay on the couch in his room with his walker in front of the couch. R5 stated the staff help him with toileting and scooting his chair at the dining room table. Observation on 02/25/26 at 08:22 AM Certified Medication Aide (CMA) C went into room and told R5 breakfast was ready. R5 sat up on the couch independently and then stood up without staff assistance. He reached for his walker and then walked down to the dining room with staff providing cueing and directions while he walked. Interview on 02/24/26 at 02:23 PM CMA C reported that R5 needed help with getting clean clothes out and cued during dressing. He needed directions to the toilet but could usually complete the task once he got there. Interview on 02/25/26 at 08:27 AM Certified Nurse Aide (CNA) F reported the amount of assistance R5 needs varies depending on the day. Sometimes we must help him with getting dressed and help in the bathroom and other times we just have to cue and give him directions. CNA F reported R5 gets confused easily and turned around and will sometimes have his walker turned around backwards and try to use it that way so we cue him and give	S3081		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089047	A. BUILDING: _____ B. WING _____	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACES AT HERITAGE GROVE ESTATES	1608 SW 37TH STREET TOPEKA, KS 66611

(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
S3081	Continued From page 2 direction when he is walking some place. Interview on 02/25/26 at 01:04 PM Licensed Nurse B reported staff having to cue and supervise R5 was new to her and confirmed he should have had a new FCS completed when he needed more supervision. The administrator failed to ensure designated staff completed a FCS when R5 had a significant change in status. - R8 moved into the facility on 12/15/25 with diagnoses of glaucoma and atrial fibrillation. R8's "Functional Capacity Screen" (FCS) dated 12/15/25 identified R8 was independent with all activities of daily living and management of his medications and medical treatments. Review of R8's January 2026 "Medication Administration Record" (MAR) identified facility staff initialed they administered some of his medications and that he also self-administered some of his medications. Interview on 02/26/26 at 10:41 AM Licensed Nurse B confirmed she should have completed a new FCS when staff started administering some of R8's medications. The administrator failed to ensure designated staff completed a FCS when R8 went from self-administering all of his own medications to the staff administering some and R8 administering some.	S3081		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089047	A. BUILDING: _____ B. WING _____	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACES AT HERITAGE GROVE ESTATES	1608 SW 37TH STREET TOPEKA, KS 66611

(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
S3085	Continued From page 3	S3085		
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)(3) The facility reported a census of 53 residents (R). The sample included three residents, one focused record review, and two closed record reviews. Based on record review and interview the administrator failed to ensure designated staff completed the "Negotiated Service Agreement" for two (R6 and R7) of three sampled residents based on the resident's service needs, related to podiatry services. Findings included:	S3085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089047	A. BUILDING: _____ B. WING _____	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACES AT HERITAGE GROVE ESTATES	1608 SW 37TH STREET TOPEKA, KS 66611

(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
S3085	Continued From page 4 - R6 moved into the facility on 02/15/22 with diagnosis of Lewy body dementia. R6's "Functional Capacity Screen" dated 09/18/25 identified she required physical assistance with all activities of daily living and management of her medications. Interview on 02/24/26 at 11:50 AM Administrative Staff A reported the "Negotiated Service Agreement" and "Health Care Service Plan" (NSA/HCSP) are separate documents but are used together as the full "Negotiated Service Agreement" to identify services provided by facility staff. R6's NSA/HCSP did not include that she received podiatry services from a local company or who was responsible for payment of services. R6's record included visit progress notes from a local podiatry company with consent for treatment signed in 2022. Interview on 02/25/26 at 01:43 PM licensed Nurse B confirmed R6's NSA/HCSP did not include a description of her podiatry services, who provided them and who was responsible for payment of the services. The administrator failed to ensure designated staff completed R6's NSA/HCSP to include a description of the podiatry services she received, who provided them, and who paid for them. -- R7 moved into the facility on 09/13/24 with a diagnosis of dementia.	S3085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089047	A. BUILDING: _____ B. WING _____	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACES AT HERITAGE GROVE ESTATES	1608 SW 37TH STREET TOPEKA, KS 66611

(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
S3085	Continued From page 5 R7's "Functional Capacity Screen' dated 09/17/25 identified he was independent with all activities of daily living except management of medications and medical treatments. He had impaired cognition, had a risk for falls, and impaired hearing. Interview on 02/24/26 at 11:50 AM Administrative Staff A reported the "Negotiated Service Agreement" and "Health Care Service Plan" (NSA/HCSP) are separate documents but are used together as the full "Negotiated Service Agreement" to identify services provided by facility staff. R7's NSA/HCSP lacked a description of services related to podiatry. R7's medical record included progress notes from a local podiatry company. Interview on 02/25/26 at 01:39 PM Administrative staff confirmed the NSA/HCSP's did not include outside provider services as they should. The administrator failed to ensure R7's NSA/HCSP included a description of services related to podiatry, who provided the service and who was responsible for payment of the service.	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	S3092		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089047	A. BUILDING: _____ B. WING _____	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACES AT HERITAGE GROVE ESTATES	1608 SW 37TH STREET TOPEKA, KS 66611

(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
S3092	Continued From page 6 365 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 53 residents(R). The sample included three resident, one focused record review, and two closed record reviews. Based on interview, and record review the executive director failed to ensure designated staff reviewed and revised the "Negotiated Service Agreement" for two (R5 and R7) of three sampled residents and one (R8) of one focused review when the resident had a significant change in service needs. Findings included: - R5 moved into the facility on 11/11/25 with diagnosis of dementia. R5's "Functional Capacity Screen" (FCS) dated 11/11/24 identified he was independent with dressing, toileting, and walking/mobility. Interview on 02/24/26 at 11:50 AM Administrative	S3092		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089047	A. BUILDING: _____ B. WING _____	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACES AT HERITAGE GROVE ESTATES	1608 SW 37TH STREET TOPEKA, KS 66611

(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
S3092	Continued From page 7 Staff A reported the "Negotiated Service Agreement" and "Health Care Service Plan" (NSA/HCSP) are separate documents but are used together as the full "Negotiated Service Agreement" to identify services provided by facility staff. R5's NSA/HCSP dated 11/11/25 identified for dressing, toileting, and ambulation the resident could complete task independently without staff assistance. It did not idenify his need for a secured "Memory Care Unit" or his need for supervision with cares. Observation/interview on 02/24/26 at 02:18 PM R5 lay on the couch in his room with his walker in front of the couch. R5 stated the staff help him with toileting and scooting his chair at the dining room table. Observation on 02/25/26 at 08:22 AM Certified Medication Aide (CMA) C went into room and told R5 breakfast was ready. R5 sat up on the couch independently and then stood up without staff assistance. He reached for his walker and then walked down to the dining room with staff providing cueing and directions while he walked. Interview on 02/24/26 at 02:23 PM CMA C reported that R5 needed help with getting clean clothes out and cued during dressing. He needed directions to the toilet but could usually complete the task once he got there. Interview on 02/25/26 at 08:27 AM Certified Nurse Aide (CNA) F reported the amount of assistance R5 needs varies depending on the day. Sometimes we must help him with getting	S3092		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089047	A. BUILDING: _____ B. WING _____	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACES AT HERITAGE GROVE ESTATES	1608 SW 37TH STREET TOPEKA, KS 66611

(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
S3092	Continued From page 8	S3092		

dressed and help in the bathroom and other times we just have to cue and give him directions. CNA F reported R5 gets confused easily and turned around and will sometimes have his walker turned around backwards and try to use it that way so we cue him and give direction when he is walking some place.

Interview on 02/25/26 at 01:19 PM Licensed Nurse B reported staff having to cue and supervise R5 was new to her and confirmed he should have had an amended NSA/HCSP to identify that he needed supervision with dressing, toileting, and walking/mobility and his need for living in a secured unit.

The administrator failed to ensure designated staff reviewed/revised R5's NSA?HCSP when he had a significant change in status.

- R7 moved into the facility on 09/13/24 with a diagnosis of dementia.

R7's "Functional Capacity Screen' dated 09/17/25 identified he was independent with all activities of daily living except mangaement of medications and medical treatments. He had impaired cognition, had a risk for falls and impaired hearing.

Interview on 02/24/26 at 11:50 AM Administrative Staff A reported the "Negotiated Service Agreement" and "Health Care Service Plan" (NSA/HCSP) are separate documents but are used together as the full "Negotiated Service Agreement" to identify services provided by facility staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089047	A. BUILDING: _____ B. WING _____	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACES AT HERITAGE GROVE ESTATES	1608 SW 37TH STREET TOPEKA, KS 66611

(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
S3092	Continued From page 9	S3092		

R7's NSA/HCSP identified he required supervison and reminders for showering and some assistnce with washing tasks, staff will administer medications as ordered. The NSA/HCSP did not include the resident needed services related to a secured "Memory Care Unit" or that he had used services of an outside provider.

R7's record revealed he moved from the "Assisted Living" side of the facility to the secured "Memory Care Unit' on 12/12/26.

Per interview on 02/25/26 with a local Home Health agency, R7 received speech therapy services from 10/30/25 to 12/23/25.

R7's record lacked arevised NSA/HCSP or an amended NSA/HCSP to identify when he received speech therapy or moved to the "Memory Care Unit'.

Interview on 02/25/26 at 01:40 PM licensed Nurse B confirmed he should have had an amended NSA/HCSP to identify when he had changes in service needs.

- R8 moved into the facility on 12/15/25 with diagnoses of glaucoma and atrial fibrillation.

R8's "Functional Capacity Screen" (FCS) dated 12/15/25 identified R8 was independent with all activities of daily living and management of his medications and medical treatments.

Interview on 02/24/26 at 11:50 AM Administrative Staff A reported the "Negotiated Service Agreement" and "Health Care Service Plan"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089047	A. BUILDING: _____ B. WING _____	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACES AT HERITAGE GROVE ESTATES	1608 SW 37TH STREET TOPEKA, KS 66611

(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
S3092	Continued From page 10 (NSA/HCSP) are separate documents but are used together as the full "Negotiated Service Agreement" to identify services provided by facility staff. R8's NSA/HCSP identified he self administered his medications. Review of R8's January 2026 "Medication Administration Record" (MAR) identified facility staff initialed they administered some of his medications and that he also self-administered some of his medications. Interview on 02/26/26 at 10:41 AM Licensed Nurse B confirmed she should have completed an amended NSA/HCSP when staff started administering some of R8's medications. The administrator failed to ensure designated staff reviewed/revised R8's NSA/HCSP when he went from self-administering all of his own medications to the staff administering some and R8 administering some.	S3092		
S3130 SS=E	26-41-203 (d) Special Care Services (d) Special care. Any administrator or operator of an assisted living facility or residential health care facility may choose to serve residents who do not exceed the facility ' s admission and retention criteria and who have special needs in a special care section of the facility or the entire facility, if the administrator or operator ensures that all of the following conditions are met: (1) Written policies and procedures are developed and are implemented for the operation of the special care section or facility.	S3130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089047	A. BUILDING: _____ B. WING _____	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACES AT HERITAGE GROVE ESTATES	1608 SW 37TH STREET TOPEKA, KS 66611

(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
S3130	Continued From page 11 (2) Admission and discharge criteria are in effect that identify the diagnosis, behavior, or specific clinical needs of the residents to be served. The medical diagnosis, medical care provider ' s progress notes, or both shall justify admission to the special care section or the facility. (3) A written order from a medical care provider is obtained for admission. (4) The functional capacity screening indicates that the resident would benefit from the services and programs offered by the special care section or facility. (5) Before the resident ' s admission to the special care section or facility, the resident or resident's legal representative is informed, in writing, of the available services and programs that are specific to the needs of the resident. (6) Direct care staff are present in the special care section or facility at all times. (7) Before assignment to the special care section or facility, each staff member is provided with a training program related to specific needs of the residents to be served, and evidence of completion of the training is maintained in the employee's personnel records. (8) Living, dining, activity, and recreational areas are provided within the special care section, except when residents are able to access living, dining, activity, and recreational areas in another section of the facility. (9) The control of exits in the special care section is the least restrictive possible for the residents in that section.	S3130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089047	A. BUILDING: _____ B. WING _____	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACES AT HERITAGE GROVE ESTATES	1608 SW 37TH STREET TOPEKA, KS 66611

(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
S3130	Continued From page 12 This REQUIREMENT is not met as evidenced by: KAR 26-41-203(d)(3) The facility reported a census of 53 residents. The sample included three residents and three focused record reviews. Based on observation, interview, and record review for two (R5, R7) of three sampled residents the executive director failed to ensure designated staff obtained a written medical providers order for admission into the "Special Care" (Memory Care) unit of the facility. Findings included: - R5 moved into the facility on 11/11/25 with a diagnosis of dementia. According to R5's electronic medical record, he originally moved into the "Assisted Living" (AL) area of the facility. R5's record included a "Reservation/Change of Unit Agreement" identifying he moved from his room in AL, to a room in Memory Care. The memory Care unit is a locked/secured unit for residents with dementia. Observation on 02/25/26 at 08:22AM on the "Memory Care Unit", AM Certified Medication Aide (CMA) C assisted R5 to come out for breakfast. R5 got up from the couch independently and walked out to the dining room table using his front wheel walker following CMA C. Interview on 02/25/26 at 08:27 AM Certified Nurse Aide (CNA) F reported R5 can get	S3130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089047	A. BUILDING: _____ B. WING _____	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACES AT HERITAGE GROVE ESTATES	1608 SW 37TH STREET TOPEKA, KS 66611

(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
S3130	Continued From page 13	S3130		

confused easily and turned around, so we cue him and help when needed. CNA F reported that R5 used to live in the assisted living side of the facility and moved here when he started to get more confused.

Interview on 02/25/26 at 01:04 PM Licensed Nurse B confirmed R5's record lacked an order for him to move into the Memory Care Unit.

The executive director failed to ensure designated staff obtained a medical provider's order for R5 to move into the "secured" Memory Care Unit.

- R7 moved into the facility on 09/13/24 with a diagnosis of dementia.

According to R7's electronic medical record he originally moved into the "Assisted Living" (AL) initially and then on 12/12/25 he moved into the "secured" Memory Care Unit.

Observation on 02/25/26 at 08:25AM on the "Memory Care Unit", R7 came out of his room walking down the hall using his front wheeled walker without any difficulty and walked over to the dining room table and sat in a chair.

Interview on 02/25/26 at 10:34 AM Certified Medication Aide C reported staff help R7 get out his clean clothing in the mornings, but he can dress himself usually. She confirmed he used to live in the AL side but since he has moved to the Memory Care Unit he has not had any behaviors and his confusion is better.

Interview on 02/25/26 at 01:25 PM Licensed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089047	A. BUILDING: _____ B. WING _____	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACES AT HERITAGE GROVE ESTATES	1608 SW 37TH STREET TOPEKA, KS 66611

(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
S3130	Continued From page 14 Nurse B reported the medical provider was supposed to get her an order and confirmed R7 did not have an order to move to the Memory Care Unit in his record. The executive director failed to ensure designated staff obtained a medical provider's order for R7 to move into the "secured" Memory Care Unit.	S3130		
S3175 SS=E	26-41-205 (a) (1) Self Administration of Medication (a) Self-administration of medication. Any resident may self-administer and manage medications independently or by using a medication container or syringe prefilled by a licensed nurse or pharmacist or by a family member or friend providing this service gratuitously, if a licensed nurse has performed an assessment and determined that the resident can perform this function safely and accurately without staff assistance. (1) An assessment shall be completed before the resident initially begins self-administration of medication, if the resident experiences a significant change of condition, and annually. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(a)(1) The facility reported a census of 53 residents	S3175		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089047	A. BUILDING: _____ B. WING _____	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACES AT HERITAGE GROVE ESTATES	1608 SW 37TH STREET TOPEKA, KS 66611

(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
S3175	Continued From page 15 (R). The sample included three residents, one focused record review, and two closed record reviews. Based on observation, interview and record review the administrator failed to ensure a licensed nurse completed an assessment for self-administration of medications for one (R7) of three sampled residents and one (R8) of one focused record prior to self administering medications and annually thereafter. Findings included: - R7 moved into the facility on 09/13/24 with a diagnosis of dementia. R7's "Functional Capacity Screen' dated 09/17/25 identified he was independent with all activities of daily living except management of medications and medical treatments. Interview on 02/24/26 at 11:50 AM Administrative Staff A reported the "Negotiated Service Agreement" and "Health Care Service Plan" (NSA/HCSP) are separate documents but are used together as the full "Negotiated Service Agreement" to identify services provided by facility staff. R7's NSA/HCSP identified facility staff will administer medications as ordered. It did not identify the Certified Medication Aide prepared R7's insulin and he self-injected it. Review of R7's record included a "Self Administer Medications' assessment dated 09/19/24 which identified he could not self-administer any of his medications. R7's record lacked any additional assessment to	S3175		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089047	A. BUILDING: _____ B. WING _____	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACES AT HERITAGE GROVE ESTATES	1608 SW 37TH STREET TOPEKA, KS 66611

(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
S3175	Continued From page 16 identify he could self-administer his insulin. Observation on 02/24/26 at 09:04 AM Certified Medication Aide C prepared R7's insulin pen for him to self-inject. After preparing the pen correctly, she handed an alcohol wipe to R7 who wiped off part of his abdomen and then handed him the insulin pen. R7 took the pen and poked the area where he had wiped, pushed the plunger after the needle engaged and then pulled it back out after the needle disengaged. Interview on 02/25/26 at 01:31 PM Licensed Nurse B reported R7 had been self-administering his insulin since he moved in and confirmed staff failed to complete an assessment that identified he was capable of self- injecting his insulin. The administrator failed to ensure designated staff completed an assessment prior to R7 self-injecting his insulin to ensure he could do so accurately and safely. - R8 moved into the facility on 12/15/25 with diagnoses of glaucoma and atrial fibrillation. R8's "Functional capacity Screen" dated 12/15/25 identified R8 was independent with all activities of daily living including medication administration. Interview on 02/24/26 at 11:50 AM Administrative Staff A reported the "Negotiated Service Agreement" and "Health Care Service Plan" (NSA/HCSP) are separate documents but are used together as the full "Negotiated Service Agreement" to identify services provided by facility staff.	S3175		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089047	A. BUILDING: _____ B. WING _____	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACES AT HERITAGE GROVE ESTATES	1608 SW 37TH STREET TOPEKA, KS 66611

(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
S3175	Continued From page 17 R8's NSA/HCSP dated 12/15/25 revealed R8 expressed the desire to self administer his medications and his medical provider agreed. Review of R8's record lacked an assessment to identify if R8 could safely and accurately self-administer his medications. Interview on 02/26/26 at 10:37 AM Licensed Nurse B confirmed a Self-administration assessment had not been completed by staff for R8 to self-administer his medications. The administrator failed to ensure designated staff completed a self-medication assessment for R8.	S3175		
S3186 SS=D	26-41-205 (b) Administration of Selected Medications (b) Administration of select medications. Any resident who self-administers medication may select some medications to be administered by a licensed nurse or medication aide. The negotiated service agreement shall reflect this service and identify who is responsible for the administration and management of selected medications. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (b)	S3186		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089047	A. BUILDING: _____ B. WING _____	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACES AT HERITAGE GROVE ESTATES	1608 SW 37TH STREET TOPEKA, KS 66611

(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
S3186	Continued From page 18 The facility reported a census of 53 residents (R). The sample included three residents, one focused record review, and two closed record reviews. Based on observation, interview, and record review the executive director failed to ensure one (R7) of three sampled residents "Negotiated Service Agreement" included the selected medications the resident chose to self-administer. Findings included: - R7 moved into the facility on 09/13/24 with a diagnosis of dementia. R7's "Functional Capacity Screen dated 09/17/25 identified he was independent with all activities of daily living except management of medications and medical treatments. Interview on 02/24/26 at 11:50 AM Administrative Staff A reported the "Negotiated Service Agreement" and "Health Care Service Plan" (NSA/HCSP) are separate documents but are used together as the full "Negotiated Service Agreement" to identify services provided by facility staff. R7's NSA/HCSP identified facility staff will administer medications as ordered. It did not identify the Certified Medication Aide prepared R7's insulin and he self-injected it. Observation on 02/24/26 at 09:04 AM Certified Medication Aide C prepared R7's insulin pen for him to self-inject. After preparing the pen correctly, she handed an alcohol wipe to R7 who	S3186		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089047	A. BUILDING: _____ B. WING _____	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACES AT HERITAGE GROVE ESTATES	1608 SW 37TH STREET TOPEKA, KS 66611

(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
S3186	Continued From page 19 wiped off part of his abdomen and then handed him the insulin pen. R7 took the pen and poked the area where he had wiped, pushed the plunger after the needle engaged and then pulled it back out after the needle disengaged. Interview on 02/25/26 at 01:33 PM Licensed Nurse B confirmed R7's NSA/HCSP did not include that he chose to self inject his insulin and facility staff administered the rest of his medications. The administrator failed to ensure designated staff completed R7's NSA/HCSP to include that he chose to self inject his insulin after Certified Medication Aides prepared his insulin pen.	S3186		
S3211 SS=E	26-41-205 (g) (3) OVER THE COUNTER DRUGS (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and the medication container. This REQUIREMENT is not met as evidenced by:	S3211		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089047	A. BUILDING: _____ B. WING _____	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACES AT HERITAGE GROVE ESTATES	1608 SW 37TH STREET TOPEKA, KS 66611

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3211	Continued From page 20 KAR 26-41-205 (g)(3) The facility reported a census of 53 residents. Based on observation and interview, the executive director failed to ensure a Licensed Nurse or Pharmacist labeled all over-the-counter medications with the resident's full name. This includes the resident's full name on the original manufacturer's medication package and the medication container/tube. Findings included: - During the initial tour on 02/24/26 at 10:55 AM Certified Medication Aide (CMA) D unlocked the Garden medication cart for inspection. Observation revealed the following over-the-counter medications without a resident full name: fiber gummies and a bottle of Omeprazole. CMA D unlocked the Second-floor medication cart outside room 213 at 11:00 AM which revealed the following over-the-counter medications without a resident's name on the container: Centrum, Pepto-Bismol, Calcium, Tylenol ES, and a bottle of Vitamin A. Interview on 02/24/26 at 11:02 AM CMA D reported she thought the bottles needed to have the resident's room number on them and did not realize they needed to have the resident's full name on the medication container. Interview on 02/24/26 at 05:05 PM Administrative Licensed Nurse B confirmed over-the-counter medications should have had a resident's full name on the bottles.	S3211		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089047	A. BUILDING: _____ B. WING _____	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACES AT HERITAGE GROVE ESTATES	1608 SW 37TH STREET TOPEKA, KS 66611

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3211	Continued From page 21 The executive director failed to ensure all over-the-counter medications included the full name of the resident they belonged to, including the name on the original manufacturer's medication package and the medication container.	S3211		
S3248 SS=F	26-41-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff records shall contain the following documentation: (1) Evidence of licensure, registration, certification, or a certificate of successful completion of a training course for each employee performing a function that requires specialized education or training; (2) supporting documentation for criminal background checks of facility staff and contract staff, excluding any staff licensed or registered by a state agency, pursuant to K.S.A. 39-970 and amendments thereto; (3) supporting documentation from the Kansas nurse aide registry that the individual does not have a finding of having abused, neglected, or exploited a resident in an adult care home; and (4) supporting documentation that the individual does not have a finding of having abused, neglected, or exploited any resident in an adult care home, from the nurse aide registry in each state in which the individual has been known to have worked as a certified nurse aide.	S3248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089047	A. BUILDING: _____ B. WING _____	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACES AT HERITAGE GROVE ESTATES	1608 SW 37TH STREET TOPEKA, KS 66611

(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
S3248	Continued From page 22 This REQUIREMENT is not met as evidenced by: KAR 26-41-102(d)(1)(2) The facility reported a census of 53 residents. Based on record review of five newly hired employees, the executive director failed to have evidence of Registry/Licensure verification completed for one of five newly hired staff who required specialized education and training verified upon hire. The executive director also failed to one of five newly hired staff had a criminal background check completed by the required department upon hire. These failures had the potential to affect all residents in the facility. The findings included: - Review of one of five newly hired staff files revealed the following: CMA E hired on 09/28/25 did not have a registry check completed until 10/15/25, 18 days after her hired date. Designated staff also failed to submit CMA E's criminal background check until 10/28/25, 31 days after her hire date. Interview on 02/25/26 at 08:22 AM Administrative Staff A reported the facility looked and were not able to find a registry check or criminal background check that was completed on or before her hire date. The executive director failed to ensure designated staff conducted a registry check and criminal background check for verification of	S3248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089047	A. BUILDING: _____ B. WING _____	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACES AT HERITAGE GROVE ESTATES	1608 SW 37TH STREET TOPEKA, KS 66611

(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
S3248	Continued From page 23 certification and criminal history for CMA E prior to working at the facility.	S3248		
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 53 residents (R). The sample included three residents, one focused record review and two closed record reviews. Based on interview and record review the administrator failed to ensure three (R5, R6, R7) of three sampled residents record contained documentation of all incidents, symptoms, and other indications of illness or injury, what was done, and the results of action taken. Findings included: - R5 moved into the facility on 11/11/25 with diagnosis of dementia. R5's "Functional Capacity Screen" (FCS) dated 11/11/24 identified he was independent with dressing, toileting, and walking/mobility. Interview on 02/24/26 at 11:50 AM Administrative	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089047	A. BUILDING: _____ B. WING _____	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACES AT HERITAGE GROVE ESTATES	1608 SW 37TH STREET TOPEKA, KS 66611

(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
S3261	Continued From page 24 Staff A reported the "Negotiated Service Agreement" and "Health Care Service Plan" (NSA/HCSP) are separate documents but are used together as the full "Negotiated Service Agreement" to identify services provided by facility staff. R5's NSA/HCSP dated 11/11/25 directed staff to provide assistance with administration of medications and staff needed to give him ample time to absorb communication and time to respond. Review of R5's nursing progress notes included: 12/24/25 at 04:17 PM - R5 extremely confused, attempting to into other resident rooms, did not know where he was or why. His gait is more unsteady and requiring 1:1 supervision for safety. 12/24/25 at 04:45 PM son called and will come to the facility. The record lacked follow up if the son came, did resident calm or continue to need 1:1 supervision the next day. 12/26/25 at 04:12 PM the resident stated he was still confused but not as bad. 01/01/25 included resident continues to have alternating episodes of confusion and appropriate orientation. 01/07/26 at 03:35 PM - Follow with resident regarding transition to Memory Care from apartment. The record lacked documentation of the resident moving to the memory care unit, reasons for moving, and documentation of how he initially adjusted upon moving to the secured unit. 01/19/26 05:38 PM right hand swollen and bruised, x-ray ordered and negative for fracture.	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089047	A. BUILDING: _____ B. WING _____	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACES AT HERITAGE GROVE ESTATES	1608 SW 37TH STREET TOPEKA, KS 66611

(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
S3261	Continued From page 25 The record lacked documentation if the swelling went down and if the resident had any discomfort with the swelling/bruising. Interview on 02/25/26 at 01:22 PM Licensed Nurse B confirmed the documentation in the resident's chart lacked sufficient documentation. The administrator failed to ensure designated staff documented in R5's record to include all incidents, symptoms of illness, what was done and results of action. - R6 moved into the facility on 02/15/22 with diagnosis of Lewy body dementia. R6's "Functional Capacity Screen" dated 09/18/25 identified she required physical assistance with all activities of daily living and management of her medications. Interview on 02/24/26 at 11:50 AM Administrative Staff A reported the "Negotiated Service Agreement" and "Health Care Service Plan" (NSA/HCSP) are separate documents but are used together as the full "Negotiated Service Agreement" to identify services provided by facility staff. R6's NSA/HCSP directed staff to provide resident assistance with activities of daily living including medication administration and management. Review of R6's nursing progress notes included the following: 10/28/25 - New orders to increase Carbo-Levodopa (for Parkinson's) from once a day to twice a day.	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089047	A. BUILDING: _____ B. WING _____	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACES AT HERITAGE GROVE ESTATES	1608 SW 37TH STREET TOPEKA, KS 66611

(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
S3261	Continued From page 26 The record lacked symptoms the resident had for the need to increase and if the increase was effective in resolving symptoms. 10/30/25 - New orders for A&D ointment topically in am around old PEG tube site and Cephalexin (antibiotic) three times a day for seven days for PEG site infection. 11/06/25 - new order for a different antibiotic for seven days. The record lacked documentation related to A&D treatment and antibiotics for infection at old PEG tube site. 12/24/25 - new order for Colace (stool softener) daily. The record lacked documentation if adding Colace help improve bowel movements. Interview on 02/25/26 at 01:45 PM Licensed Nurse B confirmed documentation with follow up in the nurses' notes was lacking. The administrator failed to ensure designated staff documented in R6's record all symptoms, what was done and follow up as to the results of action taken. - R7 moved into the facility on 09/13/24 with a diagnosis of dementia. R7's "Functional Capacity Screen' dated 09/17/25 identified he was independent with all activities of daily living except management of medications and medical treatments. He had impaired cognition, had a risk for falls and impaired hearing. Interview on 02/24/26 at 11:50 AM Administrative Staff A reported the "Negotiated Service	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089047	A. BUILDING: _____ B. WING _____	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACES AT HERITAGE GROVE ESTATES	1608 SW 37TH STREET TOPEKA, KS 66611

(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
S3261	Continued From page 27 Agreement" and "Health Care Service Plan" (NSA/HCSP) are separate documents but are used together as the full "Negotiated Service Agreement" to identify services provided by facility staff. R7's NSA/HCSP identified he required supervision and reminders for showering and some assistance with washing tasks, staff will administer medications as ordered. R7's record revealed he moved from the "Assisted Living" side of the facility to the secured "Memory Care Unit' on 12/12/26. Review of R7's nursing progress notes included the following: 03/27/25 - order for lumbar X-ray, Cephalexin (antibiotic), and increase Gabapentin (antiseizure used to treat nerve pain) at bedtime. The record lacked documentation on x-ray results, antibiotic follow up and how the results of increasing the Gabapentin. 04/10/25 - new order to increase Gabapentin from bedtime to twice a day. The record lacked documentation of reasons for the increase in medication. 04/23/25 - new order for a topical cream to affected area of foot for potential athletes foot daily for two weeks. The record lacked documentation if the skin condition resolved. 06/26/25 - new order for Augmentin times 10 days. Records did not specify reason for the new antibiotic. 07/03/25 - DPOA informed of new orders to increase Olanzapine (antipsychotic) for bipolar and continue Augmentin for left ear infection.	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089047	A. BUILDING: _____ B. WING _____	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACES AT HERITAGE GROVE ESTATES	1608 SW 37TH STREET TOPEKA, KS 66611

(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
S3261	Continued From page 28 The record lacked documentation of symptoms to need the increase in her Olanzapine. 09/11/25 - new order to start Norco (narcotic pain medication) twice a day for arthritis pain. The record lacked follow up assessment if pain improved. 09/25/25 - new order for Voltaren gel three times a day for knee pain. The record lacked documentation if it helped with her knee pain. 12/15/25 - on 12/12/25 resident moved from Assisted living to the secured Memory Care Unit. The record lacked documentation of residents' need for moving to a secured Memory Unit. Interview on 02/25/26 at 01:39 PM Administrative Staff A reported they had someone come in and they had identified concerns with incomplete documentation. Administrative Staff A confirmed they knew documentation was lacking. The administrator failed to ensure designated staff documented all incidents, symptoms of illness, what was done and results of what was done in the resident's record.	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	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089047	A. BUILDING: _____ B. WING _____	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACES AT HERITAGE GROVE ESTATES	1608 SW 37TH STREET TOPEKA, KS 66611

(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
S3310	Continued From page 29 (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 53 residents(R). Based on interview and record review for three (R5, R6, and R7) of three sampled residents, the administrator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. by the failure to complete the TB symptom screening annually. Findings included: - R5 moved into the facility on 11/11/25 with a diagnosis of dementia. Review of R5's record include documentation of hospitalization on 12/04/25 and return to the facility on 12/11/25. R5's record identified staff completed his last TB Symptom Screen on 11/11/25. - R6 moved into the facility on 02/15/22 with diagnosis of Lewy bodies dementia. R6's record included documentation of	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089047	A. BUILDING: _____ B. WING _____	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACES AT HERITAGE GROVE ESTATES	1608 SW 37TH STREET TOPEKA, KS 66611

(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
S3310	Continued From page 30 hospitalization on 09/03/25 to 09/18/25 and again on 11/09/25 to 11/11/25. R6's record identified her last TB symptom screen completed on 02/26/25. Interview on 02/25/26 at 01:02 PM Licensed Nurse B confirmed she had not completed a TB symptoms screen when R5 or R6 returned from the hospital. Review of the department's "Tuberculosis (TB) Guidelines for Adult Care Homes" June 2013 revealed each resident shall have a TB Symptom Screen completed upon return from hospitalization or therapeutic leave. The administrator failed to ensure designated staff completed TB Symptom Screen when R5 and R6 returned from the hospital. - R7 moved into the facility on 09/13/24 with diagnosis of dementia. Review of R7's record identified he had TB skin tests administered on 08/15/25 and 08/21/25 and identified they were both negative. However, the record failed to identify what date the results of the skin tests were read. Interview on 02/25/26 at 01:20 PM licensed nurse reviewed R7's record and confirmed it did not include the date staff read the results of the TB skin test. Review of the department's "Tuberculosis (TB) Guidelines for Adult Care Homes" June 2013 required documentation for two-step skin test	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089047	A. BUILDING: _____ B. WING _____	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACES AT HERITAGE GROVE ESTATES	1608 SW 37TH STREET TOPEKA, KS 66611

(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
S3310	Continued From page 31 shall include the date each skin test was administered and the date each skin test was read. The administrator failed to ensure designated staff included all the required documentation for TB skin testing.	S3310		