STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CELEBRATION VILLA OF HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(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 the licensure resurvey with attachedd complaint numbers 183260, 180847, and 174958 for the above named facility conducted on 10/17/23, 10/18/23, and 10/19/23.	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: K.A.R. 26-41-202 (a) The facility reported a census of 68 residents. The sample included 7 "Residents'" (R), and 1 closed record review. Based on interview and record review the administrator failed to ensure	S3085		

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
	N089063	A. BUILDING: _____ B. WING _____	10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CELEBRATION VILLA OF HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(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 1	S3085		

the development of a written "Negotiated Service Agreement" (NSA), based on the residents' "Functional Capacity Screen" (FCS), service needs, and preferences that included a description of the services the resident would receive, identification of the provider of each service and the identification of each responsible party for payment if outside resources were used for R1, R2, R3, R4, R5 and R6.

Findings included:

- Record review on 10/18/23 for R1 revealed an admission date of 07/31/23 with diagnoses of sepsis, diabetes mellitus with neuropathy, morbid sever obesity, anxiety disorder, cellulitis of right lower limb, staphylococcal arthritis of the right knee, and long-term use of anti-coagulants.

Review of R1 FCS dated 08/29/23 revealed R1 required physical assistance with bathing, dressing, toileting, transferring, management of his medications, and management of his treatments.

Review of R1 medical record revealed a document titled "Kansas Location /Support Plan/ Individual Support Plan" (KS LOC/Support Plan/ISP) and was dated 08/17/23. The document stated R1 would receive full assistance from facility staff for bathing two times per week and would require assistance with a slide board "2-1" by assistance would be required due to fall risk, non-weight bearing and would require a bed bath. R1 would require full assistance with dressing, toileting, and medication management.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CELEBRATION VILLA OF HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(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 2 Interview with Administrators A and B on 10/17/23 at 01:09 PM, they confirmed the KS LOC/Support Plan/ISP was the NSA. - Review of R2 records revealed an admission date of 09/08/22 with diagnoses of dementia, major depressive disorder, anxiety disorder, and cerebral infarction. Review of R2 FCS dated 07/11/23 revealed R2 required physical assistance with bathing, dressing, toileting, transferring, walking, management of her medications, and management of her treatments. She had impaired short-term memory, impaired memory recall, and impaired decision making, and she used a wheelchair mobility device. Review of R2 medical record revealed a document titled KS LOC/Support Plan/ISP and was dated 07/11/23. The document stated R2 would receive moderate assistance from facility staff for bathing two times per week, full assistance with dressing, turning and repositioning, mobility with assistance, transferring, toileting, management of medication and treatments, and would require supervision. Interview with Administrators A and B on 10/17/23 at 01:09 PM, they confirmed the KS LOC/Support Plan/ISP was the NSA. - Review of R3 records revealed an admission date of 09/21/21 with diagnoses of Agoraphobia	S3085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CELEBRATION VILLA OF HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(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		

with panic disorder, metabolic encephalopathy, obstructive and reflux uropathy, need for assistance with personal care, gastro-esophageal reflux disease, epilepsy, insomnia, other speech and language deficits following nontraumatic subarachnoid hemorrhage, Parkinson's disease, hypertension, and other hypotension.

Review of R3 FCS dated 09/20/23 revealed R3 required physical assistance with bathing, dressing, toileting, transferring, walking, and supervision with eating. He lacked the ability to manage his own mediations, was frequently incontinent of his bladder, had impaired short-term memory, impaired memory recall, and impaired decision making. He was usually able to make himself understood and he usually understood others. He was marked with falls and impaired decision making.

Review of R3 medical record revealed a document titled KS LOC/Support Plan/ISP and was dated 09/20/23. The document stated R3 would receive full assistance from facility staff for bathing two times per week, dressing, and moderate assistance with toileting. Qualified facility staff would manage his medications, treatments and would supervise him.

Review of R3 medical record revealed documents titled "Outside Agency Form", and they were dated 06/28/23 to 10/02/23 and were for a local home health agency that had provided "Occupational Therapy" for R3.

Interview with Administrators A and B on 10/19/23 at approximately 02:00 PM, they

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CELEBRATION VILLA OF HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(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	S3085		

confirmed the KS LOC/Support Plan/ISP was the NSA, and that R3 NSA lacked the name of the outside provider, a description of services they were going to provide and the responsible party for the OT services.

- Review of R4 records revealed an admission date of 12/01/22 with diagnoses of unspecified dementia, thyroid disorder and essential hypertension.

Review of R4 FCS dated 09/28/23 revealed R2 required physical assistance with bathing, dressing, toileting, transferring, walking, and eating. She lacked the ability to manage her own medications and was frequently incontinent. She had impaired short-term memory, impaired memory recall, and impaired decision making. She was sometimes able to make herself understood and she sometimes understood others. She was marled with falls and impaired decision making. She used a walker and wheelchair mobility device.

Review of R4 medical record revealed a document titled KS LOC/Support Plan/ISP and was dated 09/28/23. The document stated R4 would receive full assistance from facility staff for bathing twice a week, dressing, turning and repositioning, transferring, toileting and management of her medications.

Review of R4 electronic medical record under the "Progress Notes" tab, revealed the following entry made on 10/13/23 at 01:56 PM "R4 continues on services with the local home health, however, it looked like all therapies will

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CELEBRATION VILLA OF HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(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 discontinue in the next week as R4 had reached maximum potential". Interview with Administrators A and B on 10/19/23 at approximately 02:00 PM, they confirmed the KS LOC/Support Plan/ISP was the NSA, and that R4 NSA lacked the name of the outside provider, a description of services they were going to provide and the responsible party for the therapy services. - Review of R5 records revealed an admission date of 01/27/23 with diagnoses of Alzheimer's disease, type two diabetes mellitus, anxiety disorder, essential hypertension, and chronic kidney disease stage three. Review of R5 FCS dated 07/24/23 revealed R5 required supervision with bathing and dressing. He had impaired short-term memory, impaired memory recall and impaired decision making. He lacked the ability to manage his own medications and was able to make himself understood and he usually understood others. He was marked with falls and impaired decision making. Review of R5 medical record revealed a document titled KS LOC/Support Plan/ISP and was dated 07/24/23. The document stated R5 would receive prompting and reminding from facility staff for bathing twice a week, dressing, and medication management. Interview with Administrators A and B on 10/17/23 at 01:09 PM, they confirmed the KS LOC/Support Plan/ISP was the NSA.	S3085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CELEBRATION VILLA OF HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(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 6 - Review of R6 medical records revealed an admission date of 12/19/22 with diagnoses of hyperlipidemia, essential hypertension, peripheral vascular disease, and unspecified fracture of the left femur closed fracture. Review of R6 FCS dated 07/27/23 revealed R6 required physical assistance with bathing and dressing, and she used a walker assistive device. Review of R6 medical record revealed a document titled KS LOC/Support Plan/ISP and was dated 07/23/23. The document stated R6 would receive minimal assistance from facility staff for bathing and dressing. Review of R6 progress notes dated 08/11/23 at 01:54 PM a "Social Services Note" "R6 was seen by social worker again on 08/07/23. She is having difficulty coping with the recent death of her peer. Continue to work on coping skills" Interview with Administrators A and B on 10/19/23 at approximately 02:00 PM, they confirmed the KS LOC/Support Plan/ISP was the NSA, and that R6 NSA lacked the name of the outside provider, a description of services they were going to provide and the responsible party for the social work services.	S3085		
S3165 SS=E	26-41-204 (d) Health Care Services (d) The negotiated service agreement shall contain a description of the health care services to be provided and the name of the licensed nurse responsible for the implementation and supervision of the plan.	S3165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CELEBRATION VILLA OF HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(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
S3165	Continued From page 7	S3165		

This REQUIREMENT is not met as evidenced by:
K.A.R. 26-41-204 (d)

The facility reported a census of 68 residents. The sample included 7 "Residents'" (R), and 1 closed record review. Based on interview and record review the administrator failed to ensure the name of the licensed nurse responsible for the implementation and supervision on the "Health Service Plan" (HSP) was on the written "Negotiated Service Agreement" (NSA) for R1, R2, R3, R4, R5 and R6.

Findings included:

- Record review on 10/18/23 for R1 revealed an admission date of 07/31/23 with diagnoses of sepsis, diabetes mellitus with neuropathy, morbid sever obesity, anxiety disorder, cellulitis of right lower limb, staphylococcal arthritis of the right knee, and long-term use of anti-coagulants.

Review of R1 FCS dated 08/29/23 revealed R1 required physical assistance with bathing, dressing, toileting, transferring, management of his medications, and management of his treatments.

Review of R1 medical record revealed a document titled "Kansas Location /Support Plan/ Individual Support Plan" (KS LOC/Support Plan/ISP) and was dated 08/17/23. The document stated R1 would receive full

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CELEBRATION VILLA OF HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(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
S3165	Continued From page 8	S3165		

assistance from facility staff for bathing two times per week and would require assistance with a slide board "2-1" by assistance would be required due to fall risk, non-weight bearing and would require a bed bath. R1 would require full assistance with dressing, toileting, and medication management.

The NSA lacked the name of the licensed nurse responsible for the implementation and supervision of the HSP.

Interview with Administrators A and B on 10/19/23 at 02:00 PM, they confirmed the KS LOC/Support Plan/ISP was the NSA, and the document lacked the name of the licensed nurse responsible for the implementation and supervision of the HSP.

- Review of R2 records revealed an admission date of 09/08/22 with diagnoses of dementia, major depressive disorder, anxiety disorder, and cerebral infarction.

Review of R2 FCS dated 07/11/23 revealed R2 required physical assistance with bathing, dressing, toileting, transferring, walking, management of her medications, and management of her treatments. She had impaired short-term memory, impaired memory recall, and impaired decision making, and she used a wheelchair mobility device.

Review of R2 medical record revealed a document titled KS LOC/Support Plan/ISP and was dated 07/11/23. The document stated R2 would receive moderate assistance from facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CELEBRATION VILLA OF HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(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
S3165	Continued From page 9	S3165		

staff for bathing two times per week, full assistance with dressing, turning and repositioning, mobility with assistance, transferring, toileting, management of medication and treatments, and would require supervision.

Interview with Administrators A and B on 10/19/23 at approximately 02:00 PM, they confirmed the KS LOC/Support Plan/ISP was the NSA, and the document lacked the name of the licensed nurse responsible for the implementation and supervision of the HSP.

- Review of R3 records revealed an admission date of 09/21/21 with diagnoses of Agoraphobia with panic disorder, metabolic encephalopathy, obstructive and reflux uropathy, need for assistance with personal care, gastro-esophageal reflux disease, epilepsy, insomnia, other speech and language deficits following nontraumatic subarachnoid hemorrhage, Parkinson's disease, hypertension, and other hypotension.

Review of R3 FCS dated 09/20/23 revealed R3 required physical assistance with bathing, dressing, toileting, transferring, walking, and supervision with eating. He lacked the ability to manage his own mediations, was frequently incontinent of his bladder, had impaired short-term memory, impaired memory recall, and impaired decision making. He was usually able to make himself understood and he usually understood others. He was marked with falls and impaired decision making.

Review of R3 medical record revealed a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CELEBRATION VILLA OF HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(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
S3165	Continued From page 10	S3165		

document titled KS LOC/Support Plan/ISP and was dated 09/20/23. The document stated R3 would receive full assistance from facility staff for bathing two times per week, dressing, and moderate assistance with toileting. Qualified facility staff would manage his medications, treatments and would supervise him.

Interview with Administrators A and B on 10/19/23 at approximately 02:00 PM, they confirmed the KS LOC/Support Plan/ISP was the NSA, and the document lacked the name of the licensed nurse responsible for the implementation and supervision of the HSP.

- Review of R4 records revealed an admission date of 12/01/22 with diagnoses of unspecified dementia, thyroid disorder and essential hypertension.

Review of R4 FCS dated 09/28/23 revealed R2 required physical assistance with bathing, dressing, toileting, transferring, walking, and eating. She lacked the ability to manage her own medications and was frequently incontinent. She had impaired short-term memory, impaired memory recall, and impaired decision making. She was sometimes able to make herself understood and she sometimes understood others. She was marled with falls and impaired decision making. She used a walker and wheelchair mobility device.

Review of R4 medical record revealed a document titled KS LOC/Support Plan/ISP and was dated 09/28/23. The document stated R4 would receive full assistance from facility staff for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CELEBRATION VILLA OF HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(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
S3165	Continued From page 11 bathing twice a week, dressing, turning and repositioning, transferring, toileting and management of her medications. Interview with Administrators A and B on 10/19/23 at approximately 02:00 PM, they confirmed the KS LOC/Support Plan/ISP was the NSA, and the document lacked the name of the licensed nurse responsible for the implementation and supervision of the HSP. - Review of R5 records revealed an admission date of 01/27/23 with diagnoses of Alzheimer's disease, type two diabetes mellitus, anxiety disorder, essential hypertension, and chronic kidney disease stage three. Review of R5 FCS dated 07/24/23 revealed R5 required supervision with bathing and dressing. He had impaired short-term memory, impaired memory recall and impaired decision making. He lacked the ability to manage his own medications and was able to make himself understood and he usually understood others. He was marked with falls and impaired decision making. Review of R5 medical record revealed a document titled KS LOC/Support Plan/ISP and was dated 07/24/23. The document stated R5 would receive prompting and reminding from facility staff for bathing twice a week, dressing, and medication management. Interview with Administrators A and B on 10/19/23 at approximately 02:00 PM, they confirmed the KS LOC/Support Plan/ISP was the NSA, and the document lacked the name of the	S3165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CELEBRATION VILLA OF HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(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
S3165	Continued From page 12 licensed nurse responsible for the implementation and supervision of the HSP. - Review of R6 medical records revealed an admission date of 12/19/22 with diagnoses of hyperlipidemia, essential hypertension, peripheral vascular disease, and unspecified fracture of the left femur closed fracture. Review of R6 FCS dated 07/27/23 revealed R6 required physical assistance with bathing and dressing, and she used a walker assistive device. Review of R6 medical record revealed a document titled KS LOC/Support Plan/ISP and was dated 07/23/23. The document stated R6 would receive minimal assistance from facility staff for bathing and dressing. Interview with Administrators A and B on 10/19/23 at approximately 02:00 PM, they confirmed the KS LOC/Support Plan/ISP was the NSA, and the document lacked the name of the licensed nurse responsible for the implementation and supervision of the HSP. The administrator failed to ensure the name of the licensed nurse responsible for the implementation and supervision on the "Health Service Plan" (HSP) was on the written "Negotiated Service Agreement" (NSA) for R1, R2, R3, R4, R5 and R6.	S3165		
S3250 SS=D	26-41-105 (a) Resident Records a) The administrator or operator of each assisted	S3250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CELEBRATION VILLA OF HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(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
S3250	Continued From page 13 living facility or residential health care facility shall ensure the maintenance of a record for each resident in accordance with accepted professional standards and practices. (1) Designated staff shall maintain the record of each discharged resident who is 18 years of age or older for at least five years after the discharge of the resident. (2) Designated staff shall maintain the record of each discharged resident who is less than 18 years of age for at least five years after the resident reaches 18 years of age or at least five years after the date of discharge, whichever time period is longer. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-105 (a) (1) The facility reported a census of 68 residents. The sample included 7 "Residents'" (R), and 1 closed record review. Based on interview and record review the administrator failed to ensure the facility maintained the records for at least five years for a R8 who discharged on 08/28/22. Findings included: - Interview on 10/17/23 at approximately 04:30 PM with Administrators A and B, they stated the facility sold on 12/01/22, and the prior facility took all discharged resident records. They confirmed they would have to contact the prior	S3250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CELEBRATION VILLA OF HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(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
S3250	Continued From page 14 company attorneys to gain access to the closed record for R8. R8 electronic record received for review on 10/18/23 at 03:42 PM. R8 physical medical record did not arrive during the survey process. The administrator failed to ensure the facility maintained the records of discharged residents for at least five years after the resident discharged.	S3250		
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: K.A.R. 26-41-105 (f) (11) The facility reported a census of 68 residents. The sample included 7 "Residents'" (R), and 1 closed record review. Based on interview and record review the administrator failed to ensure the resident record contained documentation of all incidents, a other indications of illness or injury, to include the date and time of the occurrence action taken and results of the actions for R2, R3, R4, and R5. Findings included:	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CELEBRATION VILLA OF HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(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 15 - Review of R2 records revealed an admission date of 09/08/22 with diagnoses of dementia, major depressive disorder, anxiety disorder, and cerebral infarction. Review of R2 FCS dated 07/11/23 revealed R2 required physical assistance with bathing, dressing, toileting, transferring, walking, management of her medications, and management of her treatments. She had impaired short-term memory, impaired memory recall, and impaired decision making, and she used a wheelchair mobility device. Review of R2 medical record revealed a document titled KS LOC/Support Plan/ISP and was dated 07/11/23. The document stated R2 would receive moderate assistance from facility staff for bathing two times per week, full assistance with dressing, turning and repositioning, mobility with assistance, transferring, toileting, management of medication and treatments, and would require supervision. Review of R2 electronic medical record under the "Progress Note" tab dated 08/27/23 to 10/05/23 revealed the following entries: 08/27/23 at 05:54 PM "Nurse on duty called to assess resident because resident was complaining of shortness of breath at supper. When resident got back to her room in her recliner, she stated her breathing felt a little better ...listened to lung sounds and noticed some low-pitched crackles bilaterally ... Certified Medication Aide gave resident an as needed Loratadine. Resident may be on the list to see	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CELEBRATION VILLA OF HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(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 16 Nurse Practitioner tomorrow morning ...resident stated she was not in any pain at this time ..." The documentation lacked an entry for the results of the Loratadine and any monitoring until R2 saw the Nurse Practitioner. The next entry was on 08/28/23 at 01:35 after the resident saw the Nurse Practitioner. 10/05/23 at 03:51 PM Nurse Practitioner saw the resident for constipation. A new order was written for Colace 100 milligrams and to increase her Senna 8.6 milligrams to "2 by mouth every day for constipation". The documentation lacked an entry for follow up on the medication change to address R2 constipation. - Review of R3 records revealed an admission date of 09/21/21 with diagnoses of Agoraphobia with panic disorder, metabolic encephalopathy, obstructive and reflux uropathy, need for assistance with personal care, gastro-esophageal reflux disease, epilepsy, insomnia, other speech and language deficits following nontraumatic subarachnoid hemorrhage, Parkinson's disease, hypertension, and other hypotension. Review of R3 FCS dated 09/20/23 revealed R3 required physical assistance with bathing, dressing, toileting, transferring, walking, and supervision with eating. He lacked the ability to manage his own mediations, was frequently incontinent of his bladder, had impaired short-term memory, impaired memory recall, and	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CELEBRATION VILLA OF HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(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 17	S3261		

impaired decision making. He was usually able to make himself understood and he usually understood others. He was marked with falls and impaired decision making.

Review of R3 electronic medical record under the "Progress Note" tab dated 08/05/23 to10/18/23 revealed the following entries:

08/08/23 at 04:10 PM "Resident complained of not feeling well today. Nurse on duty notified and performed an assessment ... Resident was given some sprite and let out a bug burp and felt better afterwards nor further charting needed at this time".

The document lacked follow up on R3 complaint of not feeling well, the documentation further lacked notification of R3 primary care provider and durable power of attorney.

10/18/23 at 05:00 PM "R3 continued to have behaviors where he would come into the hallway and lower himself to the ground, aides have been stern and stopped him several times, but he has lowered himself to the ground three times today and he had been redirected back to his room."

The document lacked an entry of "all incidents", actions taken to address the behaviors and results of each action taken.

- Review of R4 records revealed an admission date of 12/01/22 with diagnoses of unspecified dementia, thyroid disorder and essential hypertension.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CELEBRATION VILLA OF HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(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 18 Review of R4 FCS dated 09/28/23 revealed R2 required physical assistance with bathing, dressing, toileting, transferring, walking, and eating. She lacked the ability to manage her own medications and was frequently incontinent. She had impaired short-term memory, impaired memory recall, and impaired decision making. She was sometimes able to make herself understood and she sometimes understood others. She was marled with falls and impaired decision making. She used a walker and wheelchair mobility device. Review of R4 medical record revealed a document titled KS LOC/Support Plan/ISP and was dated 09/28/23. The document stated R4 would receive full assistance from facility staff for bathing twice a week, dressing, turning and repositioning, transferring, toileting and management of her medications. Review of R4 electronic medical record under the "Progress Notes" tab, dated 08/13/23 to 10/13/23 and revealed the following entries: 08/13/23 at 11:36 AM It was reported to the nurse by overnight staff that R4 had no urine output in her brief in the morning. The concern was that resident was not taking in enough fluids and producing enough output. At 08:00 AM R4 was still in her room asleep in her bed. The nurse obtained her vital signs and found her brief to be wet with "Urine output" ... "Urine output is not being measured by this facility for resident. Staff instructed to encourage fluids and monitor closely if fluid intake decreased or out put decreases, will continue to monitor".	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CELEBRATION VILLA OF HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(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 19 The documentation lacked results of the actions taken, follow up on resident for low urinary output, and notifying the primary care provider of the symptom / indication of illness. 10/05/23 at 08:43 AM "Certified medication aide called nurse on duty down to resident having low pulse and high blood pressure. When nurse took pulse, it was 71 beats per minute ... Certified medication told to give medication". The next note was entered on 10/05/23 at 03:45 PM and was entered by the Nurse Practitioner. The documentation lacked an entry by the nurse to follow up on the concern the resident was experiencing symptoms of a low blood pressure. - Review of R5 records revealed an admission date of 01/27/23 with diagnoses of Alzheimer's disease, type two diabetes mellitus, anxiety disorder, essential hypertension, and chronic kidney disease stage three. Review of R5 FCS dated 07/24/23 revealed R5 required supervision with bathing and dressing. He had impaired short-term memory, impaired memory recall and impaired decision making. He lacked the ability to manage his own medications and was able to make himself understood and he usually understood others. He was marked with falls and impaired decision making. Review of R5 electronic medical records under the "Progress Note" tab revealed the following entries dated 08/09/23 to	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CELEBRATION VILLA OF HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(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 20 08/09/23 at 00:17 AM Fax sent to Nurse Practitioner. Resident had been having sleepless nights, obsessed of a story about kids being down in the hill and got hurt. R5 was wandering the hallway up until about midnight ..."We are wondering if you would consider a as needed melatonin to aid sleep/or a better suggestion? The documentation was reviewed from 07/07/23 to 09/09/23, the documentation lacked any entries for the resident being up and pacing the hallways at night. 10/13/23 at 08:30 PM "Nurse on duty was informed that R5 was exposing himself to another resident in his room. Nurse on duty asked resident what happened, and resident could not give an explanation. Nurse on duty told staff to continue to monitor resident and to give an as needed to help with his behavior". The document lacked documentation of follow up on the "as needed" medication that was administered, and the documentation further lacked other actions taken prior to administering an "as needed" medication to help with his behavior. The administrator failed to ensure the resident record contained documentation of all incidents, a other indications of illness or injury, to include the date and time of the occurrence action taken and results of the actions for R2, R3, R4, and R5.	S3261		
S3310 SS=E	26-41-207 (b) (5-6) (c) Infection Control Policies (b) (5) prohibiting any employee with a	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CELEBRATION VILLA OF HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(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 21 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: K.A.R. 26-41-207 (c) The facility reported a census of 68 residents. The sample included 7 "Residents'" (R), 1 closed record review, and 5 newly hired employees. Based on interview and record review the administrator failed to ensure the facility's compliance with the department's "Tuberculosis" (TB) guidelines for adult care homes adopted by reference in K.A.R. 26-39-205. for 1 newly hired staff and R1 and R2. Findings included: - Record review on 10/19/23 for newly hired "Certified Nurse Aide" (CNA) C, revealed she began employment on 03/28/23. Review of the facility document titled "Tuberculin Skin Test	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CELEBRATION VILLA OF HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(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 22 Record" revealed the first step was administered on 09/27/23 and read negative on 09/29/23, this was approximately six months after CNA C was hired. The second step was administered on 10/09/23 and read negative on 10/22/23. Interview with Licensed Nurse D on 10/17/23 at approximately 03:00 PM, she confirmed the required TB test was not administered to CNA C within 1 to 7 days of employment. - Review of R1 medical record revealed an admission date of 07/31/23. The medical record contained a TB screening dated 08/29/23. Interview with Licensed Nurse D on 10/17/23 at approximately 03:00 PM, she confirmed R1 record lacked the required two step TB test being performed within one to seven days of admission to the facility. - Review of R2 medical record revealed an admission date of 09/08/22. The medical record contained documentation of a completed two step TB test dated 09/18/22, and a completed TB screening questionnaire dated 09/08/22. The record lacked the annual screening questionnaire of 09/23. Interview with Licensed Nurse D on 10/17/23 at approximately 03:00 PM, she confirmed the record for R2 lacked the annual TB screening for 09/23. The administrator failed to ensure the facility's compliance with the department's TB guidelines	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CELEBRATION VILLA OF HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(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 23 for adult care homes adopted by reference in K.A.R. 26-39-205. for 1 newly hired staff and R1 and R2.	S3310		