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 _____	03/13/2025

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 a Re-Licensure survey with complaint investigation 192410 for the above named Assisted Living facility conducted on 03/10/25, 03/11/25, 03/12/25 and 03/13/25.	S 000		
S3083 SS=D	26-41-201 (e) Functional Capacity Screen as Basis for NSA (e) Designated facility staff shall use the results of the functional capacity screening as a basis for determining the services to be included in the resident ' s negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(e) The facility reported a census of 79 residents(R). The sample include six residents and one closed record review. Based on interview, and record review the operator failed to ensure designated staff completed one (R2) of one closed records "Functional Capacity Screen" accurately to reflect the resident's behaviors and impaired decision-making abilities. Findings Included: - R2's medical record revealed he moved into the facility on 04/02/24 with a diagnoses of multiple sclerosis and anxiety disorder. . R5's "Functional Capacity Screen" (FCS) dated 10/28/24 did not identify the resident had any inappropriate behaviors or impaired decision-making abilities.	S3083		

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

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S3083	Continued From page 1 R5's "Negotiated Service Agreement" dated 10/28/24 identified staff would support the resident to make appropriate decisions and that he "drinks alcohol, has issues when drinking and at times drinks and drives his corvette." It also identified it took housekeeping staff two or more hours to clean his room at this time. Review of R2's electronic progress notes included multiple documentation of the resident having bowel movements in bed or on the floor instead of going into the bathroom. It also included documentation of the resident using drinking glasses to urinate in and leaving them sitting around in his apartment instead of using the toilet or his urinal. The documentation included multiple falls with documentation of the resident drinking alcohol as contributing to his falls. On 05/27/24 staff documented at approximately 08:40 PM the resident had been sitting out in his car since 07:00 PM and had an open beer in the cupholder and a couple packs of alcoholic beverages in his car. Later that same evening Certified Medication Aide on duty went to look for the resident and his car was gone. Facility staff contacted his wife who said she would try and get ahold of him. Later that evening at approximately 10:10 PM staff observed the resident sitting on the ground next to his car. His walker was beside him with a case of beer on it and empty cans on the ground. The resident said his leg gave out on him as he was getting out of the car. On 09/29/24 staff documented the resident had driven his car into the grass next to the dumpster	S3083		

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S3083	Continued From page 2	S3083		

in the back of the facility. The resident reported he came back to the back to throw away his beer cartons. Staff also observed a 12 pack of alcoholic beverages and a box of empty cans sitting on the floorboard. The resident's son moved the car while staff assisted the resident back into the building. The resident refused to go to his room and said he needed to get to a local department store and the nurse explained he should not be driving since he had been drinking. The resident continued to say he was going to leave but was unable to because family had his keys.
On 10/10/24 staff documented the resident returned to the facility and smelled like he had consumed a lot of alcohol. Staff assisted the resident back to his room.
10/26/24 staff documented they observed resident attempting to enter the facility with groceries. There were three beer cans by the drivers back tire and the resident admitted to drinking and driving. Staff explained to the resident it was illegal to drink and drive and he said he only had two beers.

Interview on 03/12/25 at 08:54 AM Certified Nursing staff G reported R2 was not a clean man and would urinate in drinking dups and leave them all over his room. He also had BM in his bed and on his floor even though he was able to get in and out of bed on his own and to the bathroom.

Interview on 03/12/25 at 08:55 AM Certified Medication Aide (CMA) H reported R2 had behaviors. He would not listen to any recommendations about how dinking could affect his medications and that he shouldn't drink and

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CELEBRATION VILLA OF HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

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S3083	Continued From page 3 drive. CMA H explained on time he was at a local restaurant and got belligerent, so the police were called. He left before the police got there and got his pickup instead of his car since the police were looking for his car. Interview on 03/12/25 at 04:58 AM Administrative Licensed Nurse B acknowledged R2 had impaired decision making related to drinking and driving and behaviors related to having BM on the floor and urinating in drinking cups. Administrative Licensed Nurse B confirmed she should have coded R2's FCS as having behaviors and impaired cognition. The executive director failed to ensure designated staff completed R2's FCS accurately to identify his socially inappropriate behaviors and impaired decision-making abilities.	S3083		
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	S3085		

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CELEBRATION VILLA OF HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

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S3085	Continued From page 4 (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 79 residents (R). The sample included six sampled residents and one closed record review. Based on observation, record review, and interview the executive director failed to ensure designated staff completed the "Negotiated Service Agreement" for five (R3, R4, R5, R6, R7) of six sampled residents based on the resident's "Functional Capacity Screen" and service needs, which included a description of the services the resident received and the provider of each service, and payment source if the service was provided by an outside resource. Findings included: - Review of R3's medical record revealed she moved into the facility on 06/05/24 with diagnosis of Alzheimer's disease. R3's "Functional Capacity Screen" (FCS) dated 02/28/25 Identified R3 required physical assistance with activities of daily living and had a risk for falls. R3's change of condition "Negotiated Service Agreement" dated 11/28/24 did not include a description of Home Health services, who provided them or who was responsible for	S3085		

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S3085	Continued From page 5	S3085		

payment of services.

R3's "Negotiated Service Agreement" (NSA) dated 02/28/25 identified R3 was currently on case load with a local Home Health Agency for physical therapy and speech therapy. The NSA failed to identify payment source for Home Health.

Observation on 03/11/25 at 03:20 PM the resident stood without assist of visitor and then she walked down the hall to participate in the afternoon activity. She used her two wheeled walker with her daughter walking behind her with a wheelchair.

Interview on 03/12/25 at 03:50 PM Home Health staff reported R3 started services on 11/22/24 for skilled nursing, physical therapy, occupational therapy, and speech therapy.

Interview on 03/13/24 at 10:31 AM Administrative Licensed Nurse B reviewed R3's NSA dated 11/28/24 and acknowledged it did not include that she was receiving Home Health services and acknowledged she had not included the payment source for Home Health services.

The executive director failed to ensure R3's NSA included a description of services related to Home Health, who provided the service, and the payment source for the service.

- Review of R4's medical record revealed she moved into the facility on 09/17/23 with diagnoses of Alzheimer's disease, osteoporosis.

R4's "Functional Capacity Screen" (FCS) dated

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	N089063	A. BUILDING: _____ B. WING _____	03/13/2025

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CELEBRATION VILLA OF HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

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S3085	Continued From page 6 01/22/25 identified the resident required physical assistance with activities of daily living and had a risk for falls. R4's "Negotiated Service Agreement" (NSA) dated 01/22/25 identified she was at risk for falls and staff to remind her to use her walker if seen not using it. It also identified Hospice attempted to bathe the resident twice a week. The NSA failed to identify services related to history of falls, who provided Hospice services, and payment source for Hospice. R4's Service plan included a "Fall Risk" section with multiple interventions including, encourage to stay in common area, physical and occupational therapy, staff to walk with resident to meals, encourage to call for assistance, staff to remain in main living room when residents are present, lock brakes on wheelchair. Observation on 03/11/25 at 09:12 PM Certified Nurse Aide C went into R4's room to assist her to get up for the day. R4 was sleeping in her recliner. Staff gently woke her and allowed her time to wake up. R4 reached for staff and then staff helped her to stand up and transfer into her locked wheelchair. Staff pushed her into the rest room and had R4 hold onto the grab bar to stand up and then staff assisted her to sit on the toilet and get ready for the day. Interview on 03/13/25 at 10:55 AM Administrative Licensed Nurse B acknowledged the NSA dated 01/22/25 did not include which Hospice the resident used or payment source for Hospice and acknowledged the NSA did not include fall interventions but they were on the service plan.	S3085		

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S3085	Continued From page 7 The executive director failed to ensure R4's NSA included identification of who provided Hospice services and payment source for Hospice services as well as a description of services to help reduce risk for falls. - Review of R5's medical record revealed she moved into the facility on 06/15/23 with diagnosis of Alzheimer's disease. R5's "Functional Capacity Screen" dated 02/10/25 identified the resident required physical assistance with management of medications and medical treatments and had a current problem or was at risk for falls. R5's "Negotiated Service Agreement" (NSA) dated 02/10/25 identified that facility medication techs would administer medications but failed to identify services to be provided related to management of medical treatments. It included "has a history of falls, see fall care plan". The NSA also identified staff needed to remind R5 to use her walker. It also lacked a description that the resident received outside services from a local company for podiatry and who paid for those services. Review of R5's medical record included notes from a local company that provided in house podiatry services. Interview on 03/11/25 at 12:12 PM Administrative Licensed Nurse B reported the NSA and care plan are one document except for falls because there is not a place on the NSA for falls. Administrative Licensed Nurse B stated she had	S3085		

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S3085	Continued From page 8	S3085		

falls in the electronic record under service plan, but they are not signed by family. She also acknowledged the NSA did not include a description of services related to fall risk and did not include payment source for Hospice services. She also acknowledged it did not include podiatry services provided by an outside resource.

The executive director failed to ensure R5's NSA included a description of services related to falls and the payment source for Hospice services.

- Review of R6's medical record revealed she moved into the facility on 01/18/25 and had a diagnosis of Alzheimer's disease.

R6's "Functional Capacity Screen" dated 02/17/25 identified R6 had a current problem or risk for falls.

R6's "Negotiated Service Agreement" did not identify she was at risk for falls except that she reported having one fall in the past 60 days. It identified she was working with a local company for physical therapy services.

R6's "Service Plan" identified she used a cane for ambulation and occasionally needed assistance to use a walker for ambulation.

Observation/Interview on 03/11/25 at 03:23 PM R6 invited surveyor into her room. R6 walked throughout her apartment without use of an assistive device and reported everything was going well.

Interview on 03/12/25 at 04:44 PM Administrative

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CELEBRATION VILLA OF HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

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S3085	Continued From page 9 Licensed Nurse acknowledged the NSA did not include the payment source for Home Health services. The executive director failed to ensure R6's NSA included the payment source for outside services provided by local Hom Health agency. - Review of R7's medical record revealed she moved into the facility on 12/06/24 with diagnosis of osteoporosis and hypertension. R7's "Functional Capacity Screen" dated 01/06/25 revealed she was independent with activities of daily living and had a history of falls. R7's 'Negotiated Service Agreement" (NSA) dated 01/06/25 did not identify that R7 received Skilled Nursing from a local Home Health agency. Review of R7's nursing progress notes included documentation on 12/21/24 R7 received skilled nursing and occupational therapy services. Interview on 03/12/25 at 02:30 PM Home Health staff reported R7 received skilled nursing services and physical therapy services with them from the time she moved into the facility and was discharged on 01/23/25. Interview on 03/12/25 at 04:46 PM Administrative Licensed Nurse looked through R7's NSA dated 01/06/25 and acknowledged it did not included that R7 received skilled nursing services from a local Home Health agency. The executive director failed to ensure R7's NSA	S3085		

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	N089063	A. BUILDING: _____ B. WING _____	03/13/2025

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

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S3085	Continued From page 10 included that she received services from a local Home Health agency, what services she received, and payment source.	S3085		
S3092 SS=E	26-41-202 (d) Negotiated Service Agreement Revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements:(1) At least once every 365 days; (2) following any significant change in condition, as defined in K.A.R. 26-39-100; (3) at least quarterly, if the resident receives assistance with eating from a paid nutrition assistant; and (4) if requested by the resident or the resident ' s legal representative, facility staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. This REQUIREMENT is not met as evidenced by: KAR 26-41-202 (d)(2) The facility reported a census of 79 residents(R). The sample included six residents and one closed record review. Based on observation, interview, and record review the executive director failed to ensure designated staff reviewed and revised the "Negotiated Service Agreement" for two (R3, R7) of three sampled residents when the resident had a significant change in service needs related to skilled therapy.	S3092		

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	N089063	A. BUILDING: _____ B. WING _____	03/13/2025

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

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S3092	Continued From page 11 Findings included: - Review of R3's medical record revealed she moved into the facility on 06/05/24 with diagnosis of Alzheimer's disease. R3's "Functional Capacity Screen" (FCS) dated 02/28/25 Identified R3 required physical assistance with activities of daily living and had a risk for falls. R3's "Negotiated Service Agreement" (NSA) dated 02/28/25 identified R3 was currently on case load with a local Home Health Agency for physical therapy and speech therapy. R3's record included an amended NSA dated 06/06/24 for physical and occupational therapy through a local Home Health agency and discharged on 09/29/24. R3's record did not include any additional amended NSAs. Observation on 03/11/25 at 03:20 PM the resident stood without assist of visitor and then she walked down the hall to participate in the afternoon activity. She used her two wheeled walker with her daughter walking behind her in the wheelchair. Interview on 03/12/25 at 3:50 PM Home Health office staff reported R3 started services on 11/22/24 for skilled nursing, physical, occupational, and speech therapy. She discharged from skilled nursing on 01/08/25 and discharged from occupational therapy on 01/15/25.	S3092		

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S3092	Continued From page 12 Interview on 03/13/25 at 10:30 M Administrative Licensed Nurse B acknowledged she had not completed an amended NSA when Home Health discharged her from skilled nursing or occupation therapy since she was still getting other services from the home Health agency. The executive director failed to ensure designated staff reviewed/revised R3's NSA when she discharged from skilled nursing services and occupational therapy services. - Review of R7's medical record revealed she moved into the facility on 12/06/24 with diagnosis of osteoporosis and hypertension. R7's "Functional Capacity Screen" dated 01/06/25 revealed she was independent with activities of daily living and had a history of falls. R7's 'Negotiated Service Agreement" (NSA) dated 01/06/25 did not identify that R7 received Skilled Nursing from a local Home Health agency. Review of R7's nursing progress notes included documentation on 12/21/24 R7 received skilled nursing and occupational therapy services. It also included documentation on 03/03/25 that R7 had been working with a different Home Health agency for physical therapy services. Interview on 03/12/25 at 02:30 PM Home Health staff reported R7 received skilled nursing services and physical therapy services with them from the time she moved into the facility and was discharged on 01/23/25.	S3092		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S3092	Continued From page 13 Interview on 03/12/25 at 04:46 PM Administrative Licensed Nurse looked through R7's record and acknowledged it did not have and amended NSA completed for when she discharged from one Home Health agency and started therapy with another company. The executive director failed to ensure designated staff reviewed and revised R7's NSA when she was discharged from one Home health company and then later started physical therapy services with a different Home Health agency.	S3092		
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) The facility reported a census of 79 residents(R). The sample included six residents and one closed record review. Based on observation, interview, and record review the executive	S3186		

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 _____	03/13/2025

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

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S3186	Continued From page 14	S3186		

director failed to ensure one (R8) of six sampled residents Negotiated Service Agreement included the selected medications the resident chose to administer.

Findings included:

- R8's medical record revealed she moved into the facility on 11/21/23 with a diagnoses of chronic kidney disease and osteoporosis.

R8's "Functional Capacity Screen" dated 02/26/25 identified she was independent with activities of daily living but needed physical assistance with management of medications an medical treatments.

R8's "Negotiated Service Agreement" (NSA) dated 02/26/25 identified she needed help with management of medications due to cognitive decline and service would be provided by facility medication tech. The NSA did not identify the resident chose to self-administer any of her medications.

Interview on 03/11/25 at 03:37 PM R8 invited surveyor into her apartment. She said she does a few of hew own medications and pointed to the multi-vitamin gummy and the ear drops on her counter. R8 reported she had an earache awhile back and used the drops and she is not sure if she really needs the vitamins because the facility also giver her a vitamin every day.

Interview on 03/13/25 at 10:23 AM Administrative Licensed Nurse B reported the medications a resident chose to self administer were written on

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	N089063	A. BUILDING: _____ B. WING _____	03/13/2025

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CELEBRATION VILLA OF HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

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S3186	Continued From page 15 the self-administration medication assessment. She did not realize it had to be listed on the NSA. The executive director failed to ensure designated staff identified what select medications R8 chose to self-administer in her NSA.	S3186		
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 79 residents(R). The sample included six residents and one closed record review. Based on interview and record review the executive director failed to ensure four (R3, R4, R5, R7) of six sampled residents record contained documentation of all incidents, symptoms, and other indications of illness or injury, what action was taken, and the results of action taken. Findings included: - Review of R3's medical record revealed she moved into the facility on 06/05/24 with diagnosis	S3261		

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	N089063	A. BUILDING: _____ B. WING _____	03/13/2025

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S3261	Continued From page 16 of Alzheimer's disease. R3's "Functional Capacity Screen" (FCS) dated 02/28/25 Identified R3 required physical assistance with activities of daily living and had a risk for falls. R3's "Negotiated Service Agreement" (NSA) dated 02/28/25 facility staff assisted R3 with activities of daily living and the medication tech administered her medications. R3's electronic nursing "Progress Notes" included the following documentation: 06/19/24 - hydrocortisone to left temple for dermatitis x 14 days - The record lacked follow up if R3's skin condition healed or not. 07/09/24 - Voltaren gel to left shoulder three times a day for pain. The record lacked follow up on R3's left ear and pain in her left shoulder. 7/29/24 - Schedule Tramadol (narcotic pain medication) every morning 08/24/24 - resident complaining of pain more often per family and request Tramadol be scheduled more frequently. 08/24/24 - New order for Tramadol twice a day and continue with as needed orders. The record lacked follow up as to the resident's pain and increase in scheduled Tramadol. 09/18/24 - apply steroid cream to affected areas on chin twice a day until healed. The record lacked follow up on skin conditions. 10/02/24 - zinc cream to affected areas on face twice a day for four weeks for lesion on face. The record lacked documentation of skin condition to face and if treatment was effective.	S3261		

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S3261	Continued From page 17 Interview on 03/12/24 at 04:33 PM Administrative Licensed Nurse B reported the nurses chart by exception meaning if something out of the ordinary happened. They document and follow up on antibiotics, falls, and any behaviors a resident might have. Interview on 03/13/24 at 10:32 AM Administrative Licensed Nurse B reviewed notes and acknowledged nurses had not been documenting on skin conditions or following up on the results of medication changes. The executive director failed to ensure designated staff documented all incidents, symptoms, and other indications of illness or injury, what action was taken, and the results of action taken. - Review of R4's medical record revealed she moved into the facility on 09/17/23 with diagnoses of Alzheimer's disease and osteoporosis. R4's "Functional Capacity Screen" (FCS) dated 01/22/25 identified the resident required physical assistance with activities of daily living and management of medications and had impaired cognition. R4's "Negotiated Service Agreement" (NSA) dated 01/22/25 identified facility staff provided assistance with activities of daily living, medication techs administered medications and staff provided reminders, cues and redirection throughout the day.	S3261		

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S3261	Continued From page 18 Review of R4's electronic nursing "Progress Notes" revealed the following documentation: 05/29/24 - Mucinex times five days, Zithromax (antibiotic) as ordered. The record lacked follow up related to resident's cough and did it resolve. 06/07/24 - went to emergency room post fall and started Cephalexin for cellulitis. The record lacked follow up on cellulitis and results of antibiotics. 06/26/24 - (19 days later) - Keflex (antibiotic) times 14 days for cellulitis. 09/02/24 - resident with bed sore on each side of buttock that are approximately .5 inches long and appears scabbed over. The record lacked follow up on skin condition. 09/23/24 - new order for Ativan (antianxiety) in am and 02:00 PM for anxiety The record lacked follow up as to results of scheduled Ativan. Interview on 03/12/25 at 04:33 PM Administrative Licensed Nurse B reported the nurses chart by exception meaning if something out of the ordinary happened. They document and follow up on antibiotics, falls, and any behaviors a resident might have. Interview on 03/13/24 at 10:56 AM Administrative Licensed Nurse B reviewed notes and acknowledged nurses had not been following up on the results of medication changes. The executive director failed to ensure designated staff documented all incidents, symptoms, and other indications of illness or injury, what action was taken, and the results of action taken.	S3261		

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S3261	Continued From page 19 - Review of R5's medical record revealed she moved into the facility on 06/15/23 with diagnosis of Alzheimer's disease. R5's "Functional Capacity Screen" dated 02/10/25 identified the resident required physical assistance with activities of daily living, management of medications and medical treatments and had impaired cognition. R5's "Negotiated Service Agreement" (NSA) dated 02/10/25 identified that facility staff would provide assistance with activities of daily living, medication techs would administer medications, and staff would provide reminders, cueing and safety checks due to impaired cognition. R5's electronic nursing "Progress Notes" included the following documentation: 01/08/24 - Please apply compression stockings in am and off at bedtime or edema. The record lacked follow up if R5's edema improved with compression stockings. 04/16/24 - started Remeron (antidepressant) and discontinued Seroquel (antipsychotic). The record lacked follow up related to results of changing medications. 07/17/24 - new order to start Triamterene and Hydrochlorothiazide (both diuretics). The record lacked follow up as to the results of starting diuretic medications. 11/15/24 - New order for Z-pack (antibiotic) for cough and congestion The record lacked documentation if the resident's cough/congestion improved with antibiotics. 11/29/24 - resident with pitting edema and	S3261		

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S3261	Continued From page 20	S3261		

husband educated to elevate residents' legs and feet.
The record lacked follow-up related to resident's edema.

Interview on 03/12/25 at 04:33 PM Administrative Licensed Nurse B reported the nurses chart by exception meaning if something out of the ordinary happened. They document and follow up on antibiotics, falls, and any behaviors a resident might have.

Interview on 03/12/25 at 04:34 PM Administrative Licensed Nurse B reviewed notes and acknowledged nurses had not been following up on the results of medication changes.

The executive director failed to ensure designated staff documented all incidents, symptoms, and other indications of illness or injury, what action was taken, and the results of action taken.

- R7's medical record revealed she moved into the facility on 12/06/24 with diagnosis of osteoporosis.

R7's "Functional Capacity Screen" dated 01/06/25 revealed she was independent with activities of daily living and had a history of falls.

R7's 'Negotiated Service Agreement" (NSA) dated 01/06/25 revealed the resident walked with a walker and medications were bubble packed by the pharmacy specifically for her to be able to self administer.

The residents electronic nursing "Progress

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CELEBRATION VILLA OF HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

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S3261	Continued From page 21 Notes" included the following documentation: 12/06/24 - joint swelling to left knee form previous fall, Home Health to provide wound care and wrap knee. The record lacked nurse assessment and follow up r/t swollen knee and wound. Interview on 03/12/25 at 04:33 PM Administrative Licensed Nurse B reported the nurses chart by exception meaning if something out of the ordinary happened. They document and follow up on antibiotics, falls, and any behaviors a resident might have. Interview on 03/12/24 at 04:50 PM Administrative Licensed Nurse B reviewed notes and acknowledged nurses should have documented on R7's knee and wound on her knee. The executive director failed to ensure designated staff documented all incidents, symptoms, and other indications of illness or injury, what action was taken, and the results of action taken.	S3261		
S3298 SS=F	26-41-206 (d) Food Preparation (d) Food preparation. Food shall be prepared using safe methods that conserve the nutritive value, flavor, and appearance and shall be served at the proper temperature. (1) Food used by facility staff to serve to the residents, including donated food, shall meet all applicable federal, state, and local laws and regulations. (2) Food in cans that have significant defects, including swelling, leakage, punctures, holes,	S3298		

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S3298	Continued From page 22 fractures, pitted rust, or denting severe enough to prevent normal stacking or opening with a manual, wheel-type can opener, shall not be used. (3) Food provided by a resident ' s family or friends for individual residents shall not be required to meet federal, state, and local laws and regulations. This REQUIREMENT is not met as evidenced by: KAR 26-41-206(d) The facility reported a census of 79 residents. Based on interview, and record review the executive director failed to ensure dietary staff monitored food temperatures to ensure it was prepared and served at the proper temperature. Findings included: - During initial tour on 03/10/25 at 11:54 AM dietary staff from the main kitchen brought down a food cart to the memory care unit. Surveyor did not observe Food temperature logs on the cart or anywhere in the kitchenette or by the steam table. In the Memory Care ,the only documentation was for "Meal Attendance Log". Observation on 03/10/24 at 12:22 PM Certified Nurse Aide (CNA) C moved the kitchen cart out of the kitchenet and proceeded to fix plates. The food had been put in the steam table and surveyor did not observe food temp logs or thermometers in the area.	S3298		

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S3298	Continued From page 23 Interview on 03/10/24 at 12:27 PM CNA C stated she had not checked the temperature of the food after dietary staff brought the cart to the unit. She looked in a couple of the drawers and did not find a thermometer. Interview on 03/10/25 at 12:40 PM dietary staff D reported he had not personally documented food temperatures on a log but thought they were on the clip boards and pointed over to the wall. Review of the clip boards did not include any food temperature logs. On 03/10/25 at 12:42 PM another dietary staff got a different clipboard from the other wall and said these were the forms staff were supposed to fill out with food temperatures on them. The forms included today's menu but did not have any temperatures of foods prepared. On 03/10/25 at 01:07 PM Dietary Manager E reviewed the "Dining Manager Production Sheet" and reported he brought the forms over and they were the ones staff are supposed to document food temperatures on. Dietary Manager E contacted dietary staff F regarding food temperature logs and then provided additional logs for review. Review of the logs provided included the last half of August and September of 2024, and October of 2024 that had 14 days with no food temperatures documented. It lacked food temperature monitoring for November and December of 2024 and January and February of 2025.	S3298		

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S3298	Continued From page 24 The executive director failed to ensure dietary staff monitored food temperatures to ensure they were prepared and served at the proper temperatures.	S3298		
S3299 SS=F	26-41-206 (e) (1) Facility Food Storage (e) Food storage. Facility staff shall store all food under safe and sanitary conditions. (1) Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving. This REQUIREMENT is not met as evidenced by: KAR 26-41-206(e) The facility reported a census of 79 residents. Based on observation and interview the executive director failed to ensure designated staff stored all food under safe and sanitary conditions. Findings included: - Observations during the kitchen tour on 03/10/25 at 12:43 PM revealed the following in the walk-in cooler: Plastic container labeled gravy and dated 03/02/25. Partially used bag of icing not sealed or dated. Plastic container labeled Marinara and dated 02/26/25. Plastic container with individual plastic containers labeled salsa and dated 02/26/25.	S3299		

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S3299	Continued From page 25 Partially used chub of hamburger that had browned on the ends that was not dated or labeled. Interview on 03/10/25 at 01:12 PM Dietary Staff D acknowledged food items left over were good for use up to seven days and the items dated 02/26/25 should have been thrown out. He also stated staff were supposed to label and date all food items when they were opened. Review of the "Food Storage Policy for Priority Life Care" provided by Executive Director on 03/17/25 revealed all food items will be labeled whtn opened with the date and use-by date and dietary staff to check dates regularly and discard any expired items. The executive director failed to ensure designated staff stored foods in manner to ensure dietary staff discarded leftovers after seven days, sealed, dated, and labeled all foods properly.	S3299		