| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| CELEBRATION VILLA OF HEARTHSTONE EAST | 3415 SW 6TH AVENUE TOPEKA, KS 66606 |

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| S 000 | INITIAL COMMENTS<br><br>The following represents the findings of a resurvey with attached complaint 194434, 196564, 196917, 197127, 197165, 197462, 197611, 197807, and 197817 at the above named assisted living facility conducted 02/02/26-02/05/26. | S 000 | | |
| S3026 SS=J | 26-41-101 (f) (1) Staff Treatment of Residents ANE<br><br>(f)The administrator or operator shall ensure that all of the following requirements are met:<br>(1) No resident shall be subjected to any of the following:<br>(A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion;<br>(B) neglect; or<br>(C) exploitation.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-101(f)(1)(B)<br><br>The facility reported a census of 75 residents with six residents included in the sample. Based on observation, interview, and record review the administrator failed to protect cognitively impaired Residents (R) 1, R5, and R6 at risk for elopement from neglect by the failure to provide staff adequate door alarm and elopement training. This failure placed R1, R5 and R6 in immediate jeopardy when the cognitively impaired residents exited the facility without staff knowledge. R1, R5 and R6 walked outside, unsupervised, and were found by passers-by | S3026 | | |

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

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who reported to police and were returned to the facility approximately three hours, two hours, and seven- and one-half hours respectively after they exited the facility.

Findings included:

- Record review for R1 revealed an admission date of 04/18/24 with a diagnosis of mild cognitive impairment.

The 12/10/25 Functional Capacity Screen (FCS) identified R1 was independent with transfers and walking/mobility; she had no cognitive difficulties; and was at risk of falling.

The 12/10/25 Negotiated Service Agreement (NSA) identified R1 was independent with transfers and walking/mobility, required cognitive assistance when evacuating in case of an emergency, and needed attendance in unfamiliar places. The NSA failed to address services provided to prevent falls.

The 12/10/25 "Brief Interview for Mental Status" documented R1 was unable to recall two of three words from a prior question with a total score of 13, which indicated intact cognition.

The "Resident Roster" provided by the facility on 02/02/26 documented R1 had severe impaired cognition.

Record review of 12/10/25 (before elopement) "Wandering Risk Assessment" failed to document R1 as forgetful. The assessment indicated a low risk for elopement. The record failed to include an updated or completed

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assessment after the elopement.

The 05/17/25 at 02:16 PM "Health Status Note" documented R1's son felt the resident's Alzheimer's disease was worsening.

The 06/04/25 at 10:44 AM "Communication - with Family" documented R1's son was concerned her memory was "slipping more."

The 06/08/25 at 03:18 PM "Incident Note" documented R1 had an unwitnessed fall outside facility's front entrance and when asked about fall her response was "I don't know what happened."

The 06/12/25 at 04:35 PM "Communication - with Family" documented R1's son was concerned because her memory was worse, and she was more confused.

The 06/16/25 at 12:59 PM "Behavior Note" documented R1's son reported R1 had called him three times and left messages about her late husband and a drug dealer.

The 12/04/25 at 05:00 PM "Monthly Wellness Check" note documented R1 was at baseline with occasional forgetfulness.

The 01/04/26 "Monthly Wellness Check" note documented R1 had times of forgetfulness and occasional agitation.

The "Incident Information" signed by Administrative Staff A on 01/15/26 sent to the state agency documented R1 was last seen by Certified Nurse Aide (CNA) H at approximately

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| S3026 | Continued From page 3<br><br>07:50 PM. The front door alarm and patio door alarms were both triggered at approximately 08:00 PM. Staff failed to respond to the alarms assuming it was other staff locking the doors. The local police department brought R1 to the facility at 10:50 PM.<br><br>Certified Medication Aide (CMA) I's "Witness Statement" dated 01/06/26 documented R1 was found on a road at least 1.4 miles away and being returned by law enforcement. R1 asked immediately after returning to the facility if her (late) husband knew and stated she left out the front door because she was mad and disgusted but was not sure why.<br><br>Review of CMA J's "Witness Statement" dated 01/06/26 revealed CMA J saw the front door alarm but did not check the doors or ask other staff about the alarm.<br><br>Review of facility's "SMARTcare" alert log revealed the "main front door" and "main entry inside" doors both alerted at 08:01 PM. The log had two highlighted alarm locations and times which showed the same alarms were not triggered until 11:08 PM, the time when R1 was returned to the facility.<br><br>The weather on 01/06/26 according to www.Wunderground.com had a temperature of 34 degrees Fahrenheit from 09:53 PM to 10:53 PM.<br><br>Observation on 02/04/26 at 02:22 PM revealed the route R1 took to exit the building from her last seen location in her room to the front main door was approximately 115 steps. | S3026 | | |

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| S3026 | Continued From page 4<br><br>Observation on 02/04/26 at 11:35 AM revealed a possible route R1 walked after she exited the building. The route was down a sidewalk next to a four-lane street with a speed limit of 40 miles per hour (MPH). She would have walked 1.4 miles west, crossed at least one intersection with four-lanes and a turning lane in each direction, then three miles south. Many areas cross business entrances and do not have smooth or defined sidewalks. The spot where R1 was found by a citizen took approximately 85 minutes to walk.<br><br>Observation on 02/04/26 at 02:22 PM revealed R1 ambulated in her room independently. She was able to state her name but was unable to name her location.<br><br>On 02/04/26 at 02:22 PM R1 stated she did not go outside very often but if she did, she went with her husband. She stated she had not fallen inside the facility, only outside. R1 recalled a night she went outside to walk and got mixed up. She stated she only went about three blocks, and she met a lady who helped her.<br><br>On 02/02/25 at 03:38 PM CMA G confirmed nothing prevented the residents from going through the doors to the outside. If an alarm activated staff would check the door and look outside for any residents.<br><br>On 02/04/26 at 12:05 PM Administrative Nurse E stated R1 was found at an intersection 3.7 miles from the facility by a passerby on 01/06/26. She confirmed the police notified the facility they were transporting her back and she arrived | S3026 | | |

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| S3026 | Continued From page 5<br>approximately three hours and seven minutes after exiting the facility.<br><br>On 02/05/26 at 10:06 AM Administrative Staff A confirmed she expected staff to check each door alarm and observe for residents outside the facility.<br><br>The administrator failed to protect cognitively impaired R1 from neglect by the failure to ensure staff responded to door alarms and properly assessed R1 to prevent elopement.<br><br>- Record review for R5 revealed an admission date of 12/01/22 with diagnoses of dementia, respiratory failure, encephalopathy, and history of transient ischemia attacks.<br><br>The 09/03/25 FCS identified R2 required physical assistance with bathing, dressing, and management of medications and treatments; was independent with transfers and walking/mobility; had short-term memory, memory recall, and decision-making cognitive difficulties; was at risk for falls; and had impaired decision-making.<br><br>The 09/03/25 NSA identified R2 had mild to moderate disorientation or difficulty in recalling and retaining information which required cueing, demonstrated inappropriate judgement related to safety, and received reminders for meals and activities. R5 required supervision in the home and was unable to leave unattended. Staff observed her every hour.<br><br>The "Resident Roster" provided by the facility during entrance documented R5 had moderate wandering behavior. | S3026 | | |

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| S3026 | Continued From page 6<br><br>The 09/03/25 "Brief Interview for Mental Status" scored R5 at 11 of 15 points indicating moderate cognitive impairment.<br><br>The 02/10/25 "Wandering Risk Assessment" indicated R5 as a low risk for wandering. The assessment failed to document R5's diagnosis of dementia.<br><br>The 01/01/26 - 01/31/26 "Medication Administration Record" showed R5 took sertraline for anxiety, started on 02/27/25.<br><br>The next "Wandering Risk Assessment" completed 09/30/25 (after elopement) documented R5 continued to be scored at three points. The assessment failed to indicate R5's dementia diagnosis, use of an anti-anxiety medication, and history of wandering.<br><br>Review of the facility's reported "incident information" to the department revealed R5 was last seen in the dining room "on 09/30/25 [sic] at approximately 6:30 PM" by CNA H. At approximately 08:10 PM CMA J went to R5's apartment and did not find her there. The local police had brought R5 to a neighboring building at approximately 08:15 PM who notified the facility of R5's whereabouts.<br><br>Review of "Incident Note" dated 09/29/25 at 10:28 PM revealed a peer saw R5 go outside through the dining room door. An unknown amount of time passed before she walked off the property. The police later notified facility staff R5 fell in a neighborhood to the south, was taken by neighbor to another location, and notified law | S3026 | | |

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enforcement who subsequently brought her back to the facility. After return to the facility, R5 stated she was "going to a picnic." Staff started every 15-minute status checks for R5.

Review of "Witness Statement" provided by neighboring facility staff documented the local police department arrived with R5 to their facility at 08:30 PM. She notified the facility via radio after unsuccessful phone call attempts. The police left the other building and met the facility's nurse on duty outside.

Review of facility's "Care Record Report" for September 2025 revealed every two-hour checks began the following day, 09/30/25, at 10:00 AM.

Observation on 02/02/26 at 04:45 PM revealed the dining area door had no audible alarm and did not send alerts to staff when the door was opened.

Observation on 02/04/26 at 11:10 AM revealed a possible route R6 took to exit the facility and property. She would have walked approximately 8 steps to the unalarmed exterior door. When leaving the outdoor patio, R5 would have taken approximately 14 steps across grass to a paved road then at minimum 150 feet into the neighboring residential community where she was found.

On 02/02/26 at approximately 02:15 PM Unlicensed Staff K stated she knew of some residents who were not to leave the facility unattended, but she did not have a list or pictures.

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On 02/04/26 at 01:33 PM Administrative Nurse E stated R5 was confused at the time of the elopement thinking she was walking home. She left her walker in the parking lot and walked through the grass where she fell.

On 02/04/26 at approximately 01:40 PM Administrative Nurse B confirmed the dining room door alarm was changed after R5's elopement to start alarming at 05:00 PM.

During an interview with law enforcement records staff member on 02/05/26 at 09:55 AM via phone revealed a bystander found R5 who had fallen and called the police notifying them she was confused and not able to provide much information. Law enforcement was able to determine an approximate location she lived by contacting her family and was able to transport her back to the facility.

The administrator failed to protect cognitively impaired R5 from neglect by the failure to provide accurate assessments and the failure to secure all exit doors.

- Record review for R6 revealed an admission date of 02/03/25 with diagnoses of Alzheimer's disease and cognitive communication deficit.

The 03/03/25 FCS identified R3 was independent with transfers and walking/mobility; had short-term memory and memory recall cognitive difficulties; and was at risk for falls.

The 03/03/25 NSA identified R6 was independent with mobility, staff observed her every eight hours, staff reminded her of meals

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and activities. R6 required staff attendance when outside the facility or when she wandered.

The 06/04/25 "Wandering Risk Assessment" documented R6 was at a low risk for wandering.

Review of 07/13/25 at 02:14 PM "Incident Note" revealed the local fire department called to notify staff R6 left the facility and fell after walking a "couple" blocks. She was confused, had a skin tear, and was taken to the local emergency room.

The 07/14/25 at 11:57 AM "Incident Note" documented R6 stated she "got turned around then fell."

Interview with an Emergency Medical Service (EMS) staff member on 02/05/26 at 10:40 AM via phone revealed R6 was found at 01:45 PM on 07/13/25 lying along a road 0.3 miles from the facility. EMS staff who responded documented R6 showed signs of dementia and could not remember recent events.

On 02/02/26 at approximately 02:15 PM Unlicensed Staff K stated she knew of some residents who were not to leave the facility unattended, but she did not have a list or pictures.

On 02/04/26 at approximately 12:10 PM Administrative Nurse E stated R6 was able to go outside unassisted, and staff did not know she had left on 07/13/25.

The administrator failed to protect cognitively impaired R6 from neglect by the failure to provide adequate staff training on wander risk

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| S3026 | Continued From page 10<br>residents.<br><br>The facility's 06/29/18 "Missing Resident/Elopement Policy and Procedure" documented a sign in and out system was utilized requiring residents to sign when leaving the facility and note expected return time. All residents at risk of elopement were to have a photograph taken and put in a "Wander Risk Resident Profile" which was to be available at the reception desk. The policy failed to instruct staff on interventions for residents at low or moderate risk of elopement.<br><br>The Immediate Jeopardy was removed on 02/05/26 when the following actions were documented by the facility and accepted by the department at 01:49 PM.<br><br>1. On 10/01/25 the maintenance director changed the dining room patio door alarm to trigger from 05:00 PM to 08:00 AM.<br>2. 1:1 care was provided to R5 on 09/30/25 until she could move to a secured unit<br>3. R5 was treated for a urinary tract infection, started on an antibiotic 10/01/25<br>4. R1 received a mediation review and adjustment on 01/08/26<br>5. On 01/07/26 Administrative Staff A confirmed all exit door alarms functioned properly<br>6. On 01/07/26 the maintenance director placed a door alarm on R1's apartment door to notify staff when she left her apartment and she was placed on hourly checks until she could move to secure unit<br>7. On 01/08/26 Administrative Staff A completed staff elopement drills and door alarm training for each shift | S3026 | | |

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| S3026 | Continued From page 11<br>8. On 01/08/26 Administrative Staff A completed elopement training for all staff<br>9. Review of the elopement policy to be completed 02/05/26 with residents to ensure they understand sign-in and out procedures<br>10. Staff to be present at front desk at all times between 08:00 AM and 08:00 PM starting 02/05/26<br>11. Director of Nursing to complete Brief Interview for Mental Status assessments on all residents between 02/05/26 and 02/13/26 to ensure cognitive levels are accurate and residents locations are appropriate<br>12. Administrative Staff A to complete four weekly elopement drills starting 02/09/26<br>13. All staff meeting for elopement and procedural training on 02/09/26 | S3026 | | |
| S3085 SS=E | 26-41-202 (a) Negotiated Service Agreement<br><br>(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:<br>(1) A description of the services the resident will receive;<br>(2) identification of the provider of each service; and<br>(3) identification of each party responsible for payment if outside resources provide a service. | S3085 | | |

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| S3085 | Continued From page 12<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-202(a)(1)<br><br>The facility reported a census of 75 residents with six residents included in the sample. Based on interview and record review the administrator failed to ensure the Negotiated Service Agreement (NSA) was fully developed based on the resident's Functional Capacity Screen (FCS), service needs, and preferences for resident (R)1, R2, R3, R4, R5, and R6 including a description of the services the resident received.<br><br>Findings included:<br><br>- Record review for R1 revealed an admission date of 04/18/24 with diagnoses of mild cognitive impairment and spinal stenosis.<br><br>The 12/10/25 FCS identified R1 was independent with bathing, dressing, toileting, transfers, and walking/mobility; required physical assistance with management of medications and treatments; had no cognitive difficulties; and was at risk of falling.<br><br>The 12/10/25 NSA identified R1 was independent with bathing, dressing, toileting, transfers, and walking/mobility, required cognitive assistance when evacuating in case of an emergency, and needed attendance in unfamiliar places. The NSA failed to address services provided to prevent falls. | S3085 | | |

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| 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 |
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| S3085 | Continued From page 13<br>- Record review for R2 revealed an admission date of 04/07/25 with diagnoses of repeated falls, hemiplegia, and polyneuropathy.<br><br>The 05/07/25 FCS identified R2 required physical assistance with bathing, dressing, toileting, transfers, walking/mobility, and management of medications and treatments; had short term memory, memory recall, and decision making cognitive difficulties; had impaired vision; and was at risk of falling.<br><br>The 05/07/25 NSA identified R2's caregivers assisted with bathing, dressing, toileting, transfers, and walking/mobility; staff reminded and cued for activities and meals; and staff administered medications three times a day. The NSA failed to address services provided to prevent falls.<br><br>Review of "Incident note" dated 01/21/26 at 05:08 AM revealed R2 attempted to transfer from bed to wheelchair and sustained a fall. The intervention was for staff to check and ensure wheelchair brakes are set at bedtime.<br><br>- Record review for R3 revealed an admission date of 03/27/25 with diagnoses including dementia and delusional disorders.<br><br>The 07/28/25 FCS identified R3 required physical assistance with bathing, dressing, toileting, and transfers; was unable to perform management of medications and treatments; required supervision with walking/mobility; was independent with eating; was frequently incontinent of urine; and had short-term and long term memory, memory recall, and decision | S3085 | | |

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| S3085 | Continued From page 14<br>making cognitive difficulties; had impaired decision making; and was at risk of wandering and falls.<br><br>The 07/28/25 NSA identified R3 was provided moderate to full assist with bathing, dressing, toileting, and transferring; was dependent on staff for bladder incontinence; staff provided 24 hour direct supervision and reminders/cues for activities and meals for cognition; and staff supported R3 to make appropriate decisions. The NSA failed to address prevention of falls.<br><br>Further review revealed R4, R5, and R6 were at risk of falls according to their FCS and their NSAs lacked services to prevent falls.<br><br>On 02/04/26 at approximately 01:18 PM Administrative Nurse B confirmed the computer generated NSAs did not have fall interventions therefore all residents at risk of falls did not have services on their NSAs.<br><br>The facility's undated "Executing Negotiated Risk Agreements" policy documented when a risk such as a fall was identified, a plan would be developed to reduce the risk.<br><br>The administrator failed to ensure R1, R2, R3, R4, R5 and R6's NSAs described the services they received, and the provider of the service based on their FCS. | S3085 | | |
| S3092 SS=E | 26-41-202 (d) Negotiated Service Agreement Revisions<br><br>(d) Each administrator or operator shall ensure the review and, if necessary, revision of each | S3092 | | |

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| S3092 | Continued From page 15<br>negotiated service agreement according to the following requirements:(1) At least once every 365 days;<br>(2) following any significant change in condition, as defined in K.A.R. 26-39-100;<br>(3) at least quarterly, if the resident receives assistance with eating from a paid nutrition assistant; and<br>(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.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-202(d)(2)<br><br>The facility reported a census of 75 residents with six residents included in the sample. Based on interview and record review the administrator failed to ensure facility staff reviewed and revised the Negotiated Service Agreement (NSA) for Resident (R) 5 and R6 upon significant change in condition as defined in K.A.R. 26-39-100.<br><br>Findings included:<br><br>- Record review for R5 revealed an admission date of 12/01/22 with a diagnosis of dementia.<br><br>The 12/02/25 Functional Capacity Screen (FCS) identified R5 required physical assistance with bathing and dressing; was independent with transfers and walking/mobility; had short-term and long-term memory, memory recall and | S3092 | | |

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| S3092 | Continued From page 16 | S3092 | | |

decision-making cognitive difficulties; had impaired decision-making; and was at risk of falls.

The 12/02/25 NSA identified facility staff would provide assistance with bathing and dressing, and prompting with grooming, activities, and meals. The NSA documented R5 demonstrated inappropriate judgement related to safety and had a history of falls.

Review of 12/31/25 "Incident Note" at 06:22 PM documented R5 had fallen and was unable to recall what happened. Her walker was on the "opposite side of the door." The video surveillance failed to capture the fall and the intervention was to remind R5 to use her walker when ambulating and continue with current plan of care.

Review of 12/31/25 "Incident Note" at 10:51 PM documented R5 had fallen near her closet and unable to recall event. She was not wearing any footwear, and her walker was beside her couch. The intervention documented was to continue plan of care.

Review of 01/25/26 "Incident Note" at 07:01 AM documented staff were alerted of R5 falling via video surveillance. R5 was not using her walker and was partially dressed. The intervention was to assist R5 to get ready earlier in the morning.

On 02/04/26 at approximately 01:18 PM Administrative Nurse B confirmed R5's NSA failed to include fall interventions.

- Record review for R6 revealed an admission

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| S3092 | Continued From page 17<br>date of 02/03/25 with diagnoses including Alzheimer's and anxiety.<br><br>The 09/13/25 (most recent) FCS identified R6 required physical assistance with bathing and management of medications and treatments; was independent with dressing, toileting, transfers, mobility, and eating; was usually continent of bladder; had short-term memory and memory recall cognitive difficulties; and was at risk for falls.<br><br>The 09/13/25 NSA identified facility staff would provide assistance with bathing; management of medications and treatments; and observed every eight hours for cognition. Falls were not addressed on the NSA.<br><br>Review of 12/27/25 at 06:00 AM "Incident Note" revealed R6 reported she had fallen earlier in the day and was unable to recall any other details. The note failed to indicate an intervention to prevent future falls.<br><br>Review of 12/28/25 at 08:43 PM "Incident Note" revealed R6 had a fractured bone in her wrist with a brace in place. The staff were to assist R6 with dressing, undressing, escort her to meals, and complete status checks until she could safely complete on her own.<br><br>On 02/04/26 at approximately 02:15 PM R6 stated after she had the cast put on she needed more assistance with her activities of daily living.<br><br>On 02/04/26 at approximately 01:18 PM Administrative Nurse B confirmed R6's NSA failed to include fall interventions and was not | S3092 | | |

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| S3092 | Continued From page 18<br>revised when she began requiring more assistance.<br><br>The facility's undated "Executing Negotiated Risk Agreements" policy documented when a risk such as a fall was identified, a plan would be developed to reduce the risk.<br><br>The facility's undated "Post Fall Evaluation" policy instructed staff to update the care plan and service plan when a fall intervention is indicated.<br><br>The administrator failed to ensure facility staff reviewed and revised the NSA for R5 and R6 upon change in condition. | S3092 | | |
| S3171 SS=E | 26-41-204 (i) Health Care Services Standards of Practice<br><br>(i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-204(i)<br><br>The facility reported a census of 75 residents with six included in the sample. Based on observation, interview, and record review the administrator failed to ensure a licensed nurse completed an assessment for the purpose to use a bed assist device, ability to use a bed assist safely without risk of entrapment, and to confirm the bed assist device was not a restraint for Resident (R) 2, R4, R5, and R6. | S3171 | | |

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| S3171 | Continued From page 19<br><br>Findings included:<br><br>- Record review for R2 revealed an admission date of 04/07/25 with diagnoses of repeated falls, hemiplegia, and polyneuropathy.<br><br>The 05/07/25 Functional Capacity Screen (FCS) identified R2 required physical assistance with bathing, dressing, toileting, transfers, walking/mobility, and management of medications and treatments; had short term memory, memory recall, and decision-making cognitive difficulties; had impaired vision; and was at risk of falling.<br><br>The 05/07/25 Negotiated Service Agreement (NSA) identified R2 received assistance from staff and required use of railings for transfers.<br><br>The "Resident Roster" provided by the facility on 02/02/26 documented R2 had a bed assist device.<br><br>R2's record lacked documentation of a bed assist device assessment.<br><br>Observation on 02/04/26 at 02:41 PM revealed a bed assist device was attached to R2's bed.<br><br>- Record review for R4 revealed an admission date of 08/27/24 with diagnoses of muscle weakness and unsteadiness on feet.<br><br>The 12/03/25 FCS identified R4 required physical assistance with bathing, dressing, toileting, transfers, walking/mobility, eating, and management of medications and treatments; was | S3171 | | |

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| S3171 | Continued From page 20<br>frequently incontinent of bladder; had short term memory, memory recall, and decision-making cognitive difficulties; had impaired hearing and decision making; and was at risk of falling.<br><br>The 12/03/25 NSA identified R4 received assistance from staff and required use of railings for transfers.<br><br>The "Resident Roster" provided by the facility on 02/02/26 documented R4 had a bed assist device.<br><br>R4's record lacked documentation of a bed assist device assessment.<br><br>Further review revealed the "Resident Roster" provided by the facility on 02/02/26 indicated 25 of 75 of the residents (including R5 and R6) had bed assistive devices.<br><br>Bed assist device assessments were requested for all residents which the facility failed to provide.<br><br>On 02/04/26 at 04:02 PM Administrative Nurse B confirmed all residents who had bed assist devices records lacked documentation of a bed rail assessment.<br><br>The administrator failed to ensure a licensed nurse completed an assessment for the purpose to use a bed assist device, ability to use a bed assist safely without risk of entrapment, and to confirm the bed assist device was not a restraint for R2, R4, R5, and R6. | S3171 | | |

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| S3211 | Continued From page 21 | S3211 | | |
| S3211 SS=E | 26-41-205 (g) (3) OVER THE COUNTER DRUGS<br><br>(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.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-205(g)(3)<br><br>The facility reported a census of 75 residents. Based on observation and interview the administrator failed to ensure a licensed pharmacist or licensed nurse placed the full names of residents on the original packages of six over-the-counter (OTC) medications in the medication storage areas.<br><br>Findings included:<br><br>- Observation on 02/02/26 at 02:32 PM revealed the memory care medication cart contained the following OTC medications were not labeled with residents' full names: | S3211 | | |

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| S3211 | Continued From page 22<br>One 1.8 ounce tube hemorrhoidal cream<br>One bottle acetaminophen 500 milligram, 250 capsules<br>One bottle aspirin 81 milligram, 300 tablets<br><br>On 02/05/25 at approximately 02:35 PM Administrative Nurse B confirmed the OTC medications were not labeled with residents' full names.<br><br>- Observation on 02/02/26 at 03:52 PM revealed the medication room contained the following OTC medication not labeled with resident's full names:<br><br>One bottle vitamin c 500 millgrams, 60 softgels<br>One box Zicam cold remedy 25 tablets<br>One box guaifenesin 400 milligrams, 30 tablets<br><br>On 02/05/25 at 03:57 PM Certified Medication Aide G confirmed the OTC medications were not labeled with resident's full names.<br><br>The administrator failed to ensure a licensed pharmacist or licensed nurse placed the full names of residents on the original packages of six OTC medications. | S3211 | | |
| S3215 SS=E | 26-41-205 (h) Medication Storage<br><br>(h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations.<br>(1) Licensed nurses or medication aides shall | S3215 | | |

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| S3215 | Continued From page 23<br>store non-controlled medications and biologicals managed by the facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals.<br>(2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides.<br>(3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the facility.<br>(4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-205(h)<br><br>The facility reported a census of 75 residents. Based on observation and interview, the administrator failed to ensure medications were stored in accordance with each pharmacy or manufacturer's recommendations or those of federal and state laws and regulations. | S3215 | | |

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| S3215 | Continued From page 24<br>Findings included:<br><br>- Observation on 02/02/26 at 02:32 PM revealed the memory care medication cart contained the following medications and were expired:<br><br>One bottle nitroglycerin 0.4 milligram (mg), 25 tablets expired 12/10/25<br>One bottle polyethelene glycol 3350, 14 packets of 17 gram each expired 7/3/25<br>One bottle guaifenesin 100mg/5ml with pharmacy label expired date 7/3/25<br>One bottle vitamin c 500mg, 500 caplets expired 09/25 per manufacturer label<br>One bottle Losartan 100mg, 90 tablets expired per pharmacy label 01/24/26<br>One bottle docusate sodium 100mg, 250 softgels expired 09/25<br>One bottle Preparation H 1.8-ounce pharmacy label expired 11/2/25<br>One bottle diclofenac sodium 1% 100 grams expired pharmacy label 6/12/25<br>One bottle Nystatin 100,000 units per gram, 30 grams pharmacy label expired 12/6/25<br><br>On 02/05/25 at approximately 02:35 PM Administrative Nurse B confirmed the medications were expired.<br><br>- Observation on 02/02/26 at 03:52 PM revealed the medication room contained the following medications were expired:<br><br>One bottle loperamide 1mg/7.5 milliliters, eight fluid ounces with expiration 09/25<br>One bottle guaifenesin 600mg/dextromethorphan 400mg, 20 tablets expired 04/24 | S3215 | | |

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| S3215 | Continued From page 25<br><br>On 02/02/26 at 03:57 PM Certified Medication Aide G confirmed the medications were expired.<br><br>- Observation on 02/04/26 at 02:05 PM revealed R6's bathroom wire shelf contained the following medications with some expired:<br><br>Three bottles Systane eye drops expired 04/19 and 03/24<br>One bottle acetaminophen 500mg, 24 gelcaps<br>One bottle loperamide 2mg, 24 caplets<br>One bottle Theratears 1 fluid ounce expired 6/22<br>One bottle loratadine 10mg, 45 tablets expired 01/24<br>One bottle Aleve 220mg, 90 caplets<br>One bag menthol 5.8mg, 80 drops<br><br>On 02/04/26 at 04:10 PM Administrative Nurse B confirmed medications should not be in R6's bathroom.<br><br>The administrator failed to ensure medications were stored in accordance with each pharmacy or manufacturer's recommendations or those of federal and state laws and regulations. | S3215 | | |
| S3280 SS=F | 26-41-104 (d) Disaster and Emergency Preparedness<br><br>(d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following:<br>(1) Orientation of new employees at the time of employment to the facility ' s emergency management plan;<br>(2) education of each resident upon admission to the facility regarding emergency procedures; | S3280 | | |

| 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 _____ | 02/05/2026 |

| 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 |
|---|---|---|---|---|
| S3280 | Continued From page 26<br>(3) quarterly review of the facility ' s emergency management plan with employees and residents; and<br>(4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-104(d)(4)<br><br>The facility reported a census of 75 residents. Based on record review and interview, the administrator failed to ensure disaster and emergency preparedness by ensuring the performance of an emergency drill annually with staff and residents to include an evacuation of the residents to a secure location.<br><br>Findings included:<br><br>- Review of the last two annual evacuations which were requested on 02/03/26 at 08:34 AM via email revealed the last evacuation was completed 10/23/24.<br><br>On 02/05/26 at 09:53 AM Maintenance Staff D confirmed the records lacked documentation for a full evacuation completed in 2025.<br><br>The administrator failed to ensure disaster and emergency preparedness by the failure to ensure the performance of an emergency drill annually with staff and residents to include an evacuation | S3280 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| S3280 | Continued From page 27<br>of the residents to a secure location. | S3280 | | |
| S3310 SS=F | 26-41-207 (b) (5-6) (c) Infection Control Policies<br><br>(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;<br>(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<br>(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<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-207(c)<br><br>The facility reported a census of 75 residents with six residents included in the sample. Based on interview and record review the administrator failed to ensure the facility remained in compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in KAR 26-39-105 for all sampled residents.<br><br>Findings included:<br><br>- Record review for Resident (R) 1 revealed an | S3310 | | |

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

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| S3310 | Continued From page 28 | S3310 | | |

admission date of 04/18/24. Her record lacked documentation of a symptom screen since 12/17/24.

Record review for R2 revealed an admission date of 04/07/25. Her record lacked evidence of documentation an initial TB symptom screen and a TB skin test was administered within seven days of residency.

Record review for R3 revealed an admission date of 03/27/25. Her record lacked evidence of documentation a TB skin test was administered within seven days of residency.

Record review for R4 revealed an admission date of 08/27/24. Her record lacked documentation of a symptom screen since 12/16/24.

Record review for R5 revealed an admission date of 12/01/22. Her record lacked documentation of a symptom screen since 12/12/24.

Record review for R6 revealed an admission date of 02/03/25. Her record lacked documentation of a symptom screen upon admission and a second step of the TB two-step skin test.

On 03/25/24 at approximately 02:16 PM Administrative Nurse B confirmed R2 and R3's records did not have TB skin tests documentation; R1, R4, and R5 did not have annual symptoms screens completed, R6's record lacked a second step of the skin test, and R2 and R6 were missing symptoms screens

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

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|---|---|---|---|---|
| S3310 | Continued From page 29<br>upon admission.<br><br>The June 2013 department's "Tuberculosis (TB) Guidelines for Adult Care Homes" documented each new resident shall receive a two-step TB skin test and symptom screen questionnaire within seven days of admission. Each resident shall have an annual TB symptom screen.<br><br>The facility's undated "Mantoux Testing Policy" instructed staff to complete a two-step Mantoux test within three days of admission of a new resident unless it was completed within three months prior to admission.<br><br>The administrator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in KAR 26-39-105. | S3310 | | |