STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175154	A. Building B. Wing	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lexington Park Nursing & Post Acute Center	1031 SW Fleming Court Topeka, KS 66604

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure an environment free from accident hazards when staff propelled Resident (R) 49, R29, R28, and R24 through the hallway in wheelchairs without having foot pedals, requiring the residents to hold their feet up while being pushed. Findings included:- Review of the Electronic Medical Record (EMR) revealed the following: 1. The EMR for R49 documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) and polyosteoarthritis (a degenerative joint disease characterized by the breakdown of cartilage and bone in five or more joints simultaneously). R49's Annual Minimum Data Set (MDS), dated 02/20/26, documented a Brief Interview for Mental Status (BIMS) score of four, indicating severe impairment in thinking and memory. The assessment documented that she used a wheelchair for mobility. She required supervision or touching assistance when eating and required substantial to maximum assistance for all transfers and her other activities of daily living (ADL). R49's Cognitive Loss/Dementia Care Area Assessment (CAA), dated 02/20/26, documented she had the presence of inattention and disorganized thinking. R49's Communication CAA, dated 02/20/26, documented she had an impaired ability to make herself understood through verbal and non-verbal expression of ideas and wants. R49's Care Plan dated 09/03/25, documented staff were to propel her in her wheelchair. Staff were also instructed to use the sit-to-stand lift (a mechanical aid designed to help individuals with limited mobility move from a seated to a standing position) if she was weaker than usual or transfer seemed unsafe. An observation on 04/27/26 at 08:16 AM revealed staff wheeled R49 in hallway in her wheelchair without foot pedals attached. R49 had to hold her feet in the air. Further observation revealed the wheelchair foot pedals were in R49's room, lying on the floor under the air conditioning unit close to her bed. Observed on 04/28/26 at 07:48 AM, Certified Medication Aide (CMA) R pushed R49 in her wheelchair from the nurse's station area to the resident's room without foot pedals on the wheelchair. On 04/28/26 at 07:53 AM, CMA R stated that the charge nurse informed the staff they were allowed to push residents in their wheelchair without foot pedals if a resident could hold their feet up. On 04/28/26 at 08:32 AM, Licensed Nurse (LN) G said resident preference and ability determined whether foot pedals were required to be used. LN G also stated that if the resident had a lower BIMS cognition score, then foot pedals were to be used. On 04/28/26 at 08:36 AM, Administrative Nurse D stated residents should have foot pedals on the wheelchair if they cannot propel themself and resident preference was a determining factor on whether foot pedals were to be used on the wheelchair. Administrative Nurse D also said the facility did not have a policy related to wheelchair safety. 2. R29's EMR documented diagnoses which included sciatica (nerve pain and irritation in the lower back down the legs), sepsis (a life-threatening systemic reaction that develops due to infections that cause inflammation throughout the entire body), acute and chronic congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), and anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues). R29's admission MDS, dated 04/06/26, documented a BIMS score of 15, which indicated intact cognition. The assessment documented R29 had no falls. The MDS documented R29 required assistance with wheelchair (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mobility. R29's Care Plan, dated 04/24/26, documented R29 could propel herself short distances in her wheelchair but required staff assistance for longer distances such as to the therapy room or the unit scale. R29's Care Plan, dated 04/24/26, documented R29 needed staff to assist her with transferring and mobility, but she was working with therapy to increase her strength and coordination to help with independence. R29's Medicare A Progress Note, dated 04/28/26 at 11:41 AM, documented R29 had weakness and required assistance with care. Observed on 04/28/26 at 09:20 AM, Consultant HH pushed R29's wheelchair to her room without any foot pedals on the chair. R29's feet were dragging on the floor. 3. R24's EMR documented diagnoses which included unspecified dementia, restlessness and agitation, and restless leg syndrome. R24's Annual MDS, dated 02/20/26, documented a BIMS of five, indicating severe cognitive impairment. The MDS documented that R24 used a wheelchair for mobility. R24 required partial to moderate assistance for transfers and toileting hygiene and required supervision to touching assistance for bathing. R24's Care Plan documented an intervention, dated 06/23/22, for staff to check on R24 frequently because she had poor safety awareness. Another intervention, dated 04/11/22, instructed staff to help R24 propel with her wheelchair. Observed on 04/27/26 at 10:16 AM, CNA N pushed R24 to his room in his wheelchair without foot pedals. The foot pedals were sitting on the floor outside his room by the door. On 04/28/26 at 07:53 AM, CMA R stated that the charge nurse informed the staff that they were allowed to push residents in their wheelchair without foot pedals as long as a resident was capable of holding their feet up. On 04/28/26 at 08:32 AM, Licensed Nurse (LN) G said resident preference and ability determined whether foot pedals were required to be used. LN G also stated if a resident had a lower BIMS cognition score, then foot pedals were to be used. On 04/28/26 at 08:36 AM, Administrative Nurse D stated residents should have foot pedals on the wheelchair if they cannot propel themself and resident preference was a determining factor on whether foot pedals were to be used on the wheelchair. Administrative Nurse D also said the facility did not have a policy related to wheelchair safety. The facility did not provide a policy related to wheelchair safety and transporting residents by wheelchair.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to adequately store medications and/or biologicals when staff failed to lock an unattended medication cart. Findings included:- An observation on 04/28/2026 at 08:47 AM revealed the 100-hall medication cart sitting across from the nurse's station was unlocked. There were no staff present at the nurse station or within sight of the medication cart. The keys for the cart rested on top of the unattended cart. During an interview on 04/28/2026 at 09:10 AM, Certified Medication Aide (CMA) S stated the medication cart was to be locked when unattended and the key was never to be left on the cart while it was unattended. During an interview on 04/28/2026 at 09:35 AM, Licensed Nurse (LN) H stated the medication cart was never supposed to be left unlocked and unattended and if she found it like that, she would lock it and go find the staff member responsible for the cart. During an interview on 04/28/2026 at 09:38 AM, Administrative Nurse D stated the facility policy directed staff to never leave the cart unlocked and always have the key on them. The facility policy stated that medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to display accurate posted nurse staffing information which contained all the required data. Findings included:- On 04/27/2026 at 07:43 AM, an observation revealed a daily staffing sheet hanging on the wall near the nursing station at the facility. The Daily Nursing Staffing Information sheet, dated 04/27/26, listed the number of employees and the hours but lacked the facility name and did not post the daily nursing staff total hours. On 04/29/26 at 09:15 AM, Administrative Nurse D reported he had not noticed the nursing daily staff sheet did not have total numbers on the daily sheet and said that he was aware it should be posted on the daily nursing staffing sheet. Administrative Nurse D further stated he was unaware the facility name needed to be on the daily nurse staffing sheet. Administrative Nurse D stated he will make the necessary corrections for the daily nurse staff posting. The facility Daily Nurse Staff Posting policy with a revised date of 11/28/17 documented the facility will post the full-time equivalent number of nursing personnel responsible for providing direct care, daily for each shift. The policy documented general guidelines, which stated at the beginning of each shift the number of licensed nurses (RNs and LPNs) and the number of unlicensed personnel (CMAs, CNAs, and nurses aid trainees) who provide direct care to residents will be posted using the daily nurse staffing form. Shift posting information shall include only the number of full-time equivalents on duty for that day for that shift. Daily posting shall be recorded on each facility's daily nurse staffing form, which will be retained for 18 months.