

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175171	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER Heritage Grove Estates		STREET ADDRESS, CITY, STATE, ZIP CODE 1610 SW 37th Street Topeka, KS 66611	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. Based on record reviews and interviews, the facility failed to provide regular in-service education based on the outcome of performance reviews. This placed the residents at risk of impaired care. Findings included:- The facility's employment records documented nine nurse aides were employed at the facility for at least one year. The facility's in-service records documented that 2 of those nurses' aides reviewed had not completed in service education on the outcome of performance reviews for competencies. Certified Nurse Aide (CNA) M, hired 08/28/2014, lacked competency review and in-services based on performance evaluations. CNA N, hired 06/28/2023, lacked competency review and in-services based on performance evaluations. On 07/22/2026 at 09:00 AM, Administrative Nurse D stated the facility had recently been bought, and they presently have new owners. Administrative Nurse D stated the employee's personnel files had been located but they lacked documentation of the current yearly competencies and in-services based on performance evaluations. The facility's Required Training, Certification and Continuing Education of Nurse Aide, policy dated 2025, documented the facility would comply with State and Federal regulations and requirements as they pertain to the training certification and continuing education of its nurses' aides. In-service training would be provided by qualified personnel and would be based on the needs of the residents in the facility and any area of weakness determined in the nurse aides performance reviews and facility assessment. Documentation of in-services would be forwarded to the Human Resource Director and maintained in the employee's personnel file. It is the responsibility of the employee to attend required in-service training courses to maintain employment status with the facility.		

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, record review, and interview, the facility failed to ensure a sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections when staff failed to sanitize multi-resident use equipment between resident use. Staff also failed to utilize adequate infection control measures when providing urinary catheter care for Resident (R) 15. The facility also failed to establish a water management program to prevent the growth of Legionella disease (Legionella is a bacterium which can cause pneumonia in vulnerable populations) and other water-borne pathogens. Findings included:- 1. On 07/20/2026 at 02:00 PM, observation revealed R15 sat in a wheelchair in the family area by the nurses' station. Staff asked the resident if he would like to go to his room and sit in his recliner, and he replied: That sounds good, let's go. Certified Nurse Aide (CNA) MM propelled R15 in a wheelchair to his room, while CNA P retrieved a full-body lift machine. Both aides donned a gown and applied gloves and assisted R15 to transfer, using a full lift machine, from wheelchair to a recliner. CNA P doffed the gown and discarded gloves in the trash can, left the room (without washing her hands), and took the full lift machine down the hall to the cubby where they were stored when not in use, then went to another resident's room to provide care. CNA P did not sanitize the full lift machine after using it. CNA MM placed the urinary catheter bag on a trash can next to the left side of R15's recliner, with the uncovered bag touching the floor, retrieved a graduated cylinder from the resident's bathroom, and placed it on the floor, without placing a barrier underneath the graduated cylinder. CNA MM unclipped the catheter spout from the bag, opened it, let the dark yellow urine drain into the graduated cylinder, closed the spout clip, then attached it to the holder on the urinary bag. CNA MM took the graduated cylinder to the bathroom, poured the urine into the toilet, placed the graduated cylinder on the toilet back, without rinsing it. CNA MM removed and discarded the gown and gloves, tied up the bag, and left the room without washing her hands. At 02:15 PM, when CNA P was asked the procedure for putting away a lift after using it for a resident, she stated: We put it in the room and plug it in. 2. On 07/21/2026 at 07:57 AM, observation revealed Certified Medication Aide (CMA) R used a blood pressure cuff to check a resident's blood pressure, did not sanitize it, and checked another resident's blood pressure with the same cuff. CMA R popped out medications from pill cards without using hand hygiene before the procedure. CMA R verified the observations and stated she typically did not sanitize the blood pressure cuff after use. 3. On 07/21/2026 at 8:25 AM, observation revealed Administrative Nurse E provided wound care for R29's left lateral leg wound without wearing a gown as required. 4. On 07/21/2026 at 08:50 AM, observation revealed CMA R entered R1's room (who was on Enhanced Barrier Precautions (EBP- infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high-contact care) to administer R1 his medications. R1 was leaning to the left against the wall and down in bed. CMA R, without donning a gown or applying gloves, assisted R1 in repositioning in bed. 5. On 07/21/2026 at 01:00 PM, observation revealed R3 in bed on her back. CNA R and Administrative Nurse E entered R3's room (who was on EBP) and transferred the resident with a full lift machine from her bed to a wheelchair. CNA R removed and discarded the gown and gloves, took the full lift machine, without sanitizing it, out of the resident's room down the hall to the place where they are stored, and came back to the room. CNA R stated he generally does sanitize the lift once he gets it back to the storage area; he would go back and do it later. CNA R propelled the resident in a wheelchair to the dining room. 6. On 07/22/2026 at 7:54 AM, observation revealed CMAS took the blood pressure machine into the dining room and checked R49's blood pressure(the amount of force your blood uses to get through your (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	arteries). CMAS rolled the cart back to her medication cart and did not sanitize the cuff (an inflatable sleeve wrapped around the upper arm). CMA S verified she had not sanitized the blood pressure cuff after using it to check R49's blood pressure and stated typically the blood pressure cuff should be sanitized after each use, with the wipes staff have in the medication cart. 7. Record review revealed a lack of documentation that the facility had a water management program. On 07/22/2026 at 12:34 PM, Administrative Nurse D stated staff should place a resident's catheter bag towards the bottom of the bed, not touch the floor, place a barrier on the floor, then put the graduated cylinder (a device used to measure the volume of a liquid) on it. Staff should unhook the spout from the catheter bag holder, wipe with an alcohol wipe, place the spout in the graduated cylinder, unclip the closure to the drainage spout, and let the urine drain into the graduated cylinder. Administrative Nurse D stated staff should close the drainage spout, use an alcohol wipe on the spout tip, then place it back into the spout holder, then take the graduated cylinder, empty the urine in the toilet, then wash it and place it back in a plastic bag. Administrative Nurse D stated all resident shared equipment should be sanitized between uses. Administrative Nurse D stated staff should wash their hands when entering a resident's room and before exiting the room. Administrative Nurse D stated if a resident is on EBP for having a wound, staff should wear a gown and apply gloves. On 07/22/2026 at 11:22 AM, Administrative Staff A verified the facility lacked documentation regarding a water management program to prevent the growth of Legionella and other waterborne pathogens. Administrative Staff A stated the facility maintenance executive left last Friday with no notice. The facility's updated Infection Prevention and Control Program Policy states that documented hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures. All reusable items and equipment requiring special cleaning, disinfection, or sterilization should be cleaned in accordance with our current procedures governing the cleaning and sterilization of soiled or contaminated equipment. The facility's updated EBP Policy documented implementation of EBP makes gowns and gloves available immediately near or outside of the resident's room. Personal Protective Equipment (PPE) for EBP was only necessary when performing high-contact care activities. High-contact resident care activities include: dressing/bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use; central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC lines, midline catheters, urinary catheters, and wound care. The facility's undated Water Management Program Policy documented that it was the policy of the facility to establish water management plans for reducing the risk of legionellosis and other opportunistic pathogens. The policy documented that a water management team had been established to develop and implement the facility's water management program, including how Legionella and other water-borne pathogens grow and spread. Education is consistent with each team member's role. The maintenance director would maintain documentation that describes the facility's water system.		

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on record review and interviews, the facility failed to ensure the nurse aides received the required number of in-service training hours per year. Findings included:- Review of the employee records revealed the following: Certified Nurse Aide (CNA) M employee file documented a hire date of 08/28/2014. The file lacked evidence of the required 12-hour in-service. The facility was unable to provide the documentation upon request. CNA N file documented a hire date of 06/28/2023. The file lacked evidence of the required 12-hour in-service. The facility was unable to provide the documentation upon request. On 07/22/2026 at 07:50 AM, Administrative Nurse D stated the facility was unable to find out if CNA M and CNA N had completed any of the 12-hour in-service required hours. On 07/22/2026 at 9:00 AM, Administrative Nurse D stated the facility had recently been bought, and they presently have new owners. Administrative Nurse D stated the employee's personnel files had been located, but they lacked documentation of the in-service hours, and the online training program lacked any documented in-service training hours for either employee. Administrative Nurse D verified the nurse aides were to have the 12 hours in-service hours each year, and said the facility was implementing a new program to track the employees continuing education hours. The facility's Required Training, Certification and Continuing Education of Nurse Aide, policy dated 2025, documented the facility would comply with State and Federal regulations and requirements as they pertain to the training certification, and continuing education of its nurses' aides. The facility would provide at least 12 hours of in-service training annually, based on employment date. Not calendar year. Documentation of in-services would be forwarded to the Human Resource Director and maintained in the employee's personnel file. It is the responsibility of the employee to attend required in-service training courses to maintain employment status with the facility.		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interviews and record review, the facility failed to conduct a criminal background check as required for one facility employee. The employee was allowed access to residents without knowing if they had been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law. Findings included:- On 07/22/2026 at 02:30 PM, a review of staffing for background checks was completed for facility staff. Upon request and review, the facility was unable to provide evidence that a criminal background check had been completed for Maintenance Staff U, who had worked at the facility since 06/23/2026. On 07/22/2026 at 03:00 PM, Administrative Staff A stated the facility would obtain criminal background/record checks on all employees prior to the employee working at the facility. Administrative Staff A verified she could not find a criminal record check for Maintenance Staff U. The facility's Background Investigation dated 2025, documented job references, drug screenings, licensure verification, and criminal record checks are conducted on all personnel making application for employment with the facility. Driving record checks are conducted when the job in question requires the employee to drive as part of their assigned duties. The Human Resource department will conduct all applicable background investigations on each individual making application for employment with the company and on any current employee if such background investigation is appropriate for the position for which the individual has applied. The company would not conduct a background investigation without applicants or employees advanced consent. Applicants or employees who do not consent to a background investigation would not be considered for the position that the company has determined to require the completion of a background investigation. If the background investigation discloses any material misrepresentation or omission by the applicant or employee on the application form or reveals information indicating that the individual may not be appropriate for hire, the company would investigate the matter further. Upon completion of the investigation, if the company determines that the applicant or employee's background makes him/her unsuitable for the position he/she is seeking, the applicant will not be employed, if already employed, would be terminated.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to provide Resident (R) 6, R8, and R44 and/or their representatives with a written notification of transfer for facility-initiated transfers and a bed hold policy upon transfer to the hospital. The facility further failed to notify the long-term care ombudsman (LTCO) of R6, R8, and R44's transfers to the hospital. Findings included:- 1. R6's Discharge Minimum Data Set (MDS), dated 05/19/2026, documented a planned discharge to an acute hospital with a return anticipated.R6's Entry MDS, dated 05/20/2026, documented a re-entry to the facility from an acute hospital.R6's Discharge MDS, dated 06/15/2026, documented an unplanned discharge to an acute hospital with a return anticipated.R6's Entry MDS, dated 06/19/2026, documented a re-entry to the facility from an acute hospital.On 07/21/2026 at 11:46 AM, the bed hold, written notification of transfer, and LTCO notification were requested from the facility for R6. The facility was unable to provide the requested information regarding R6's transfers to the hospital on [DATE] and 06/15/2026. - 2. R8's Discharge MDS, dated 04/27/2026, documented an unplanned discharge to an acute hospital with a return anticipated.R8's Entry MDS, dated 05/01/2026, documented a re-entry to the facility from an acute hospital.On 07/21/2026 at 11:46 AM, the bed hold, notification of transfer, and LTCO notification were requested from the facility for R8. The facility was unable to provide the requested information regarding R8's transfer to the hospital on [DATE]. 3. R44's Discharge MDS, dated 11/19/2025, documented an unplanned discharge to an acute hospital with a return anticipated.R44's Entry MDS, dated 11/24/2025, documented a re-entry to the facility from an acute hospital.On 07/21/2026 at 11:46 AM, the bed hold, written notification of transfer, and LTCO notification were requested from the facility for R44. The facility was unable to provide the requested information regarding R44's transfer to the hospital on [DATE].On 07/21/2026 at 01:21 PM, Administrative Staff A stated that she was unable to find any record of the bed holds, written notification of transfer, or notification to the ombudsman for R6, R8, and R44's transfers to the hospital. She stated that the facility did have a packet that nursing staff was supposed to complete when a resident was transferred to the hospital, but that had not been done. Administrative Staff A stated the facility had a change in ownership back in February 2026 and the prior administrator and staff had not completed the bed hold, notice of transfer, and ombudsman notification. She stated she had been at the facility since June 2026 and had not realized it was not completed, and she had not assigned that task to any certain staff member yet, but going forward a Performance Improvement Plan (PIP) would be initiated that outlined which staff were responsible for each item.The facility's Transfer and Discharge policy dated 2026 directed the facility to provide a transfer/discharge notice to the resident and resident's representative in a language and manner in which they can understand. The facility provided a notice of transfer and the facility's bed hold notice policy to the resident and representative as indicated. The Social Services Director, or designee, provided copies of notices for emergency transfers to the Ombudsman, but they may be sent when practicable.The facility's Bed Hold Notice policy, dated 2026, directed in the event of an emergency transfer of a resident, the facility provided a written notice of the facility's bed-hold policies to the resident and/or the resident representative within 24 hours. The facility documented multiple attempts to reach the resident's representative in cases where the facility was unable to notify the representative. The facility kept a signed and dated copy of bed-hold notice information given to the resident and/or resident representative in the resident's file and/or medical record.		

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. :Based on observation, record review, and interview, the facility failed to complete the Care Area Assessment (CAA), analysis of findings, related to a Comprehensive Minimum Data Set (MDS), for Resident (R) 30 and R31, in order to address the underlying cause, risk factors, and other contributing factors to ensure the resident received care based on their individual needs. Findings included:- 1. R30's admission MDS, dated 05/05/2026, triggered CAAs for the following: Communication, Functional Abilities, Urinary Continence and Indwelling Catheter, Nutritional Status, Pressure Ulcer/Injury, and Pain. R30's CAA Worksheet, dated 05/13/2026, documented the triggered CAA areas lacked completion with an analysis of findings.-2. R31's admission MDS, dated 06/29/2026, triggered CAAs for: Cognitive Loss/Dementia, Visual Function, Functional Abilities, Urinary Continence and Indwelling Catheter, Nutritional Status, Dehydration/Fluid Maintenance, Dental Care, and Pressure Ulcer/Injury. R31's CAA Worksheet, dated 06/29/2026, documented the Nutritional Status CAA had been completed. R31's remaining triggered CAA areas were completed on 07/02/2026 by Administrative Nurse F lacked completion with an analysis of findings. On 07/22/2026 at 11:45 AM, Administrative Nurse F stated she had been hired in June 2026 and completed the MDSs for the residents. She stated the MDS triggered the CAA, and she completed the CAA worksheet. Administrative Nurse F stated she had never documented anything in the analysis of finding area and was unaware that she needed to. On 07/22/2026 at 12:35 PM, Administrative Nurse D stated that the MDS would trigger the CAA area and either the MDS Coordinator, social services, or dietary staff would complete the CAA, and they should be documenting information regarding items checked on the CAA worksheet to assist with the development or revision of the care plan. The facility's MDS 3.0 Completion policy, dated 2026, directed the responsibility for completion of each CAA was clearly assigned. Staff documented the key findings based on the CAA review, including the nature of the condition, complications and risk factors that affected the care planning decision, factors that were considered in developing the care plan interventions, and the need for referrals or evaluation by appropriate health professionals.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, record review, and interview, the facility failed to apply the standards of practice when staff recorded an incorrect opened date on Resident (R) 28 and R73 insulin pens in response to the survey. Findings included:- On 07/20/2026 at 08:10 AM, observation of the North Treatment Cart Hall 2 revealed R28's Lantus (long-acting insulin) flex pen were labeled with that day's date. R73's Humalog (rapid-acting insulin) flex pen, two Lantus Solostar flex pens, and one Lantus flex pen were labeled with that days date. Further observation of the insulin pens revealed they were not full, and some were half empty. On 07/20/2026 at 08:35 AM, Licensed Nurse (LN) G verified the nurses should date the insulin pens when they were opened and mark with the discard date. LN G verified that the dates had not been on the insulin pens, and when she realized the survey team was in the facility, she went ahead and labeled the pens with that days date. LN G stated she was an agency nurse and did not know when the pens had actually been opened. On 07/20/2026 at 03:15 PM, Administrative Nurse D stated if R28 and R73 insulin pens did not have a date on them, and they were opened and in use, the nurse should not date them when she is going to use them; she should discard the opened undated insulin pens and get new pens to use and date them when she opens them and first uses them. The facility's Insulin Pen policy dated 2026, documented the facility would use insulin pens in order to improve the accuracy of insulin dosing, provided increased resident comfort, and serve as a teaching aid to prepare residents for self-administration of insulin therapy upon discharge. Insulin pens must be clearly labeled with the resident's name, physician's name, date dispensed, type of insulin, amount to be given, frequency, and expiration date. If the label is missing, the pen will not be used; a new pen must be ordered from the pharmacy. Once opened, clearly labeled insulin pens may be stored at room temperature in a locked medication cart.		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to identify trauma-based triggers related to Resident (R) 8's post-traumatic stress disorder (PTSD- a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress). The facility failed to implement individualized interventions to prevent re-traumatization to R8. Findings included:- R8's Electronic Medical Record (EMR) documented diagnoses of encephalopathy (a broad term for any brain disease that alters brain function or structure), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and PTSD.R8's Significant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of six, which indicated severely impaired cognition. R8 needed partial to substantial staff assistance with cares. The MDS documented an active diagnosis of PTSD.R8's Psychosocial Well Being Care Area Assessment (CAA) dated 06/19/2026 documented her memory appeared great; her mood also appeared great. The CAA did not mention R8's PTSD.R8's Care Plan dated 04/08/2026 documented her psychosocial history was that her memory appeared great and her mood also appeared great. The care plan directed staff that social services was to assist as needed. R8's Care Plan lacked a care area to address her PTSD, any triggers that might cause re-traumatization, and interventions if re-traumatization would occur.R8's Social Services- Initial Assessment and History dated 04/08/2026 in the assessments tab of the EMR documented a diagnosis of PTSD. The assessment lacked any goal or interventions related to R8's PTSD.R8's EMR lacked evidence of assessment to identify her history of trauma and/or triggers which may cause re-traumatization. The EMR lacked goals and interventions to minimize or eliminate the effect of the trigger on the resident.On 07/21/2026 at 08:52 AM, R8 laid in her bed resting.On 07/22/2026 at 07:45 AM, Social Services X stated that on admission, an initial assessment and history were done on each resident. Social Services X stated that the facility did not have an assessment specific to trauma-informed care. Social Services X stated that R8 did have a diagnosis for PTSD, and a care plan area should have been added to the care plan to address R8's PTSD and any triggers that could possibly cause any re-traumatization.On 07/22/2026 at 12:35 PM, Administrative Nurse D stated that social services did an assessment on each resident on admission that should address if they had PTSD, and it should trigger it to be added to the care plan. Administrative Nurse D stated she could not say for certain why R8's PTSD was not triggered for a care area on the care plan, but she should have information that lists the trauma history, her possible triggers and interventions to minimize the triggers.The facilities Trauma-Informed Care policy documented The facility will identify triggers which may re-traumatize residents with a history of trauma. Trigger-specific interventions will identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident, and will be added to the residents care plan. While most triggers are highly individualized, some common triggers may include but are not limited to: experiencing a lack of privacy or confinement in a crowded or small space; exposure to loud noises or bright/flashing lights; certain sights, such as objects that are associated with their abuser; sounds, smells, and physical touch. Trauma-specific care plan interventions will recognize the interrelation between trauma and symptoms of trauma such as substance abuse, eating disorders, depression, and anxiety. These interventions will also recognize the survivor's need to be respected, informed, connected, and hopeful regarding their own recovery.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review and interview, the facility failed to provide appropriate and adequate narcotic drug reconciliation when staff failed to accurately record controlled substance doses on the narcotic count record and further failed to immediately report a discrepancy in Resident (R) 60's count. Findings included:- On 07/20/2026 at 09:15 AM, Observation in the south medication room refrigerator revealed an emergency medication kit (e-kit) without an expiration date or documentation regarding what was in it. Certified Medication Aide (CMA) R opened it by putting in the code. The e-kit had 12 milliliters (mL) of lorazepam (a class of medications that calm and relax people) oral concentrate for R60. CMA R verified it had no expiration date and stated it belonged to R60, who had recently passed away. CMA R stated that usually when a resident passes, their medications would be returned to the pharmacist when he came to the facility. R60's Controlled Drug Record revealed that on 06/30/2026 at 12:00 PM, staff administered lorazepam, 0.25 ml to R60, and the amount remaining was 14.75. The next entry was 07/05/2026, without a time, 0 amount administered, and amount remaining 12 ml. The Narcotic Count Sheet, from 06/30/2026, had missing signatures on July 3, 7, 8, 14, and 15 in the nurse going off signature line. On 07/21/2026 at 11:25 M, Administrative Nurse D verified missing documentation on the narcotic count sheet and the discrepancy in the count on the controlled drug record. Administrative Nurse D stated she was unaware of the discrepancy in the count and stated staff should count narcotics every shift with the on-going and off-going nurse or CMA. Administrative Nurse D stated staff should have reported to administration when there was a discrepancy in the count. Administrative Nurse D verified the resident had passed away on 06/30/2026 and stated the pharmacist should have picked up the medication. The facility's undated Controlled Substance Administration and Accountability Policy documented the controlled drug record serves the dual purpose of recording both narcotic disposition and patient administration. For areas without automated dispensing systems, two licensed nurses account for all controlled substances and access keys at the end of each shift. The charge nurse or other designee conducts a daily visual audit of the required documentation of controlled substances. Spot checks are performed to verify that controlled substances that are destroyed are appropriately documented and medications removed from either the automated dispensing system or medication cart/cabinet have a documented physician order. Any discrepancies which cannot be resolved must be reported immediately as follows. Notify the DON, charge nurse, or designee and the pharmacy. Complete an incident report detailing the discrepancy, steps taken to resolve it, and the names of all licensed staff who were working when the discrepancy was noted. The DON, charge nurse, or designee must also report any loss of controlled substances, or theft is suspected, to the appropriate authorities such as local law enforcement, Drug Enforcement Agency, state board of nursing, state board of pharmacy, and possibly the state licensure board for nursing home administrators. Staff may not leave the area until discrepancies are resolved or reported as unresolved discrepancies.		

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NAME OF PROVIDER OR SUPPLIER Heritage Grove Estates		STREET ADDRESS, CITY, STATE, ZIP CODE 1610 SW 37th Street Topeka, KS 66611	
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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 label Resident (R)1, R28, R39, and R73s insulin flex pens when initially opened for use. Findings included:- On 07/20/2026 at 08:10 AM, observation of the North Treatment Cart Hall 2 revealed R28's Lantus (long-acting insulin) flex pen was not labeled with the correct date opened or the correct discard date. R73's Humalog (rapid-acting insulin) flex pen, two Lantus Solostar flex pens, and one Lantus flex pen were not labeled with the correct date opened or the correct discard date. On 07/20/2026 at 08:35 AM, License Nurse (LN) G verified the nurses should date the insulin pens when they were opened and mark with the discard date. LN G verified the dates marked on the pen were not the accurate dates they were opened. On 07/20/2026 at 09:00 AM, observation of the North Treatment Cart Hall 1 revealed R1's Novolog (rapid acting insulin) flex pen was not labeled with the date opened or the discard date. R39's Humalog insulin flex pen was not labeled with the date opened or the discard date. On 07/20/2026 at 09:05 AM, LN H verified the nurses should date the insulin pens when they are opened and indicate the discard date. On 07/20/2026 at 03:15 PM, Administrative Nurse D verified the nurse should label and date the insulin flex pens with the date they were opened and the date of discard. Medlineplus.gov directs open, unrefrigerated Novolog, Humalog, and Lantus can be used within 28 days; after that time, they must be discarded. The facility's Medication Storage policy dated 2025, documented the facility would ensure all medications housed on the premises would be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security.		

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews, the facility failed to ensure the collaboration of care between Resident (R) 8 and R27's hospice provider and the facility which included the hospice provider contact information, the services the hospice provider would provide to the resident, the supplies, equipment and medications the hospice provider would provide for R8 The facility failed to ensure the hospice provider provided the current hospice plan of care (POC) for R8 and failed to ensure R27's most recent hospice certification and POC was provided. Findings included:- 1. R8's Electronic Medical Record (EMR) documented diagnoses of encephalopathy (a broad term for any brain disease that alters brain function or structure), chronic respiratory failure (a long-term condition where the lungs cannot properly oxygenate the blood or remove carbon dioxide), and atrial fibrillation (rapid, irregular heartbeat).R8's Significant Change Minimum Data Set (MDS) dated [DATE] documented R8 had a Brief Interview for Mental Status (BIMS) score of six, which indicated severely impaired cognition. R8 was receiving hospice services.R8's Functional Abilities Care Area Assessment (CAA) dated 06/11/2026 documented R8 had an activities of daily living (ADL) self-care performance deficit and needed assist with self-care tasks to include bathing, transfers, personal hygiene tasks, bed mobility, dressing, eating, toilet use, and locomotion related to limited mobility, chronic respiratory failure and dependence on oxygen, functional bowel and bladder incontinent, limited mobility, deconditioning, and psychotropic medication use. R8's Care Plan revised on 07/01/2026, documented R8 received hospice services. R8's Care Plan directed staff to: encourage the resident to make simple decisions related to his care to give the resident a sense of functional ability and control; evaluate the needs of the patient and caregiver for additional resources that hospice could provide; hospice certified nursing assistance to visit twice per week and would provide showers and/or bed baths; the hospice nurse to visit once per week and as needed; and poor skin integrity to be expected related to end of life terminal prognosis. R8's care plan lacked staff direction on how to contact the hospice provider, the supplies hospice would provide, the durable medical equipment (DME) that hospice would provide or the medications that hospice would provide.R8's Orders tab of the EMR documented a physician's order dated 06/30/2026 for hospice services related to encephalopathy.R8's hospice provider binder lacked the hospice's POC that should contain the following information: the most recent hospice plan of care specific to each patient; hospice election form; physician certification and recertification of the terminal illness specific to each patient; names and contact information for hospice personnel involved in hospice care of each patient; instructions on how to access the hospice's 24-hour on-call system; hospice medication information specific to each patient.; hospice physician and attending physician (if any) orders specific to each patient.On 07/21/2026 at 07:52 AM, R8 laid in her bed resting. -2. R27's EMR documented diagnoses of chronic respiratory failure, congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), and diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin).R27's Quarterly MDS dated 06/30/2026 documented she had a BIMS score of six, which indicated severely impaired cognition. R27 received hospice services.R27's Care Plan revised on 10/25/2025 documented she received hospice services. R27's Care Plan directed staff to respect do not resuscitate (DNR) wishes; hospice would attend family care meetings; medications provided by hospice; DME provided by hospice; skilled nursing to visit one to two times per week and as needed (PRN); chaplain to visit one to two (continued on next page)		

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	times per month PRN; Social Service/Counselor to visit one to two times per month and PRN.R27's Orders tab of the EMR documented a physician's order dated 10/16/2024 to admit to the facility with hospice services for acute to chronic respiratory failure.R27's hospice provider binder at the nurse's station contained past certification and recertification periods since her admission on [DATE] to 05/26/2026. R27's hospice binder lacked the most recent recertification signed by the hospice medical director and lacked the current hospice POC.On 07/22/2026 at 08:57 AM, R27 sat at the dining table eating breakfast.On 07/22/2026 at 10:45 AM, Licensed Nurse (LN) I stated that each resident on hospice had a binder that was in the cabinet at the nurse's station. The hospice provider was responsible for maintaining the information in the binder. LN I stated the residents' care plan should reflect the information, supplies, and visits provided by hospice.On 07/22/2026 at 12:35 PM, Administrative Nurse D stated that each resident had their own hospice binder at the nurse's station, and the hospice provider was responsible for making sure all the information in the binder was current and correct, including any recertifications and POC. Administrative Nurse D stated that all hospice residents' facility care plans should indicate the hospice provider, how to contact hospice, the supplies provided by hospice, medications supplied, and how often hospice staff would make visits.The facility's Services Agreement for R7's hospice dated 04/17/2026 documented the hospice POC means a written, patient-specific care plan established, maintained, reviewed and modified, if necessary, as frequently as the patient's condition required but no less than every 15 calendar days established by the Interdisciplinary Group with Attending Physician involvement: Initially completed by a hospice registered nurse within forty-eight (48) hours after the election of hospice care. Established within five (5) calendar days after the election of hospice care; identification of the patient's/family's problems and needs for physical, psychosocial, emotional, and spiritual care; the scope and frequency of services needed to meet the patient and family's needs and by whom the service would be provided, prescribed and required medical equipment, supplies, medications, treatments and the level of care; realistic and achievable goals; all physician orders; a comprehensive assessment of each hospice patient's needs; and maintained in the hospice patient's medical record.The facilities Hospice Agreement for R27's hospice provider dated 02/11/2026 documented: Hospice shall maintain professional, financial, and administrative responsibilities for the services provided by Facility. Admission/Assessments -Hospice shall maintain responsibility for admitting patients to the Hospice program. Hospice shall perform a Patient/Family Assessment on all Patients in accordance with policies and regulations. Hospice shall notify Facility, either orally or in writing, of each Hospice Patient authorized by Hospice for admission. Hospice shall furnish the Facility with a copy of the Patient/Family Assessment. Assessing Continued Eligibility -Hospice shall have sole authority for assessing a Hospice Patient's continued eligibility for Hospice Services and for discharging a Hospice Patient from Hospice. Professional Management Responsibility. Hospice shall retain financial, administrative, and professional management responsibility for the contracted services. Hospice shall ensure that Facility services are furnished in a safe and effective manner, by persons meeting the qualifications necessary to provide effective Hospice care, in accordance with the Patient's Interdisciplinary Plan of Care, and other requirements of regulatory and accrediting bodies. Continuity of Care -Hospice shall ensure the continuity of patient and family care in the home, outpatient, and inpatient settings. The Hospice maintains responsibility for coordination of discharge planning for Hospice Patients, as appropriate, in collaboration with Facility's Social Services Department. Hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. It was the hospice's responsibility to provide services at the same level and to the same extent as those services would be provided if the facility resident were in his or her own home.		

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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 post the actual scheduled hours worked for nursing staff directly responsible for resident care per shift. Findings included:- On 07/20/2026 at 08:30 AM, upon entrance into the facility, a Daily Nurse Staffing Sheet was observed posted on the bulletin board across from the North nurse's station, dated 07/20/2026 and documented the date, the nurse and aides names who were on duty and the hours they worked, but lacked a breakdown of the Registered Nurse (RN), Licensed Practical Nurse (LPN), Certified medication Aide(CMA) and Nurse Aides (NA) who were working each shift with amount of calculated hours they worked each shift. On 07/21/2026 at 07:30 AM, observation revealed the facility posted the Daily Nurse Staffing Report with the nurse and aides names who were on duty and the hours they worked. On 07/22/2026 at 7:20 AM, observation revealed the facility posted the Daily Nurse Staffing Report with the nurse and aides names who were on duty and the hours they worked. On 07/22/2026 at 08:10 AM, Administrative Nurse D and Administrative Staff A verified the Daily Nurse Staffing Report should be posted daily with the RN, LPN, CMA, and NA total hours worked per shift with the number of staff for each shift, and the facility census. The facility's Nursing Staffing Posting policy, dated 2025, documented the facility would make sure nurse staffing information is readily available in a readable format to residents, staff, and visitors at any given time. The Nurse Staffing Sheet will be posted on a daily basis and will contain the following information:Facility nameThe current dateFacility's current censusThe total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift. (RN, LPN, and Certified Nurse Aides) The facility would post the Nurse Staffing Sheet at the beginning of each shift.The information would be presented in a clear readable format and in a prominent place readily accessible to residents, staff, and visitors. Nursing schedules and posting information would be maintained in the Human Resources Department for review for a minimum of 18 months or as required by State law, whichever is greater.		