STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175555	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Healthcare Resort of Topeka	6300 SW 6th Avenue Topeka, KS 66615

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. The facility reported a census of 67 residents. Based on observation, interview, and record review, the facility failed to prepare food under sanitary conditions, related to the use of unsanitary pots and pans used to prepare food in the main kitchen, where all residents meals are prepared prior to distribution to two satellite kitchens, which include the east kitchenette that served the residents of the long-term care and skilled residents of the facility.Findings included: - On 12/15/2025 at 10:45 AM, observations during the main kitchen tour with Dietary Staff CC revealed the following concerns: Three pots had a black and brown substance built up on the outside and inside of the pots in areas that would come in contact with the food items prepared in the pots. Twenty-four sheet pans had a baked-on brown substance inside and outside of the pans and along the outer rim of the sheet pans. The sheet pans were stacked one on top of another. On 12/15/2025 at 10:45 AM, Dietary Staff CC verified the above findings and agreed the pots and sheet pans were not sanitary and were in need of cleaning and/or replacement to ensure a clean, sanitizable surface during food preparation. On 12/18/2025 at 10:23 AM, observation and interview during the follow-up tour of the kitchen with Dietary Staff CC revealed a four-quart and an eight-quart aluminum pot, both with pitted insides and discolored bottom in areas which would have direct contact with foods during preparation. Dietary Staff CC confirmed the inside surfaces of the two pots were not sanitary and in need of replacement. The facility policy Policy: Handling Soiled, Damaged, or Non-Restorable Pots and Pans, dated 01/06/2025 documentation included the policy purpose included to ensure food-contact cookware (pots and pans) used by Dietary Services maintained in a sanitary and safe condition, define removal from use, deep cleaning, discard criteria (including pitting) and procedures for replacements when items are beyond restoration.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 67 residents; there were 18 residents sampled, which included two residents selected for closed record review. Based on observation, interview, and record review, the facility failed to ensure nursing documentation in Resident (R) 27's health record met the professional standards of care when staff repeatedly documented application of a brace or splint even when they did not apply the device, inaccurately representing the provision of treatments.Findings included:- R27's Electronic Medical Record (EMR) documented diagnosis of hemiplegia and hemiparesis following cerebral infarction (stroke) affecting the left non-dominant side (weakness and paralysis on one side of the body), other lack of coordination (a neurological sign characterized by a loss of muscle control, leading to uncoordinated movements), and Parkinson's disease with dyskinesia (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness).R27's Annual Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The assessment documented R27 had impairment to one side and required set-up, supervision, or touching assistance with activities of daily living (ADL) such as oral and personal hygiene. He required partial to moderate assistance with toileting hygiene.The Activities of Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA), documented that R27 required ADL assistance for self-care or mobility activities.R27's Quarterly MDS, dated 11/25/19, documented a BIMS score of 15. The assessment documented R27 had impairment on one side and required set-up, supervision, or touching assistance with ADL, such as oral and personal hygiene, and he required partial to moderate assistance with toileting hygiene.R27's Care Plan recorded an intervention dated 01/31/24 that directed staff to assist the resident with wearing a splint on his left hand and middle finger during sleeping hours and removing it when he was up. Staff were to monitor his skin integrity as indicated. R27's Orders tab revealed a physician order, dated 08/12/24, which documented staff were to assist the resident with wearing a splint on his left hand, wrist, and finger during sleeping hours and remove it when up.R27's December 2025 Medication Administration Record/ Treatment Administration Record (MAR/TAR) reviewed from 12/01/25 through 12/17/25 documented R27's arm splint had been applied at 08:00 PM and removed at 08:00 AM each day, including the night of 12/17/25, with no refusals documented.During an observation on 12/15/25 at 11:39 AM, R27 was in bed with his left fingers contracted and swollen. He did not have a brace or splint on the left hand. There was a sign on the wall from the therapy staff that directed staff to make sure the brace straps were tight and also included instruction to assist the resident with applying his left WHFO [wrist hand finger orthotic] at nap time and remove after naps. R27 stated that it was his fault he did not wear the brace because he did not like calling the staff in to assist him. He further stated that he had just awakened from a nap and that he would usually awaken around 04:30 AM and then nap each day from 08:30 AM until lunch time.On 12/16/25 at 09:21 AM, R27 stated he never wore the arm brace at night because it made it difficult to do things.On 12/18/25 at 10:04 AM, Certified Nurse Aide (CNA) N stated that R27's arm brace had been applied before he got into bed, and that sleeping hours included any sleep during the day. She further stated that any refusal would have been reported to the nurse and marked as refused. CNA N said that R27 had refused the brace sometimes at night and that he was alert and oriented and would call the staff if he wanted it on.On 12/18/25 at 10:08 AM, CNA M stated that R27 did not wear his brace at all during the day and that when she arrived in the morning, he was already awake and had the brace off. She further stated that if he refused the brace, she would have marked it as refused and notified the nurse.On 12/18/25 at 10:16 AM, Licensed Nurse (LN) G stated that the CNAs completed the task of applying and removing the arm brace, but the nurses documented it as completed on the TAR. She also stated that if R27 refused the brace, it should be marked as refused and noted in the chart indicating the refusal.12/18/25 at 10:17 AM, Administrative Nurse D (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated that the TAR was charted in real time and that refusals of any treatment, including braces, should be charted. Administrative Nurse D verified the CNA staff were allowed to assist with placement and removal of assistive braces, but said that any refusal was to be reported to the nurse, and it was expected that the nurse make a progress note in the chart about any refusal and provide the resident with education. Administrative Nurse D stated she expected the documentation in the resident's clinical record to be correct and accurately reflect the care provided. She said the record allowed staff to review for consistent patterns of refusal, so that the provider could be notified, and the care plan updated to reflect that the resident had potential for refusal. On 12/28/25 at 11:54 AM, R27 stated that he did not wear the brace the previous night and that the last time he wore it was the night of 12/15/25.On 12/18/25 at 11:54 AM, Consultant GG stated that R27 needed to wear the splint for an hour during the day, and that he had an alarm to remind him of when to wear it. On 12/18/25 at 11:55 AM, Consultant HH stated that R27 was able to apply the splint himself and that he had a reminder on his phone set for 09:00 AM. She further stated that he could not get the straps tight enough and required assistance. Consultant HH also stated that she had discussed with R27 that he did not always want to wear the brace or ask for help, and that was why the reminder was put in his phone, so that he was able to put the brace on himself.The facility policy Policy/Procedure-Nursing Clinical: Medication and Treatment, dated 01/2025, documented that all treatments, such as wound dressing, catheter care, urine output totals, application/removal of splint/brace/slings, etc., were to be completed on the TAR.