STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089081	A. BUILDING: _____ B. WING _____	C 01/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLEY PLACE #1	618 SW OAKLEY AVENUE TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations are the result of a survey for re-license with attached complaint conducted on 1/5/21, 1/6/21 and 1/7/21 at the above named home plus facility in Topeka, KS.	S 000		
S5105 SS=E	26-42-202 (a) Negotiated Service Agreement a) The administrator or operator of each home plus shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-42-202 (a) The census equaled 8 the sample included 3 residents. Based on reviews of facility records for residents (#106,107), the operator failed to ensure the Negotiated Service Agreement (NSA) completed for residents who required health care services, contained a description of the services the resident will receive, identification of the provider of each service and identification of each party responsible for payment if outside	S5105		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089081	A. BUILDING: _____ B. WING _____	C 01/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLEY PLACE #1	618 SW OAKLEY 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
S5105	Continued From page 1	S5105		

resources provide a service.

Findings included:

- Record review for resident #106 recorded admission date of 7/15/19 with diagnoses of glaucoma, hypertension, hypothyroidism and depression.

Functional Capacity Screen (FCS) dated 1/7/20 recorded resident unable to perform bathing, dressing, toileting, transfer, walk/mobility and management of medications and treatments, resident is incontinent of bladder. Resident has problems with cognition (long term memory, short term memory, memory recall and decision making).

Negotiated Service Agreement/ Health Care Service Plan (NSA/HCSP) dated 1/7/20 recorded staff to assist resident with bathing, dressing, toileting, transfer, walk/mobility and management of medications and treatments. Outside provider listed for physical therapy services.

Interview on 1/6/20 at 2:07pm with licensed nurse #B stated resident received hospice services with nursing services 1-2 times a week and chaplain visitations and NSA lacked a description of the services provided by this outside provider.

NSA lacked a description of the services the resident will receive from the outside provider.

- Record review for resident #107 recorded admission date of 4/19/19 with diagnoses of dementia and osteoarthritis.

Functional Capacity Screen (FCS) dated 9/17/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089081	A. BUILDING: _____ B. WING _____	C 01/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLEY PLACE #1	618 SW OAKLEY 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
S5105	Continued From page 2 recorded resident unable to perform bathing, dressing, toileting, transfers, walk/mobility and management of medications and treatments. Resident is incontinent of bladder and has problems with cognition (long term memory, short term memory, memory recall and decision making). Negotiated Service Agreement/ Health Care Service Plan (NSA/HCSP) dated 8/7/20 recorded staff to assist resident with bathing, dressing, toileting, transfers, walk/mobility and management of medications and treatments. Outside provider listed with pay source. NSA lacked description of services provided by the outside provider. Interview on 1/6/20 at 2:07pm with licensed nurse #B confirmed resident received outside provider services from a hospice provider and the HCSP lacked a description of those services. For residents #106 and 107 the operator failed to ensure the Negotiated Service Agreement (NSA) completed for residents who required health care services, contained a description of the services the resident will receive, identification of the provider of each service and identification of each party responsible for payment if outside resources provide a service.	S5105		
S5130 SS=E	26-42-202 (j) NSA Outside Resources (j) If a resident's negotiated service agreement includes the use of outside resources, the designated staff shall perform the following: (1) Provide the resident, the resident's legal representative, the case manager, and, if agreed to by the resident or resident ' s legal	S5130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089081	A. BUILDING: _____ B. WING _____	C 01/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLEY PLACE #1	618 SW OAKLEY 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
S5130	Continued From page 3	S5130		

representative, the resident ' s family, with a list of providers available to provide needed services; (2) assist the resident, if requested, in contacting outside resources for services; and

(3) monitor the services provided by outside resources and act as an advocate for the resident if services do not meet professional standards of practice.

This REQUIREMENT is not met as evidenced by:
K.A.R. 26-42-202(j)(3)

The census equaled 8 the sample included 3 residents. Based on interview and reviews of facility records for 3 of 3 sampled residents (#105,106,107), the operator failed to ensure monitoring of the services provided by outside resources.

Findings included:

- Record review for resident #105 recorded admission date of 11/20/20 with diagnoses of dementia.

Functional Capacity Screen (FCS) dated 11/10/20 recorded resident required assistance with bathing and unable to perform management of medications and treatments.

Negotiated Service Agreement/ Health Care Service Plan (NSA/HCSP) dated 11/4/20 recorded staff to assist resident with bathing and management of medications and treatments.

NSA recorded Outside provider for physical and occupational therapy services (PT/OT).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089081	A. BUILDING: _____ B. WING _____	C 01/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLEY PLACE #1	618 SW OAKLEY 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
S5130	Continued From page 4 Record lacked documentation/monitoring of outside services for PT/OT. Interview on 1/6/21 at 2:07pm with licensed nurse #B confirmed resident continued to receive outside services and OT visited resident today. She confirmed resident record lacked monitoring of the outside services. - Record review for resident #106 recorded admission date of 7/15/19 with diagnoses of glaucoma, hypertension, hypothyroidism and depression. Functional Capacity Screen (FCS) dated 1/7/20 recorded resident unable to perform bathing, dressing, toileting, transfer, walk/mobility and management of medications and treatments, resident is incontinent of bladder. Resident has problems with cognition (long term memory, short term memory, memory recall and decision making). Negotiated Service Agreement/ Health Care Service Plan (NSA/HCSP) dated 1/7/20 recorded staff to assist resident with bathing, dressing, toileting, transfer, walk/mobility and management of medications and treatments. NSA recorded resident received outside services for Hospice. Most recent hospice documentation on record was dated 12/13/19, team care plan showing admission to hospice on 7/1/19, and a log sheet recorded services for a shower on 3/12/20. Interview on 1/6/21 at 2:07pm with licensed nurse	S5130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089081	A. BUILDING: _____ B. WING _____	C 01/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLEY PLACE #1	618 SW OAKLEY 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
S5130	Continued From page 5 #B stated resident continued to receive hospice services of nursing visits 1-2 times a week and chaplain calls. Resident no longer received showers due to Covid quarantine practices in place. She confirmed record lacked monitoring of the outside services for hospice care. - Record review for resident #107 recorded admission date of 4/19/19 with diagnoses of dementia and osteoarthritis. Functional Capacity Screen (FCS) dated 9/17/20 recorded resident unable to perform bathing, dressing, toileting, transfers, walk/mobility and management of medications and treatments. Resident is incontinent of bladder and has problems with cognition (long term memory, short term memory, memory recall and decision making). Negotiated Service Agreement/ Health Care Service Plan (NSA/HCSP) dated 8/7/20 recorded staff to assist resident with bathing, dressing, toileting, transfers, walk/mobility and management of medications and treatments. NSA recorded outside services for hospice. Records contained outside agency form for admission to hospice orders on 8/3/20, and hospice plan of care dated 8/20/20. Records lacked monitoring of hospice services for the resident. Interview on 1/6/21 at 2:07pm with licensed nurse #B confirmed resident continued to receive hospice services and record lacked monitoring of the outside service provider.	S5130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089081	A. BUILDING: _____ B. WING _____	C 01/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLEY PLACE #1	618 SW OAKLEY 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
S5130	Continued From page 6 For residents #105, 106, 107, the operator failed to ensure monitoring of the services provided by outside resources.	S5130		
S5155 SS=E	26-42-204 (a) Health Care Services (a) The administrator or operator in each home plus shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-42-204(a) The facility reported a census of 8 residents. The sample included 3 residents. Based on record review, observation and interview for 2 sampled residents (#106, 107), who required health care services, the operator failed to ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. Findings included: - Record review for resident #106 recorded admission date of 7/15/19 with diagnoses of glaucoma, hypertension, hypothyroidism and depression.	S5155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089081	A. BUILDING: _____ B. WING _____	C 01/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLEY PLACE #1	618 SW OAKLEY 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
S5155	Continued From page 7 Functional Capacity Screen (FCS) dated 1/7/20 recorded resident unable to perform bathing, dressing, toileting, transfer, walk/mobility and management of medications and treatments, resident is incontinent of bladder. Resident has problems with cognition (long term memory, short term memory, memory recall and decision making). Negotiated Service Agreement/ Health Care Service Plan (NSA/HCSP) dated 1/7/20 recorded staff to assist resident with bathing, dressing, toileting, transfer with 2 staff assist, walk/mobility and management of medications and treatments. Observation on 1/5/21 at noon in the dining room revealed resident in a Broda chair at the dining table. At 1:42pm in resident's room revealed a broad chair in the room resident asleep in bed. HCSP lacked entries for resident use of a specialized Broda chair and lacked interventions for incontinence and cognition. HCSP also lacked a plan for evacuation in case of emergency when resident required 2 staff to assist with transfers. Interview on 1/6/21 at 2:07pm with licensed nurse #B confirmed HCSP lacked entries for resident use of a Broda chair, that resident is unable to toilet and is on a check and change schedule and HCSP lacked entry for scheduled incontinence care and resident is confused and cannot make her needs known and HCSP lacked entries for interventions for cognitive function. She confirmed HCSP also lacked a plan for evacuation of the resident who required assist of 2 staff to exit the building in the case of an evacuation	S5155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089081	A. BUILDING: _____ B. WING _____	C 01/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLEY PLACE #1	618 SW OAKLEY 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
S5155	Continued From page 8 - Record review for resident #107 recorded admission date of 4/19/19 with diagnoses of dementia and osteoarthritis. Functional Capacity Screen (FCS) dated 9/17/20 recorded resident unable to perform bathing, dressing, toileting, transfers, walk/mobility and management of medications and treatments. Resident is incontinent of bladder and has problems with cognition (long term memory, short term memory, memory recall and decision making). Negotiated Service Agreement/ Health Care Service Plan (NSA/HCSP) dated 8/7/20 recorded staff to assist resident with bathing, dressing, toileting, transfers with assist of 2, walk/mobility and management of medications and treatments. Observation on 1/5/21 at 11:45am in resident's room revealed resident in bed with an air mattress with bolsters and a wheelchair with pressure reduction cushion. HCSP lacked entries for resident use of an air mattress with bolsters and a pressure reduction wheelchair cushion. HCSP lacked entries for interventions for cognition problems and a plan for toileting/incontinence care and evacuation plan. Interview on 1/6/21 at 2:07pm with licensed nurse #B confirmed HCSP lacked entries for resident use of an air mattress with bolsters and pressure reduction wheelchair cushion. She confirmed HCSP lacked entries for a plan for incontinence care and cognition issues stating staff follows a check and change plan and confirmed resident does not understand instructions. She confirmed	S5155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089081	A. BUILDING: _____ B. WING _____	C 01/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLEY PLACE #1	618 SW OAKLEY 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
S5155	Continued From page 9 HCSP also lacked a plan for evacuation of the resident who required assist of 2 staff to exit the building in the case of an evacuation. For resident #106 and 107 the operator failed to ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement.	S5155		
S5215 SS=F	26-42-104 (d) Disaster and Emergency Preparedness Education (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the home ' s emergency management plan; (2) education of each resident upon admission to the home regarding emergency procedures; (3) quarterly review of the home ' s emergency management plan with employees and residents; and (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. This REQUIREMENT is not met as evidenced by: KAR26-42-104 (d) (3) The census equaled 8 residents. Based on interviews and review of records, for all residents,	S5215		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089081	A. BUILDING: _____ B. WING _____	C 01/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLEY PLACE #1	618 SW OAKLEY 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
S5215	Continued From page 10 the operator failed to ensure disaster and emergency preparedness when the operator failed to ensure quarterly reviews of the facility's emergency management plan with residents. Findings included: - Review of the facility's disaster and emergency management plan on 1/5/21 at 12:30pm recorded reviews of the plan monthly with staff and evacuation drills every 2 months with staff and residents. Records lacked documentation of reviews of the emergency management plan with facility residents. Interview on 1/5/21 at 12:40pm with licensed nurse #B confirmed records lacked documentation of quarterly resident reviews of the emergency management plan. For all residents the operator failed to ensure disaster and emergency preparedness when the operator failed to ensure quarterly reviews of the facility's emergency management plan with residents.	S5215		
S5300 SS=D	26-42-205 (d) (1-2) Facility Administration of Medications (d) Home administration of resident ' s medications. If a home is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care	S5300		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089081	A. BUILDING: _____ B. WING _____	C 01/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLEY PLACE #1	618 SW OAKLEY 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
S5300	Continued From page 11 provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the home has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(d) The facility reported a census of 8 residents. The sample included 3 residents. Based on record review and interview for 1 resident (#105), the operator failed to ensure all medications and treatments were administered in accordance with a medical care provider's written order and professional standards of practice. Findings included: - Record review for resident #105 recorded admission date of 11/20/20 with diagnoses of dementia. Functional Capacity Screen (FCS) dated 11/10/20 recorded resident required assistance with bathing and unable to perform management of medications and treatments. Negotiated Service Agreement/ Health Care Service Plan (NSA/HCSP) dated 11/4/20	S5300		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089081	A. BUILDING: _____ B. WING _____	C 01/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLEY PLACE #1	618 SW OAKLEY 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
S5300	Continued From page 12 recorded staff to assist resident with bathing and management of medications and treatments. January 2021 medication administration record recorded the following as needed (PRN) pain medications administered by certified medication aides (CMAs) 11 times between 1/1/21 and 1/5/21. Tramadol (narcotic for pain) 50mg (milligrams) administered by CMAs 4 times. Bayer Back and Body (pain) 2 tablets administered by CMAs 2 times. Tylenol/acetaminophen (pain) 650mg administered by CMAs 5 times. Record lacked documentation of consultation with a licensed nurse prior to administration of PRN medications to the resident for this nursing task. Interview on 1/6/21 at 1:55pm confirmed record lacked documentation of nurse consultation stating facility policy allows for administration of PRN medications by a CMA if the resident can say where the pain is. For resident #105 the operator failed to ensure all medications and treatments were administered in accordance with a medical care provider's written order and professional standards of practice.	S5300		